Optimal midwifery decision-making during 2nd stage labour: the integration of clinical reasoning into midwifery practice

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Optimal Midwifery Decision-Making during 2nd Stage Labour:
The Integration of Clinical Reasoning into Midwifery Practice

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A dissertation submitted in fulfilment of the requirements for the award of
Doctor of Philosophy

16 April 2012
STATEMENT OF ORIGINALITY

I certify that the work presented in this thesis is, to the best of my knowledge and brief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University.

16 April 2012

Signature of Candidate

Date
ABSTRACT

Research Question:
What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?

Thesis:
Good clinical reasoning and good midwifery practice are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour.

Background Literature:
Previous research in decision-making primarily focussed on antenatal period. Literature on 2nd stage labour including the factors perceived to influence the midwife was extremely limited. No research has addressed the research question for this study.

Methodology:
Post-Structural Feminism provided the methodological foundations for this study. A modification of Denzin’s Interpretative Interactionism was used as research design. Twenty-six midwives were interviewed and invited to give both a negative and a positive decision-making story.

Key Findings:
Collectively, good clinical reasoning and good midwifery practice produce optional midwifery decision-making during 2nd stage labour. Out of a total of 16 stories there were only five cases of optimal midwifery decision-making during 2nd stage labour. Second stage labour is a unique and rapidly changing situation and this research found that the woman being the final decision-maker was not essential to optimal decision-making during this time. Further, some midwives abdicated responsibility for decision-making to the women and/or their support people.

Conclusion:
Midwifery education and practice should be designed to build clinical reasoning skills to a high level of proficiency. Midwifery, as a woman-centred discipline, however, needs more than cognitive clinical reasoning to reach optimal decisions. Midwives take a woman-centred approach to care and need to be able to make an independent decision if and when the woman is unable to participate fully in decision-making.
PUBLICATIONS ARISING FROM THIS RESEARCH

Refereed Journal Articles

Published


Conference Presentations

Accepted


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My sincere thanks are expressed to the midwives" who participated in this study and shared their positive and negative decision-making experiences during 2nd stage labour.

Throughout my PhD journey, Professor Kathleen Fahy and Dr Deborah Sundin have given guidance and supervision for which I am sincerely grateful. I have been nurtured yet challenged, supported yet encouraged to explore my knowledge base and confront new concepts, which has reshaped who I am as a student, midwife, academic, woman, wife and mother.

My sincere thanks are expressed to Vanessa Owen, my friend, mentor and critical reader.

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### GLOSSARY

<table>
<thead>
<tr>
<th><strong>Accountability</strong></th>
<th>“…the obligation of being answerable for one's own judgments and actions to an appropriate person or authority recognised as having the right to demand information and explanation…”(^1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth</strong></td>
<td>I acknowledge that the term birth is often used in broader terms, however in this study, birth is considered to be the time from the beginning of the (2^{nd}) stage of labour up to and including the hour after the birth of the baby.</td>
</tr>
<tr>
<td><strong>Birth Sanctum</strong></td>
<td>“…a homely environment designed to optimise the privacy, ease and comfort of the woman…” (2 p18).</td>
</tr>
<tr>
<td><strong>Birth Territory</strong></td>
<td>The environment that is external to the woman/baby. It includes the physical features of the environment (terrain) and the use of power by people within the environment (jurisdiction) (3)</td>
</tr>
<tr>
<td><strong>Clinical Decision-making</strong></td>
<td>“…A complex process involving observation, information processing, critical thinking, evaluating evidence, applying relevant knowledge, problem solving skills, reflection and clinical judgement to select the best course of action which optimises a patient’s health and minimises any potential harm” (4, 5). Act or process of choosing a preferred option or course of action from a set of alternatives. It precedes and underpins almost all deliberate or voluntary behaviour (6).</td>
</tr>
<tr>
<td><strong>Clinical (Bayesian) Inference</strong></td>
<td>A form of statistical reasoning in which prior probabilities ((^2)) are modified in the light of data or empirical evidence in accordance with Bayes’ theorem to yield posterior probabilities, which may then be used as prior probabilities for further updating in the light of subsequent data (7). Bayesian techniques are used in the assessment of probabilities, in particular where additional (if still probabilistic) information can refine estimations of the likelihood of events (6)</td>
</tr>
<tr>
<td><strong>Clinical Judgement</strong></td>
<td>“…the assessment of alternatives” (8).</td>
</tr>
<tr>
<td><strong>Clinical Reasoning in Nursing</strong></td>
<td>Clinical Reasoning in nursing is “the process by which nurses collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes and reflect on and learn from the process” (9)</td>
</tr>
<tr>
<td><strong>Critical Thinking</strong></td>
<td>“…Purposeful, self regulating judgement using interpretation, analysis, evaluation, drawing conclusions and explaining supporting evidence” (4)</td>
</tr>
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</table>

A purposeful activity in which one explores all perspectives, including strengths and limitations in order to facilitate the decision-making process (10).
<table>
<thead>
<tr>
<th><strong>Decision-making</strong></th>
<th>Act or process of choosing a preferred option or course of action from a set of alternatives. It precedes and underpins almost all deliberate or voluntary behaviour (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disintegrative Power</strong></td>
<td>Disintegrative power is an „ego“-centered use of dominating power that disintegrates other forms of power within the environment and imposes the user’s self-serving goal. It may be used by the woman, the midwife and/or any other person in the territory. The use of „disintegrative power“ undermines the woman’s ability to be able to feel, trust and respond spontaneously to her bodily sensations and intuitions. This is a disintegration of the woman’s body-mind-spirit unity that separates her from her embodied power thus weakening her and lowering her energy (3).</td>
</tr>
<tr>
<td><strong>Egoic Birth</strong></td>
<td>is defined as “…using energy that is hard, determined or manipulative of others to get what she/he wants and to block out other knowledge or possibilities” (11).</td>
</tr>
<tr>
<td><strong>Forced Birth</strong></td>
<td>“…power is used to try and force a particular type of birth.” (12 p234).</td>
</tr>
<tr>
<td><strong>Genius Birth</strong></td>
<td>“…A „genius birth“ is defined as one where a woman responds to labour challenges by drawing from usually hidden capacities deep within her embodied self. In actualising her inner power, she combines it with her conscious intention to experience a physiologically normal birth. A „genius birth“ is not contrived but, rather, is conscious and effortful even if, in taking account of her holistic wellbeing at that particular moment of her life, medical interventions are accepted” (12 p235).</td>
</tr>
<tr>
<td><strong>Heuristic decision-making</strong></td>
<td>It is a process of reasoning that just occurs therefore cannot be rationally explained (13)</td>
</tr>
<tr>
<td></td>
<td>Enabling a person to discover or learn something for themselves: a „hands-on“ or interactive heuristic approach to learning. Computing and proceeding to a solution by trial and error or by rules that are only loosely defined (14).</td>
</tr>
<tr>
<td><strong>Hypothetico-Deductive Theory</strong></td>
<td>“The standard research method of empirical science in, which hypotheses are formulated and tested by deducing predictions from them and then testing the predictions through controlled experiments, hypotheses that are falsified being rejected and replaced by new ones” (9).</td>
</tr>
<tr>
<td><strong>Integrative Power</strong></td>
<td>Integrates all forms of power within the environment to some shared higher goal. The primary aim of using „integrative power“ is to support integration of the woman’s body, mind and spirit so that she feels able to respond spontaneously and expressively to her bodily sensations and intuitions. The integration of ego and inner self which is inherent in body-mind-spirit increases her energy, strength and power (12).</td>
</tr>
</tbody>
</table>
| Intuitive Humanistic decision-making | An understanding without rationale (15).  

“...Judgement is a product of interaction between an individual and environment and cannot be understood by studying either in isolation (4) to “act on a sudden awareness of knowledge that is related to previous experience, perceived as a whole, and difficult to articulate” (16). |
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<tbody>
<tr>
<td>Jurisdiction</td>
<td>Having the power to do as one wants in the birth environment (2).</td>
</tr>
<tr>
<td>Macro</td>
<td>The birth space within the broader environment that operates as an integrated social system (17)</td>
</tr>
<tr>
<td>Meso</td>
<td>“.the environment” including the birthing unit and the hospital (17)</td>
</tr>
<tr>
<td>Micro</td>
<td>“.individual birth space (17)”</td>
</tr>
<tr>
<td>Midwife</td>
<td>A midwife “works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures” (18, 19).</td>
</tr>
<tr>
<td>Midwifery</td>
<td>The discipline of midwifery is based on a philosophy of primary health care and partnership with the woman. The woman/midwife partnership model of care is woman-centred. Women-centred care embraces trust, empowerment, a supportive environment and continuity of care (20).</td>
</tr>
<tr>
<td>Midwifery Abdication</td>
<td>“...the midwife surrenders her voice and/or forsakes her midwifery skills and/or knowledge, consciously or unconsciously, failing to fulfil and be accountable for her own professional behaviour in accordance with professional frameworks as (primary) maternity care provider for the woman”.</td>
</tr>
<tr>
<td>Midwifery Domination</td>
<td>Is a form of „disintegrative power“ that is based on the midwife’s use of disciplinary power. „Midwifery domination“ is disturbing because it interferes with the woman’s labouring process by inducing the woman to become docile or weak. Being docile requires the woman to follow the midwife’s advice and therefore disintegrates her own embodied knowledge and power. Alternatively it may lead to resistance and fighting on the part of the woman which disrupts the mind body spirit integration needed to birth well (12)</td>
</tr>
<tr>
<td>Midwifery Guardianship</td>
<td>„Controlling who crosses the boundaries of the birth space and creating and maintaining harmony within the room. The aim is to allow the woman to experience undisturbed labour and birth so that she can access her own „integrative power“ (3).</td>
</tr>
<tr>
<td><strong>Midwifery Partnership</strong></td>
<td>Midwife/woman partnership is a woman-centred approach where the midwife and the woman work together in ways where the woman experiences the relationship of „professional friendship,” „being equal”, „sharing common interests” „involving the family”, „building trust”, „reciprocity”, „taking time” and „sharing power and control” (22) (p. 210).</td>
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</tr>
<tr>
<td><strong>Worthwhile/worthileness</strong></td>
<td>“...of value or importance...”(33) “..derivatives”(34)</td>
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the ANMC Code of Ethics for Midwives (32) and the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (14).
Chapter 1

Introduction

This Chapter contextualises the work in this thesis. Recently, the State Coroner for Queensland reported on the case of Baby Samara Lee Hoy (35). The coroner highlighted poor midwifery decision-making during 2nd stage labour as having contributed to the baby’s death. Essentially, during the last hours of the woman’s labour, the baby’s heart rate rose from a baseline of 125 beats per minute (bpm) over a period of several hours to 170bpm: this rising heart rate was indicative of fetal distress. The midwives, however, did not engage in clinical reasoning because, if they had, they would have taken appropriate action: at a minimum that would have involved consultation with the woman and the doctor. The baby’s heart rate should then have been continuously monitored via electronic fetal monitor. In this case the midwives did not seek to consult with a medical practitioner for approximately four hours. The doctor eventually performed a forceps delivery and Baby Samara was born extremis through fresh meconium. The midwives’ failure to actively engage in clinical decision-making, in conjunction with “substandard obstetric care” was ruled by the Coroner to have contributed to the baby’s death. This case highlights the importance of good clinical reasoning and good midwifery practice in 2nd stage labour. Further, it demonstrates the importance of: safety and quality in midwifery practice and individual midwifery accountability. Also lacking in this case was any sense that the midwives were working within a midwifery philosophy which places the woman at the centre of decision-making in her own care. The action of the midwives contravenes Australian midwifery regulatory codes of conduct (14, 31). This story frames many of the main issues that this thesis addresses.

The research question that guided this study is:

“What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?”
The aim of this study is to produce a model for midwife decision-making during 2nd stage labour that is consistent with good clinical reasoning and good midwifery practice.

This chapter begins by defining the key terms associated with this study (Table 1.1). Next, the research problem is identified before presenting the background to the research problem including specific midwifery issues such as: safety and quality in healthcare, safety and quality in midwifery, individual accountability within a midwifery philosophy and the woman as decision-maker. In the next section an overview of my journey to the research topic is provided with a synopsis of myself: acknowledging my identity as a woman, a feminist and a midwife. Next, the original research question is presented and how the focus of the research changed over time is described. The study’s significance as it relates to: safety and quality of midwifery care for the woman and baby, theoretical contribution to the midwifery profession and midwifery education and the organisation is stated. The final section of this chapter briefly outlines how the remainder of the thesis is presented.

I acknowledge that the term birth is often used in broader terms, however in this study I have limited birth from the beginning of 2nd stage labour up to and including the birth of the baby (28).

