

# ***Coming to Realisation***

By

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requirements for the degree

of

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## **Declaration.**

**I certify that this thesis contains no material which has been submitted for any other degree in any tertiary institution.**

**Any material previously published or help received in the preparation of this thesis have all been acknowledged in the body of the work.**

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## Authority to Access.

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# Abstract

Grounded theory research methodology has been used to explore the midwife's understanding and beliefs of the woman's pain of labour. A group of seven midwives working in a rural hospital participated in this study. The participants had all practiced midwifery in the rural setting for more than two years.

When working in this rural hospital midwives are also required to work as general nurses providing care for the sick and aged. As the birthing population of the rural setting is falling so is the opportunity for midwives to practise their craft. Thus they are practising predominately as registered nurses. However there exists an anomaly for them in managing pain relief. Contemporary midwifery allows the well woman to experience some or all her pain of labour while the sick patient has his pain relieved as soon as possible.

Data from the participants' interviews was analysed using constant comparative analysis. The core variable *coming to realisation* and five concepts hearing, seeing, knowing, birthing and midwife believing and their associated sub-concepts were identified. With time and confidence the midwives in their practice environment have applied they apply these aspects of learning to other labouring women thus complimenting complementing their formal education.

This research study identified areas of experiential learning that occur and develop the practice of the midwives. It was also discovered there exists for each midwife a paradox of realisation. This occurs when the expected outcome is not anticipated. This element has the ability to undermine the confidence of the midwife in her experiential knowledge.

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# Dedication

to an unborn child with love

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# Chapter 1

## Introducing the study

### Introduction

Women living in rural communities in Tasmania often have to travel long distances to give birth in regional hospitals. However, in some rural areas, where a general practitioner has obstetric qualifications women may choose to remain and have their babies. The terms of employment in these hospitals encourage registered general nurses to also practise midwifery. This creates a dichotomy for these midwives between the practice philosophies of nursing and midwifery. The registered nurse endeavours to alleviate the pain of the sick patient while the midwife supports the healthy labouring woman helping her to cope with her pain with little or no pharmacological analgesia.

Much has been written and explored in midwifery and obstetrics that pertains to the needs of the woman, technology and medical intervention. However there exists a deficit in research which relates to the midwife, how she performs within her profession, how she reflects on her practice and how she defines the influences on her practice (Hicks, 1991; Seibold et al.1999). The aspect of research chosen for this study is the midwives' understanding and beliefs of the woman's pain of labour.

### Research Task

The study has been designed to generate a theory which encapsulates the social process of determining midwife's beliefs and understanding of the woman's pain of labour when birth takes place in a rural hospital. Data collected from unstructured interviews with seven midwives working in one rural hospital in Tasmania was analysed using the qualitative method of constant comparative analysis. The

midwives have varied backgrounds, some having practiced in large regional hospitals before coming to the rural hospital while others have predominately practised in the rural setting. All the midwives were prepared for practice in hospital-based educational programmes. The participants were experienced midwives having been licensed for approximately 20 years. An average licensure of 20 years, however, does not take into account the midwives career having been interrupted by family commitments and other career practice although during these times the midwives' maintained their licence to practice. Therefore it is difficult to reveal an accurate estimate of the duration of the midwives' professional careers.

In the rural hospital midwifery becomes an adjunct to the total of health care services provided. The midwife's predominate practice is as a general nurse caring for ill patients. Also a change to the community demography is impacting on midwife's practice. Each year there are less women birthing in the rural hospital due to the falling birth rate within the local community. In 1990, ninety-seven women birthed at the hospital where the research was conducted while the number in 2003 was twenty-seven. These figures reflect the trend across the state of Tasmania where the crude birth rate fell from 27.1 per 1,000 in 1947 to 12.1 per 1,000 in 2000 (Austats, 2002).

## Research Question.

What are the midwife's understanding and beliefs of the woman's pain of labour ?

## Organisation of the Thesis.

This study is presented in 5 chapters. Chapter 1 has introduced the research topic. The literature review presented in Chapter 2 describes the historical development of midwifery practice, the contemporary midwives role, midwifery models of practice and the rural hospital environment.

Chapter 3 introduces Grounded Theory the qualitative research method used to

undertake the research. A description of Grounded Theory and symbolic interactionism which underpins Grounded Theory is included. This chapter also provides an overview of the research design, data collection, data analysis, ethical considerations, establishing trustworthiness and the study's limitations.

The findings of the study are presented in chapter 4. The conceptual model which best represents the theory is identified and described. The conceptual model includes the core variable and 5 concepts with their associated sub-concepts. Each concept and sub-concept is defined and supported with extracts from the collected data.

Chapter 5 discusses the conclusions drawn from the study. It describes the implications for midwifery practice and further research.

## Background to Study.

The study has been carried out as part of the requirements for the Master of Nursing program at the University of Tasmania. I am a registered nurse and a midwife. I have been employed in both of these capacities for the last 15 years at the rural hospital in which the research was undertaken. Before undertaking this study I believed that knowledge of how midwives practice was limited. Thus I decided to examine an aspect of midwifery practice in a rural hospital.

The study explored how midwives working in this rural hospital developed their understanding and beliefs of the woman's labour pain. The midwife provides support, encouragement and available resources to the woman during childbirth (Guilliland and Pairman, 1995). Thomas (1998) comments that the pain of labour is an acceptable experience for the birthing woman. However, debate continues throughout midwifery communities as to the need and benefit of the pain experience (Wagner, 1997).

## Value of the study.

The study is valuable because it explored an area of practice that has not been largely investigated in research, Hicks (1991, p.13) comments “midwives produce significantly fewer research articles than nurses. This pattern is confirmed in the literature search of nursing and midwifery....”. Midwives themselves have been overlooked when explanation of midwifery or obstetric practice has been researched. The study while small has interpreted phenomena within the setting and while this is not generalisable it does encourage further research into midwifery practice. The study has both a professional and social value as the midwife empowers the woman to seek and meet her needs. Studies reveal that women who acknowledge support from the midwife have felt more positive about their birth experience (Tarkka, 1996). Midwives practising the art of midwifery deserve to have their practice explored and validated. Within the midwifery practice domain there exists a silence of description of the midwife profession and the midwife persona (Hunter, 2001). This study explores one area of midwifery practice.

## Assumptions underpinning the study.

Over several years I have observed midwives in the rural hospital. I believe that within their own practice they applied knowledge, that was personally and contextually acquired, to their practice. They had gained this contextualised knowledge from their interaction with birthing women and their colleagues. The midwives maintained personal identity in their midwifery beliefs nurturing and developing them in the less restrictive practice environment of the rural hospital. Louise Silverman (cited in Duffin, 2001) believes one of the most important factors a midwife can offer a woman is that of building confidence, to be able to allay fear and provide significant support during pregnancy and childbirth. Sarah Stone (cited in Duffin, 2001) proposes that much of the dissatisfaction of midwifery care from the women’s perspective is incorporated within the fear that midwives have of potential litigation. Kirkham (1999) states that midwifery practice is being coerced not to step too far a field from the medical and general nursing boundaries. For midwives

endeavouring to enhance the experience for women and their families much of the struggle includes ethical and moral issues. Thus it is significant to explore how these midwives in the rural hospital function with an individuality that reflects their contextual situation and their limited interaction with midwives in other midwifery practice domains.

## Summary.

The topic chosen for the study is a poorly researched area of midwifery practice. There is little discussion in the literature that pertains specifically to the midwife. The research that exists has come from reflecting women's needs and experiences of midwifery and obstetric care (Hunter, 2001.) As a midwife working in a rural hospital and observing my colleague's midwifery practice over several years I decided to investigate their understanding and beliefs of the woman's pain in labour. In chapter 1 the thesis topic has been introduced and the research method has been identified. The remaining chapters include the literature review, an explanation of the research method, a discussion of the research findings and a conclusion which describes the implications of the findings for midwifery practice and research.

## Chapter 2.

# Literature Review.

## Introduction.

In this chapter, literature which provides a descriptive background to the research topic will be reviewed. Literature related to the substantive area of the study is reported during theory generation (Glaser, 1992). This process is part of the grounded theory method and according to Glaser (1992) prevents the researcher from becoming biased. Denzin and Lincoln (2000) note that the purpose of delaying the literature review is to encourage the researcher's analytic process. A historical overview of midwifery practice from its earliest beginning to the present day, midwifery models of care and the rural hospital environment are all described as a means of establishing a context for the study.

## Midwifery Practice: Historical Perspectives.

The English meaning of midwife is "with woman" while translated from the French the meaning of midwife, "sage – femme" is a wise woman (Sullivan, 2002; Hunter, 2001), and the art of midwifery has been the business of women throughout history. These definitions direct the way in which midwives work, the underpinning philosophy of their practice and their intuitive actions with women and other health professionals.

Through the centuries women in midwifery have been received with mixed emotions sometimes recognised as heroines sometimes to be feared as witches. Midwives were recognised and their practice recorded in the bible. In the book of Genesis 35:17 the midwife is mentioned helping Rachel to birth her son; also the woman Tamar who gave birth to twins. One twin allegedly the first put out his hand and the midwife put a red cord around the wrist, the hand was withdrawn and consequently this baby

became the second twin to be born (Sweet, 1997). Midwives were considered to be magical and with mystique they performed the care role for women in labour.

The midwife of biblical times,

*"----- was sometimes revered, sometimes feared sometimes acknowledged as a leader of society, sometimes tortured and killed. The midwife had knowledge and skill in an area of life that was a mystery to most people. Since women had no access to formal education it was assumed that the midwife's power came from supernatural sources, such as an alliance with the devil". (Ulrich, 2003, p.1).*

During the 5<sup>th</sup> to 13<sup>th</sup> century the Church was charged with imposing strict regulation on the practice of medicine. The 13<sup>th</sup> century is remembered as the beginning of the witch-hunts, which focused on the eradication of women healers many of whom were also midwives. This societal activity continued until the 17<sup>th</sup> century (Ehrenreich and English, 1973). From the 13<sup>th</sup> century barber surgeon guilds began to establish themselves. These groups of men saw an opportunity to undertake a profitable vocation in medicine including obstetrics. Although they did not invent forceps as we know them they introduced intervention. Forceps became part of midwifery in the 17<sup>th</sup> century (Ehrenreich and English, 1973). The 17<sup>th</sup> century is recognised as the time of regulatory control of midwifery practice, "man midwives" established themselves, with practice becoming the privilege of the physician (Bogossian, 1998, p.24).

By 1902 in England, midwives were controlled by the Midwives Act. This caused the encapsulation of midwifery practice to that of an occupation controlled by medicine. Midwives were from this time subservient to medicine and medical technology. Their reliance and practice of mystical knowledge was deemed unlawful.

## Midwifery Practice: Following White Settlement in Australia.

Midwives during early settlement of Australia were predominately for convict women



who had often been brutalised during their transportation to this country. While male convicts were considered lesser beings, the women were thought to be even lesser characters (Adcock et al. 1984). The government of the day determined that a woman's worth was measured by her childbearing capabilities (Adcock et al. 1984). In these early years of colonial development midwifery practice occurred in hospital tents "erected on the west side of Sydney Cove, and the first colonial hospital was established by 29 January 1788" (Adcock et al. 1984, p.22). It transferred to George Street North, in April 1788 to be known as "General Hospital", the first hospital of the settlement (Adcock et al 1984, p.22).

Female factories also provided midwifery services for many convict women who were usually attended by one of their own. In time, some of these convict women came to be midwives for the free settler women in the town of Sydney and surrounding region (Adcock et al. 1984; Wright, 1991). Doctor-surgeons attended women of worth at confinement with or without the assistance of a midwife. Midwives attended the women of lower socio-economic groups.

The first notion of a maternity care unit in the new colony was developed in the "Female Factory at Parramatta" (Adcock, 1984, p.26). Societal groups for example, The Benevolent Society of New South Wales and in Tasmania the Young Women's Christian Association who were to be known as the Amateur Nursing Band, became involved in the provision of midwifery care, and in time gained substantial control of midwifery practice (Adcock et al. 1984; Bogossian, 1998; Wright, 1991; AusStats, 1985). In New South Wales a service known as "The Ladies Monthly Nurse" began, these midwives provided care to the woman and her family in the home for one month when the birth of the baby was expected, one week prior to confinement and for three weeks post confinement (Adcock, 1984, p.30).

By 1806 there is evidence that two - three midwives were employed in the colonial settlement. In 1838, midwife attendance had extended to many women, who were confined without the attendance of a doctor (Adcock, 1984). It is believed that "by 1850 it was unlikely that formal training in midwifery existed" (Adcock et al. 1984, p.28). During the mid 1850's - 1860's Adcock (1984) describes the activities of

and there is evidence to say they were successful, as they were listed ten years later to be providing care.

By the mid 19<sup>th</sup> century the training of midwives became the expected practice and was structured on the British model. Formal training of midwives was occurring by the early 1900's, and these hospital-trained midwives were replacing many untrained women leading to the demise of the colonial community midwifery practice. By 1907 there were at least four training schools in New South Wales (Wright, 1991).

## Early Midwifery Practice in Tasmania.

The attitude that convict women were “worthless workers” and should be “appropriately married off to their class” also existed in Tasmania. In September 1827 the “Female Factory” of Hobart Town was noted to have “7 nursing children and 2 lying-in women” (Fawcett, 2000, pp. 5-6).

Towards the end of the 19<sup>th</sup> century in North East Tasmania (the setting of the current study), unskilled midwives cared for women giving birth. The doctor was not expected to attend unless there was a complication (Beswick, 2003). Cottage hospitals existed throughout the district but generally birth was conducted at home within the family and supported by a midwife (Beswick, 2003). Oral histories of Doherty, (1998) and Mather, (2000) describe the midwives of the late 19<sup>th</sup> century as unqualified but capable women who attended homebirths and helped the family during the mother's lying-in period.

In 1901 a Midwives Act was introduced but this act was not implemented until June 1902 (Wilson, 1988). The Registrar of Midwives commenced in 1902, (Bogossian, 1998). This act changed the practice of midwifery for some. Laws were imposed that clarified who could be a midwife and how and where they would practice. With licensing came a control that midwives had previously not experienced. At this time most midwives worked privately and gained clients by advertising. Generally midwives registered a room of their home from where they practised. Records in Tasmania suggest that registering a room was the initial establishment of the lying-in

hospital (Wilson, 1988). This enabled Tasmania's lay midwives to continue in practice thus often avoiding certification of their midwifery status. The Midwives Act of 1911 was an endeavour to tighten up the conditions for registration, with a minimum age of 23 years and it raised penalties for non-compliance to the act. This had little impact on the midwifery work that was happening especially in the country areas. The Nurses Registration Act 1927 replaced the Midwives Act but still allowed suitably certificated midwives to practise from a room within their own home. This was seen to change as communities built local hospitals and people gained greater access to vehicular transport (Kelly, 1977).

By 1918 in Tasmania Wilson (1988, p.123), suggests "of 638 midwives on the Tasmanian register only 259 had gained certificates enabling them to practice under Tasmanian legislation". In 1927 a Nurses Registration Act was legislated which is understood to have included midwifery practice as a specialist area of nursing practice. Even though a requirement was made for midwives to be certified as early as 1901 it took some years for the practice of midwifery by lay midwives in the community to be fully excised.

## Midwifery Practice in the Twentieth Century.

Australia became a federated country in which the states desired self-administration although maintaining strong links to the mother country, England were maintained. The provision of midwifery care was taken over by the physicians. Many in the early colony days had accepted nursing and midwifery care from their peers but as the colony progressed toward greater wealth there was a desire for provision of professional services (Wright, 1991). Nursing had become the support of medicine and midwives were being educated within this doctrine. A need to control practice was seen by both physicians and nurses as desirable as they viewed midwifery as an extension of their health care role. Thus nurses progressed the regulation of nursing and within this, included midwifery. The Nurses Act's that were established around Australia controlled both nursing and midwifery under the title of nursing.

In Australia midwifery training has traditionally been in the hospital as a specialist qualification. Training was based on apprentice model. The 1970's saw a dynamic shift to the university for nursing education. Reports completed by DEST 2001 and 2002, such as the National Review of Nursing Education cited the earlier Dawkins report as having provided information and planning strategies. These reports impact on how nurses were educated. Thus in the 1970's following the Dawkins Report it was perceived appropriate to change nursing education to the tertiary system. At this time tertiary education was being provided in what was known as Advanced Education Colleges and the Universities. There was a consistent separation around Australia of teaching and nursing from law, medicine and other professions. The DEST National Review of Nursing Education Report, (2002) highlighted a need for the education of nurses, midwives and others to have a national strategy to contemporise nursing education and support the shift and expansion of studies in the university communities.