1. Definitions of key terms

A brief definition of the key terms is given below in table 1.1, however full clarification of the terms can be found within the chapters of this thesis and the glossary.

Table 1.1 Definitions of key terms

| **A Necessary Condition:** A condition X is said to be necessary for a condition Y to occur, if (and only if) the nonexistence or non-occurrence of X guarantees the nonexistence or non-occurrence of Y (23). E.g. a sperm and an ovum uniting are both necessary conditions for pregnancy to occur. |
| **A Sufficient Condition:** A condition X is said to be sufficient for a condition Y, if (and only if) the existence or occurrence of X guarantees the existence or occurrence of Y (23). E.g. A fertilized ovum and successful implantation and growth within a healthy endometrium are the sufficient conditions for pregnancy to occur. |
| **Optimal:** best or most favourable option or outcome (24). |
**Midwifery**: "Midwifery means „with woman”. The definition of midwifery used in this study is The Australian College of Midwives (ACM) philosophy which is consistent with the Confederation of Midwives (ICM) philosophy and Model of Midwifery Care (36) See Appendix 1 and 2.

**Decision-Making**: Act or process of choosing a preferred option or course of action from a set of alternatives. It precedes and underpins almost all deliberate or voluntary behaviour (6).

**Second (2nd) Stage Labour**: is that time from the end of the first stage of labour, where, if a vaginal examination was performed there is no cervix able to be felt, up until to the birth of the baby (37, 38).

### 2. The Research Problem

Midwifery decision-making during 2nd stage labour is directly related to the safety and quality of the care that women and babies receive during birth. The discipline of midwifery has a role to play in ensuring that the midwives are educated and competent in decision-making. As shown in Chapter 2 existing theories and models for midwifery decision-making often follow a modified nursing process model which diminishes the role of the woman. Alternately, models of midwifery decision-making seek to make the woman decision-maker in her own care. Placing the woman as the sole decision-maker diminishes the critical importance of the clinical knowledge and reasoning skills that the midwife needs to be able to talk decisions through with the woman. Whilst the woman as the final decision-maker is generally laudable it is not always possible. Birth, for example, is a time where rapid decisions are required in a complex, fast changing situation where decision-making is influenced by the environment and the people within it. I questioned how adequate the existing theories and guidelines for decision-making are for midwives and women during 2nd stage labour. These thoughts led to the formulation of the research question (above).

### 3. Background to the Research Problem

During this study I sought a deeper understanding of the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour. For this study the primary focus was on the term „optimal“. Optimal is defined as “...best or most favourable option or outcome (24). Optimal, in this study, denotes the best possible conditions applied to midwifery decision-making during 2nd stage labour in order to achieve the best possible results for women and her baby. It includes seven
characteristics I believe are required to achieve optimal midwifery decision-making during 2nd stage of labour. These characteristics are list in Chapter 2 (p 48). These characteristics place the women-centred philosophy of midwifery at the centre of decision-making. Optimal midwifery decision-making during 2nd stage of labour is a formal approach to midwifery decision-making. Conscious, cognisant good clinical reasoning is applied in order to verify the clinical reasoning used is optimal. It includes intuition, but optimal midwifery decision-making does not privilege intuition, Rather optimal acknowledges midwifery decision-making is complex and requires both the objective and subjective elements. When related to midwifery knowledge and skills, optimal means midwifery decision-making considers both the woman and the baby as an indivisible whole. The result of achieving this element of optimal midwifery decision-making during 2nd stage labour is good midwifery practice. When applied to midwifery decision-making, „optimal” maximises the best or most favourable outcome for the woman and the baby.

Midwives practice within an historical and political context, bound by culture and policy. This section of the chapter presents this background to the research problem including specific midwifery issues such as: safety and quality in healthcare, safety and quality in midwifery, individual accountability within a midwifery philosophy and the woman as decision-maker.

3.1 Safety and Quality in Health Care

Historically, the quality of care provided by health professionals has been the responsibility of professional and registering authorities using a self-governing system which excluded health care organisational management (39). As health care became more complex, risk, uncertainty, diagnostic errors and health care became synonymous (40, 41). This led to the rise of clinical governance, first in the United Kingdom (UK) followed by rest of the western world. Clinical governance in the UK is defined as “…a framework through which NHS (National Health Service) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (42). The seven pillars of clinical governance are:

1. Risk management;
2. Patient and public involvement;
3. Clinical audit;
4. Clinical effectiveness;
5. Staffing and staff management;
6. Education, training and continuing professional development, and
7. Use of information (43).

In 2000 the Australian Council for Safety and Quality in Health Care (ACSQHC) formed a national committee. ACSQHC’s role was to provide leadership to improve safety and quality of healthcare and reduce risk by providing a framework within which local organisations could work to improve and assure the quality of clinical services for patients (44). In 2004 ACSQHC undertook a national review of governance arrangements within Australian healthcare settings: this resulted in raising the awareness of the issue of safety and quality (45).

In 2006 the Australian Commission on Safety and Quality in Health Care was established by the Australian State and Territory Governments subsuming ACSQHC (46). This entity is now known as „The Commission”. The Commission was tasked to develop a national strategic framework and associated work program to guide its efforts in improving safety and quality across the health care system in Australia. Health care organisations, within the framework of clinical governance, have to be committed to continuously improving the safety and quality of care and services provided to consumers whilst meeting the community needs (47). The proposed benefit of clinical governance is that it improves the safety and quality of health care by reducing the risk of harm. Further, clinical governance means that health care services are able to be held accountable to the patients, the public and the government (48).

For health care practitioners, decision-making is a complex multi-dimensional activity which often occurs in rapidly changing and unpredictable situations (49, 50). The probabilities of particular health outcomes cannot be precisely gauged. Often there is
inadequate time to allow for full and thoughtful assessment and planning. Thus, good quality clinical reasoning and decision-making are at the centre of quality health care.

3.2 Safety and Quality in Midwifery Practice

The discipline of Midwifery claims to be able to provide high quality safe maternity care. Midwives use their expertise and evidenced-informed knowledge to facilitate the woman’s empowerment. When the woman feels empowered then her body, mind and spirit function in a holistic and integrated way. Only when a woman’s body, mind and spirit function optimally may she feel safe, and supported enough to experience a “Genius Birth” (12, 25, 26, 51). (The concept of “Genius Birth” is discussed in Chapter 2).

Midwifery is a woman-centred, political, primary health care discipline founded on the relationships between women and their midwives. Continuity of (care) relationship is the quality gold standard for midwifery practice because it enables the woman and the midwife to know and trust each other (52). Women-centeredness places the woman in the position of control as she is the decision-maker in her own care. Woman-centeredness undermines the power and control which may be exercised by various stakeholders including the health care system, the medical establishment and capitalist organisations that seek to make a profit out of birth (53-55). The midwife’s knowledge of the woman may be crucial during 2nd stage labour if the midwife has to make a rapid decision and act on it without having time to consult with the woman. Clearly, good midwifery decision-making is an essential component of quality midwifery practice.

Good clinical reasoning in midwifery is essential for the safety and quality of the care for women and babies. If this statement were untrue then women would be as well to birth with only a doula. Midwives, as independent health professionals are held legally and professionally accountable for their clinical reasoning and decisions (56, 57). The midwife must, if called to, be able to explain and justify an action (58). The midwife must be able to explain and justify their decision-making and the way in which they arrived at them, for example: their clinical reasoning (59).
Midwifery decision-making requires evidenced-based knowledge, intrapersonal negotiation, sensitivity, awareness and consideration for the environment and the people within it (51, 60). Robbie Davis-Floyd defines evidence-based decision-making as “…a process of involving women in making decisions about their care and of finding and weighing up information to help make those decisions” (p. 9). A midwife’s decision-making abilities depend upon a sound theory and evidence base and a mindful engagement with the changing clinical situation. Ritualised practice, a personal determination to have a „normal birth” or slavishly following hospital policies all undermine good clinical reasoning and decision-making.

In framing this study I wanted to ensure that any model of optimal midwifery decision-making that may emerge from my research be in harmony with the ACM and the ICM philosophies of Midwifery (20, 57, 61).

4. My Journey To This Topic

4.1 Why I became interested in this topic

Whilst working as a midwife in England, I observed a primary midwife assisting a woman to birth. After the baby’s head had birthed and before birth of the shoulders, the midwife pushed two fingers into the woman’s vagina. The woman’s hips briefly lifted off the bed and she said “Ouch, what are you doing?” The midwife calmly said, “Oh, I’m just feeling for the cord in case it’s around your baby’s neck.” This one midwifery action raised my awareness of how a midwife could medicalise birth: the normally self-determining woman became a patient and the midwife alone was the decision-maker of care. When I moved from England to Australia, I observed the same phenomena. I began to realise that midwives may not be making decisions at all but merely carrying out a medical procedure in a ritualised way (62). I began to ask the following questions: Why did these midwives act as they did? What factors influenced and/or drove their practice? How did they reconcile the philosophy of woman-centred midwifery and „checking for the cord” without the prior knowledge or permission of the woman? I became sensitised to the clinical decision-making surrounding a nuchal cord. Nevertheless, as my interest in this topic grew, my focus became more refined. I still believe many midwives perform the ritualised practice of a vaginal examination during birth to check for a nuchal cord. Further, I believe such
an invasive and often painful intervention violates women’s rights and therefore requires attention (62). But I wanted to explore what needed to be in place to support optimal midwifery decision-making. Further, what challenges did these necessary and sufficient conditions pose for midwives and the midwifery profession? From this an overarching research question developed, which ultimately led to this PhD study.

I come to this study as a woman, wife, mother and midwife and academic. I entered nursing 30 years ago, a blank slate and ready to absorb the teachings offered within a School of Nursing in England. I methodically learnt the physiology and pathophysiology of the body systems, with each “block” of knowledge tested to confirm absorption of learning. I became a passive observer of rituals, interventions and the dominant paradigm of biomedical power. My practice became synonymous with that ethos.

Sixteen years ago I entered midwifery. My thoughts and actions were revolutionised as I became exposed to woman-centred care, which I saw as being the polar opposite from the nursing paradigm. This midwifery exposure necessitated a shift in my personal philosophy from the biomedical approach of disease to a primary healthcare model that occurred in partnership with the woman. My focus became women-centred and was on working in partnership with women through their birthing journey. I began to take responsibility for my actions, shifting my stance beyond that of medical utilitarian consequences to consider the worthwhileness, by grounding them within the ethos of midwifery. Once this euphoric feeling passed, I observed the foundational philosophies, values and ethics of some midwives and obstetricians were/are quite different. In my experience these differences can lead to power struggles and ultimately compromised care. The patriarchal nature of society and gender-based issues maintain this power (63). I became troubled by the frequency that I observed medical dominance, acts of paternalism/maternalism and exclusion of women in decision-making.

As a senior midwife academic I have questioned, probed, challenged, and debated the incongruities of medicalised childbirth and the philosophy of midwifery. I have taught and continue to teach the concept of women-centeredness and holism, which
focuses on interconnections between mind, body, spirit, family, community and environment. I pay attention to women’s invisible energy flows, obstacles and liberation. Midwives ideally connect with women, respecting and acknowledging their body wisdom by providing them space to experience and value pregnancy and birth (60). I firmly believe midwifery should be emancipatory. To this end I have and will continue to challenge with conviction the concept of paternalism/maternalism. I now recognise these beliefs identify me as a feminist.

Some midwives are oppressed and I want to challenge this by placing the findings from this study at the forefront of midwives’ consciousness. I want to:

- Offer midwives some understanding of how their current situation arose;
- Explore how environmental systems and people within them function;
- Facilitate the participating midwives’ awareness of their capacities and options to resist or not resist conforming pressures by offering an empirically grounded decision-making model for optimal decision-making during 2nd stage labour;

Consequently, as I start this research study I am a neophyte feminist researcher who needs to continue to explore the most appropriate ways to conceptualise and theorise about the necessary and sufficient conditions that influence midwifery clinical decision-making during birth. I acknowledge my limitations in feminist theory and accept that this will develop as I critically analyse more literature and undertake my journey through this research process. My evolutionary approach to feminist research practice is well supported within methodological literature (64-68). My feminist principles will be expanded upon in Chapter 5.

I chose to focus 2nd stage of birth because it is a time when decisions may need to be made rapidly and the woman may be in an altered mental state. When the woman cannot, or should not, participate in extended discussion about possible alternative diagnoses, alternative courses of action etc, then a midwife has to make an independent decision which can be subsequently redeemed in discussion with the woman as being “a good, woman-centred decision. This study is not focussed on
trying to establish differences between midwives in various models of care; the focus is to use the model of clinical reasoning, the philosophy of midwifery and the codes of midwifery ethics and conduct to arrive at a decision about Good Decision-Making and Good Midwifery Practice.