Nursing was considered a professional discipline that required academic focus for education that was not provided by the apprentice style vocational training. The Commonwealth government sought information on the education of the nurse. The term nurse included general and specialist nurse roles. The education of nurses on the university campus followed a similar profile to other academic schools. Once the undergraduate nursing programmes were soundly established the specialist nurse areas including midwifery drifted to the university campuses and were offered to nurses and others as a variety of post-graduate and in the case of some universities under graduate programs (DEST, Nursing Education and Practice Today Report, 2002).

Across Australia midwifery programmes vary in curricula, content and cost. Some Australian states provide several pathways to achieve education to be licensed as a midwife. They can include Graduate Diploma of Midwifery, Bachelor of Midwifery, and Double Degree in Nursing / Midwifery. Today a variety of programmes exist that include men or women who may or may not have previously completed general nursing education. In the past Australia had been dramatically out of step with many other countries who recognised midwifery as a discipline not

, 2001). Midwifery is becoming recognised as a stand-alone profession. However in Tasmania currently there exists only one pathway to education as a midwife. The University of Tasmania offers a Graduate Diploma of Midwifery. The last training for midwives in a Tasmanian hospital closed in August 1997 at the Royal Hobart Hospital.

Efforts by the professional organisation for midwives the Australian College of Midwives Incorporated, (ACMI), have endeavoured to establish national standards for midwifery education. Currently ACMI have no authority to approve curriculum. This remains responsibility of the nursing/midwifery board of each state and territory.

Both nursing and midwifery have become available professions for men and women. It is difficult to define a specific time when men were admitted to midwifery education in Australia but Sweet, (1997) describes the uninhibited admission of men to midwifery education in Britain, following the advent of anti-discrimination legislation. Hicks, (1991, p.13) states men have found a significant role in nursing with a suggested "occupancy of 10% of the nursing population but midwifery has a male occupancy of 0.1%".

## Contemporary Midwifery Practice.

### The Role of the Midwife.

The World Health Organisation, WHO (1992, appendix 4) definition of a midwife is:

"----- a person who, having been regularly admitted to an educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and /or legally licences to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help

She has an important task in health counselling and education, not only for women, but also within the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practise in hospitals, clinics, health units, domiciliary conditions or any other service". This definition was recognised by the International Confederation of Midwives in 1972 and amended in 1990. The definition describes a midwife with a broad role of care for the woman and family. Historically the midwife was the friend of the woman who then became the obstetric handmaiden of the consultant obstetrician (Kirkham, 1999). In recent years there has been a paradigm shift in care principles resulting in a return to the midwife being with the woman, her support and advocate.

The WHO (1997) describe care of the woman in birthing that reflects the individual woman's needs through evidence based practice and informed consent. There exists an inference that in some settings intervention is liberal, not offering the woman the opportunity to birth with minimal medicalisation, (Leap, 1994; Wagner, 1997;). Banks suggests that labour is not "normal or abnormal" but a "journey of childbirth" (Banks, n.d. p.1).

WHO (1994) states that world wide 15% of women will require intervention and high-level obstetric care. The issue is enabling midwifery support to be available to this group of women as part of the continuum of their pregnancy and birth experience (WHO, 1997). Midwifery care offered to women in today's western culture reflects the ideology of the midwife being with woman. The relationship between the midwife and the woman is developed to support the woman physically, psychologically and emotionally (Hunter, 2002). It is believed there is value in this type of relationship for the woman and also the midwife. The expectation is that the midwife will be the guiding expert and lead the woman and her partner with confidence to being parents. This style of practice is a reflection of a woman-centred care model, "Regardless of the type of midwife or birth setting, all midwifery practice philosophies reflect the concept of being with woman during childbirth" (Hunter, 2002, p.651). A feature of the literature was the paradigm shift, an evolution of the role of the midwife from lay

person to doctor's handmaiden to autonomous practitioner.

Today the relationship role between the midwife and the woman is significant. The relationship appears as the foundation of the midwife role. There are many aspects to the development of a relationship. At times these relationships are not clearly defined. When the midwife is able to provide continuous and supportive care during birthing Guilliland and Pairman (1995) suggest that the mother often expresses a greater sentiment of fulfilment and knowledge of her birthing experience. Seibold et al. (1999, p.23) describe the midwife as "acting as head coach" or allowing the woman "to act out". Leap, (1994, p.9) refers to the midwife as the "skilled companion" while Bluff and Holloway, (1994) in their study found women expressed comfort and confidence from being guided during the birth process. The skills of the midwife permit the woman to feel empowered and able to direct her birth. When the woman is seemingly out of control the midwife uses soothing and confident care to reassure and guide the woman toward meeting her goals of birthing, (Seibold et al.1999). It is difficult to call this an equal relationship. It is definitely a valid, respectful, professional and friendship styled relationship but the balance of power does not appear equal. The power at times would be with the woman and at others with the midwife.

Within the relationship, is the midwife's ability to listen and hear what the woman is asking or stating. Stapleton et al. (2002) have challenged midwives to reflect on how they exchange information with women. They expressed that often when time is restricted "women receive information by leaflet..." which gave "the perception women held of midwives as being busy people" thus inhibiting the woman's comfort to pursue with the midwife issues of concern and relationship building (Stapleton et al. 2002, p.395). The dilemma for midwives and women is understanding what each wants and how achievable this is.

McCrea et al. (1998) discuss the midwife's role with the intent that an equal relationship is achieved. They infer that women and midwives will be equally fulfilled by their interpersonal exchange. The implication is that the midwife is the warm professional. With the woman she plans and implements the necessary care. This

exchange fails to acknowledge the intrinsic and extrinsic factors that require the midwife to be a skilful guide who “supports and assists with her presence as she engages with the clients in a one-to-one interaction” (Hunter, 2002, p.651). Women have been noted to have expectations of the role of the midwife that include the principle of working together.

*“----me doing the work and going through the agony, I felt that it was the three of us working together that achieved the birth. Its such a strange relationship with a midwife, as you speak through intense pain, when you are on another planet and not at all 'normal', especially in this case when there wasn't any time. Someone could really annoy you through either being too weak or too overbearing. Sarah was perfect for us. We didn't need to be fussed over but we didn't want to be left on our own either. She took control but respected our characters” (Clarke, 2000 p.17).*

Leap (1994) also describes the midwife's role as being with.

However this description fails to describe many of the midwife's activities. Thomson, (2000, p. 418) in her discussion of medicalisation in midwifery describes midwife's work as “spending time--, an emphasis on counselling; establishment of trust; emotional support; and empowerment of women”. An emphasis exists on the relationship that is formed. The descriptors outline the criteria as more than a physical/clinical completion of tasks but the inclusion, development and continuum of emotional and social support for the pregnant woman (Hunter, 2002). Kennedy (cited in Hunter, 2002, p. 652) discusses these concepts as “three dimensions of midwifery-therapeutics, caring and the profession. Maintaining a supportive presence and staying with the woman in labour as she desires, with adequate time to meet the woman's needs”. Some midwives described a notion of “supporting normalcy, being present and not interfering unless necessary”(Hunter, 2002, p.652). Thus there is evidence of the predominant themes of midwifery practice being trust and relationship between women and midwives. Historically, before licensure and formal education midwives were the women in the community who had a gift for caring for women who were



birthing. Often they had children of their own or had been apprenticed to the role by an older midwife in the community village. The midwife's role was to provide care, support for the woman through her knowledge of effective birth care.

The actual equality of power in the relationship would appear to be a theoretical appraisal rather than a clinical one. Fleming, (1997) in her study of midwives in private practice in New Zealand comments on the equality of relationship, she believes is an ideal and not a reality. Women are considered to be the designer of the relationship. In some situations there is little consultation with the midwife although she is expected to meet all the woman's needs. Fleming, (1998) comments that her study revealed that women and midwives had different perceptions of the relationship that were not always complimentary. Her discussion highlights the notion, that midwives felt they were abused or there was potential for abuse by their women clients at times. There exists an expected sacrifice by midwives who empower the woman. While the trust and friendship are established with the woman, the care expectations challenge the midwife (Guilliland, 1999; Kirkham and Stapleton, 2000). The relationship of women and midwives is not always one of a reciprocated equality. From the feminist perspective midwives have remained a subservient population (Kirkham, 1999; Hunter, 2001). While women have found a voice, it appears that midwives remain doing care for others while neglecting their own needs (Hunter, 2001).

Hunter, (2001) also describes midwives experiencing an invisible festering of discontent as they struggle to meet the expectations of models of care. Issues include a significant feeling of powerlessness. In response, midwives are noted as using subtle behind the scene tactics to improve their situation. From this interpretation it suggests that initially the woman and midwife have negotiated a care plan based on a model of care that is woman-centred. The power of the relationship is fluid. When designing the birth plan the woman sets her goals. At any point the relationship power can change, as it is dependent on the activities of the woman. Fleming (1998) highlighted issues that included the women's demands on the midwives during the antenatal period. Scheduled visiting time was non-negotiable from the woman's point of view.

There was an expectation that the midwife would conform. Midwives were shown as putting emphasis on the relationship building, while the woman's focus was far less concerned with this aspect.

*“ Midwives were seen to be the ‘medical half’ of the relationship. Yet it’s with the aim of moving away from the medicalization that midwives advertise their services”  
(Fleming 1998, p.10).*

Further adverse reporting of the relationship occurs in the commentary of Kirkham and Stapleton (2000.) This paper contemplates the notion that while women have achieved a considerable degree of choice and empowerment, in being the vehicle to assist, the midwife has actually made her role more subservient. There has been a lack of change in the structures and systems that provide midwifery care. The lack of change to funding has had an impact on the power of the midwife role. Midwives are cited as feeling more stress in the provision of continuous care with limited staffing resources, in addition to lack of support from peers and supervisors. An ethnographic study by Kirkham (1999) explored the increasing sacrifice that midwives expressed they were now making to enable the woman to fully benefit from woman-centred care.

In contemporary midwifery practice it appears that the relationship between women and midwives is far from the ideal but is central to the practice of midwifery. The rules of the relationship are those negotiated within the agreed boundaries between the woman and midwife (Guilliland,1999). The midwife's role is unique within the health system as she works with the well woman providing physical, psychological, emotional and social support while maintaining the relationship, and guiding without being intrusive while being with the woman (Leap, 1994).

## Midwifery Models of Care.

Within Australia various midwifery models of care are used. Some are determined by the policy of the institution and guided by the leading obstetrician on staff (Wagner,

1997). Contemporary midwifery models include the partnership model, the shared care model of care, team midwifery, independent midwifery practice and the obstetric model.

Historically the medical profession controlled the process of pregnancy, labour, delivery and the puerperium. However in the 1970's some childbearing women began to seek choices for their pregnancies, births and after care. The women were supported by a growing movement of midwives who have worked towards re-establishing the art of midwifery care. This has led to the development of a variety of models of care and has encouraged midwifery practice to be less prescriptive. Women have been invited and encouraged to participate in decisions the planning of their labour and birth. The most remarkable shift in birthing is the shift to a practice model that is woman-centred (Leap, 1994; Guilliland and Pairman, 1995; Guilliland,1999;). Within this context models of care have developed that maintain the focus on the woman's needs.

### The partnership model.

The interpretation of this model is a relationship between the woman and the midwife to work as co-equals. The expectation is a holistic approach to care that reflects respect and friendship while maintaining a professional role. This is a model of care that is predominately used in the homebirth setting. The midwife is perceived as negotiating and contracting her services to the woman for the appropriate remuneration. The woman receives skilled professional care from a midwife whom she has been able to befriend during antenatal, birth and postnatal periods. A significant feature of home birth is the midwife is an invited guest. This is not so in most other settings where the woman is in an unfamiliar environment (McCrea et al. 1998.)

It is suggested that the midwife shares a professional role and a friendship with the woman. This approach reflects the midwife's personal and professional qualities. The partnership enhances the woman's self-knowledge, personal attributes (physically and psychologically) through the childbirth journey. The partnership model is founded on

the premise of an equal relationship being established between the woman and the midwife. There is a significant focus on developing and maintaining the status of equality and power sharing within the relationship (Guilliland and Pairman, 1995).

### Shared Model of Care.

The shared care midwifery model has several variations. In seeking a common definition of shared care I have used the Victorian Government information on birthing alternatives (Victorian Government Health Information Service, 2003). The underlying premise of shared care is that a woman receives care from several collaborative health professionals in relation to childbearing. The shared care model is a broad concept and evolved from a shift in the traditional obstetric model of care. Sweet, (1997) describes shared care as the collaborative care between the midwife and doctor provided to childbearing women.

Because of its broad criteria, shared care is practised in various settings. Within the shared care menu is the concept of choosing a main care provider who is supported by another who has a less significant role in the process. In some settings there may be a number of providers involved in the delivery of care to the one woman. Shared care models include combinations of G.P. and Obstetrician, G.P. and midwife, Community Midwife, Obstetrician and Midwife and occasionally a private midwife may be included in the equation. Most models of shared care are government funded under the Medicare scheme. The private midwife cannot be paid by Medicare funding, her costs would be met by the woman (Victorian Government Health Information Service, 2003.)

### Team Midwifery.

In team midwifery the midwife is a primary care provider for a number of women and is supported by a second midwife. This model of care supports the midwife in maintaining her role and not being subjected to early burnout. The sharing of clients with other midwives can provide a long-term service to a community or region.

Referral or sharing with a doctor may be part of the model but generally for the low risk mother the care provision is by midwives only. The setting for team midwifery practice is usually the hospital or birth centre. There are some variations where antenatal visits are completed in the home or the community. Team midwifery within the hospital provides an alternative for women who wish to have midwifery care.

The aim of team midwifery is to develop and sustain the continuity of midwifery care to women (Victorian Government Health Information Service, 2003). Women in the team programme visit a doctor usually two to three times in the antenatal period. Team midwifery thus incorporates within its concept some of the elements of shared care. The practice of team midwifery occurs in major Tasmanian regional hospitals (Carroll, 2002). The first evaluation of team midwifery was completed in the United Kingdom in 1989 by Flint et al. cited in National Health Research and Medical Council Report, (1998, p.22). While “no significant maternal or neonatal outcomes were found the concept of continuity of care provided women greater satisfaction and less intervention”.

### Caseload Midwifery.

Caseload midwifery also known as know your midwife scheme is practised in Tasmania. It is sporadic and reliant on the model of care of the particular institution (Carroll, 2002). The premise of this model is the development of a relationship between a particular midwife and the woman. Other midwives may meet the woman two or three times during her antenatal period but will have a secondary role to play at the time of birth. The expectation is that the primary midwife will be available to the woman when she requires her assistance (Victorian Government Health Information Service, 2003). In this model each midwife carries a caseload of four to five women for the month. The midwife is allocated the woman’s care and endeavours to provide a continuing role through antenatal, birth, and the postnatal periods.

## Independent midwifery practice.

Independent midwives offer a service to childbearing women who wish to experience natural childbirth in their own homes or birth centres. Midwives practising within the description of other midwifery models are protected by their employer vicarious liability insurance. The independent practice midwife is alone and currently in Australia her access to professional indemnity is non-existent due to the exorbitant costs of insurance premiums. However she is not unregulated with each state nursing or nursing/midwifery act commenting on independent practice (Bogossian, 1998). The woman who employs the independent midwife negotiates the elements of the pregnancy and birth plan with the midwife and accepts her practice. There is no government funding to support the woman to pay this midwife.

Independent midwives perceive a need in the community for their practice, from women who desire a natural birth experience without the influence of the medical model. With a philosophy of holistic care midwives have often provided their service at great cost to themselves (Enkin et al. 2000). Many work part time in other settings to be able to continue to practise independently. The service unfortunately remains elitist from a socio economic view. Many women would be unaware of such a service, as the media does not broadly advertise it. Regulation within a country defines the amount of activity such a model of care is able to provide (Guilliland and Pairman, 1995).

## The Obstetric model.

In this model, care is typically managed and directed by the obstetricians and midwives would follow the doctor's orders. This is the model of care that has been challenged by many midwives. Leap (1994) in her discourse challenges midwives to recognise dependence on medicalisation and not become obstetric servants. It is argued that the obstetric model is not appropriate care for well women (Banks, n.d; Davis, 1994; Leap, 1994; Homer et al. 2001; National Maternity Action Plan, 2002). In Australia there is a consistently high rate of medical intervention and the obstetric model remains predominately the considered safe option for the majority of the

community (National Maternity Action Plan, 2002).

The obstetric model has a well-defined history of development. It eventuated from the outlawing of the unlegislated art of midwifery (Bogossian, 1998). This was not only a local Australian issue but also a global affront on midwifery practice (Ehrenreich and English, 1973). In Britain in 1567 a midwife was licensed but in later years physicians and surgeons successfully removed the privileges of midwives, and took over the practice of midwifery and duly called it obstetrics (Ridgway, 2002). The Midwives Act was introduced in both Britain and Tasmania in 1902. This meant that parliament and medicine had control of midwifery practice (Stevens, 2002).

Models of practice have appeared in many settings advocating midwife led and woman centeredness. In recent years there has been discussion and at times criticism of models of care (Leap, 1994; Guilliland and Pairman, 1995; Wagner, 1997; Homer et al. 2001). Benjamin, Walsh and Taub, (2001) completed a study comparing team and caseload midwifery with their findings supporting a caseload model. They asserted that there was less medical intervention with caseload than with team midwifery. Review of models by Carroll in Tasmania states "Team midwifery is like a vocation – so is caseload. It is not sustainable for practical reasons...If the midwife lives along way from the hospital, she is not likely to want to come on call - be a service provider" (Carroll, 2002, p.4).

There currently exists a multiplicity of midwifery models. The literature suggests that to progress to midwife-led woman centred care, a shift is needed. Leap, 1994 in her discussion of the midwifery model encourages the theme of a model "that places the woman centre stage". The woman is empowered to be "actively involved in choosing her lead maternity carer" (Guilliland, 1999, p.4). The concept for making a midwifery model the predominant principle of maternity care, is the woman, her pregnancy and her choice. The pivotal catalyst and driving force for midwife led woman centred care model is the woman (Viisainen, 2001).

# Midwifery Practice in Rural Hospitals.

## Definitions of “Rural”.

Couper comments that it is impossible to provide a generalised definition of the word “rural”. He states “rural cannot be defined as non-urban, as rural and underserved are not interchangeable (some rural areas are not underserved, e.g. well known tourist areas, and some underserved areas may be in inner cities). ‘Rurality’ is like beauty, which is in the eye of the beholder. Defining ‘rural’ is useful as a focus on which to build recommendations and policy, which will in turn impact on underserved areas” (Couper, 2003, p.2).

An Australian perspective presented by the Commonwealth Department of Education, Science and Training Report (DEST, 2001), suggests no one definition is appropriate but an acceptance of a way of living that is not urban. There is a perceived risk of higher mortality and morbidity of disease, higher exposure to workplace accident, socio-economical disadvantage, and inequitable access to health services when one resides in a rural setting (DEST, 2001).

## Tasmanian Health Practice in the Rural Environment

The range of health services offered in the rural environment is varied. Health care may be available in a multi purpose centre or in a small district hospital, which has accident/emergency facilities, surgical and medical beds and occasionally some midwifery care (National Rural Health Alliance Report, 1999-2003). When midwifery is practised in a rural hospital, the nurses employed must hold the dual qualifications of registered nurse and be endorsed to practice midwifery. He/she must also be willing to practise as a midwife. However the registered nurse has been educated to provide care for illness management and illness prevention. The midwife has been educated to provide assistance to the pregnant woman. This woman is well and considered to be a low risk pregnancy (Davis, 1997).

The rural hospital has several peculiarities. Because of isolation the caregiver is free from the strong influence of the specialist consultant. The nurse/midwife is able to



the midwife and the birthing woman work alone during the birth process, being supported by the General practitioner with obstetric qualifications, when the baby's arrival is expected. Thus the nurse/midwife in this setting refines her practice from the influence of patients, peers, pregnant women and G.P. The nurse/midwife in the rural setting is considered to have expertise of a generalist. She is not perceived as a specialist in any area of nursing but has significant expertise in her practice (Hegney, 2002).

From hospital records held in North East Tasmania there is a demonstrated decline in the birth rate over the last two decades (AusStats, 2002). With the fall in birth rate the midwifery component of rural practice has declined significantly. The ability to attract midwives to rural areas has become increasingly difficult. There is limited work for a partner and limited education opportunities for children. Midwives are generally not seeking to practice as a midwife and a general nurse (Guilliland and Pairman, 1995). The nurse midwife concept is recognised as favourable for the employer, (Davis, 1997), due to the ability of an employer to redeploy the skilled practitioner. Financial considerations drive government and private health providers who need to manage budgets to deliver health care. The anomaly is that to work in the rural hospital the professional often needs to be both a nurse and midwife. But the contemporary midwifery ethos recognises the separation of the two disciplines (Gilliland and Pairman, 1995; Davis, 1997; Homer, Brodie and Leap, 2001).

## Summary.

In this chapter, the literature review has endeavoured to provide a descriptive background to the topic to be researched. The development of midwifery practice from its earliest beginnings to the present day, contemporary midwifery practice, midwifery models of care and midwifery practice in a rural hospital have all been described.

## Chapter 3.

### Research Method and Data Collection.

#### Introduction.

This chapter describes the method used to carry out this research. It includes the research approach, a description of the research method of grounded theory, the research design, selection of participants and the process of collecting and analysing the data. The chapter also includes the notions related to trustworthiness, as well as ethical and limitation issues.

#### Research Approach.

A qualitative approach was chosen for this project because these methods allow the exploration of experience and the lived story of participants (Denzin and Lincoln, 2000). Minichello et al. (1999) describes it as allowing the researcher to share an intimacy with the reader. Qualitative research supports the notion that behaviour is best understood in the context of participant's stories and setting. Clarke (1995) believed that qualitative research evolved from the narrative and not statistical evidence. Hancock (1998) states that qualitative research is interested in understanding behaviour and social phenomena of how people think, feel and relate to their situation. The data is not manipulated, what is presented is accepted as the peculiarity of the particular study (Clarke, 1995).

The current study explored the understanding and beliefs of a group of midwives working in a rural hospital with regard to the pain being experienced by labouring women. The role of the midwife in part is one of support, encouragement and guidance during childbirth (Guilliland and Pairman, 1995). It is accepted that pain will be experienced during labour (Thomas, 1998) however, there is continuing debate as to how to manage this pain, its purpose and benefit to women. My aim was

women's pain during labour, what they believe regarding the pain of labour and how their beliefs underpin their practice. It was therefore appropriate to use a qualitative research method given I wanted to elicit a rich description of phenomena within a particular context.

A small number of participants were involved in the study. This means that while the findings are not generalisable to the broader community of midwives, they will offer a revealing insight and explanation of a component of a minority group of midwives practice. Hancock, (1995, p.5) states when writing about qualitative research "the explanations that emerge are genuinely new knowledge and are used to develop new theories about phenomenon". Therefore the aim of the study was to investigate the understanding and beliefs the midwives had of the pain of labour. To complete this study Grounded Theory was the qualitative method chosen.

## Symbolic Interactionism.

The theoretical framework of grounded theory is founded on the research tradition of symbolic interactionism (Chenitz and Swanson 1986). Herbert Mead (1863-1931) was a philosopher and social psychologist who founded "a social philosophy" that contextualised man's experience of social interaction in human daily life (Glaser and Strauss, 1967; Grbich, 1999, p.172). From the teaching of Mead, Herbert Blumer progressed the notion of symbolic interactionism (Chenitz and Swanson, 1986; Benoliel, 1996; Gribich, 1999). Blumer refined the teachings describing concepts of mind, self and society (Kendall, 1999). According to Blumer people learn "self concept" and achieve a "sense of self" (Grbich, 1999, p.172). Symbolic interactionism considers the way people behave in their social interactions. Holloway and Wheeler, (1996, p.100) state that "symbolic interactionism focuses on the actions and perceptions of individuals, their ideas and intentions". The explanation is individualized in that it is attributable to an individual.

Grounded theory takes account of symbolic interaction and allows the researcher to construct theory from the language and behaviours of individuals in a social context.

“This approach is particularly useful to conceptualise behaviour in complex situations, to understand unresolved or emerging social problems, and to understand the impact of new ideologies” (Chenitz and Swanson, 1986, p. 7). The purpose of grounded theory is to generate theory from the everyday lives of people. The researcher, when using the grounded theory method, accepts the meaning that each participant infers through his own language and behaviour.

## Grounded Theory.

Grounded theory was the research method used for this study. It has been defined as “the discovery of theory from data” (Glaser and Strauss, 1967, p.1). Grounded theory method was first described by sociologists Glaser and Strauss in the 1960’s. They expressed disillusion with the focus of qualitative research at the time (Glaser and Strauss, 1967), because they believed that data was being continually reformed and modified to fit theory. The method of grounded theory evolved from their classic work *Awareness and Dying by Glaser and Strauss*, (Stern et al. 1982). Glaser and Strauss as sociologists considered that the generation of theory provided an obvious method to verify social process. They believed strongly that theory must be understandable and applicable (Glaser and Strauss, 1967).

The aim of the method “is to generate theory about social and psychological phenomena ” (Chenitz and Swanson, 1986, p.3). The method uses a systematic approach “that illuminates human behaviour....” (Chenitz and Swanson, 1986, p.5). Glaser and Strauss, (1967, p.3) describe the interrelated functions of theory as to:

- “Enable prediction and explanation of behaviour;
- Be useful in theoretical advance in sociology;
- Be usable in practical applications....;
- Provide a perspective on behaviour ....;
- Guide and provide style for a research on particular areas of behaviour.”

A strength of grounded theory in nursing research is its problem solving or phenomena exploration that is similar to the problem solving process of nursing practice (Holloway and Wheeler, 1996). The process allows the nurse researcher to

collect data and explore phenomena using a process that she is familiar with. Another strength often proffered in relation to grounded theory is its ability to prevent the researcher from presenting hypotheses which they then try and fit the data to. Further, it has been suggested that an advantage of using a grounded theory method is its ability to be “understood by the sociologists of any view point, to students and to significant laymen” (Glaser and Strauss, 1967, p.3).

As with any research method grounded theory has limitations. Glaser (Glaser and Strauss, 1967) proposes one limitation when he warns that novice researchers can produce a descriptive account of the subject under study rather than capturing the process of the phenomena (Denzin and Lincoln, 2000). Another limitation, particularly for the novice researcher, is the fact that it remains an evolving method. Following its inception there has been a separation of stances taken by its founders. Glaser defends the original interpretation of the method while Strauss and Corbin added another layer to the analysis process. Hall and Callery (2001) postulate that in trying to demystify the method, Corbin and Strauss in adding an extra process to the analysis led to it becoming very mechanical. Further, some writers have suggested that the method allows only a micro-level view of the world when it concentrates on how individuals make sense of the subject under study with the larger political and social influences being ignored, for example power and gender issues ((Manis and Meltzer, 1978; Angus, 1986).

Application of the method to the current study is appropriate. As a researcher and a midwife I was beginning without a hypothesis or a particular question of enquiry. What existed was an interest in how a group of midwives in a rural setting explicated their understanding and beliefs of a woman’s pain of labour. As midwifery is predominately a female profession, it is appropriate to choose a method that does not constrain the research to the idea of a woman as a biological machine or a societal member by her gender (Crooks, 2001). Grounded theorists have been commended as expanding the knowledge of women and their social processes (Benoliel, 2001).

# Research Design.

## Research question.

What do midwives in a rural hospital understand and believe about the woman's pain of labour?

## Aims of the study.

- : To understand the midwife's perspective.
- : To develop a substantive theory grounded in the data.
- : To document one aspect of midwifery practice in a rural hospital.

The nature of grounded theory allows the researcher to construct the theory from the collected and analysed data (Glaser and Strauss, 1967). Information derived from each interview is compared and analysed to form categories and codes. Analysed data was collapsed into properties, categories and concepts. Eventually a time was reached when the concepts became repetitive, no new information was being unearthed and the core variable *coming to realisation* emerged.

## Selection of Participants

The participants were midwives who had worked in a rural hospital for a minimum of 2 years. It was not an issue whether they had been hospital or university educated as the study sought their individual appreciation of pain in labour. Some of these midwives had worked in both rural and regional midwifery units. The midwives who participated in the research ranged in age from 30 to 55 years and were all female. The study was introduced to the midwives at a ward meeting. There was also a brief overview of the research at several ward handovers to inform those who were unable to attend the initial meeting. If midwives wished to participate they were encouraged to make contact with myself. Following this informal contact I discussed with each respondent the aim and process of the research. I gave each interested participant the information sheet and consent form for completion. Following receipt of completed consent forms I contacted each willing participant and duly arranged a date and venue for an interview.

# Sources of Data.

## Unstructured interviews.

Unstructured interview is described by Chenitz and Swanson (1986, p.66), as an interview that has form is “intensive, in-depth” and seeks data in the words of the participants. The interviewer comes to the interview seeking information on only a few topics and structures the conversation around this. During the interview the researcher may ask the participant various questions around the chosen topic exploring it from many different angles. The unstructured interview is different to other forms of interview as there are no predetermined interview questions except for the initial one. The introductory question was: “I want to explore your understanding and beliefs as a midwife of a woman’s pain in labour. Tell me about your understanding of the pain of labour”.

The unstructured interview was the primary source of data collection. It allowed the greatest freedom to capture the experience of each midwife. Openness is considered an essential credential for the researcher (Koch, 1998). The informal interview style has the least researcher impact on the participant. The duration of the interview was planned to be approximately 1 hour.

The unstructured interview is more than a social conversation. The unstructured interview has some elements of form as the researcher steers the conversation to reveal data. Melia (1987) comments that there exist narrow parameters when data collection is from unstructured interview, and there is a need to balance the interview for research ideas and theory purpose, while the participants explore their ideas and thoughts through their conversation. Denzin and Lincoln (2000) in their appraisal of the unstructured interview comment that it allows non-prescriptive collection of material compared with other methods. This was encouraging as I was seeking the richness of the midwives stories.

There were several considerations to be addressed when undertaking the interview. These included the setting, presentation of myself to the participants, being trusted by the participants in the researcher role and most importantly gaining a rapport with the participants (Minichelo, 1999; Denzin and Lincoln, 2000). A risk I perceived for myself was to lose my focus and control

of the interview as Denzin and Lincoln describe it “to go native” (Denzin and Lincoln, 2000, p.655).

With permission from the participants the interviews were tape recorded and transcribed by myself. Each midwife was given a pseudonym and any identifying information was fully de-identified. As a beginning researcher the purpose of tape-recording allowed me the opportunity to focus on the interview and not be distracted with note taking. It also prevented the overlooking of data, as some data during interview may seem insignificant but at analysis was important (Stern and Pyles, 1985). Tape recording allowed me to capture the subtle voice changes and the use of language. It meant I could review the interviews at length during the transcription and data analysis. The participants were fully aware that the interview was being tape-recorded. They were informed if they particularly did not want any part of the conversation recorded, this would be respected. Before commencing the next interview analysis occurred. This was the process of categorising and coding collected data. The codes became the focus of the next and following interviews. Emerson (1998) comments that codes are the beginning of the outcome and continue to change and evolve with each completed interview.

My basic premise was to use the unstructured interview to acquire the most elaborate story of each participant. I had a fear of the power of researcher influence. Thus I believed in using an open-ended question such as: I want to explore your understanding and beliefs as a midwife of a woman’s pain in labour. Tell me about your understanding of the pain of labour”. Participants were encouraged to share their story with little prompting from myself. In the initial interview I found myself restricting my responses to monosyllables and body language to allow the participant to continue with minimal engagement (Denzin and Lincoln, 2000).

## Literature.

The literature reviewed before data collection was that which provided a descriptive background to the substantive area of the study i.e. the development of midwifery practice, midwifery in the



rural hospital and midwifery models of care.

Literature related to the data was reviewed during data analysis. Grounded theory method advocates that literature is sought at two different intervals in research. First a literature review is completed in the beginning of the research project but its purpose is limited to setting the background of the study. The second literature review is the collection of data from the literature for the comparison with the core process. The literature at times may not agree with the emerging theory but it should be considered as a source of data and thus a tool for testing emerging theory. The literature is “to establish the study’s purpose, background and significance” (Chenitz and Swanson, 1986, p.44).

Self as source of data.

As a midwife and the researcher I am considered a source of data, “a study is enhanced by theoretical sensitivity (Glaser, 1978; Strauss and Corbin, 1990;). This consists of disciplinary or professional knowledge as well as both research and personal experiences, that the researcher brings to his or her inquiry”(Denzin and Lincoln, 1978, p.173). I completed my midwifery training 25 years ago. I have practiced both in regional and rural hospitals during my professional career. I have been a member of the professional organisation for midwives, Australian College of Midwives Inc. (ACMI) for many years. During my professional life I have maintained contacts with midwives who work in various settings. Some midwives practise within the medical model, whilst others utilise a midwifery-led woman-centred philosophy.