5. The Development of the Research Question

An initial pilot study was directed by the question:

“What factors influence midwives clinical judgement processes during birth?”

However, the participants highlighted two important components of decision-making during the pilot data collection phase of the work in this thesis. First, it became clear that whilst these midwives valued „normal birth“ this did not necessarily translate to „woman-centred care“. Second, these two midwives were not necessarily engaging in decision-making in a systematic way. I came to see that specific guidelines for midwives” decision-making had to be embedded within a midwifery philosophy to achieve the best outcomes for mother and child. It became clear that it was necessary to refocus the lens of the main study. Consequently, in consultation with my supervisors, the research question was modified to:

“What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?”

6. Significance

In midwifery, decisions which are of the highest quality and safety, are those that optimise the psychophysiology of woman and baby taking into account the contextual factors affecting the woman and baby (69). This study will be concerned with examining midwives” decision-making during 2nd stage labour. A review of the contemporary literature highlights that within midwifery there has been no study systematically investigating what are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour. The present study will make a contribution to understanding how midwives currently make decisions and what the necessary and sufficient conditions affecting that decision-making are.
6.1. Safety and Quality of Midwifery Care for Woman and Baby

It is essential that all stakeholders including consumers, clinicians, staff and the government are confident that health care delivery is:

- Informed by evidence;
- Delivered within a partnership philosophy, and
- Evaluated and soundly governed within a safety and quality framework.

The safety and quality of midwifery care for women and babies has the potential to be improved by the findings of this study. The aim, of developing a model of optimal midwifery decision-making, if achieved, would enable a woman-centered and rigorous decision-making process to be adopted by midwives. Having an agreed model for optimal midwifery decision-making during labour would enhance quality by promoting transparency and allowing for consensual checking of knowledge and reasoning (4). Likewise, a consensual decision can be made and justified against the data (70-77). The study also has the potential to improve midwifery practice by providing steps of good midwifery practice that will be consistent with Birth Territory Theory and the midwifery professional framework (here on known as the „Framework“). The „Framework“, is comprised of: the Australian Nursing and Midwifery Council (ANMC) Code of Professional Conduct for Midwives in Australia (30), the ANMC National Competency Standards for the Midwife (31), the ANMC Code of Ethics for Midwives (32) and the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (14). The implications, therefore, of this study is that an optimal midwifery decision-making model may enable the midwife to fully embrace her autonomy and accountability in her decision-making. By embracing a holistic, woman-centred philosophy as the basis for decision-making the midwife acknowledges the woman’s right to make decisions about her care. It is anticipated that by using the findings of this study midwives will be able to create an optimal decision-making environment that promotes the safety of the birthing woman and the baby.
6.2 Theoretical Contribution to the Midwifery Profession and Midwifery Education

This study has the potential to improve midwifery by offering a theoretical model of optimal midwifery decision-making during 2nd stage labour, whereby midwives will be able to demonstrate a clear process of clinical reasoning and good midwifery practice. The decision-making model offered by this study will encompass the International Confederation of Midwives (ICM) Global Standards for Midwifery Education (78) that recognise “...the midwife’s scope of practice describes the circumstances in which the midwife may make autonomous clinical decisions.”(78). Intrinsically linked with a midwife’s professional autonomy is accountability, which Etuk (79) claims are bound within the midwife’s professional identity. Accountability is defined as “...the obligation of being answerable for one’s own judgments and actions to an appropriate person or authority recognised as having the right to demand information and explanation...”(80). The ICM Essential Competencies for Basic Midwifery Practice states that the midwife is responsible and accountable for clinical decisions and actions. Midwives are therefore held accountable for their clinical practice (58), and in turn, their decision-making by the institution, the woman and her family, the community and the midwifery profession. Accountability is therefore interwoven with autonomy and having the freedom to make a choice from a range of options then actioning it. This study will provide a model for optimal midwifery decision-making, which describes, explains and predicts how midwives actually make decisions. These factors involved in decision-making can then be taught by using the model offered by this study: thus offering a theoretical contribution to the midwifery profession.

6.3 Organisation

Collaboration between midwives and doctors in the care of individual women requires an organisation to actively encourage and promote an evidence-based framework for care; including decision-making. Midwives, as primary carers, need to continuously engage in clinical reasoning and cue acquisition when providing care. By integrating good clinical reasoning and good midwifery practice, into an agreed optimal midwifery decision-making model has the potential to improve how midwifery decision-making occurs within an organisation. An optimal midwifery decision-making model should improve openness and inter-professional collaboration through
transparency of midwifery decision-making processes in order to achieve a desired outcome. Further, the focus of woman-centeredness within good midwifery practice fosters a midwife/woman partnership approach to decision-making. Ultimately, the potential of improving the quality and safety and midwifery accountability within the organisation is enhanced through a mutually agreed model for how not only midwifery decisions, but also collaborative decision should occur: giving confidence to healthcare organisations, women and their families.

7. Thesis Outline

The thesis is divided into six chapters. Chapter 2 outlines the theory of Birth Territory, demonstrating why the „micro level” of this theory is used to form part of what constitutes good midwifery practice. The „Framework” is introduced to address the theory’s limitations. A critical review of the predominant existing decision-making theories from medicine, nursing, and midwifery is also offered in Chapter 2. Chapter 3 provides a review of the related literature to specifically explore midwives’ decision-making during 2nd stage labour. The strategy and criteria for this review, which was undertaken in 2008, 2009 and again in 2011 is outlined, which demonstrates how the five studies were included. The methodology used in this study is Post Structural Feminist Interpretive Interactionism which is discussed in detail in Chapter 4. This discussion illustrates and justifies Post-Structural Feminist Interpretative Interactionism as the most appropriate methodology for this research. Chapter 5 presents the analysis and interpretation of the participating midwives stories. Chapter 5 concludes with the construction of a conceptual model of optimal midwifery decision-making during 2nd stage labour. The final chapter of this thesis is Chapter 6: the Conclusion. This chapter addresses the implications for midwives, women, babies and midwifery education, practice and the midwifery profession in relation to this research. Recommendations for practice, research, theory and policy are provided and finally the strengths and limitations of this study are addressed.
Chapter 2
Review of the Related Theory

Introduction

This chapter reviews theories that are useful for answering the research question. A theory is defined as providing “…a systematic view of phenomena by specifying the interrelationships between concepts using definitions and propositions with the purpose of description, explanation and prediction about a phenomenon in the world” (81, 82). The purpose for writing a theory may vary. Some theory is written with the aim of describing a phenomenon by creating new concepts (descriptive theory). Other theory may describe and explain a phenomenon in the world by linking concepts together in propositional statements that have the form: if “x” condition is present, then “y” condition is also found to occur (explanatory theory). Other theory may aim to describe, explain and predict a phenomenon of interest (predictive theory; sometimes called “situation producing theory”). A concept is an abstract idea of phenomena, objects or actions. For example: “midwife”, “decision-making” and “good” are all concepts (82) A proposition is “…a statement of relationship between two or more concepts” (83 p410). The word “theory” is used expansively here to encompass related terms including “philosophy”, “model” and “framework”.

In this chapter, two main types of theory are reviewed. One is theory to expand the conceptualisation of “good practice in midwifery” beyond the Philosophy of Midwifery already discussed in Chapter 1. The other type of theory is those that aid conceptualisation of good decision-making. The chapter begins by providing the rationale for using Birth Territory Theory to augment Midwifery Philosophy. In that section, the key concepts of Birth Territory Theory, relevant to this study, are defined (Table 2.1). The next section of this chapter presents a review of existing decision-making theories. The review begins with theory arising from information processing, which was adopted by medicine as a decision-making model: it was renamed Hypothetico-Deductive Theory (84). The nursing Clinical Reasoning Cycle (85) is then presented as an example of a nursing adaptation of hypothetico-deductive reasoning. Next, the Intuitive-Humanistic Theory of Nurse Patricia Benner (86), and others is considered. Dual Processing Theory of decision-making is presented. The ICM Clinical Decision-Making Framework in Midwifery Care is then reviewed and the
ANMC Midwifery Practice Decisions Flowchart and Midwifery Practice Decisions Summary Guide. Finally Page’s (51) five steps of evidenced-based midwifery is reviewed, which was necessary to explore their usefulness to the midwifery profession both in terms of midwifery practice and the education of midwives.

2 Birth Territory Theory

Birth Territory Theory was chosen to provide theoretical guidance and support for this study for several reasons. First, Birth Territory Theory was developed by four Australian midwives who have a combination of academic and clinical expertise including years of experience in a variety of midwifery models of care: thus I thought their ideas about what makes „good midwifery” were credible at face value. Second, Birth Territory Theory emphasises the profound impact of the environment on the psychophysiology of the woman and baby; particularly during labour which is pertinent to the present study. Third, Birth Territory Theory provides an aim for midwifery practice which is missing from the Midwifery Philosophy for example: in Birth Territory Theory the aim is to support women to have a „Genius Birth”. Birth Territory Theory has well defined components that can be tested against empirical data, such as that generated within this study. Lastly, Birth Territory Theory and the authors behind it resonate with my own international and national experiences of midwifery practice.

For this study, the primary focus was on Birth Territory during labour. Birth Territory is defined as „...the environment that is external to the woman/baby. It includes the physical features of the environment (terrain) and the use of power by people within the environment (jurisdiction)” (17). This includes the terrain of the birthing room, the woman, the midwife and her support person. At the micro-level, Birth Territory can mean „individual birth space”, whilst the birth space within the broader environment that operates as an integrated social system is considered to be the macro-level. Birth Territory Theory also acknowledges the power in the birth environment (term jurisdiction). The theory acknowledges the historical, regulatory, legal, professional and political frameworks that direct, limit and control what is possible in the environment. This totality, the macro and the micro-environment for birth, is termed “Birth Territory” (2).
2.1. Definitions

Table 2.1 identifies and defines the key concepts within Birth Territory Theory, which are pertinent to this study. These will be discussed below in relation to my research question.

Table 2.1 Definitions of Key Concepts used in Birth Territory

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrative Power</td>
<td>“Integrative power” integrates all forms of power within the environment to some shared higher goal. The primary aim of using “integrative power” is to support integration of the woman’s body, mind and spirit so that she feels able to respond spontaneously and expressively to her bodily sensations and intuitions. The integration of ego and inner self which is inherent in body-mind-spirit increases her energy, strength and power (17).</td>
</tr>
<tr>
<td>Disintegrative Power</td>
<td>Disintegrative power is an “ego”-centered use of dominating power that disintegrates other forms of power within the environment and imposes the user’s self-serving goal. It may be used by the woman, the midwife and/or any other person in the territory. The use of “disintegrative power” undermines the woman’s ability to be able to feel, trust and respond spontaneously to her bodily sensations and intuitions. This is a disintegration of the woman’s body-mind-spirit unity that separates her from her embodied power thus weakening her and lowering her energy (17).</td>
</tr>
<tr>
<td>Genius Birth</td>
<td>“....A “Genius Birth” is defined as one where a woman responds to labour challenges by drawing from usually hidden capacities deep within her embodied self. In actualising her inner power, she combines it with her conscious intention to experience a physiologically normal birth. A “genius birth” is not contrived but, rather, is conscious and effortful even if, in taking account of her holistic wellbeing at that particular moment of her life, medical interventions are accepted” (12 p235).</td>
</tr>
<tr>
<td>Forced Birth</td>
<td>Where power is used to try and force a particular birth. Two types: medically and maternally forced (17).</td>
</tr>
<tr>
<td>Egoic (Power) Birth</td>
<td>“...using power that is „hard“, „determined“ or „manipulative“ of others in order to get what she/he wants and to block out other knowledge or possibilities....” (3 p26)</td>
</tr>
<tr>
<td>Midwifery Guardianship</td>
<td>“Controlling who crosses the boundaries of the birth space and creating and maintaining harmony within the room. The aim is to allow the woman to experience undisturbed labour and birth so that she can access her own „integrative power“ (3).</td>
</tr>
<tr>
<td>Midwifery Domination</td>
<td>“Midwifery Domination” is a form of „disintegrative power“ that is based on the midwife’s use of disciplinary power. „Midwifery domination“ is disturbing because it interferes with the woman’s labouring process by inducing the woman to become docile or weak. Being docile requires the woman to follow the midwife’s advice and therefore disintegrates her own</td>
</tr>
</tbody>
</table>
embodied knowledge and power. Alternatively, it may lead to resistance and fighting on the part of the woman, which disrupts the mind body spirit integration needed to birth well (17).

| Birth Sanctum | “...a homely environment designed to optimise the privacy, ease and comfort of the woman...” (2 p18). |
| Surveillance Room | “...clinical environment designed to facilitate surveillance of the woman and to optimise the ease and comfort of the staff (2 p18).” |

### 2.2 Integrative and Disintegrative Power

The concept of „power“ in Birth Territory Theory is based, in part, on Foucauldian ideas (87). Foucault argued that power and knowledge were inseparable and created the term „power/knowledge“. Birth Territory Theory argues that an individual’s power can be used integratively to promote woman’s empowerment or disintegratively thus disempowering the woman. Integrative power, when used by a midwife, facilitates the woman to integrate her mind, body and spirit in order to achieve the best possible birth: a „Genius Birth”.