## Data Analysis.

Analysis of the data began with the first interview. During the interview some mental note was taken of ideas that were presented. After the interview these ideas were noted and revisited when the transcription of the interview was completed. This began the constant comparative analysis process. Each interview transcript was reviewed collating ideas then establishing categories and codes, “grounded theory is a systematic method” (Chenitz and Swanson 1986, p.91). These were noted in the margins of the transcripts. This activity was applied to each interview; the coded information was then applied to each consecutive interview. This continual process of analysis is tested using theoretical sampling. Theoretical sampling is best described as actively looking from many different angles at the data being coded by analysis. At a

time when no new information can be found the code is deemed saturated and the researcher moves on to sort and develop the emerging theory. Chenitz and Swanson (1986, p.9) state “simultaneous data collection and analysis are critical elements in Grounded Theory research”. This process continues for all interviews and data collected for the study.

Memoing is an intense and valuable characteristic of grounded theory method (Minichelo et al.1999). Memoing is a process of note taking from the data. It may be in the columns of the transcripts or journalled separately, but usually both. Memoing links and sorts the ideas to categories and codes. Memoing is an activity that is managed parallel to note taking, coding and category development. It is a method of keeping the researchers thoughts and ideas in a manageable format and accessible during the continuing analysis. Memos were written when completing the categorising and coding. This strategy was used to keep the researcher faithful to the collected data (Denzin and Lincoln, 2000). Memoing occurred throughout the project as categories and codes were constructed from the collected data. It provided the relationship that linked categories “we bring raw data right into our memos so that we maintain their connections and examine them directly” (Denzin and Lincoln, 2000, p.517). Minichelo (1999, p.130) comments that memos extend further than just being the link pin for categories and codes. He infers that they also include “researcher insight” are “descriptive” and “ include theories”.

## Establishing Trustworthiness.

The revelation in qualitative research that not one view is necessarily correct allows freedom to explore the social realities that each participant shared. The findings are then presented as a study with a perceived concept of trustworthiness. Koch (1996) suggests that the ultimate check of trustworthiness is whether the reader is able to believe the results and the emergent theory. The importance of qualitative research is the “balance between the credibility of the research enterprise and systematic marshalling of evidence to support a conclusion” (Minichelo, 1999, p.46). The internal mechanisms provide the trustworthiness. The method used to collect the data

and the process of analysis becomes the checking mechanism (Koch, 1996).

Lincoln and Guba (1985) describe four criteria for establishing trustworthiness. These are credibility, transferability, dependability and confirmability. Dependability and confirmability can be described as co-dependent thus, are often described together.

Credibility or the truth-value lie in the researcher's ability to present the studied human behaviour in the contextual way that is interpretable and believable to the reader (Lincoln and Guba, 1985). The findings are credible when they are recognisable by those who have similar experience. Glaser (1978) suggests that findings are made credible by the correcting nature of constant comparative analysis. Glaser (1978) describes factors of work, relevance and modifiability as equitable to the criteria of credibility proposed by Lincoln and Guba (1985).

Transferability is described by Lincoln and Guba (1985) as having sufficient data available that can be applied or transferred to enable other investigators to develop outcomes and assumptions. Glaser (2000, cited in Nathaniel, 2003) argues that grounded theory is uniquely transferable because of its conceptual rather than descriptive nature. The constant comparative analysis works the data to an abstractness that enables the theory to be modifiable thus transferable to other groups. Glaser (1978, p40) wrote "these deducted hypotheses are not forced on the data when they fit poorly, they are discarded and others emerge in their place by constant comparative analysis. This method underlines the fact that interpretations must be researched and grounded just as much as the patterns themselves."

Dependability is determined by various audit techniques (Lincoln and Guba, 1985). Memoing and note taking are two valid means of providing the researcher with an audit trail. These activities are used to confirm the dependability of the study. This is also a means of establishing confirmability a fourth criteria described by Lincoln and Guba (1985). Confirmability is the audit process. Glaser (1998) discourages use of tape recordings and computer programs he encourages the use of note taking, journaling and written aspects of grounded theory record such as memoing. This deepens the relationship of the researcher with the data demanding the development

of a grounded approach from the researcher.

The intent of any study is to have the reader believe the findings. Koch (1996) believes to establish trustworthiness the researcher should develop a criterion that fits the study and then validate this process by establishing the trail of process. To this end it is suggested that the researcher keep a journal of her progress throughout the study. This documentation is then used to show the validity and rigour of the study (Koch, 1996). She suggests the use of transcripts in the body of the thesis or appendices inform credibility (Koch, 1998).

As the researcher for this study the application of note taking and memoing has been valuable to maintain trust to the collected data. An easily accessible trail of data collection and analysis has developed from these intensive activities. While Glaser discourages the use of transcription it is not an enforced criteria. For myself, transcribing interviews immersed me in the data. The participant's stories are trusted thus extracts are included in the thesis to support authenticity.

## Ethical Considerations.

A qualitative study has a moral obligation not to harm participants (Mathers et al. 1998). Ethics committees in their deliberation of the studies consider the researcher qualifications and ethical aspects with a no harm approach to participants (Roberts and Taylor, 1995; Grbich, 1999). This study was presented to the Northern Health and Science Ethics Committee of the University of Tasmania and approval was gained.

An information sheet (appendix 1) and consent form (appendix 2) were given to all midwives who showed interest in the study. They were advised to return the consent form or make further inquiries of the researcher following the meeting held to introduce the study. The objective was to allow the midwives to volunteer for the project.

To maintain anonymity participants were encouraged to select a pseudonym for themselves and for any clients or others they chose to mention in the interview. In a small hospital I believed it was important for me to be able to de-identify each interview from the individual midwife participant early in the analysis process. This thought was reflected by my need to immerse my focus on the detail of each story and not be distracted or biased by my previous knowledge and relationship with each participant.

Confidentiality was discussed with each participant. The midwives were assured that only pseudonyms would be used in the transcripts or included in findings. Participants were given permission to ask for the tape to be turned off at any time. If they wished they could talk about an issue they did not want recorded or have a part of the discussion erased. All participants were informed that they could withdraw from the study at anytime without impediment to their relationship with myself.

Another ethical consideration not mentioned often is fidelity (Mathers et al.1998). The premise is that if you promise to do something you actually complete the task. I was very aware of this when negotiating interview times and places with the participants. Most of the midwives who volunteered for the interviews were full time workers, often with families and other commitments to the local community. Thus their spare time is of great value and not an item for squander. Fidelity extends to the obligation of presenting the findings, to the participants and remaining faithful to the study objectives (Mathers et al.1998).

The interviews were tape recorded and transcribed by myself. Analysis of the data was undertaken with support of my supervisor. All hard copy data was securely maintained according to National Health and Research Medical Council (NHRMC) and University guidelines. All data tapes, transcripts and findings will be destroyed 5 years after the study is completed according to NHMRC guidelines.

## Limitations

The size of the study may be considered not large enough to produce generalisable data that can be reliable and informative. The grounded theory method does not seek a large number of participants. The activity endeavours to collect data with depth, description and to saturation of the subject with a resultant emergent theory being achieved (Koch, 1998).

A second issue was my experience as a novice researcher. The study was undertaken as a part of my master of nursing programme. Fortunately, I have been guided and advised by a supervisor who has been patient and nurturing. She has previous experience in completing a published Ph.D study using Grounded Theory.

Thirdly I admit to reservations because of my relationship with the participants as colleagues working in the same hospital. Initially I feared that the midwives invited to participate might have been reluctant. This was not to be the case. I was also aware because of my proximity to the participants and midwifery practice there was potential to create a bias when reviewing the data. However I found that my midwifery experience allowed me to explore some of the subtle comments shared during the interviews. No funding was applied for to undertake this study. All costs for the study have been met by myself. This study is limited to one particular institution and is a beginning project.

## Summary.

This chapter details grounded theory method which was used to complete this study. The research design and data collection using unstructured interviews, literature review and self as a source are included. The process of data analysis and the formation of a grounded theory were discussed. Informed consent, protection of participant's rights, establishing trustworthiness and the study's limitations were also considered.

## Chapter 4.

### Presenting the Findings

#### Introduction.

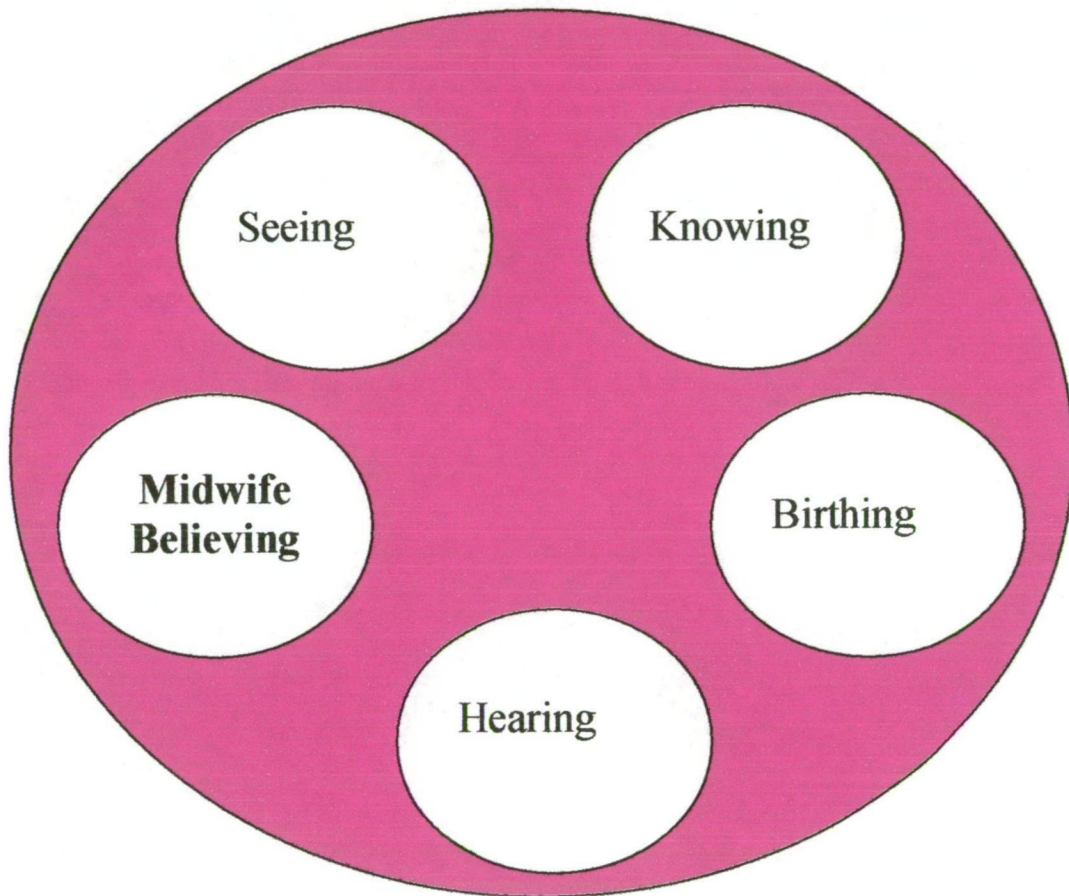
The aim of this research study was to produce a detailed description and analysis of a group of midwives' understanding and beliefs regarding pain, when caring for the labouring woman in a rural hospital. Data was collected from participants' interviews as well as current literature and analysed according to the method proposed by Glaser and Strauss (1967). Five major concepts were identified that made up an initial substantive theory. The theory is presented as a conceptual framework, which illustrates the process under study. The aim of this chapter is to describe and discuss the conceptual framework, the core variable, the five concepts and their sub-concepts.

#### Conceptual Framework.

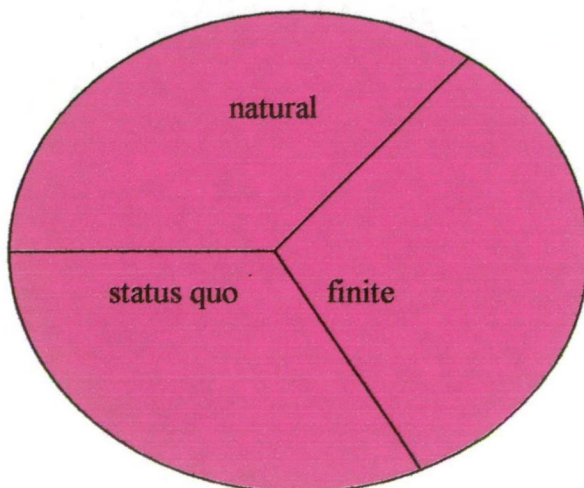
A conceptual framework according to Talbot (1995) is the network of interrelated concepts and propositions that provide a structure for organising and describing a phenomenon. The conceptual framework for this study is presented as a number of circles (figure 1). The large circle encompasses and holds within itself five smaller circles. The five small circles represent the concepts that have emerged from the data and together make up the core variable. While the smaller circles are not linked to each other each has a relationship with the larger circle or core variable. Two further circles are used to diagrammatically illustrate the sub-concepts that emerged from the data. Figure 2 represents the sub-concepts for birthing while figure 3 represents those of the midwife's believing. Concepts are the final analysis outcomes of the conceptualised data (Pandit, 1996). They are the word terms that focus the image of phenomena analysed from the data (Tierney, 1998). Birthing and midwife believing have distinct sub-concepts. The sub-concepts of birthing are natural, finite and status quo; the sub-concepts of the midwife's believing are midwife belief, emotion and

woman's inner strength. The conceptual framework is used in this study to depict the midwives' understanding and beliefs of woman's labour pains.

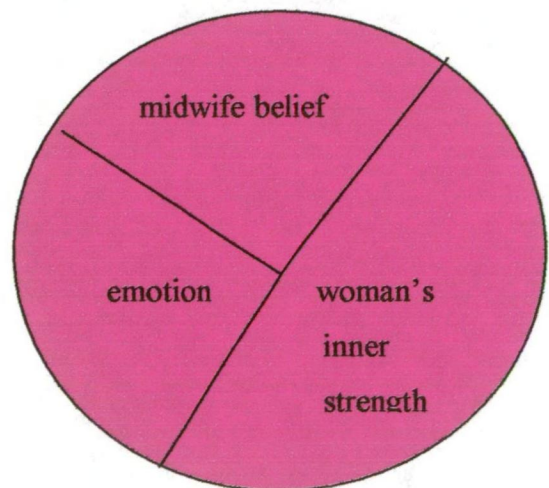
**Figure 1: Coming To Realisation**



**Figure 2: Birthing**



**Figure 3: Midwife Believing**





## Core Variable.

When using the grounded theory method the core variable is described as “a coherent, workable whole, that integrates the major ideas” (Talbot, 1995, p.447). It develops from the constant comparison analysis of the codes and “emerges naturally in the process and explains the social processes related to the phenomena” (Talbot, 1995, p.447). The core variable of this study *coming to realisation* recognises an involvement of a midwife practise which occurs over time. This change affected their understanding and beliefs about a woman’s pain in labour. Pain relief was a topic discussed in the student midwives’ educational programmes. Initially they talked about how this theoretical knowledge was their benchmark as beginning practitioners. With experience they recognised a change within themselves. They had added to their practice dimension the use of observed knowledge, body language and intuition. Some also recognised a reliance on their personal experience of giving birth. It is this coming to an awareness of and the grasping of the value of this practice knowledge that forms the core variable.

*“I think midwives recognise different behaviours in other midwives.*

*The different ways of doing, with different women and of managing labour pain. We have taken that on more and more, and have educated women and it has sort of been a progression from there” (Midwife 6).*

In the context of the core variable, the term realisation is the idea of knowing that you understand by having grasped and comprehended awareness of how your understanding has evolved. From an anthropological framework realisation is related to the concepts of aesthetic, ethical and religious phenomena that is “each stage is a way of seeing life, a way of understanding the world” (Amilburu, n.d.p.1). Realisation is the acknowledgement of knowing the activity around the individual. It is this knowledge supported by the elements of consciousness that allow the midwives’ awareness.

To have realisation a degree of consciousness is necessary. Consciousness like realisation is a difficult concept to describe. Often in society consciousness is determined by a person’s vague understanding of the physical conscious state “the

person is conscious if in a state of alertness or arousal” (Goldman, 1993, p.1). For the purpose of this paper the conscious state is described as “a primary or core sense of ‘conscious’ in which it applies to partial psychological (or perhaps processes or representations), such as individual beliefs, plans, or emotions” (Goldman, 1993, p.1). Consciousness is the factor that allows the midwife to apply her realisation of understanding and beliefs related to the woman’s pain of labour. *Coming to realisation* is the individual midwife’s ability of knowing, being aware and grasping that perceived knowledge. The preliminary words used *coming to* are relevant as they show this knowledge is not complete but continues through the midwives professional careers. The acquisition of knowledge impacts on the midwife’s care delivery. She can be seen to shift from an actively managed care model to an expectant managed model (Sookhoo, 2002).

The managed care model is particularly relevant to the beginning midwife as this predominately guides her practice. A managed care model is generally based on a timeline by which the woman must progress through labour. The midwife is expected to complete regular and sometimes invasive observations such as continuous foetal monitoring, vaginal examinations and blood profiles on the foetus near to the event of birth (Wagner, 2000). The expectant model is dependent on the midwife’s ability to understand the woman and her pain of labour. The midwife applies of her knowledge and beliefs to give support to the labouring woman. When using an expectant model practice the midwife evaluates the woman’s progress by observing her activity and applies this understanding to support the woman. The midwife using this model engages in each midwife woman relationship with greater individuality than the midwife using a managed care model.

One of the participants talked about the individuality of the woman’s pain. She described the misunderstanding of pain and how through years of practice she has learnt to let the mother establish her own needs.

*“I believe the pain of labour is real pain and labour is painful and anyone who thinks labour is not painful is kidding no one but himself or herself. I also believe that people experience different pain, people’s pain levels are different; in labour ward people have different pain thresholds.*

*individual, how they respond to pain, the strength of the individual pain and then they tell me." (Midwife 6).*

The midwife participants were registered nurses before completing midwifery education. In this rural hospital they also practice as general nurses. Their dual role as registered nurse and midwife meant the participants had a strong need to relieve pain and to make people well. Thus there is an anomaly for midwives when working with labouring women who are usually well and completing a normal life event. The dilemma for the midwife is to understand the woman's pain and its value to the woman who experiences it.

## Concepts.

Five concepts emerged from the data they were hearing, seeing, knowing, birthing and midwife believing. The sub-concepts of birthing are natural, finite and status quo. The sub-concepts of midwife believing are midwife belief, emotion and woman's inner strength. The concepts play a significant role in the choices that the midwives make when supporting and encouraging women to manage their pain of labour.

### Hearing.

Hearing is defined as "to perceive by the ear; to listen to; to receive information by the ear" (The Budget Macquarie Dictionary, 1998). The midwives hear the noise of labour, the pain of the woman expressed either intelligibly or unintelligibly. In western language noise has been referred to as a nuisance something that can create and causes discomfort for the populace (Sanglid, 2002). This definition is reflective of unordered noise. Noise is considered as a negative community experience and society talks about managing noise and setting standards so that it is not disruptive to the neighbour. Continuous noise is considered a health problem; "quality of life is affected by occupational noise at work, and by environmental noise outside and at times infiltrating the home. While nobody dies as a result of noise and very few people are seriously injured by it, the cumulative impacts of noise pollution are being

increasingly acknowledged” (Newton, 2001, p.1). When noise is given order as in music, verbalisation or song it is deemed acceptable within a culture. There exists no one definition of noise but it is composed of a variety of concepts that relate usually to the source (Sanglid, 2002). Thus ordered noise develops aesthetic qualities.

Midwives describe hearing the noise of the birthing woman and using it as an indicator of progress and a subjective measure of labour pain. Labour noise was the sound either comprehensible or not that some women expressed when in pain. Midwives talked about responding to these sounds and using them to guide their practice. In contrast to the general community response to noise, the midwives gave this noise order. Noise is a stimulus causing a response within the environment of its conception, (Legrady, 2002). Midwives related the noise of the woman as an indicator of her coping with the pain of labour.

*“some people believe you have to scream to have a healthy baby. Italian ladies don’t have to be in very much pain at all to be screaming out ‘mama-mia’. That’s the way they are. It also depends on the type of noise they make. Is it a panic noise? Is it an absolute agonising feeling? It maybe a coping noise. It depends on the type of noise they are making” (Midwife 5).*

With feeling and commitment one midwife proffered the idea that noise of labour can be the “birth song”.

*“ I have just noticed when looking at how other midwives practice, they might offer pain relief a bit earlier than I would. You see I don’t really have a problem with women screaming or calling out, it doesn’t worry me. I know some people worry when they see some people in pain. They want to fix it, but in childbirth it doesn’t worry me. I actually refer to it calling it the birth song. I don’t get upset if people are noisy in labour. It doesn’t worry me in second stage if people are pushing and they are noisy. I used to say as a student when you are pushing close your mouth and don’t make any noise. Push down into your bottom and don’t make any noise. I don’t say that now at all, I never say that, I don’t mind if people are noisy”.*  
*(Midwife 3).*

between the midwife and the woman. Noise can be unintelligible as McKay (cited in McKay and Roberts, 1990, p.269) describes “ the maternal sounds of work and effect during second stage, as exemplified by guttural, grunting, uhhhh sounds that are low pitched and may be characterised as primal or animalistic are perceived by both mother and caregiver to be typical, adaptive, and helpful”. Midwife participants expressed how through time their experience had changed their view of noise in labour; they had an acceptance and recognition of noise as a purposeful cue.

*“when I was training everyone was sedated because if they made a noise that wasn’t on. No one could cope with that. It made everyone feel uncomfortable, so the Doctor would sedate them down pretty well” (Midwife 5).*

Noise in labour is an expression by the woman of her experience and progress (McKay and Roberts, 1999). For the midwife noise is an expression of the woman’s primal or cultural management of her labour. The use of hearing as an observation tool encourages a subtle practice shift from an obstetric managed labour with pain being fully relieved to an expectant model of support. When midwives listen to sensory indicators they are more willing to allow the labour to progress individually. The noise allows midwives to practice their art of midwifery with women. Midwives are being less intrusive and less reliant on medical technology. “An important behavioural cue that mediates the nurses’ (*midwives*) behaviour is the sounds a parturient makes and what these communicate about the maternal state of being” (McKay and Roberts, 1999, p.268). If midwives are not confident in using this concept it can have the resultant effect of leaving them a little bewildered. Not all women vocalise their progress there are some who internalise their noise. These women will often say to the midwife “I feel like pushing” as reflected by one midwife.

*“then all of a sudden the noise would change. It was just the most amazing thing. As a student I would sit there and think how do midwives do this, it must be magic and with experience I have realised you can understand her noise in labour. That’s why this woman recently, flawed me because she played cards right to the very end and went to the pushing bit. I sort of didn’t expect that. It was actually amazing as a midwife to witness this.*

*I thought, it has been a fair while and I had been feeling her contractions with my hand, they were pretty good and I would say to her can you feel that and she said well I feel like I want to push. I thought I really don't think I will do a vaginal examination. I said come on we will go over to labour ward and we just got there and the membranes ruptured plonk, she was all on, it was just amazing" (Midwife 5).*

Hearing is a tool that the midwives use to determine the woman's progress. The midwives that include this in their practice domain tend to use an expectant model of support when working with the labouring woman. Some women do not always express themselves using noise, intelligible or unintelligible, but may remain relatively silent in their labour.

## Seeing

The concept seeing reflects the notion of what one sees. "See" is a simple and well-understood word. To see means to perceive by visual activity and to understand. "Understanding is seeing" (Baguley, cited in Milligan, 1999, p.2). There exists a cognitive relationship between the mind and the observed behaviour (Baguley, cited in Linguist list, 1999). Seeing is a visual observation that delivers a message to the receptive person, i.e. the midwife. The observation directs the midwife's activity to the needs of the birthing woman. The visual picture adds to her understanding of the individual woman's pain of labour. During her practice supporting the labouring woman the midwife links the seen behaviour with what she knows from previous experience and applies what she believes to be an appropriate response.

*" I always look at her. To see if the pain is unbearable for the woman or whether she is managing it; whether the pain is appropriate for her stage of labour. How she herself is coping with it, her pain tolerance what she is able to cope with. I always try and think that people will cope with their pain and manage it naturally and we wait and watch", (Midwife 2).*

Tschudin (1981, p.2177) states, "we constantly signal with our bodies what we cannot say with words". The use of cues from body language will give information to the

observer. In some situations the observed behaviour reflects truly how the woman feels. Some women will verbally report a version of their coping that is not reflective of their behaviour. "Verbal cues alone are difficult to clarify --- understanding the incongruity between verbal and body language is also enlightening" (Antai-Otong, 1999, p.24). The visual experience of seeing the woman labour increases the midwives knowledge of the situation. Without conversing the midwife gains information that she believes is representative of the woman's situation. Midwives talked about using the knowledge from their visual experience to define the different stages of labour. If they were comfortable with their appraisal they were less likely to apply other assessments such as vaginal examinations or cardiotocography.

*"...the pain is different for each stage of labour. The cervix dilating is a different pain to the expulsive contractions of the second stage. The pain is different at transition, when you are just about fully dilated up. I mean, you can by looking at the woman tell the type of pain she is experiencing. You can tell which stage someone is in by what you see. It comes with experience. I certainly wasn't taught that in mid (educational programme). I was taught to look at how people were coping, not the different pain of different stages of labour, I certainly wasn't taught that." (Midwife 7).*

Midwives described how their midwifery practice evolved through their experience. The midwife became more confident to trust her understanding having learned through her relationships with labouring women. She accepted a realisation that from repeated practice her knowledge is valid, thus she applies it more and more. She tests and benchmarks this knowledge with each birthing experience and the experience of other midwives.

*"Watching the woman, is probably more indicative than watching the clock or even how your ve's (vaginal examinations) have been going. Because she might be a multipara, that's only been 2 cms, then suddenly she looks a bit more distressed, and behaving more in the manner that she is about to deliver, then you know. You know because you have seen it before and you know how it feels. She's further on than thought, the body language will tell you." (Midwife 4).*

Seeing plays an important role in the midwives' practice. For these midwives, the rural hospital allows them autonomy to develop and practice their art of midwifery using their understanding.

## Knowing.

For the purpose of this study knowing is defined as "to have knowledge, or clear and certain perception, as of fact or truth; to be cognisant or aware, as of some fact, circumstances, or occurrence; have information, as about something" (The Budget Macquarie Dictionary, 1998). Knowing is the intuitive knowledge that the midwife has developed and lends to her practice. Intuition is without scientific or mathematical fact. Intuition is described "as a perception" that is usually proved to be a truth but generally not based "on conscious reason" (Perkins, 2002, p.2). It is sometimes described as insight or the conscious acceptance of an idea without sound rationalisation (Perkins, 2002). In this study intuition is accepted as an understanding of labour pain. Midwives spoke of their intuitive skills being enhanced by their knowledge. This knowing experienced by the midwives relates to understanding that is not always bound by factual evidence. It is often something that is difficult to explain in relation to existing reasoning and is not necessarily factorial in its presentation. Within the concept of knowing exists the idea of conjecture especially in relation to an ability to predict outcome.

To the midwives knowing meant an expression of their personal understanding of a woman's pain of labour. The midwives did not experience the pain but believe they knew how the woman felt. The intuitive criteria they use, they had learnt from one to one relationships they had with women and discussion with other midwives.

*"There are all different types of pain that people experience. The ways to help the pain can be different for each woman. So as you get more experience you are better able to pick up signals and develop ideas that you think will work for the woman." (Midwife 4).*

These midwives, trusted women to know intuitively how to labour. The rationale for this knowing was trusting the pain to complete its purpose. In trusting the pain the midwife intuitively trusted the woman. Midwives described that in early years of their



practice they were dependent on learned knowledge from their education. With time they began to use the knowledge that came from their practice. They talked about applying this knowledge and being confident to suggest to the woman alternative ways of relieving pain.

*"In our hospital you can almost give home birth experience to women. They are allowed to labour and you use your experience to support and care. You try things for pain the non-pharmacological things. In the city I would be frustrated with restrictions that are in a teaching hospital."*  
(Midwife 2).

The findings show that knowing is an intuitive practice of the experienced midwife. Intuition enhances the midwife's practice when she is providing a supportive relationship to the woman.

*"I have just really clarified for myself in the last year and a half, after all these years, what I really do believe about labour pain until then it was all a bit jumbled up. When I was a junior midwife I really didn't have a good understanding about pain in labour. I thought women had pain and we had to get rid of it, so we'd give drugs. I suppose it wasn't until I was pregnant that I began really reading, learning and watching. I probably learnt more about looking after a woman in labour and letting her experience her pain. I read a lot more of the natural birth stuff, looking at pain from a completely different viewpoint totally different from what I had been taught as a student. Childbirth is a natural process, we are women and we are made to have babies. Pain is part of using your body to work with birth, we learn to trust women."* (Midwife 3).

The beginning midwife does not always understand the activity of the mature midwife who has been in practice for numerous years. The "mature" midwife ignores the technology and assesses the woman. These skills the participants considered to be acquired through years of practice. They believed that within oneself a knowing develops. This knowledge is dependent on watching, listening and intuition. The

comfort with which intuitive knowledge is accepted and used relates closely to the midwives understanding of what the pain of labour is for the woman and the influence of policy and practice in the setting.

## Birthing.

Birthing is defined as the process of a baby being born. The notion of birthing is not a static moment but a series of interlinked events at the conclusion of a woman's pregnancy i.e. the completion of the pregnancy by the birth of the newborn child. This notion has been adapted from the following definition of live birth. Live birth is defined by the World Health Organisation as (cited in the National Center of Health Statistics, 2002, p.1) "complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such as a heartbeat, umbilical cord pulsation, or definite movement of voluntary muscles, whether the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born". The concept is reflective of how the midwife symbolises the activity of birthing.

*"The midwife's role is as a guide to help the woman through this birth event, a normal process. I am there to help the woman get to the end whatever happens. To support a safe outcome," (Midwife 3).*

Midwives described strong personal definitions of what birthing is to them.

Birthing is presented as the concept that collectively represents three sub-concepts. These sub-concepts explore the midwife beliefs of birthing. The sub-concepts are natural, finite, and status quo.

## Sub-Concepts Birth

### Natural.

A natural birth is a birth without intervention but has an obligation from midwives for the woman to be comfortable and safe (Righard, 2001). The word natural was often interchanged with normal.

*"its meant to be a natural process I would like it to be as natural as*

*possible.... Yes pain is normal and acceptable in labour”, (Midwife 2).*

There exists no defined separation of these terms in this study. Gould, (2000, p.420) describes “underlying medical culture which has led to today’s paradox where many midwives may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural”. Yet The Budget Macquarie Dictionary usage of the words natural and normal suggest they should be interchangeable. The midwives who participated in the study regularly interchanged the words natural and normal. Thus, this sub-concept uses natural and normal as one and the same in the context of this study. It is deemed acceptable for natural and normal to be interchangeable factors. However according to the World Health Organisation, (1997) natural birth is without medical intervention, while normal may include management intervention that through time have become accepted such as hospital accommodation for birth in preference to home.

The following statement illustrates a participant’s beliefs about natural birth.

*“The pain of childbirth is not like a pathological pain. I believe that because I believe labour is a natural thing. The pain is a natural part of birthing. You know between contractions normally the pain is gone and then it comes again. After the birth the pain is gone. I believe there is a purpose for the pain, I know lots of people have done work on it. It’s for a purpose, pain summons help, it helps women to find a safe place to give birth.” (Midwife 4).*

Birth pain is viewed by midwives as being a different pain experience to that of pathological disease. Midwives talk about physiological pain of childbirth, an expected and natural phenomenon, differentiated from the experience of the pain of sick patients.

*“Labour pain is a natural part of birthing. I understand it to be a different sort of pain to the pain an un-labouring person has. It is a physiological pain caused by what is happening to the body as it is going through a normal process, rather than a pathological pain which is usually caused by something abnormal or something that is broken. You can’t really equate it to any sort of pain. Talking to a pregnant lady you can’t relate it to the pain of breaking a leg because it is totally different sort of pain.*

*So I understand it as being how the body normally functions in stretching and moving and accommodating larger things in smaller spaces if that makes sense". (Midwife 3).*

Birth pain is accepted as part of the event. The need to immediately relieve it does not exist in the philosophy of the midwife participants. Distinct beliefs of pain exist. It is part of birthing. It acts as a signal to the woman, the midwife and has a purpose. The midwives continued with this notion throughout their interviews. Because the pain of labour is not always relieved and the woman is allowed to bear it, it has become a tool. The midwives use the woman's responses to the pain of labour to assess her physical, psychological and emotional well being during this time.