#### 2.2.1 Genius Birth

If a midwife (or doctor) uses integrative power, she shares her power and knowledge with the woman. The midwife supports the woman to trust her personal knowledge or innate sense of self-trust giving her-self the courage to embrace her body’s ability to birth: thus achieving a „Genius Birth“. The midwife may use various skills to facilitate integrative power such as the power of touch: holding the woman close whilst repetitively providing in-the-moment empowering words.

#### 2.2.2 Egoic Power (Birth) and Forced Birth

If a midwife (or doctor) uses disintegrative power, she utilises her ego-centred power. Ego is a self defined learnt power-based trait of one’s personality (3). The egoic self views and interacts with the environment and those in that environment from a stance of self-protection. The egoic self, however may actively use their energy to determine or manipulate the environment and people if self-protection is perceived as being required (88-90). A midwife employing egoic power, during birth, facilitates
disintegration of the woman"s mind, body and spirit, which may impact upon her ability to trust her body to birth. An „Egoic Birth“ is a possible outcome if using disintegrative power and egoic power. Further, by exerting control and dominance over the woman the person may try to force a particular birth outcome: A „Forced Birth“. A „Forced Birth“ may be medically (midwife) or maternally driven.

2.2.3 Midwifery Domination

„Midwifery Domination“ is a sub-concept of disintegrative power based upon the midwife"s misuse of her power to dominate the woman and/or decision-making (2). „Midwifery Domination“ can invoke two reactions from the woman. First, the woman subordinates her voice and rights to the midwife and the midwife’s „power/knowledge“. Second, the woman refuses to go along with the midwife"s advice leading to conflict and disharmony. In other words there is a conflict between the perceived „good outcome“ for the midwife and the woman. The woman"s freedom of choice is impeded or as Martin Hollis states “...it involves a negative idea of equality or equity...“ (91 P15). Ultimately „Midwifery Domination“ negates the concept of „Midwifery Guardianship“ and interferes with the woman"s mind, body, spirit integration needed to birth well. „Midwifery Guardianship“ means controlling who crosses the boundaries of the birth space and creating and maintaining harmony within the room. The aim is to allow the woman to experience undisturbed labour and birth so that she can access her own integrative power (17). „Midwifery Domination“, assisted in analysing midwives decision-making stories where the midwife used her power disintegratively to dominate the woman and/or the birthing situation.

2.3 Birth Sanctum and Surveillance Room

A „Genius Birth“ should occur within a safe, warm quiet environment that represents a woman"s personal sanctuary or „sanctum“. In other words, for the woman to be able to claim the personal power of achievement in her body"s ability to birth, regardless of mode of birth and/or place of birth. In this study a birth sanctum represents whether the woman"s birth territory was warm, safe and peaceful and/or if there was one-to-one care in labour or not.
Essentially Birth Territory Theory is claiming that a „Genius Birth” (the aim of the midwife and woman) is the outcome of the midwife working integratively with the woman, her support person and the maternity team to create and maintain a birth sanctum. The midwife acts as a guardian of the woman and her territory to ensure she feels “safe enough to be out of control” (26). Trust is the crux of this relationship, whereby the woman accepts and trusts the midwife’s guardian and thus surrenders herself to achieving her Genius Birth. In this way the woman’s psychophysiology functions optimally and thus she is most likely to experience the best birth possible given her total current situation. Birth Territory Theory gave guidance and direction to me in this study by illuminating the factors that may be supporting or inhibiting midwifery best practice during 2nd labour decision-making.

2.4 Limitations of Birth Territory Theory

There are two key limitations of Birth Territory Theory as it relates to „Good Midwifery Practice“ in the care of women during 2nd stage labour, which are that the theory:

- Does not adequately address clinical reasoning and joint decision-making between the midwife and the woman, and
- Does not adequately take into account the „Frameworks“ which were discussed in Chapter 1.

The next section of this chapter addresses the review of decision-making theories. To aid the focus of existing decision-making theories review, a guiding question was used:

„How adequate are existing decision-making theories as a basis for guiding good practice in midwifery clinical decision-making?“

There is some confusion in the literature about the meaning of commonly used concepts related to decision-making. Two terms that are used frequently and
interchangeably are: „clinical reasoning” and „clinical judgment”. The definitions are highlighted in table 2.4, as well as clinical reasoning in nursing:

| Clinical Judgement | "The assessment of alternatives" (8) „...derived from observation or listening to patient’s, feedback from others, measurements and investigation, and drawing conclusions” (4 p227).

  "A judgement that is used as a guide to action that is taken by a health professional in a clinical situation. A clinical judgement may or may not be based on relevant clinical features and, may or may not be based on a systematic reasoning process”.

| Critical Thinking | "...Purposeful, self regulating judgement using interpretation, analysis, evaluation, drawing conclusions and explaining supporting evidence” (4 p228).

A purposeful activity in which one explores all perspectives, including strengths and limitations in order to facilitate the decision-making process (10).

| Clinical Reasoning in Nursing | Clinical Reasoning in nursing is "the process by which nurses collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes and reflect on and learn from the process" (9).

Clinical reasoning is a form of the hypothetico-deductive approach. It is a way of trying to ensure that diagnostic and treatment decisions are based on logical thinking; not a rule of thumb or simple pattern recognition. Hypothetico-Deductive reasoning focuses on „the supposed biophysical facts” such as: facts that can be defined, measured and consensually agreed upon.

### 2.5. Decision-Making Theories

#### 2.5.1 Hypothetico-Deductive Theory

Hypothetico-Deductive Theory is the dominant approach to clinical decision-making within the health sciences. Indeed, it is central to Western Science, which arguably began with Descartes the 17th Century French philosopher. Descartes conceptually separated mind from body and placed reason (a product of the mind) in a position of
superiority over emotion (a product of the body). Descartes was a rationalist, believing as he did, that sense data was faulty and that only the rational mind could comprehend or create knowledge (93, 94). Descartes also conceptually separated the spirit from the body and claimed that the material body could legitimately be an object of scientific investigation whereas, the immortal soul and anything else that is immaterial belongs to the Church and to God and must remain beyond the reach of science (95). Western Science (in its dominant form) is sometimes called „Logico-Empiricism“. This term makes explicit the foundations of Western science which are that the combination of the philosophical schools of „rationalism“ (trust in the logical processes of the mind) and „empiricism“ (trust in the five senses) (96).

Hypothetico-Deductive Theory is defined as:

“The standard research method of empirical science in which hypotheses are formulated and tested by deducing predictions from them and then testing the predictions through controlled experiments, hypotheses that are falsified being rejected and replaced by new ones“ (9).

Hypothetico-Deductive Theory is predicated on the belief that both reasoning and sense data need to be taken into account when making good decisions (71). A scientific approach to decision-making is one of the key pillars upon which medicine claims to be a science (97, 98). Scientific reasoning depends upon the testing of logically developed theoretical knowledge against empirical data in the material world and vice versa (9, 71). Hypothetico-deductive reasoning postulates a movement from general theories to testable hypotheses and predictions, and finally to empirical observations that support or disprove the theory (6). Hypothetico-deductive reasoning when applied in health care practice is a method of deciding the best alternative from those available based upon rationality and empirical precision (99-101).

Information Processing Theory is the seminal work behind Hypothetical-Deductive Theory (99). According to this theory, humans store objective data within memory, where it is coded as symbols. Symbols are grouped in patterns in the brain: thus memory is stored in „chunks“. These patterned groups of symbols are associated with
external stimuli. These „chunks“ of symbols and past experiences are stored in long-term memory awaiting retrieval when needed (99). People recognise patterns when similar stimuli re-occur that seem to fit the person’s experience. This can result in repeating a past action or avoidance of the action (decision-making). To make a good decision and to take appropriate action(s) is dependent upon the individual’s ability to assimilate, interpret and analyse information and learn from past experience or the learning provided by others (99, 102).

Clinical reasoning is a prime example of hypothetico-deductive reasoning in medical practice. Medicine is based on the assumption that biomedical knowledge and clinical reasoning are all that a doctor needs in order to make good clinical decisions. Standing (77) claims consistent, logical, retractable and defensible decision-making is evidence of professional competence. In other words, good clinical reasoning is both a necessary and a sufficient condition for best practice in clinical decision-making.

Clinical reasoning involves a number of phases and although the names of the phases vary from author to author, the phases below are consistent with a large number of influential theorists in the field (72-74, 103, 104).

<table>
<thead>
<tr>
<th>Table 2.5.1 The Steps in Clinical Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cue acquisition</td>
</tr>
<tr>
<td>Cue clustering</td>
</tr>
<tr>
<td>Cue interpretation</td>
</tr>
<tr>
<td>Generating multiple hypotheses</td>
</tr>
<tr>
<td>Focused cue acquisition</td>
</tr>
<tr>
<td>Ruling in and Ruling out hypotheses</td>
</tr>
<tr>
<td>Making a diagnosis</td>
</tr>
<tr>
<td>Evaluate treatment options relevant to the diagnosis;</td>
</tr>
<tr>
<td>Prescribe and/or Implement treatment plan, and</td>
</tr>
<tr>
<td>Evaluate treatment outcomes</td>
</tr>
</tbody>
</table>
By applying the stages of clinical reasoning to patients, medicine seeks to rationally link diseases with clinical features. The clinical reasoning model aims to ensure patients receive the most appropriate treatment in the shortest period of time and with the least amount of unwanted effects (41, 105 cited Meehl 1954). The hypotheses generation and cue interpretation stages of Hypothetico-Deductive Theory are vital when dealing with complex data like patient symptoms (73). Hypotheses generation means holding, as tentative, one’s first “guess” based on pattern recognition and past experience and then submitting it to empirical testing. Empirical testing provides evidence to support or undermine the provisional diagnosis and/or differential diagnoses (100, 101, 106).

2.5.2 The Clinical Reasoning Cycle

An example of clinical reasoning from nursing, published in 2009, is the Clinical Reasoning Cycle. The cycle describes what (student) nurses have to do in order to effectively undertake clinical reasoning (107). In summary (student) nurses have to:

“…collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes and reflect on and learn from the process” (p 2).

Prior to using the Clinical Reasoning Cycle a (student) nurse is requested to explore and examine any pre-held preconceptions and assumptions, which may influence their decision-making. A (student) nurse may progressively move through the Clinical Reasoning Cycle steps or choose to move back and forth. Alternatively, she may decide to merge steps together. The steps are shown in the diagram below (figure 2.5.2.1 The Clinical Reasoning Cycle).
The Clinical Reasoning Cycle is based primarily on work by Hoffman and colleagues (108, 109). Hoffman’s work was contextualised to the decision-making of eight expert and novice intensive care nurses in one regional Australian hospital. The Clinical Reasoning Cycle contains some elements of the medical clinical reasoning process. To follow the cycle, nurses need to collect a set of sense data and test results, which are observable, empirical and measurable (70). Identification of a problem or a definitive diagnosis and taking an action by choosing the best alternative from those offered and then evaluating the outcomes are also the required actions in line with the cycle. The Clinical Reasoning Cycle also combines elements of reflective practice.

2.5.3 Intuitive-Humanistic Theory

Intuitive-Humanistic Theory is primarily associated with nursing (86). There is no consensus in the literature about the role intuition takes within decision-making. Definitions of intuition range from: “understanding without rationale” (110 p23); to “act on a sudden awareness of knowledge that is related to previous experience, perceived as a whole, and difficult to articulate” (16 p95). Consensus in the literature is that intuition is unconsciously inductive (77, 111). Dreyfus and Dreyfus (112) noted
that intuition contains patterns and similarity recognition, common sense, sense of
salience and deliberate rationality. For expert practitioners, knowing what to do in a
particular situation usually depends on intuitive pattern matching. Pattern matching is
defined by Mok & Stevens (111) as “…a process of making a judgement on the basis
of a few critical pieces of information” (p 59).