### Finite.

Finite is defined as the limitation or boundary of an event, (The Budget Macquarie Dictionary, 1998). The pain associated with the birthing process is a finite happening it may be over in 2 hours or 12 hours. There is an end and for the majority of women that end is surrounded by happiness. Midwives reasoned that it is acceptable for the woman to experience labour pain. They considered the pain was not continuous but the woman had breaks that allowed some recovery and a time of preparation for the next contraction.

*"they are going to have breaks in their pain with a contraction.  
If it went on and on, you couldn't cope with it. Because you have a spell in between then you prepare yourself for when it comes again. It's natural.  
You couldn't cope if it was continuous. There is a reward at the finish,  
a reward at the end of labour, with all other pain there is not much  
reward." (Midwife 6).*

There was a significant feeling that because there was an end to the pain, a product of the pain, a baby, and for most this was a happy event, the pain was good.

*" I think for the people who have had their baby, the pain is good.  
While they are going through it the pain is bad but I think once they have*

*had their baby they are happy and the pain is not relevant to them anymore. The pain ends. "(Midwife.2)*

The midwives focused on encouraging the woman to look past the pain of labour and experience the pain with a positive outlook. The end in birthing is relatively defined but the individual timeline not similar to a timeline of disease process (Wagner, 2000). While labour is technically allowed to be normal in most settings, in modern western culture a time limit is often imposed on the event for the safety of the mother and baby. The end of the event is the birth. Generally the expressed opinion was that women did not need pain relieved in labour, if by their own and the midwife's assessment they were managing (Baker et al. 2001). It was believed that most women expected and had heard from other women or antenatal classes that pain happened but it would be over when the baby birthed.

### Status quo.

Status quo is defined as the "state of affairs as it is" (Oxford Reference Dictionary, 1986). Status quo is the nomenclature given to the sub-concept that describes current community belief of childbirth as a usual life event. Generally women are well during pregnancy and parturition. Birthing is not a disease. In an attempt to define status quo, the notion adopted is reflective of both physical and psychological health. Midwives interpreted pain of labour as being a natural event for well women. Some expressed the concept of pain in the simple terms of good and bad. Good related to expected pain for well women who experience a natural labour and birth.

*"We are looking after well women. They are having a baby which is a perfectly normal process to be occurring. Whereas an illness they are ill. You recognise that the woman is having a baby and is not sick. "(Midwife 7.)*

There is a growing trust in women's physiology; their bodies are designed for childbirth (Guilliland and Pairman, 1995; Sookhoo, 2002). Women are well and when they trust their body with birth many manage without intervention. The pain of labour is part of the experience.

*"...it is a good pain if it is normal. Certainly a bad pain if the bad comes*

*from something that isn't normally in the run of a normal healthy life. If you break an arm that is not a normal event you expect. However a mental attitude to it would occur. Coping with pathological pain is different to physiological pain. We choose to have a baby." (Midwife 1).*

Status quo represents the perception of the well woman experiencing a life event that is not considered to be an impediment to life. The midwife participants explain this with their comments on pregnancy and health. They differentiate birth from disease. Status quo is representative of what is considered the usual or typical birth event.

### Midwife Believing.

The word midwife is defined according to the WHO (1992, appendix 4) definition "A midwife is a person who, having been regularly admitted to an educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and /or legally licences to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for women, but also within the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planing and childcare. She may practise in hospitals, clinics, health units, domiciliary conditions or any other service".

Believing is defined as "to have confidence (in); trust; rely; through faith (on). 2.to be persuaded of the truth of anything; accept a doctrine, principle, system, etc. 3.to have belief in; credit; accept as true" ( The Budget Macquarie Dictionary, 1998). The beliefs the midwife participants referred to in their interviews were those that exposed their spiritual socialisation. Spirituality is described as the inherent knowledge of a force greater than or beyond ourselves. That is a sense of a greater existence, the

central and the eternal presence of our souls. A belief that this physical life is not all that there is (Ayers and Gould, 1999). This concept evolved from the reflection of personal beliefs held by the participants. When discussing their understanding of the woman in the birth relationship, some midwives believed there existed an intangible knowing of self. According to some midwives spirituality was evident especially when the midwives felt they had a connection with the woman. Occasionally it was felt that this part of a relationship was very poorly developed. The extent of spirituality was individual and very dependent on the chemistry between the two parties.

Spirituality is subjective and personal. It is an understanding of the immaterial aspects of life. Within spirituality of believing is acceptance of supersensual, untouchable, and a sense greater than physical experience. While all the midwives interviewed had a spiritual aspect to their practice, they expressed it from various perspectives. For some there was a combination of aspects of their own spiritual beliefs to explain their position, others described a singular spiritual belief that influenced their practice. Spirituality in health care is becoming acknowledged as having an affect on peoples' health status. People are searching for meaning in their life and their health. Coyle (2002) states that health and wellbeing are enhanced by the recognition of belief in spirituality. For the researcher the perception of another's spiritual belief is difficult to catalogue due to its diversity. McSherry and Draper (1998, p.683) suggest "that within nursing spirituality is defined in many different ways". Therefore a singular definition of spiritual belief is unobtainable as Harrison and Burnard (cited in McSherry and Draper, 1998, p.683) state spirituality "...is uniquely experienced and interpreted by each person and each person alone can provide another with unique perceptions of his/her spirituality". The concept of believing in this study is composed of three sub-concepts that emerged from the analysis of the data. They are midwife belief, emotion and woman's inner strength.

## Sub-Concepts Midwife Believing.

### Midwife Belief.

Belief is understood in the context of the Budget Macquarie Dictionary's (1998) definition "a conviction of the truth or reality based upon grounds insufficient to afford positive knowledge".

*"I guess as a midwife we see birth as a normal process of labour rather than something that is abnormal." (Midwife 3).*

and

*"Well I think the woman has the power over the midwife in a lot of ways because I think labour is controlled by the woman. This is my view the midwife is really there as a safety net I don't take ownership of anyone's labour. I think it is quite important that the woman feels in control. it's her big thing. I think if she feels that way she will labour a lot better and she will control and manage her pain much better. (Midwife5).*

The participants expressed individual beliefs that they justified for themselves. These they accepted as a rationale for a woman's pain of labour. The beliefs were personal and subjective. The ideas presented were influenced by their socialisation, their spiritual alliance and personal experience. Some midwives believed that pain in labour was a messenger that it was the signal for the woman to find a place of safety.

*"I think it is nature we expect pain. It is a messenger that's what it is," (Midwife 6).*

and

*"Irregular contractions they are not very painful but you know things are starting. You need to get organised-it is all meant for a purpose and if we go back 2000 years we got women around us, to help us birth the baby," (Midwife2).*

It is a time for a labouring woman to gather herself with other women to achieve the birth of her baby. Some beliefs were more extraneous.

*"Oxytocin the hormone of love influences orgasm, labour and breastfeeding. I believe in giving birth, having the pain of birth and the whole mothering thing like nurturing your child," (Midwife 3).*



and,

*"I don't believe in evolution I believe we were created. I know many years ago it was thought the pain of childbirth was a punishment from the Biblical story of Adam and Eve. I don't see childbirth as a punishment. I interpret it by delving back deeper the reason is a natural process we were created so I think underlying everything that is the common denominator. We are not evolving in evolutionary terms, if we were why do we still have the pain of labour?"*  
(Midwife 3).

and,

*"It makes me a bit angry, oh not angry but as though it's a punishment you have to have pain of labour, but its there and that's the way it is. From a physical point of view physiologically the structures of the body are being stretched and pushed and pulled and contracted. I guess in modern practice if all the pain could be relieved that would be pretty good. Now I think more than 20 years on since I learnt, not that I have practiced all that time, there is still as much pain. Why?"* (Midwife 1).

The beliefs of the midwives were individual and subjective, all related to birth as a physiological experience. However they also related their understanding of labour pain as being influenced by greater intimate personal beliefs such as a higher psyche notion of faith, evolutionary, or religious theories. Midwife spirituality is all encompassing of these beliefs. "Religion is a set of beliefs outlined within a particular doctrine while spirituality is an epitome of intangibility" (Ayers-Gould, 1999, p.1). Midwives used their beliefs to accept issues that they were not always able to fully control and /or explain.

### Woman's Inner Strength.

Inner strength is defined as "a central human resource that promotes well being" Roux, Dingley and Bush (2002, p.86). The participants describe inner strength as a mindset. The midwives described some women as being aware and able to use this

knowledge of self. This uncanny ability to accept pain of labour influenced the midwives to trust women experiencing labour pain. While women were not always able to articulate this phenomenon the midwife recognised it. The midwife used this sense of inner strength to validate the experience of pain of labour and to continue to encourage the woman to work through her labour at difficult times.

For the midwife she herself experienced reinforcement of her practice and used inner strength to constitute the use of her experiential knowledge. The experience of inner strength is individual and subjective.

*“Managing and experiencing the pain of labour are important and there are many different ways you learn to assist a woman with her experience. From my Christian view I believe on drawing on a spiritual strength – maybe that is missing for some people that inner strength. I find most people with a spiritual dimension to their life be it Christendom, Buddhism, yoga or whatever have a significant inner energy or inner strength to draw on,” (Midwife 7).*

The phenomenon of inner strength is discussed in nursing literature as being related to the integral part of healing, “inner strength in women is a positive healing force, which underscores their lives being charged to live, and to be, as fully as possible”, (Roux, Dingley and Bush, 2002, p.86). The nursing opinion of inner strength is usually applied to situations of adversity. A description of adversity includes ideas such as “bad, calamities, unfortunate” (The Budget Macquarie Dictionary, 1998). The concept of inner strength in labour was described as a positive experience of achievement, a natural good. One midwife discussed birth as an event in life that was equal to your greatest achievement. The pain of labour was not viewed as an adversity but understood as a natural part of birthing and life.

*“I don’t think we should take the pain away completely. I don’t think these days many women are asking for that. This may sound stupid but in a funny sense it is a bit of a rewarding experience, the pain of labour. When you are going through it and you don’t think, “I can do this any longer and I hate the world”. You sort of think why do we have to do this. But at the end I really think you get this huge sense of triumph I guess the pain contributes to that.” (Midwife 3).*

Some midwives used the woman's inner strength inner to accept that the pain of labour did not have to be fully relieved or relieved at all for some women they supported in labour. The women determine their own ability to apply this. Inner strength is described within the context of spirituality and dually linked to intuitive awareness, (Dingley, Roux and Bush, 2001;Roux, Dingley and Bush, 2002). For the purpose of this study the analysis has recognised the woman's inner strength as affecting practice. The midwives were convinced during the interviews that inner strength of the individual woman influenced their practice and enabled them to apply their own inner strength to supporting the woman. Often in beginning practice they did not understand this concept.

*"there is an inner strength there is a power greater than us to draw from and there are many people who have a different understanding of that. But they still believe there is something to draw on. I think that is sort of how you deal with things. I guess the encouragement is to try to get the woman to seek within herself the strength. (Midwife 5).*

The intimate relationship of midwife and woman allowed the midwife to recognise and utilise this ability.

## Emotion.

Emotion is any of the feelings of joy, sorrow, fear, hate, love, etc. (The Budget Macquarie Dictionary, 1985). Emotion is a significant part of human life and behaviour. Humans spend an extensive part of their life trying to reason, rationalise and manage emotion. Emotions have been described as a roller coaster ride the up, the down, the around, the joy, the depths of despair, the happiness and the triumph. Emotion can be divided into positive and negative aspects. There has been extensive research into negative emotions. They are perceived as being easily defined and categorised while positive emotions spill over into each other (Fredrickson, 2003). Positive emotions include happiness, joy and serenity. Negative emotions are those such as anger, fear and sadness. Emotion is cross-cultural and can be recognised when linguistic capabilities are unknown and not understood, (Kobayashi, Schallert and Ogren, 2003).

*"I have never been to a birth where I don't go through the pain with the lady and experience the joy and the tears of giving birth. Obviously there are midwives who haven't had children. Maybe they don't relate to birth as emotionally but they must be able to feel in a way themselves, and reflect on how the woman is behaving. The pain intensifies the emotion. She either internalises the strength that she is getting or she gets excited in a different way. Dealing with each pain knowing it is coming closer and closer to the joy of seeing the child that she wants. (Midwife 7).*

Emotion in midwifery has passed through varying historical ages. Up until the 1700's birthing women were cared for, prepared and indulged by other women. In some cultures the ability to birth behind closed doors gave women a power within their society. In the 1800's in western society, the influence of men began to erode the woman's culture of birth. With changes in practice came changes to the woman's ability to birth. Thus women were influenced to change their birth position. They were expected to lie on their backs to give birth – a subservient and demeaning style, which resulted in powerlessness. There was increased need for pain relief as labour was prolonged thus the introduction of anaesthetics such as ether. The introduction of forceps was an extension of the Doctor's hands and arms. Birthing found a new paradigm in medicalisation. The midwife became the obstetric nurse and the intimate relationship that included emotion was lost in western culture until the middle to late 1960's (Haplin, 1995; Thomson, 2000). With change to the art of midwifery and the medicalisation of midwifery practice that had occurred, a perceived need existed to relieve all pain. A shift occurred in the experience of pain that was measured by those around the woman. Pain affects each person emotively and individually. Our western culture expects that pain will be relieved and that there exists little benefit in having such an experience. Some midwives and advocates of natural birth in recent years have argued that to relieve all labour pain is to control the woman and to cheat her from the experience of enhancement that birth can be for the woman (Wagner, 2000). This places the midwife in the unenviable position of dealing with her own emotional response to pain and subjects her to the dilemma of understanding the pain value for women she supports.

There is some dialogue that values the pain of labour. It is believed to be a valuable

experience for the mother (Leap, 2000). The midwife is left to determine for herself the management of the emotion of midwifery practice.

*"It's meant to be a natural process I would like it to be as natural as possible. I don't like the pain of labour in women as I watch it as a midwife. When it comes to the woman being fully dilated I'm happier because she can push through the pain. I cope with that a lot better than strong contractions before transition" (Midwife 2).*

Midwifery care provided by the participants is for low risk women i.e. women who have no perceived health risk with birthing (Tracy, 2000), and predominately focuses on the midwife being with the woman, working with her through the pain of birth. Midwives talk about the excitement, the triumph and joy of birth. These emotions brought balance. Thus they felt it acceptable for the woman to experience the pain of labour. Midwives expressed the feeling of exhilaration in anticipation when the woman was reaching transition, the stage just prior to the birth of the baby. They focused toward the notion of reward from labour pain. This made the struggle of labour worthwhile.

*"Transition it is all so exciting. It means that the baby is going to be born soon. The pain of pushing a baby out. I can't even imagine how it would be not having had a baby myself. So I am probably maybe a little less sympathetic than the midwives who have babies themselves. I can maybe just see it as a sort of physical thing that has to be done. I don't sort of have any emotions about a baby. I have often thought to myself am I less emotional because I haven't had a baby myself? You know I try to keep from getting personally involved." (Midwife 2).*

Midwives acknowledged variation in not having had and having had a personal birthing experience. This they believed affected their responses to each woman. The midwives acknowledged how difficult it was to evaluate the emotion of another midwife. This reinforced how personal the experience was for each of the participants.

The pain of birth is believed to be a positive emotional experience (Leap, 2000; Wagner, 2000). The midwives felt emotive about the pain. It was considered that the

pain of labour enhanced the emotion of birth.

*"I find some people you can relate to. I think you enjoy their labour more, and you can probably get close to them. Others you do not have that emotional tie, that connection with them. They are just a person. There's not that sort of bond and I think that makes your experience of the labour and the bond different. The bond is a personal thing that happens. I don't know if it makes a difference to the pain. You don't know if they are feeling the same as you. I might not feel that I have made a bond and they might not either. If they didn't, as well, their labour experience could be quite different." (Midwife 5).*

Pain is not without emotion it affects the individual who experiences it and it affects the carer. In midwifery practice the midwife balances the dilemma of fully relieving a woman's labour pain or allowing her the opportunity to experience part or all without analgesia. For the midwife this tests her understanding and beliefs of the pain of labour and affects her emotive response for each individual labour.

## The Paradox of Realisation.

While the concepts and sub-concepts make up the core variable *coming to realisation* there existed an influence that had an unsettling effect on the midwives' confidence in the concepts previously explored. This element is presented as the paradox of realisation. It is subtle and disturbs the midwives' understanding and beliefs. The paradox is a state of confusion that has emerged with the formal knowledge and the experience of practice knowledge for each midwife.