Benner (86) linked the process of decision-making to five „levels“ of experience and
practice: novice, advanced beginner, competent, proficient and expert. Benner's (86)
research findings were that, clinical decisions by less experienced nurses were
strongly based on hypothetico-deductive reasoning. Expert nurses however, Benner
(86) claimed, used intuition. An expert nurse automatically undertakes a quick
classification and intuitively screens available options, eliminating options not
perceived as relevant to the judgement and/or the decision that needs to be made
(86, 113). The resultant perceptions are of an intuitive decision-making expert nurse,
who appears quick and spontaneous while operating with profound understanding,
without necessarily being able to articulate that understanding (86, 112). Berry and
Dienes (114) argue that part of this process can be referred to as automatic whereby,
tacit nursing knowledge acquired through health care exposure and experience is
subsequently forgotten. In other words, a nurse demonstrates embodied knowing
and intuition. Embodied knowing is defined as “…personal understanding, sensory,
psychomotor (practical), affective (emotional) and interpersonal skills associated with
experience and intuition” (4 p228).

Benner (86) argues that intuition is a valuable part of nurses” clinical practice. Other
researchers go further claiming that other health professionals benefit from drawing
on intuition in clinical practice (16, 111, 115-117). Mok and Stevens (111) claim that
midwives use intuition to aid rapid subliminal judgements but do not differentiate
between novice and expert midwives. The Intuitive-Humanistic approach to best
practice in clinical decision-making and excellent practice is based on the assumption
that this process is necessary and sufficient for nursing and other health disciplines.
2.5.4 Dual Processing Theory

Dual Processing Theory is based on the Cognitive Continuum Theory. The theorists working on the Dual Processing Theory aim to “describe” how humans actually make decisions in the real world (77). This is in contrast to the Hypothetico-Deductive Theory that outlines how one “should” make decisions. The Dual Processing Theory serves as a model within which different modes of cognitive processes or systems occur. “Intuition”, also called „System 1” is one process, „analysis”, also called „System 2” is a second process (118). The Dual Processing Theory argues that all clinical reasoning processes commence when the decision-maker undertakes cue acquisition and cue interpretation (98). System 1 (intuition) is used by the clinical decision-maker if cue acquisition and cue interpretation match „stored” patterns of knowledge of the clinical features of disease (119). Some dual processing theorists believe that pattern recognition is an unconscious process of matching current cues to stored memories and acting „as if” the fit between cue and knowledge is correct without doing any cognitive reasoning to check (120). It is theoretically possible for practitioners to become conscious of their pattern recognition so that once pattern recognition is activated, cues are tested against available empirical data (71, 121). Consequently, pattern recognition may result in application of analytical reasoning leading to correct action (111, 122-125). However, if cue acquisition and cue interpretation does not match the pattern of existing stored memory then the clinical decision maker is said to use System 2 (analysis). Once System 2 is chosen, the decision-maker can opt to use various reasoning approaches such as: hypothetico-deductive, Bayesian or algorithmic (98). In summary, System 1 decision-making is quick and spontaneous whilst System 2 decision-making is slow and disciplined.

Dual Processing Theory, by focussing on how clinicians actually make decisions, does not offer a solution of how to ensure that clinical practitioners can move appropriately between intuitive and analytical modes to achieve good clinical decisions. Rather, practitioners have to select which cue to accept or dismiss using experience and heuristics in order to select an appropriate treatment and/or intervention (77). As a feminist midwifery theorist, rather than describing what is happening currently in decision-making practice, I was more concerned with developing situation-producing theory that can be used to actually enhance decision-making practices in midwifery which, in turn, is a step towards best practice.
2.5.5 *The International Confederation of Midwives (ICM)*
Framework for Decision-Making in Midwifery Care

The ICM’s five-step framework for decision-making for midwifery (126) is an adaptation of hypothetico-deductive reasoning. The five steps are noted below:

1. Collect information from the woman, from the woman’s and the infant’s records, and from any laboratory tests in a systematic way for a complete assessment;

2. Identify actual or potential problems based on the correct interpretation of the information gathered in Step 1;

3. Develop a comprehensive plan of care with the woman and her family based on the woman's or infant's needs and supported by the data collected;

4. Carry out and continually update the plan of care within an appropriate time frame, and

5. Evaluate the effectiveness of care given with the woman and her family, consider alternatives if unsuccessful, returning to Step 1 to collect more data and/or develop a new plan (p 3).

Explicit, linear and cognitive rationality is used to obtain observable, empirical and measurable data in the first two steps of the ICM decision-making framework (126). The decision-making framework is based upon the medical clinical reasoning process (71, 121). The woman is involved in the development of a plan of care in the third step of the framework and evaluation of the care given is undertaken in the fifth step.
2.5.6 The ANMC Midwifery Practice Decisions Flowchart and Midwifery Practice Decisions Summary Guide

The ANMC Midwifery Practice Decisions Flowchart (127) and Midwifery Practice Decisions Summary Guide (128) set forth a number of issues that midwives should consider before making decisions. The purpose of the framework is “identifying the agreed foundation principles for decision-making tools implemented by regulatory authorities in Australia” (127). In summary, the flow chart says that the midwife:

1. Identifies the health needs and benefits for the woman and baby;
2. Reflects on her own scope of practice;
3. Considers the organisational context, and
4. Finally selects the most appropriate and competent person to perform the activity (128).

This model is focussed on deciding which clinical activities are within an individual’s scope of practice and within the professional scope of practice of a midwife in Australia. It does not give guidance or purport to be a model of clinical decision-making that includes cognitive reasoning by the midwife and decision-making by the woman. Rather, the Flowchart is a set of principles that may be useful for basing future development of decision-making models.

More recently the Australian Nursing and Midwifery Accreditation Council (ANMAC) (2011) have required that all midwifery programs leading to registration as a midwife incorporate Lesley Page’s five steps of evidence-based midwifery. These five steps are:

1) Finding out what is important to the woman and her family;
2) Using the information from the clinical examination;
3) Seeking and assessing the evidence to inform decisions;
4) Talking it through, and
5) Reflecting on outcomes, feelings and consequences (51 p9)
Page's (51) model of decision-making works well when the midwife knows the woman and/or there is time to find out what she wants and to talk decisions through. The midwife can use her power integratively so that the power remains with the woman as the midwife and woman share a known goal. This model is most effective when a continuity of care model of midwifery is used where the midwife and woman form a reciprocal relationship that explores and clarifies the midwife's and woman's needs, wants and decision-making over a period of time. However in a fragmented model of care for example; where the midwife meets the woman during 2nd stage labour the midwife is not always able to employ Page's (51) five steps and/or establish a trusting, knowing relationship. Further 2nd stage labour is a time where rapid decisions are required in a complex, fast changing situation where multiple variables operate simultaneously that is strongly influenced by the environment and the people within it.

The decision-making model offered by Page (51) highlights the potential of decision-making but does not provide guidance to the midwife on how to undertake decision-making. Further it does not inform a midwife how to create the optimal conditions for a woman to experience a „Genius Birth”. For these reasons Page’s (51) model of decision-making are problematic (during 2nd stage labour).

2.6 Discussion

Scientific reasoning, as exemplified in Hypothetico-Deductive Theory, is the dominant paradigm within which clinical decision-making models are developed for use within the health science disciplines, including midwifery. The explicit steps used in diagnostic reasoning provide a systematic approach to making a diagnosis and prescribing treatment (77). It is an advantage that the steps can be taught and tested (72-75, 103, 104). Having a clear and agreed decision-making process promotes transparency and allows for consensual checking of knowledge and reasoning (4). Likewise, a consensual decision can be made and justified against the data (70-77). The emphasis on rationality and empirical data is also an advantage but it is a limitation if rationality and objectivity are not responsive to individual needs or are used to rule out any data that is emotional or contextual (5, 129, 130).
Rationality and analysis is reliant on the decision-maker displaying several factors: being emotionally calm; having knowledge that is organised within an individual’s idiosyncratic memory structure (131); ability to access and withdraw knowledge and experiences; flexibility of assimilated knowledge permitting reinterpretation and application to new situations (132). Memories, however, are limited and imperfect so successful knowledge recall may not be possible or efficient (41, 133).

The emotions of the doctor and the thoughts or feelings of the patient are excluded within the medical clinical reasoning process. The exclusion of any information, other than empirical objective data, is a limitation because it leaves out factors that may produce a better decision. Emotions, as Benner points out, can be a way of „intuitive” knowing (86, 134). I am arguing that the emotions of the woman and her partner/support person are relevant and should be included in optimal midwifery decision-making. The person’s phenomenological experience is not available for consensual validation: doctors exclude it from decision-making whereas midwives and women want to make the woman’s experience central to midwifery decision-making (3, 55). Further, emotions can warn us when we may be making a mistake that we do not recognise „rationally”. Consequently, these limitations contribute to poor clinical decision-making that can ultimately lead to clinical errors (77, 118, 120).

Thompson and Dowie (15) claim that the medical clinical reasoning steps are part of the nursing and midwifery clinical reasoning processes. It is true that the broad scientific method of hypothetico-deductive reasoning is contained within the ICM Framework of Decision-Making in Midwifery Care (126) and the nursing Clinical Reasoning Cycle (85) model (see table below).

<table>
<thead>
<tr>
<th>Medical Reasoning</th>
<th>ICM- Midwifery</th>
<th>CRC - Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cue acquisition</td>
<td>Collect information from the woman, from the woman's and the infant's records, and from any laboratory tests in a systematic way for a complete assessment</td>
<td>Consider the patient situation</td>
</tr>
<tr>
<td>2. Cue clustering</td>
<td></td>
<td>Collect cues/information</td>
</tr>
<tr>
<td>3. Generating multiple hypotheses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cue interpretation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Focused cue acquisition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Ruling in and Ruling out hypotheses</td>
<td>Identify actual or potential</td>
<td>Process information</td>
</tr>
</tbody>
</table>

Table 2.6 Comparing and contrasting components of decision-making models
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Making a diagnosis</td>
<td>problems based on the correct interpretation of the information gathered in Step 1</td>
</tr>
<tr>
<td>8. Evaluate the safety and efficacy of treatment options relevant to the diagnosis;</td>
<td>3. Develop a comprehensive plan of care with the woman and her family based on the woman's or infant's needs and supported by the data collected</td>
</tr>
<tr>
<td>9. Prescribe and/or Implement treatment plan,</td>
<td>5. Establish goals</td>
</tr>
<tr>
<td>4. Carry out and continually update the plan of care within an appropriate time frame</td>
<td>6. Take action by choosing the best alternative</td>
</tr>
<tr>
<td>10. Evaluate treatment outcomes</td>
<td>7. Evaluate outcomes</td>
</tr>
<tr>
<td>8. Reflection on Process and new Learning</td>
<td></td>
</tr>
</tbody>
</table>

As the table above demonstrates, the detailed and specific steps in medical clinical reasoning are not explicit in current midwifery and nursing decision-making theories. Midwifery and nursing use different terminology for similar intellectual processes. Medical reasoning excludes the person (patient) whereas nursing and midwifery make some acknowledgement of the person and their situation. Midwifery and nursing applications of clinical reasoning are less specific and prescriptive. This is because these theories subsume several steps of medical clinical reasoning into broader and less specific categories. It is clear that some steps in midwifery and nursing decision-making processes become opaque when several steps are subsumed into one. This lack of clarity means that midwifery and nursing decision-making based on these models would be less easy to consensually validate with fellow clinicians. Further, teaching and learning decision-making is much less effective due to lack of clear and specific steps. Consequently midwives and nurses who have not learned the details of clinical reasoning have a potential or actual deficit that affects their decision-making negatively (132). Hammond (135) claims that
inadequate education and practice in detailed step-by-step decision-making induces “average” decision-making by which he means that the average practitioner makes decisions rapidly by combining what knowledge they know with guess work.

The fundamental foundation of Dual Processing Theory is that pattern recognition can lead to good clinical decisions but it requires accurate knowledge and sufficient experience to have a good store of previous patterns of clinical cues (98, 136, 137). A problem, however, is that experience and knowledge are prerequisites for safe decision-making based on pattern recognition and this can mean that clinical errors are made which may have catastrophic consequences for the person (patient). Further, good clinical decisions, based on pattern recognition and heuristics, can be undermined by multiple sources of cognitive biases (41, 138). The decision-maker is not always aware of their cognitive biases because they are subtle and covert (41, 138, 139). Cognitive biases limit the decision-maker to their original “snap judgement” based on faulty pattern recognition and therefore fail to look for confirmatory or contradictory (scientific/objective) evidence and possible alternative actions (5). Dual Processing Theory highlights the potential of the decision-maker to be able to move between the two modes of cognition: analysis and intuition. I accept that using intuition is reasonable and at times necessary to reach a decision in a timely manner. However, for the sake of quality, patient safety and professional accountability, intuition must be able to be explained and rationalised in terms of available evidence and clinical features.

Benner’s (86) Intuitive-Humanistic theory has some positive elements for nursing and midwifery as it acknowledges the role of emotions and involvement with patients and their families. Nurses who used intuition in Benner’s study were not able to articulate their reasoning processes. “Holistic intuition” therefore, can neither be explained nor taught. Further, influences within the clinical cultural environment where intuition skills are learnt are not acknowledged by Benner. To claim, as Benner has, that intuitive decision-making is a hallmark of expert nursing practice is potentially dangerous and against evidence-based health care (5, 86). If midwives and nurses see intuitive decision-making as somehow ideal, then it suggests that being slow and deliberate when making decisions is evidence of being inexperienced and “not advanced” in practice.
The effect of the birth environment/context and the person’s wishes for their health care is not well addressed in any of the existing decision-making theories. Most importantly, none of the existing decision-making theories place the woman at the centre of decision-making.

Midwifery, as a woman-centred discipline, needs more than cognitive clinical reasoning to reach best-practice clinical decisions. Based on my reading and practice, I believe that midwifery optimal decision-making during 2nd stage labour should have the following characteristics:

1. Places the woman as a partner in all aspects of decision-making;

2. Considers both the woman and the baby; not as separate entities but as an indivisible whole;

3. Uses specific clinical reasoning steps OR decisions can be justified from a clinical reasoning perspective;

4. The woman is provided with up to date accurate knowledge/evidence in a timely manner;

5. The midwife takes appropriate action in a timely manner (including consultation and referral);

6. Promotes the woman as the final decision-maker in her own care (even if the woman’s decision is not consistent with dominant views of what is the „best-evidence” in a particular situation), and

7. In an emergency, the midwife can make a decision that is clinically and ethically defensible and later explained to the woman (which should be a rarity) and later the midwife engages the woman in discussion of reflection, review, and evaluation.
2.7 Conclusion

This chapter has reviewed Birth Territory Theory and related decision-making theories. Birth Territory Theory describes explains and predicts the support required by women to claim the personal power required to achieve their "Genius Birth." Birth Territory Theory encompasses the concepts of birth sanctum and birth surveillance, integrative and disintegrative power. Consequently the theory was a useful midwifery framework to guide my analysis and understanding of what constitutes "Good Midwifery Practice." My final definition will be drawn from the analysis of the midwives’ positive and negative stories in this study. Birth Territory Theory does, however, have limitations. My study is exploring midwives’ decision-making during 2nd stage labour with the primary focus on the micro level of the birthing room, the woman, the midwife and her support person/people. This study’s micro level focus can be aided by employing Birth Territory Theory and decision-making as an indivisible whole.

A major finding from the review of related decision-making theories is that a detailed model of clinical reasoning has much to offer a midwifery theory of clinical decision-making. Although clinical reasoning is necessary for good midwifery decision-making, it is not sufficient for three main reasons. First, midwives are primarily working with healthy woman who should be allowed decision-autonomy about their maternity care. The midwife, therefore, makes decisions in partnership with the woman. Second, unlike medical clinical reasoning, midwifery decision-making should incorporate both objective and subjective elements including the context of decision-making and the emotions and intuitions of both the woman and the midwife. Third, unlike any decision-making theory reviewed here, the midwife usually has to consider both the woman and the baby; not as separate entities but as an indivisible whole. These limitations in decision-making theory for midwifery practice are addressed in the Chapter 5: Findings of this thesis.

To support midwifery’s professional identity, a midwifery specific decision-making model needs to be developed that incorporates key concepts of Birth Territory Theory and supports a midwife’s professional scope of practice. This model needs to give guidance as to the factors to consider when making decisions and how to use
clinical reasoning. The model should also provide guidance to making decisions in partnership with the woman and finally, how to conceptualise and include the interests of the woman/baby in midwifery decision-making from a woman-centred midwifery philosophy.

This review of related theory: Birth Territory Theory and Decision-Making Theories informed analysis and interpretation of midwives’ stories and their personal experiences of decision-making with women during 2nd stage labour. As noted in Chapter 1, midwifery decision-making is seen philosophically as holistic and women-centred.
Chapter 3
Review of the Related Literature

This chapter outlines how a structured systematic review of the literature was undertaken to specifically explore midwives’ decision-making during 2nd stage labour. The guiding research question was:

“What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?”

In midwifery, clinical decision-making is seen as holistic and women-centred. As a discipline, midwifery is based on a philosophy of primary health care and partnership with the woman (20, 21, 61). I acknowledge that the term “birth” is often used in broader terms, however as noted earlier in this study, I have limited the definition of birth as being from the beginning of 2nd stage labour, up to and including the birth of the baby (28). This stage of labour was chosen specifically because it is a time when the midwife may have to make decisions quickly and may not always be able to meet the requirements of the ANMC National Competency Standards for the Midwife competency 3. This competency states that the midwife: “Communicates information to facilitate decision-making by the woman” (31 p17).

Introduction

As noted in Chapter 2 clinical decision-making was initially studied in medicine where hypothetico-deductive reasoning is the model guiding decision-making. The nursing perspective on clinical decision-making has largely been shaped by Patricia Benner’s groundbreaking work. Benner claimed that expert nurses use humanistic-intuitive ways of making clinical decisions rather than the “rational reasoning” as claimed by medicine (86). Clinical decision-making in midwifery is not the same as either nursing or medical decision-making because of the midwife/woman partnership where the woman is the ultimate decision-maker. Decision-making is under-researched in midwifery and, more specifically, birth, as only five research articles met the inclusion criteria in this review. Four of the studies involved qualified midwives, and one
involved student midwives. Three studies were undertaken in England, one in Scotland and one in Sweden.

3.1 Search strategy

The literature was searched initially in 2008 and 2009 and again in 2011. The initial literature search encompassed the following databases: PubMed, CINAHL and Cochrane. The combining of search strings and application of limits occurred. Studies that pertained to the nursing profession were eliminated. Studies involving women’s decision-making were excluded. Included studies were both randomised controlled trials and qualitative studies concerned with decision-making during birth irrespective of birth location. Also included were studies that related to midwives or student midwives and those professionals who practice within the field of midwifery, but are classified as nurse-midwives within their country. Five research studies met these criteria. Key words within the research question were identified and are defined along with the complete search strategy in Appendix 3. Table 3.1 (below) offers a summary of salient points within the literature reviewed.
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Aim(s)</th>
<th>Participants</th>
<th>Methods</th>
<th>Key findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Cioffi, Purcal and Arundell</td>
<td>To explore the effect of the use of clinical simulations on student midwives clinical decision-making.</td>
<td>36 student midwives</td>
<td>Simulations, Decision rules, Thinking aloud techniques</td>
<td>Students who received the simulation strategy collected more clinical information, revisited collected clinical information less, made fewer formative inferences and reported higher confidence levels.</td>
<td>Allocation of student midwives to groups not stated. No data on how simulations were delivered. Generalisability of study due to small homogeneity sample and complexity of real environmental variables midwifery practice takes place in.</td>
</tr>
<tr>
<td>2006</td>
<td>Cheyne, Dowding and Hundley</td>
<td>To explore midwives perceptions of how they decide a woman is in labour.</td>
<td>13</td>
<td>Focus groups</td>
<td>Midwives utilise hypothetico-deductive process in clinical practice but apply clinical reasoning when reflecting in groups. When diagnosing labour, management decisions are not solely reliant on diagnostic judgements</td>
<td>Generalisability of study due to small homogeneity sample Composition and diversity of focus groups Validation of women’s views.</td>
</tr>
<tr>
<td>2005</td>
<td>Lankshear, Ettorre and Mason</td>
<td>To explore complexities of work processes involving decision-making, risk, uncertainty, medical knowledge and professional autonomy in 2 delivery suites (units)</td>
<td>16 Site 1 500 hours Site 2 30 hours 3</td>
<td>In-depth interviews, Observation, Video tape</td>
<td>Decision-making moulded by perception of risk. Midwives lowest in the hierarchical approach to decision-making, but contributed overtly or covertly Decisions were socially and culturally negotiated.</td>
<td>Validity &amp; reliability considerations due to incomparable observation times between the two delivery suites. Validation of the women’s views. Transferability to an Australian context.</td>
</tr>
<tr>
<td>2001</td>
<td>Danerek and Dykes</td>
<td>To explore the meaning of problem solving in midwifery, when faced with a critical situation and no medical assistance.</td>
<td>7 midwives</td>
<td>In-depth interviews</td>
<td>Problem solving is based upon theoretical and clinical knowledge, past experiences and intuition. Midwives felt safe within their professional knowledge and in control of critical situations Midwives orchestrated collegial and technological support.</td>
<td>Transferability of study due to small homogeneity sample and the different cultural context. Validation of the women’s views.</td>
</tr>
<tr>
<td>2011</td>
<td>Styles, Cheyne, O’Carroll, Greig and Dagge-Bell</td>
<td>To explore midwives referral decisions in relation to their dispositional attitudes towards risk.</td>
<td>100 midwives from consultant-led units and community maternity units</td>
<td>Questionnaires, Vignettes</td>
<td>No association between referral scores and perception of risk, years of experience, personality or location was found. One area health authority showed midwives referred earlier than the other four health authorities.</td>
<td>Generalisability of study due to it being located within Scotland and complexity of real environmental variables midwifery practice takes place in. Details of vignettes not clear if antenatal or labour.</td>
</tr>
</tbody>
</table>
3.2 The review of sourced literature

Study One:

The effectiveness of using clinical simulation to teach midwifery students how to use hypothetico-deductive reasoning was investigated using a cohort design (140). Of the 36 midwifery students that were recruited, 18 experienced the intervention of simulation and 18 experienced the standard lecture. How student midwives were allocated to groups was not stated. The researchers developed two simulation scenarios involving written and audio taped information and a set of decision-rules. Midwifery students worked in pairs using „think-aloud“ techniques. The first scenario concerned normal labour and the other concerned physiological jaundice in the neonate. The findings indicated that midwifery students who received the simulation strategy collected more clinical information, revisited collected clinical information less often, made fewer formative inferences and had self-reported higher confidence levels than those student midwives who underwent traditional lectures (140). Midwifery students who self-completed the post-test for normal labour simulation, found that more rapid decision-making occurred in the intervention group. This study demonstrates, in student midwives, that clinical decision-making can be improved by the use of simulation. The limitations of this study in terms of generalisability include the small number of midwifery students and the homogeneity of a single student cohort. Further, the lack of definition and description of the simulation intervention makes study replication very difficult. Importantly, the findings of a controlled clinical simulation may not be generalisable to the complex world of real practice where multiple variables operate simultaneously. This is particularly so during birth where rapid decisions are often required in a complex, potentially fast changing situation that is strongly influenced by the environment and the people within it. This broader environmental context was not considered in the Cioffi et al study (140).

Study Two:

Midwives’ decision-making in relation to the accurate diagnosis of active labour was the focus of a Scottish qualitative study (141). Thirteen midwives were allocated to two focus groups. The midwives were invited to discuss how they made a differential diagnosis between active and latent labour. Content analysis identified two major categories that midwives considered when making decisions related to diagnosing
labour: the woman and the institution. More specific themes were subsumed under each category. Midwives’ diagnostic judgements were found to be predominately based upon linear collection of informational cues in order to generate one or more hypotheses. Primary cues such as those related directly to the diagnosis of labour, were sought first. This was accomplished by assessing the woman’s labour characteristics. This method of information gathering is congruent with hypothetico-deductive reasoning (136). Once the midwife reached a diagnosis, midwives then took secondary cues into account including the woman and her family’s expectations, as well as those specifically related to the daily contextual environment of the organisation. These included workload, bed allocation and staffing issues. Organisational guidelines, the midwives said, placed significant constraints on their decision-making processes. Even if a woman was seeking admission, if she was in active labour, the midwife was reluctant to admit her because they feared that the woman would be exposed to the cascade of interventions. Importantly, regardless of which decisions were made, midwives felt the need to justify their actions to colleagues indicating a lack of autonomy in decision-making. The researchers concluded, due to competing physical, psycho-social and organisational factors, that midwifery clinical decisions are not solely reliant on clinical reasoning (126).

The strengths of this study include the distinction made between the clinical decision and the management decision. The emphasis given to psychosocial and organisational factors is also reflective of the complex reality of midwifery practice. A limitation of this study is the group-based nature of the data collection where midwives tend to tell stories that place themselves in a positive light. When midwives sit together they may add to each others’ stories until a holistic picture of the hypothetico-deductive reasoning and compassionate care is presented: this may be a constructed myth rather than a reflection of actual midwifery practice. Focus groups work best when there is diversity of views and positions but there were only two focus groups from a single hospital, which undermines confidence in this study’s findings (142).