Experience is explained as "knowledge or practical wisdom gained from what one has observed or encountered, or undergone" (The Budget Macquarie Dictionary, 1998). Experience is the by-product of living. Each member of society does not live free from it. To describe experience one can accept the simple understanding of the average man on the street or it can become a philosophic debate. Experience can be personal or group based, it can be family indoctrinated or from wider societal nurturing. For the purpose of this thesis experience is part of the initial learning from

formal education and continues to develop with the midwife's practice. Experience is learning in all forms. The individual sifts and collects experience to be included in his/her own portfolio of practice.

The midwife participants were all registered nurses. In the rural hospital they are required to practice both as registered nurse and midwife. Traditionally the nurse is illustrated as displaying caring, moral and hands on persona. This is an illusion of the Nightingale School not the practice of the modern professional nurse (Bradshaw, 1999). Pearson (2003) suggests that nursing has a dilemma of conflict and confusion, which has undermined the caring role of nursing. He suggests that the modern nurse has progressed to a world of care, which has a significant proportion of technology and medical intervention within its practice domain. Midwives in the study spoke of less intervention and medical support in their practice domain when supporting the labouring woman. They considered that there was value for the woman to experience labour pain.

The personal experience of the midwife influences not only the management of pain in labour but education of women in the antenatal classes. A midwifery care model relied on the strength of the woman to manage her pain.

*"I believe having been through it myself it is an invaluable tool in how I can deal with women in labour. But as to whether it is of value to someone else who has never experienced it I'm not sure. Its totally a personal thing but they don't know what they are missing until they have it and that's rather awkward. Certainly I guess its like I've got to climb Mt. Everest because it is there. You don't really know what you can achieve with your inner strength until you put yourself in those sort of circumstances. I think as far as trying to teach women about labour pain in antenatal classes it's the way you approach it.*

*Just for an example the last antenatal class I took, I came away feeling absolutely appalled. They were so set on not experiencing the pain, when I believed it was part of the whole concept of having a baby. To the point where they even said could you have a local anaesthetic so you don't feel that stretching that inevitably comes with the stretching of the perineum. I thought what do you want out of having a baby? Don't you want the*

*whole experience at all because without the pain of it all, it just, I don't know you don't experience what you need to experience to get the glory of the end result" (Midwife 7).*

Confusion is subtle. The midwives in the study worked both with sickness and wellness. A contrast exists between the provision of midwifery care and that of the registered nurse providing health care to the sick. The nurse provides care with the aim of cure. Pain management and assessment of the ill and the well person can create confusion. Contrasting philosophies exist in the contextual setting, the rural hospital. With experience the midwife develops boundaries of professional practice. The confusion of philosophies relates to the nurse and midwife roles being acted out almost simultaneously in the rural hospital. In this context the nurse/midwife roles are interchanged frequently with her mixed patient allocation. She swaps between care paradigms of the sick to the well.

A midwife disclosed,

*"I actually see myself as a rural and remote nurse and a midwife. I would like to be a midwife all the time if it was a different place. When I look at my practice, midwifery is my favourite passion. Interesting, I think having worked here I would be frustrated at a regional hospital. I know I would be frustrated because I suppose in our hospital you can almost give home birth experience to people in the building of the hospital. I would be restricted with procedures, instructions and Dr.s orders that is in the teaching hospital. Here we don't have student doctors or a Dr. on site unless needed so we don't have the opportunity for looking for ways of intervening so I know I would be frustrated. We are pretty well able to practice as a midwife and not as when I was training. When I was training you had to do what the doctor wanted, I want to be able to use my own initiative I want to be a midwife not an obstetric nurse." (Midwife 4).*

The midwife's experience is one that is intimately involved with the birthing woman. While this relationship may be short lived in comparison to the span of one's life, it impacts significantly on the midwife and the woman. Support of the pregnant woman has changed in recent years with the rejuvenation of midwifery practice. Midwives



are being challenged to consider the notion whether the woman should experience any labour pain (Leap, 2000). She believes childbirth to be a natural event. The midwife seeks to satisfy and understand herself that to give pain relief in labour may be necessary but there is guarded application of the use of pharmacological analgesia. Flint (1986) and Leap (2000) both midwifery advocates agree birth is a natural process and women can gain fulfilment from the experience of labour pain and a natural birth experience but some may need some pain relief. The midwife has a role to be with the woman and provide her with the support that best meets the individual woman's needs for the pain of labour. The participant midwives used their understanding from their experience to determine the need for pain relief. In some situations a compromise is proposed. The midwife reasoned if the pain is too severe the woman will not be physically and psychologically enhanced by the experience of childbirth pain. Midwifery led models offer a trial of non-pharmacological pain relief as an option before narcotic analgesia or epidural anaesthesia is offered.

*"I see people in pain, the pain of labour. I don't mind early labour because it doesn't show on people's faces as much as later. They also don't make as much noise and sounds. Early in labour people seem to cope much better with pain than later in labour. It does upset me a little bit to hear people in pain, in later stages of labour and especially coming up to transition. I sometimes leave the room so I don't have to experience hearing or watching someone in pain. That's the way I deal with it, sometimes. Although I know that it is good pain and it needs to happen, I don't like to watch women in pain. I guess that I like to think women can manage naturally I am not really for epidurals and pethidine, probably nitrous oxide I don't mind as much. I prefer for the woman to go through the process without any pain relief." (Midwife 2).*

The paradox of realisation exists for each midwife in different degrees. The midwife recognises a dilemma that impacts on her practice. The dilemma relates to how best the midwife can meet the woman's needs when supporting her through the pain of labour. The midwife succeeds in accepting that the woman is able to experience the pain of labour, but some midwives acknowledge that they experience their own discomfort from the woman's pain in labour. Thus some distract themselves from the

pain focus while other midwives celebrate the pain.

The midwife in the rural hospital works a variety of clinical pathways with her allocated patient load. A philosophy of patient care for the general patient with pain is to immediately relieve pain as it is considered to have an adverse effect on the patient.

*"I have either been a midwife or a general nurse and I found that if you are working in a labour ward as a midwife and working in a general ward it can be difficult wearing two hats. You treat patients differently. You could have a woman screaming her head off with labour pain and that can be O.K. If you went down the general ward and you had a person rolling around in pain you'd be horrified, you would stop their pain immediately. I guess in lots of ways it is difficult to wear two hats." (Midwife 5).*

Thus the concept of natural birth without intervention supports these midwives to deal with the dilemma of the pain management. They employ their own understanding and beliefs to justify the "rightness" of allowing the woman to experience labour pain. In support of their practice they adapt and apply the concepts of hearing, seeing, knowing, birthing and midwife believing, and rely less on previously learned methods from their educational programmes.

## Summary.

This chapter has presented a substantive theory developed from analysis of the experiences of midwives when coping with the pain of the labouring woman in a rural hospital. The theory was presented as a conceptual framework, of a core variable composed of five concepts called hearing, seeing, knowing, birthing and midwife believing. The concept of birthing had the sub-concepts of natural, finite and status quo whilst the concept of midwife believing contained the sub-concept of midwife belief, women's inner strength and emotion. The five concepts are depicted as five distinct circles within a large circle which represents the core variable *coming to realisation*. The midwife's understanding and beliefs of the pain of labour are not

clear and discrete, but rather they are mediated by times of uncertainty identified as the paradox of realisation.

## Chapter 5.

### Concluding the Study

#### Introduction.

The purpose of this study was to explore what midwives in a rural hospital understand and believe about the woman's pain of labour. From the individual experience of the midwife participants the study develops and explains the knowledge acquired during practice and presents this outcome. Grounded theory was the research method used to complete the study. This method allowed the researcher to explore the lives of a group of midwives in the contextual setting of a rural hospital. In doing so the complex understanding and belief paradigms of the individual midwives during their relationship with the woman experiencing the pain of labour are uncovered.

This chapter provides an overview of the study, presents the propositions and discusses them. The propositions present the findings of the study and encapsulate the varying ways that midwives understand the woman's pain of labour. A brief consideration of the implications for midwifery and further research are included.

#### Overview of study.

When the woman is experiencing pain of labour the midwife is dependent on her own knowledge and experience to provide safe and effective practice. In providing support and guidance the midwife endeavours to give the woman a positive experience of birth. Women espouse many varied understandings of the role of the midwife (Benjamin et al. 2001). In this rural setting the midwife is the main professional support for the woman during labour and in most cases the sole practitioner until the birth of the baby is imminent. The midwife in the rural setting is also required to practice as a Registered Nurse providing clinical management skills to the rest of the hospital patients. Thus there exists a dichotomy of two different care philosophies for

the midwife when managing pain. The general nurse recognises that pain has a negative effect on the healing of her patient and consequently acts to relieve this (Edwards et al. 2001). The midwife has been educated toward a liberal view that labour pain for the birthing woman is mostly an enhancing and empowering experience (Mander, 2000).

This research aimed to explore how the midwife in a rural setting understood the woman's pain of labour. It is significant to consider what the midwife understands and believes, as the literature review essentially showed that there is a paucity of research that has focused on the midwife herself, (Hicks, 1991; Seibold et al. 1999).

Grounded theory the research method was used to complete this study. Data was collected using unstructured interviews from seven midwife participants. Although the midwives were all educated in hospital programmes their knowledge of pain relief differed. In today's context of midwives are no longer educated using the apprentice model in hospitals but are required to undertake some form of university study. Following analysis of data using constant comparison the core variable called *coming to realisation* emerged. Five concepts hearing, seeing, knowing, birthing and midwife believing make up the core variable. Two of these contained sub-concepts. Birthing had the sub-concepts of natural, finite and status quo; midwife believing had sub-concepts of emotion, woman's inner strength and midwife belief.

The core variable *coming to realisation* identifies the notion of development which occurs in the practice setting. The midwife did not often reflect consciously on this learning but still applied it in her work practice. The concepts were accepted as "just part of what you do". The isolation of a rural setting left the midwives less exposed to the influence of medical obstetric models and professional development opportunities (Hegney et al. 2002).

**Hearing** caused the midwives to respond to the woman experiencing labour pain (McKay and Roberts, 1991). In the earlier years of their training and student days, several midwives recalled how it was not acceptable for the woman to make a noise in labour as it created discomfort for those around her i.e. the nurse's, doctors, patients

and hospital visitors (Wagner, 1997). Thus women allegedly were given pain relief not only for their pain but also to soothe the ward. The midwives find that today the noise of the pain of labour is not unwelcome to them and they use it as an observational tool. The more confident the midwife felt with her auditory expertise the less likely she was to use invasive observational techniques such as vaginal examination for cervical assessment (Sookhoo, 2002).

**Seeing** was used to understand pain in labour. The midwife watched the woman making mental assessment of her progress using the pain of labour by viewing her behaviour. Wagner (1997, p.3) comments that, "midwives might be described as the health professionals who have good hands and know how to sit on them". The midwife participants described how they had learnt this often inadvertently observing the "old midwife" who characteristically undertook her care differently from the technological learning of the student midwife. The midwives had learnt to recognise the different stages of labour through their visual observation skills i.e. the non-verbal communication (Lundgren and Dahlberg, 2000).

**Knowing** was a difficult concept for the midwives to describe. They considered that they knew how the woman was progressing intuitively. There was no scientific basis to the assumption but a feeling of knowing. This knowing the midwives attributed to a feeling of trusting the woman's body to complete the birth that it was designed for. The intensity of intuitive knowing was individual with each midwife-woman relationship (King and Clark, 2002). The midwife used her intuitive skill to estimate the woman's ability to tolerate the pain of labour and consequently have an enhancing or non-enhancing experience (Mara, 2003).

**Birthing** as a concept represented a belief that each midwife had related to the purpose of the woman's pain of labour. This concept gave the midwives the permission they needed to allow the woman to experience the pain of labour (Leap, 2000). Birthing enabled the midwives to accept the woman's pain of labour. The midwives used the concept to rationalise and make their ideas of birth and birthing pain reasonable for themselves. It allowed them to relate their individualised belief of birth against their formal and experiential learning. The midwives knew although they

accepted that birth pain was physiological and usually there is no harm from a labour pain experience, there were times when the woman's pain made the midwife feel uneasy. The midwives intellectualised the pain of the woman's labour and described this using the three sub-concepts of birthing. These are natural, finite and status quo. Natural inferred that birth was physiological and owned by the woman. As such should be allowed to occur with as little intervention as possible to provide a safe outcome for the mother and baby.

Finite pain described a potentially narrow time frame. The midwives believed because the pain had a perceived and actual accepted end, it was different to the pain of an acute or chronic illness. The pain of labour has a defined end and therefore is finite. Status quo is the term applied to the last of the birthing sub-concepts. It explains that which is defined as typical or usual. It accounted for the commonplace or layman's understanding of birth

**Midwife believing** is related to the midwife's spiritual beliefs (McSherry, 2000).

Midwife believing was expressed by the midwives as affecting their understanding of the woman's pain of labour. Within this concept there are sub-concepts known as midwife belief, emotion, and woman's inner strength. For these midwives the woman's pain of labour was the resultant effect of the physiological process of birth. But there also existed other ideas the midwives used to understand why a woman should have labour pain and consequently experience this. The midwives expressed a need for there to be reason as well as a physiological cause for them to be able to let the woman feel the strenuous and exacting pain of labour. For this reason they applied spiritual beliefs to this vague phenomenon they expressed.

Midwife Belief is the sub-concept that considers the midwife belief system related to faith. The midwives talked of how they rationalised the pain of labour and deemed it reasonable for a woman to experience by using their faith. The faith was not necessarily based on a religious doctrine but a perception of their own socialisation about why humans exist in the world and thus the right and wrong of the pain of labour.

Emotion was mostly positive and used by the midwife to encourage the woman through strenuous labour pain. At times the midwife felt some negative stress within her own emotive state when the woman's perceived resources of endurance needed

the midwife to increase her power of encouragement (Mackin and Sinclair, 1998). At these times some midwives had a need to distract themselves from the woman and her pain to manage their own emotions.

Woman's Inner Strength was described as a resource you drew on from deep inside your soul. The midwives felt that when you had a belief system that extended past the materialistic world you were able to experience and recognise within yourself this notion of inner strength (Dingley et al. 2001). The midwives recognised it within women and within themselves and used it to encourage the woman who was struggling with her pain. The participants explained that if the woman did not have this resource or did not recognise it, the midwife was less likely to be able to use her own inner strength when supporting the woman through her pain. Their support was much more in the form of task orientation than with the added psychological resource of inner strength.

## Paradox of Realisation

While not diagrammatically represented in the conceptual framework there existed a subtle disquieting effect called the paradox of realisation. This was the feeling of disappointment when a woman's labour did not progress as the midwife expected according to the practice knowledge that she had used.

## Conclusions

The findings from this study are presented as a series of propositions. A proposition is defined as "an abstract statement that further clarifies the relationship between two concepts" (Burns and Grove, 2001, p.808). The propositions presented relate to *coming to realisation*. The midwives in this study use many ways to understand the woman's pain of labour. They have done this by using hearing, seeing, knowing, birthing and midwife believing.



Formal education contributes to the midwife's understanding of the pain of labour.

The midwives' formal education had been important for them as beginning practitioners. They described having been taught pain relief from various sources including an anaesthetist. Some believed their formal education about pain relief was minimal and not contemporary. These notions encouraged the midwife to enlarge on her knowledge. This was often difficult in the contextual setting of a rural hospital when their predominant practice domain was general nursing. Because of this impediment the midwife looked predominately to the woman and other midwives in the setting to expand her knowledge. Benner (1984, p.21) describes the formal education of the student as teaching the "features of the task world that can be recognised without situational experience". From their practice experience of the pain of labour the midwives apply their beliefs and their understanding of behaviour, which transforms their practice from a managed care model i.e. a concentration of meeting prescheduled time frames, to an expectant model of care i.e. a waiting, an acceptance that birth will occur within its individual time frame. In this way they utilise their understanding of the experience of the pain of labour in a positive way trusting the woman's body's ability to birth (Sookhoo, 2002).

The midwife evolves and expands her understanding of the pain of labour through experiential learning.

Experiential learning is gained from the practice setting and embedded into the midwife's practice domain. Bryscynski (1998, p.352) states "expert practice develops over time through committed, involved transactions....". Benner (1984 p.186) states that experiential learning is "by comparison of similar and dissimilar cases". This group of midwives found that they were using the pain of the woman's labour to understand and enhance their practice skills. Initially experiential learning was tentatively used in their practice but after repeat encounters with subsequent women it became more firmly embedded. The problem with some experiential learning is that it may not always be scientific and evidence based. Benner and Wrubel, (1989, p.202) comment on experience, "the health professional making a medical diagnosis relies

on a historical situatedness and a developed perceptual skill that together are commonly called 'experience'. Because this skill is embodied and results from a historical/contextual relationship, it completely contradicts all the Cartesian notions on which modern science is based." This describes the style of knowledge gathering used by the midwives of this rural setting. *Coming to realisation* is the recognition of learning expanding and evolving during the midwife's experience in the practice setting.

The midwife uses noise, sight and intuition to understand the woman's pain of labour.

The term "embodied expertise signifies that as human beings we know things with our feelings and bodily senses (touch, smell, sixth sense, etc) not just our rational minds" (Bryscynski, 1998, p.352). The midwives acknowledge they rely on noise, sight and intuition to understand the pain of labour and even more significantly how they will assist that woman to cope with her birth pain. They proffer their acceptance of noise, sight and intuitive skills that have been defined and developed to benchmark their individual practice knowledge. The recognition of these factors exists as a realisation, the actualisation of a consciousness of the midwives' knowledge that may be classed as the art of midwifery. Sookhoo (2002, p.77) suggests, "there is a tendency for midwives to claim specific knowledge about labour that reflects a unique 'midwifery' view of labour". This allows the midwives autonomous application of these skills.

Midwives used noise, sight and intuition as measures of the woman's labour progress.

The midwives tell how they use noise, sight and intuition when observing the woman cope with the pain of labour. These aspects they use to assess the stage of labour. In this study midwives discussed how they applied these factors to measure the woman's progress and particularly how the woman was coping with her pain of labour. The midwives state that through their experience they had learnt to be relatively comfortable allowing the woman to feel her pain. Rajan (cited in Mander, 2000, p.4)

states, “the midwife, compares the woman’s observed pain with the extremely painful labours she has attended and provides analgesia proportionate to the appearance of the pain”. The midwives avoided offering pain relief initially and during labour, if they believed the woman to be coping.

**Experiential learning gives the midwife confidence.**

Through practice the midwives had become adept at developing relationships with the labouring women. These relationships were short, intimate and autonomous. The midwives described different depths of relationship occurring but in all relationships there existed the element of spiritual belief. As midwives, they have adopted a mandate of beneficence and to provide humanistic support to their women (Woodward, 1998). Midwives liked to believe that women experienced labour pain for reasons that include the physiological and the spiritual. They had a personal need to understand the resultant pain of labour and did this by using their own spiritual beliefs. The intimacy of the relationship determined how forthright the midwife could be with the woman about her own spiritual beliefs. The midwives believed that aspects of the relationship affected elements of her practice. It seems that within the narrow practice domain of the rural hospital, the midwives were able to develop and postulate their beliefs as part of their doctrine of practice. Applying these beliefs to practice and encouraging the woman to birth within these parameters gave the midwife satisfaction in the relationship. Within each relationship the midwife evolved and evaluated her learning.

**The midwife’s belief of birthing allows her to let the woman experience the pain of labour.**

The midwives differentiate the pain of labour from pathological pain. They apply to each labour their belief of birth to help them understand the pain. In this rural hospital the midwives believed labour pain to be natural, finite and a status quo. The midwives personal beliefs are influenced by various factors of socialisation such as family, education, faith and cultural issues. Most beliefs are subjective and many are without

evidence. The midwife in this setting works predominately alone with the woman in labour. What the midwife knows of the pain of labour in this setting is from her formal education, from her experiential knowledge, and the application of birthing belief. Because of this, beliefs become enhanced and embodied in practice. The midwife measures her belief of birth when she reflectively considers the pain of labour and how it was managed.

The midwives experience a range of emotions while working with the woman in labour.

There is limited pain relief available in a rural hospital for the labouring woman and what is available does not always fully relieve labour pain. There exists a philosophy for the management of the pain of labour that does not seek to relieve this pain. The midwife encourages the woman to endure it with the expectation of the woman achieving a positive enhancement to her life experience (Leap, 2000). The midwife encourages the woman to participate with her pain in the birthing process as a positive experience. But in some situations the midwife described experiencing discomfort as a result of the woman not coping with her pain, when the labouring became prolonged, or past the estimated duration; or the intensity was greater than that which was anticipated. This notion of discomfort has been called the paradox of realisation. Some midwives in the study were more able to apply their beliefs to these situations and revel in the joy of pain while others may have not reached the same maturity or sophistication in their practice.

## Implications for practice.

With a reducing birth population in rural areas there are limitations on the midwife's opportunity to gain education and midwifery practice.

The crude birth rate provided by Austats (2000, p.1) reflects that the "crude birth rate for Tasmania has declined to be at 12.1 in 2000, the lowest rate ever recorded", which has resulted in cuts to birthing services in rural areas. This affects the availability of

government funding, and as discussed by Brodie and Barclay (2002, p.104) the need to rethink the delivery of midwifery services that have become “predominately based in acute care hospitals and with nursing models of organisation and management”.

The midwife in the rural hospital is limited in her ability to seek frequent professional development or network opportunities with midwives who work outside her rural area. This is not unusual for health workers in rural settings. Parsons (2003, p.246) states that “not only must research findings be relevant and achievable for rural..., but ways of implementing them must be appropriate, sustainable and mindful of the constraints of rural ...practice, such as isolation and difficulty getting locum cover”. It is implied that the rural settings may be limited in their opportunity to apply evidence-based practice when compared with metropolitan settings (Parsons et al. 2003). This notion supports the midwives’ application of understanding and beliefs from the pain of labour that they themselves develop through their experiential learning. Rural isolation and decline of birthing in the rural setting compromises the midwife practising as an advanced professional in midwifery. Monaghan (2001) suggests the “the profile of the average rural midwife emerges as a 47 year old woman, who has not completed further studies in nursing or midwifery, has little or no access to continuing education opportunities and works primarily as a nurse in a rural hospital or multi purpose centre”. Thus the role of the nurse in the rural setting role is often described as “Jack of all trades and master of none” (Hegney et al. 2002 p.179). Lack of contact with professionals in other hospitals has not been explored in depth but the premise is to recognise that for many, the demands of their family, the workday, available staffing for backfill, the accessibility of professional development and further education is restricted. Gibb (2003, p.243) discusses the impact of rural isolation on nurses suggesting that little is understood of “practice principles and theoretical tenets” that many may work outside the boundaries of their formal education to provide for the rural communities they serve”. The midwives in the study do not necessarily work outside the parameters of their practice but they modify practice using their experiential learning. With a falling birth rate the midwife’s accessibility to practice becomes questionable. There will be difficulties in maintaining competence without access to ongoing professional development and education.

The conflict of practice philosophies exists for the midwife working in rural hospitals.

The midwives involved in this study accept that in their rural practice they are required predominately to work as general nurses. This is not usually problematic except when pain management difficulties occur or patient staff ratios are compromised. As a midwife in a rural hospital the care domain extends from well woman birthing to the sick patient. Within this domain the midwife works with conflicting pain relief doctrines. For the well woman the midwife is encouraged by contemporary midwifery practice to allow the woman to experience her labour (Smulders, 1999; Leap, 2000; Thomson, 2000). The general nurse in practice provides the sick patient with complete or largely complete relief from his pain very quickly (Twycross, 2002). For the midwife the philosophy of pain management is quite different.

Patient/staff ratios are time constraints that dictate to the midwife how she can best provide care in the rural hospital. If she were the only registered nurse and midwife on the allocated shift, her obligations to the whole unit dictate how she will provide care if at that time she has both midwifery and general patients. In extenuating circumstances the birthing woman may have to transfer to the regional hospital if the midwifery staff are unable to provide for her care.

The midwife with experience in the rural hospital applies an expectant care model using her own enhanced understanding of the pain of labour. Information sifts into the practice of the midwife sporadically and she is influenced by the care needs of women she has birthed previously and by the views of her midwife peers. At the end of a labour the midwife has little opportunity to explore and reflect on her practice as she readily returns to her dominant role of nurse to ill patients. In most cases, the midwives explained that they were able to readily handover the care of their general patients to another health provider. However, sometimes there were issues that resulted in the labouring woman being the predominant care focus.

The implication of this situation is a lack of continuity of care. In a continuous

supported relationship, women experience greater satisfaction of labour and childbirth (Seibold et al. 1999). Throughout Australia contemporary midwifery is endeavouring to advocate midwifery models that are woman centred and reflect the practice of the midwife according to the WHO (1992) definition of a Midwife. This definition requires that a midwife after education deemed appropriate by the registering authority of her country be able to provide holistic midwifery care to the woman and her family. In the rural hospital the midwife provides a static midwifery care model, as her dominant health role is that of a general nurse Monaghan (2001, p.1) describes “rural midwives are truly multi-skilled members of the health team, providing aged, emergency and outpatient care, with midwifery often comprising less than 10% of their nursing role”. Currently the individual midwife in the rural hospital is not able to provide the woman and her family with a continuous midwifery model of care such as caseload or team midwifery. The primary care provider during antenatal, intrapartum and a six-week post-partum period remains the domain of the general practitioner.

### **The midwife acknowledges conflict within herself.**

The study has exposed a conflict for some midwives of the total acceptance of labour pain, especially when they perceive the woman to be not coping. At times the midwives have an emotive struggle with what they believe to be excessive pain in labour. Midwives have personally evolved ways to validate the issues of discomfort of labour pain for themselves by using their understanding and belief systems. From the study, evidence it has been shown that they are usually successful in achieving this. There exists a need to better understand the psychological impact that occurs on the midwife’s personality and her practice. The midwives in the study placed importance on the fact that they were able to give the woman the most enhancing experience, felt privileged to be within the relationship and worked to achieve what they believed to be the desired support for the woman. The endeavour to provide a model of care that is reflective of the art of midwifery, placed the focus on the woman and how she coped with her pain of labour while achieving the birth of her baby. The midwives have used what they understand and believe about the pain of labour to direct and evolve their practice in this rural setting. This study is important as it

uncovers the persona of the midwife and explores her perceptions of her craft. Today education programmes encourage continuity of support through midwifery models. I believe it is vital that we understand the psychological impact that these models have on the midwives themselves.

### **The silent practice of rural midwives.**

The results of this study present a view that represents the midwives in practice at this rural hospital. This small group has limited contact with colleagues outside the setting. These midwives, within their scope of practice are able to refine and evolve the domain of their practice parameters to offer and provide what they believe the woman is asking for during their labour. As births decline in rural areas the opportunity for midwives to continue to practise using the natural art of midwifery will only be viable for a small number. The decline of birth rates removes opportunity for the midwives to progress their practice with an individuality seen in the rural hospital. The practice of each midwife in this rural setting is personalised but not a culture. Although the midwives consult each other on different aspects of care, they practice alone until the birth of the baby. The implication of this practice is that it will be eroded and not recorded in the history of midwifery.

## **Suggestions further research**

Further research in to the practice of midwives and how they understand their practice will increase knowledge of how the midwife feels and responds in varying practice domains. Hicks (1991, p.13) proposed that her research had highlighted the deficit in midwifery research. She gave reasons such as lack of “academic tradition...,lack of confidence..., female domination managerially and numerically...,10% of nurses are male...,around 0.1% of the midwifery population is male” in comparison. She asserts that midwives may have “some added real or perceived obstacle in their research paths” when compared to nurses whom she also criticised for being tardy with research work.



Research studies similar to this study investigating rural and remote practice could support needs for professional development, the best practice notions for these settings and provide indications of practice deficit.

As there is a paucity of research that reflects the role, the professional persona, the creativity and views of practice of the professional midwife I believe that further research is warranted to explore these aspects. Hunter (2001, p.437) states “lack of research based evidence is surprising, given the nature of the midwife’s work. Contemporary textbooks for student midwives emphasize the significance of psychosocial aspects of care but little is known of providing such care for the midwives involved. This is in contrast to nursing...” (e.g. Sweet & Tiran, 1997). Research is needed to investigate the issues that include practice philosophies, their implication for practice, the midwives expectations and notions of their relationship with women birthing. Lundgren and Dahlberg, (2002) comment that the midwife has much unexplored territory to be investigated.

Further research into rural practice would capture how midwives work in small isolated settings and provide guidance for the provision of remote educational programmes. Research studies that explore the professional world of midwives especially in the rural context is lacking. Researchers such as Hegney et al. (2002), Gibb (2003) and Parsons et al. (2003) have explored rural nursing, including mental health but there is a gap when it comes to the role of the midwife. The value of exploring midwives’ ways of thinking, is that it will help to define the profession of midwifery as being distinct from the profession of nursing. There is no intention to provide one profession with a greater status than the other but I believe there is a need to be able to understand the professional personality of each and thus consider and provide practice parameters that fully enhance the midwife’s individuality. Brodie and Barclay (2002, p.104) sum this up in their paper discussing *Contemporary issues in Australian midwifery regulation*, “ in many western countries midwifery has always been recognised as a discipline distinct from nursing. Recently, some countries such as the United Kingdom and Ireland have reasserted the value of this distinction” they have done this by the inclusion of midwifery in the name of their legislative act i.e. *Nurses, Midwives and Health Visitors Act 1998*. Advocacy for similar recognition is

occurring in Australia.

## Reflections of a novice researcher

In writing these reflections I wish to share with you some variable feelings I have had since commencing this study. In the beginning I was encouraged to undertake this study program by a person who was supporting the clinical placement of second year nursing students in the rural setting. I was assured of great support and thus with some doubts convinced myself that this could be a worthy life experience for a clinical nurse midwife. I expected to learn and believed that learning would be a valuable asset to my own skills and as a preceptor of students.

I presented to a session that was being conducted parallel with the Honours program to find myself one of several Master of Nursing students. Without this integration with the Honours program I would most probably have not continued. These students who were enthused, stressed, and appearing vital and focused provided me with much information on housekeeping issues such as how to access the computer laboratories to where you can eat. I will be forever grateful for their tips and orientation to a lifestyle that was a vague notion to me at that time.

I conscientiously attended all the tutorial sessions scheduled for the units required before commencing my research. Planning weeks ahead around a fulltime shift work position in the rural hospital, arriving in the nick of time to the teleconference or the video link after completing a day's work. I used long service leave and annual leave to meet time frames. My plan had been to complete the study well within the university time line. I was to be thwarted at each turn. After completing 4 units of study and ready to present my ethics application my allocated supervisor accepted a life change and I was allocated a new supervisor. Unfortunately this was to be a tumultuous relationship. This supervisor and I were at either end of the spectrum of thought on midwives. Not having any midwifery background and admitting to little practice understanding of Grounded Theory created a cavern of great disparity which I found after time that I could not endure.

In a state of distress I found that it was not kosher in the university environment to inform one that you can no longer work with them and search to find a person who has some understanding of the project begun. Thus respecting decorum I then proceeded through the accepted ritual of changing my supervisor. This meant a period of time would be lost to me to progress my research and would extend my time as a student. During the tutorials that I had attended I had been impressed by a presentation by a lecturer who had spoken on Grounded Theory. Knowing this person to have a clinical background which included midwifery I sought her support to complete my program. I am grateful to her for the skill she has shared and the emotional support given to me when I consider her full life and work agenda.

This began a period of working very hard to complete this research meeting personal deadlines and learning to write in an academically accepted format. As a clinical nurse and midwife writing is not a first priority much of our information is passed on orally with limited writing which is often short, precise and static. With the help of my supervisor Judy and the support of a retired nurse academic Joan I have learnt much about the method of writing for a different audience to that of the clinical unit. I have learnt in great depth about Grounded Theory, its values and foibles. Mostly I have learnt about myself. This has been a lonely existence for the last three years as a part time student. I have neglected family, friends and all those interests that one evolves through life. I have learnt that I can endure when it would have been so easy to walk away from this project. The challenge to complete actually provided a deeper understanding of myself. This research project has become in many ways a trial of personal endurance to see how much I could persevere alone. If I had known the inevitable family challenges that were to appear in my life along the way I may not have ever begun. Those challenges include relocation of our residence for my husband's employment, a son who married and wished his mother to make all except the wedding gown for the occasion and a daughter who has required much support during a failed relationship and her witness of an armed robbery and murder in her work place. Today as I complete this thesis I feel emotional as I accept that I have come to the end. While I feel positive about the experience there are many tears that have been held back which have come from the hard knocks along the way. With

great humility I thank all those persons, including the dogs and the cats that have supported my great desire to complete this project and the knowledge they have made me learn and accept about myself.

I set out to explore the understanding that midwives in a rural hospital have of women's pain of labour and this I believe has been achieved. Midwives in this setting are strong and courageous women who give unselfishly to the women they support. Grounded theory has allowed me the opportunity to present this in a way that is reflective of practice and the contextual setting.

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