**Study Three:**

An ethnographic study design was used to explore the complexities of clinical decision-making in two delivery suites in England (143). The study was conducted
prior to the planned implementation of a computerised decision-making support system. Data collection included direct observation of midwives and doctors as well as performing in-depth interviews. Comprehensive details of the 16 people interviewed were not stated, but they did include midwives and doctors. The births were filmed onto three videotapes and took place at a delivery suite where a prototype of the computerised decision-making support system was in use. The tapes were used within the data collection. Limited details of the videotapes were given. Key findings of the research were:

1. Midwives were generally not autonomous in their decision-making;

2. There was a hierarchical order to decision-making as evidenced by:
   - Midwives sought confirmation and/or opinion for their decisions with the coordinating midwife;
   - The coordinating midwife deferred decisions to junior and/or senior medical staff, and
   - Senior medical staff deferred some decisions to Consultants.

3. Midwives overtly or covertly influenced decision-making by others higher up the hierarchical chain;

4. The individual midwife or doctor’s perception of risk shaped their decision-making;

5. Midwives tried to involve women in decision-making more than doctors;

6. Midwife/woman decisions occurred inside and outside the woman’s room;

7. Midwife/doctor decisions occurred outside the woman’s room, and

8. Women were usually not actively involved in the decision-making process.

Midwives in this study indicated that they were autonomous in some decisions such as when to consult and/or grant admission to the birth room. Women in this study were claimed to be central to midwives’ decision-making, yet this was not supported by the research evidence collected. Indeed, women were generally passive while the midwives and doctors dominated the decision-making process (14). Midwives identified risks and made decisions, however, at times, midwives had no power to
implement those decisions. Rather, the midwives’ action was often to defer to medical professionals to enact “formal” decision-making. The researchers reported that decision-making was influenced in both directions: top down decisions were open to contestation as much as bottom-up decisions could be countermanded. This resulted in decision-making being a socially and culturally negotiated activity.

A strength of this study is that it was observational and captured 500 hours of the real world of practice. Limitations of this study are; the midwives’ autonomous scope of practice and the times when the midwife is legally required to consult and/or refer to a doctor were not clearly differentiated. The doctor assumed full responsibility for subsequent decision-making if and when a midwife transferred care of the woman to them (143). The study provides evidence of the complexity of work processes and decision-making, but there are no details concerning the actual cognitive process of clinical reasoning undertaken by participants. The study has limited transferability because the majority of the observational hours (500) were at a single site. In contrast, the second site was only observed for 30 hours. The different cultural context of England and the different educational training programs for midwives also limits transferability to an Australian context. Transferability, however, may be possible within the current Bachelor of Midwifery programs being implemented across Australia, which should be internationally compatible.

**Study Four:**

A Swedish phenomenological study focused on midwives’ experiences of problem-solving in critical antenatal and birth situations where no medical assistance was available (144). Seven midwives participated in the research. Participant demographic information was limited to a statement about the midwives’ years of experience since qualifying. Data was collected via in-depth interviews and analysed using thematic analysis. Analysis identified 13 factors deemed necessary to effectively solve critical antenatal and birth problems in midwifery. These are:

1. To listen;
2. To assess;
3. To make fast decisions;
4. To possess knowledge and experience;
5. Intuition;
6. To identify a problem and find a solution;
7. Cooperation;
8. Engagement;
9. Purposefulness;
10. Concentration;
11. Euphoria;
12. Consideration, and
13. Control.

This study reported initially that the midwives employed a process of hypothetico-deductive reasoning. The midwives listened, observed and assessed the women in order to collect cues. From these cues one or more hypotheses were generated. In interpreting these cues, midwives acknowledged drawing upon theoretical and clinical knowledge and past experiences. Once this happened the midwives intuitively knew how and when to act. Midwives stated they felt confident and safe in this approach, as they had the relevant professional knowledge. This resulted in the midwives experiencing feelings of being in control of the unfolding critical situation excluding any irrelevant peripheral social and environmental influences. The midwives claim to engage in calm negotiation with the woman and peers in order to ensure a positive outcome for mother and baby. When the need arose, midwives indicated that they orchestrated collegial and technological support. Further, in anticipation of medical agreement with their decisions, the midwives prepared any necessary equipment needed. In these critical clinical situations the midwives reported feeling euphoric when they performed well (144).

Limitations of this study, in terms of providing information to answer the current research question include transferability, which is restricted because of the small number of midwifery participants. Also, the cultural context of Sweden and the
education-training program for midwives limits transferability to an Australian context. Another limitation is that midwifery problem solving in critical situations was reported to be dependent upon verbal and non-verbal interactions with the women, yet the women’s perspective were not taken in to consideration.

The midwives’ engagement in formal hypothetico-deductive reasoning may not have actually occurred, as specific examples of this are not given. Rather, midwives may have used heuristics based upon pattern matching and past experiences (99, 102). Pattern matching accuracy is dependant entirely upon how the original knowledge and resultant decision and/or appropriate actions were assimilated (145). When a midwife uses pattern recognition, especially when faced with a familiar but different clinical situation, her judgement may unknowingly be adversely affected. Reliance on pattern matching may lead to missing crucial steps in clinical reasoning such as: hypothesis formation and hypothesis testing. This is collaborated by Dreyfus and Dreyfus (112) who hypothesises that, “...experts don’t solve problems and don’t make decisions; they do what normally works” (112 p30-31). The issue of using intuition and/or heuristics to problem solve in rapidly evolving critical situations remains a clinical problem and not necessarily a sign of an „advanced practitioner” as claimed by Benner (144). This phenomenological study presents a very positive view of the research participants. Based only on their own positive stories, midwives are presented as skilled in clinical reasoning and interpersonal skills with women, families and colleagues. If a study like this was to be believed, midwives have no problems either in making or in being able to implement their planned action. These research findings stand in contrast to ethnographic studies where midwives were often not autonomous in decision-making and sometimes could not implement planned action (136).

Study Five:

Scottish midwives were the focus of a quantitative study of midwifery referral decisions in the intrapartum period (141). Subjects recruited were 100 midwives from five consultant-led units and 13 community maternity units. Data was collected using a combined questionnaire of validated measures of risk attitude and personality assessment to measure each midwife’s risk propensity. Data collected was in the form of subjects’ responses to five intrapartum vignettes that were presented in an
on-line environment. The vignettes were presented in stages, with each stage increasing in severity and complexity. Midwives were asked to decide whether to refer/not to refer to a medical practitioner for advice at each of the five stages. Comprehensive details of the intrapartum vignettes were not provided. Data analysis was via non-parametric tests and correlational analysis.

The findings demonstrated no statistically significant difference between midwives’ referral scores and locations. Midwives’ years of experience and/or personality and referral scores noted no significant correlation difference. Other findings demonstrated that midwives from one health authority significantly made referrals earlier than the midwives from the other three health authorities (p=0.04). An explanation offered by the researchers for this is that, a significant incident had recently occurred which may have been an influencing factor in the midwives’ decision-making processes. The findings from this study correlate with those of Lankshear et al (143), who found that individual midwives” and doctors” perceptions of risk shaped their decision-making.

The limitations of the Styles et al (141) study is that it is hypothetical and does not address implementation of decisions. Lankshear et al (143) found that, in practice, once a risk had been identified or dismissed by the midwives, they were not necessarily able to implement their preferred decision. Rather, midwives deferred to medical practitioners to make the actual decision, which would lead to a plan of care. The lack of clarification and description of the intrapartum vignettes used within the Styles et al (141) study makes study replication very difficult.

4 Discussion

The major findings from this literature review are that, in general, decision-making is not exclusively an autonomous process for the midwife/practitioner, nor is it always inclusive of the input of the woman as the final decision-maker. Instead, decision-making is more aptly described as being socially negotiated within and between professional groups. Midwifery decision-making usually involves hierarchies of surveillance and control (143).
In the three studies conducted within the real world of clinical practice, midwives were reported to assess risk and to make decisions. The midwives, however, frequently had to seek approval for their decisions or had to surrender the final decision-making to a colleague (136, 143, 144). These studies occurred primarily in consultant-led hospital delivery suites where care is task focused and policy driven (143). Such environments are hierarchical in structure and use bureaucratic processes which shape and limit midwives’ decisions (146, 147). This surveillance and control undermines and regulates the midwife’s ability to think and act autonomously (148). Consequently, one study reported that midwives resorted to covertly influencing decision-making by others higher up the hierarchical chain: a midwifery version of the doctor/nurse game (143).

Midwives claimed, in the three studies that were located in a clinical setting, that within their environments, midwifery was women-centred and usually took the midwife-woman partnership into consideration” (136, 143, 144). One study focusing on critical birth situations reported that midwives claimed to engage in calm negotiation with the women (144). The research evidence collected in these studies however, did not support the midwives” claims. A potential explanation for the lack of women-centred evidence in the studies may be that midwives were unintentionally using their knowledge in a subversive way (149). The midwives “believed” they were protecting the women from what may be perceived as distressing information and/or intervention, in other words with-holding or filtrating information. In fact, while trying to protect the women, the midwives are actually doing them a disservice. Further, the midwives contribute to the biomedical discourse of power and control (149). The absence of the woman being a partner in decision-making was striking and disappointing in this review. Midwifery philosophy, competencies and ethics all claim that midwives work in partnership with the woman who is the ultimate decision-maker (150).

A limitation of these studies is that each one has involved small numbers of participants. Usually only one or two research sites were involved, which limits transferability to other maternity care contexts. Another limitation is that studies using the interpretive paradigm have unacknowledged biases towards presenting idealised
versions of how midwives make and implement decisions. This happens because interpretive researchers accept what participants say at interview as one possible truth/interpretation that is co-constructed with the researcher. For example, the Swedish midwives did not appear to be questioned about presenting only positive stories which reflected women-centeredness, as well as positive decision-making and being able to implement their planned action.

5. Conclusion

In this chapter I have been guided by the research question to review the existing literature specifically related to midwives’ decision-making during 2nd stage labour. The research question was:

“What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?”

Drawing on research presented above, the theory review (Chapters 2) and my experience as a midwife, the following factors do seem to influence midwives’ decision-making processes:

1. Simulated training in hypothetical-deductive reasoning seems to be able to improve decision-making;

2. Formal processes of clinical reasoning do not feature in the midwifery research which was conducted in practice settings;

3. Pattern-matching is the most common way that health professionals make a decision;

4. The individual’s experience and knowledge influence the accuracy of their decision-making by pattern matching;

5. The individual midwife or doctor’s perception of risk and benefit strongly influence their decision-making;

6. Hierarchies of power limit midwives’ autonomy;
7. Organisational factors like staff shortages can negatively impact on midwives’ decision-making, and

8. The woman as final decision-maker plays little or no role in the midwifery decision-making reported in the above research literature.

Clinical decision-making is under-researched in midwifery. There is extremely limited research, located in the clinical environment that has specifically aimed to understand midwifery decision-making during 2nd stage labour including the factors that are perceived to influence the midwife. Future research that addresses this gap in current knowledge is required.
Chapter Four
Methodology and Research Design

Introduction

The methodology used in this study is Post Structural Feminist Interpretive Interactionism which is discussed in detail in this chapter. The outcome of this study is a model of optimal midwifery decision-making during 2\textsuperscript{nd} stage labour and therefore it is a theory-producing methodology. The chapter begins by defining the key philosophical terms used in this chapter (Table 4.1). Next, post-structuralism is discussed. The feminist methodological principles underpinning this research are presented and discussed. This discussion illustrates and justifies Post-Structural Feminist Interpretative Interactionism as the most appropriate methodology for this research. The chapter then describes the research design by outlining the steps in the research process and the methodological principles relevant to research sites, participant selection and recruitment, data collection, analysis, interpretation and model building. The research ethics for this study are then discussed. The final section of this chapter uses the standards for scientific rigour in qualitative research for example: confirmability and reflexivity, credibility and transferability (151-153) of the study to discuss the strengths and limitations of the study methodology.

Table 4.1 Definitions of Terms

The table below notes where there is general consensus about the meaning of terms only one definition is given but where logico-empiricism differs from newer research frameworks a distinction is made thus: a) = Logico-empirical definition b) = Inclusive definition.

<table>
<thead>
<tr>
<th>Science</th>
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<td>a) 'A branch of study which is concerned with a connected body of demonstrated truths or with observed facts systematically classified and more or less colligated by being brought under general laws and which includes trustworthy methods for the discovery of new truths within its domain' (154).</td>
</tr>
<tr>
<td>b) The production of knowledge by systematic and verifiable means (155).</td>
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</table>
### Research

a) A systematic, reproducible, process of problem-solving which uses empirical data, reductive processes and logical procedures to generalise from individual events in order to establish general relationship among variables (156)

b) “A scientific process of inquiry that involves purposeful, systematic and rigorous collection, analysis and interpretation of data to gain new knowledge” (157 p57).

### Philosophy

Philosophy speculates on matters as to which there is no definite knowledge. Philosophy appeals to human reason as a way of influencing scholars to a particular position or point of view. There are three main branches of philosophy: Logic, metaphysics and ethics (158).

### Methodology

Methodology is defined as the philosophical foundation for research and is conceptualised as comprised of three sub-branches: ontology, epistemology and ethics (159).

### Ontology

Ontology concerns the study of what we accept as „real” and what we accept as „existing” (142).

### Epistemology

Epistemology is defined as “…the theory of knowledge” (160) and concerns the methods used to acquire reliable and valid knowledge. Put more simply, epistemology is about how we „know” what we claim to know.

a) Rationalists argue that human reason, intrinsic to the mind, is the primary source of knowledge (154).

b) Empiricists argue that the experiences of the five senses are the primary source of knowledge. Empiricists are also objectivists believing in the objective reality which they seek to observe (161).

Logico-empiricists attempt to combine both „objective” reason and sense data as a way of acquiring sure knowledge.

In contrast, qualitative researchers believe that there is neither objective „reason” nor objective sense „data”, and that the categories and relations of human reason and perception emerge from our engagement with the world (161).

### Feminism

Feminism is the theory, research and practice of understanding and collaboratively changing the interpersonal and social factors that sustain women’s disempowerment (162). This definition is consistent with the woman-centred philosophy of midwifery that expects midwives to support the informed empowerment of the individual woman within the midwifery partnership. (61).

### Ethics

Ethics is “concerned with moral principles and values, with what ought to be the case and how people ought to live” (163). Research ethics is concerned with protecting research participants. In the case of human research this means ensuring research participants are able to give free and fully informed consent; that their privacy is protected and that they are not injured by the research either physically or psychologically (164).
**Emic**
An entirely emic perspective in research means that the perspective of the research participants are presented as „truth” or „true for them”. The researchers own perspective is not visible in the research report e.g. phenomenology (81).

**Etic**
An etic perspective in research means that the researcher interprets or re-frames that data from their own (81).

**Feminist Narrative**
Facilitates the exploration of woman as a self-conscious self who takes ownership of her own experience (26).

### 4.2 Philosophical Foundations for the Research

This section is focused on the philosophical foundation for the research methodology of the study. I draw upon ideas from three main philosophical sources: post-structuralism, feminism and interpretative interactionism and then used these ideas to explain and justify the methodological choices that have been made in the design and conduct of the research presented in this thesis.

#### 4.2.1 Post-Structuralism

Knowledge, truth and power are inextricably related within post-structuralism. Linguistic poststructuralists have shown that the meanings (truths) cannot be fixed (81). This is because of the supposedly foundational terms upon which the meanings depend are equally contingent and unstable (165). In the view of poststructuralist‟s „truth” is free, therefore, contingent upon what comes to be accepted as „truth” is a product of relations of power (87). Power in this context is defined as an “…energy, which enables an individual (or a group) to be able to do or obtain what they want” (17). The relationship between reason, power and criticism is confronted by the post-structuralist. Foucault (87) argued that power and knowledge were inseparable, renaming it „power/knowledge” which can be used to exercise greater power over other individuals and/or groups stating “…power is employed and exercised through a net-like organisation” (p. 98). In other words the use of power/knowledge can become a means of surveillance, regulation and/or discipline rather than a vehicle of emancipation. Bentham”s Panopticon has been used to demonstrate the power of surveillance to make subjects (prisoners) docile. The panopticon was a tower located on the periphery of a
prison from which the prison population could be overseen. Foucault (166) demonstrated that through constant oversight of the population, power differentials, regulation and discipline could be maintained with a minimum of effort (166). It was hypothesised that over time, external oversight, becomes internalised and thus self-regulation rendered the Panopticon unnecessary (167). In other words, consciousness of being observed is hypothesised as being fundamental to inducing self-surveillance (166).

Foucault’s (166) ultimate hypothesis is: knowledge represents power over others which societies and institutions are not afraid to use. This is known as “technology” power (168). From the Foucauldian perspective medical power is a disciplinary power to regulate how patients should interpret their body and illness (169). Within the biomechanical discourse the health professional is taught that a “patient” is to be observed, treated and discharged (170). Foucault (166) argued that people are “docile bodies” who are passive victims of domination. In other words, patients subordinate their right to voice an opinion. Anticipatory compliance may occur in both the “patient” (birthing women) and midwives in response to, and thereby re-enforcing medical power, for example: the routine use of a fetal monitoring machine being strapped to the mother’s belly, in essence, is the surveillance of the baby’s fetal heart rate in anticipation of regulation of the mother’s labour. The woman’s freedom of choice and her freedom of movement is potentially limited by this surveillance (abetted and frequently initiated by the midwife). The woman’s democratic right to make choices, including the ability to move in labour, are curtailed through medical and/or midwifery power/knowledge and technology.

The medical profession’s power/knowledge hegemony could be viewed as a large monolithic and often repressive institution. “The hospital” is symbolic of the social power of the medical profession. These institutions were ruled through the traditional biomedical focused male dominant profession. Tew (171) argues that historically, hospitals have always been patriarchal institutions renowned for their oppression and abuse of women. Hospitals highlight essential Western industrialised society concepts such as: “…urbanisation, secularisation, the dominance of professional power and the
development of the service factor” (172). Birth moved from the home to hospital in the latter half of 1900’s across Britain, Europe, North America, Australia and New Zealand (173). Birth became the domain of the male medical profession (174). Medical professionals considered childbirth as potentially dangerous, with life threatening complications demanding active medical interventions, which only their power/knowledge could prevent (175). Such life saving interventions could only happen within an institution: the hospital. This continues to be prevalent today with the safety of the woman and baby acting as a commodity that requires the employment of a techno-rational approach to birth.

Post-structuralist’s claim that meanings are capricious because those who control the power and knowledge within a society shape and control the dominant meanings (6). Post-structuralism accounts for the way in which self-serving discourses are imposed by the dominant culture (in this case, white doctors) on people who are different from them: these differences are based on race, colour, class, language, gender, sexuality, age and ability (176). For centuries, midwives have predominately practised their craft in hospitals and/or medical led units, thus their knowledge, understandings and language have been focussed through the dominant medical paradigm. Further, this predominately male profession has, over centuries, applied science to their understanding of the physiology of childbirth, which they understood as separate from the woman’s spirit and emotions (175). Biomedical language excludes terms that are critical to midwifery and midwifery decision-making for example: optimising health, women’s feelings, the impact of trust, empowerment and women-centeredness. Medical professionals/authors continue to exclude women-centred, holistic language thus reinforcing their power and knowledge (177).

The modernists and poststructuralists view the subject differently when collecting and interpreting data. These perspectives are summarised below by Sundin-Huard and Fahy (178). The below table shows how a post-structural perspective on the subject (in this study, midwives) is more complex and holistic when compared with the modernist subject of biomedical science:
<table>
<thead>
<tr>
<th>Modernism – Subject</th>
<th>Post-structural - Subject</th>
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<tr>
<td>Human beings are animals who cognitively manipulate symbols and thus create and reproduce culture (179).</td>
<td>Recognise and incorporate the emotional element of human behaviour (180)</td>
</tr>
<tr>
<td>Subjects are autonomous in their actions – able to freely have different responses if they make different meanings of situations (179)</td>
<td>Autonomy implies separateness from individuals and the ability to make decisions in one’s best interest. Subjects are socially constructed- the results of interactions and power relations (181, 182).</td>
</tr>
<tr>
<td>Subjects give meaning to their bodies, their feelings, their situation and their lives as well as the broader social context in which they live. Although the self is multi-layered, the ego is in control. Thus the self is seen as integrated (179).</td>
<td>Acknowledges multiple selves and multiple realities of social and cultural systems, resulting in „split subjectivities“ for the individual and differing prescribed discourses for differing situations and interactions (178, 179, 182, 183)</td>
</tr>
</tbody>
</table>

Within modernism the unique human self is at the centre of meaning-making and has freedom of choice. Post-structuralist theories such as Foucault, Derrida and Lacan challenge this view (178). These theorists believe the subject is socially constructed through power relations and discourses which shape and limit the subject. The subject’s speech is regulated via conformity with culture/society. The subject/self and his/her perceptions are products of discourse embedded in and articulated through/by learnt culturally specific differences (rules) (184). In other words, the subject has limited freedom of choice through context and language available to them (185-187). In Derrida’s work, the subject/self can be deconstructed, resituated and inscribed in language (188). The point, however, of post-structuralism is not to obliterate the humanist subject but to make visible one’s fictionality, acknowledging the representative
way in which fictions play a role in shaping our beliefs of what is real (189). Levine (190) argues post-structuralism encourages the subject/reader to "look at rather than through the linguistic surface" (p. xvi).

Post-structuralism reconceptualises the subject/self from a fixed entity to one that is constantly in a state of flux, metamorphosing through language. Post-structuralism enables the subject to explore and understand the object "itself" as well as the constitutive process of language and the process of knowledge (184).

Post-structuralism, therefore, refutes objectivity and scientific "truth" as oppressors; instead it turns the researcher’s focus towards plurality, diversity and multivocality of individuals and groups (191-193). In this project the diversity, plurality and subjectivities of the participants’ stories have been acknowledged as these stories have been deconstructed to reveal multiple perspectives of the phenomenon of interest.

Post-structuralists believe exploration of historical discourse is important as this brings understanding to the place oppressed groups create in order to function within their daily lives (194). An author of particular interest to feminists is Foucault. Although never claiming to be a post-structuralist, Foucault (166, 195) proposed that power/knowledge could be socially constituted to construct and legitimise various forms of power domination. Recognition of the impact of power/knowledge relationships upon "people" facilitates understanding of the process of oppression. Post-structuralism exhorts and fosters a coherence of understanding of people’s past histories (where they have come from) to where they are today. Feminists however, claim that history has always been written from the male perspective, and from their interpretation of reality and interests (196, 197). The masculine world view became endemic and thus, the only way of interpreting social reality. The masculine form is apparent in such aspects as: the gender of God, the guardian of knowledge, power and the family, whilst women have been relegated to roles such as mother, daughter, nurturer, carer (198). Historically women have been perceived as emotional, irrational and lacking in self-restraint (172). Further, women and their bodies were perceived as threatening to the moral and social stability...
of society (199). Knowledge was the result of exerting power regimes on other humans (87). To identify such "contingent and violent emergence of these regimes" would result in challenging their validity (87). Despite Foucault never "locating" women"s body as a primary source of exclusion and/or oppression, feminism embraced his argument stating that women needed to reinterpret their historical origins. Women needed to explore what has been omitted or distorted in order to be able to show the "true" reality of women"s experiences (196, 200). Feminist historians need to uncover the power struggles that occurred, enabling people to assert dominance over others.

4.2.2 Feminism

Feminism, as both theory and action, covers a broad spectrum of thinkers and activists who are committed to changing mainstream society in a way that not only involves freedom from oppression, but also incorporates liberation and equality of opportunity for women, whatever their colour, gender, or social status (162, 201, 202). Feminist research explores the political, historical and gendered practices entrenched in all knowledge production (203).

The biological/sexual differences between male and female and gender inequalities are a fundamental concept to feminist theory. Some feminists perceive gender as the organising principle which profoundly shapes/mediates conditions of women"s lives (204). Historically, the self was seen to be governed by reason and it was this view that led to sexism and the social construct of society by reason (89). Incorporating the history of women and their place within the world is promoted within feminist theory, it is "…essential and indispensable to the emancipation of women" (205).

Midwives claim to be autonomous practitioners who practice through a partnership relationship with women (206, 207). This relational environment enhances a sense of mutual empowerment. Yet this mutual empowering environment is constitutive and constrained of/by the social realm within which midwifery practices: the male dominated
medical environment. In other words, midwives experiences of midwifery decision-making will be influenced by the context, culture and history of midwifery’s place within the hierarchy of health science. Consequently, midwives striving for autonomy may perceive they have to be continually at “war” with the medically dominated system. But, whilst recognising feminist beliefs that certain conditions influence an individual’s freedom, I fundamentally believe that humans are much freer as subjects than many feminists believe. I abhor “victim” feminism because I see that subjects, in this case, midwives, bear a responsibility to influence their environment and culture.

Feminist ontological and epistemological assumptions and beliefs are reflected in differing lists of what characterises feminist research principles (208-211). As early as 1987 Harding urged feminists to acknowledge and accept these differences and turn their focus to knowledge acquisition and legitimation of knowledge rather than focusing on internal differences (65).

Olesen (66) suggests feminist research can be categorised as having one of three methodological positions: Feminist Empiricism, the Feminist Standpoint or Feminist Postmodernism. Feminist Empiricism is based upon principles of objectivist epistemology and realist ontology whilst adding a women-centred approach with the aim of enabling empowerment. Feminist Standpoint blends Marxist, phenomenological and ethnomethodological perspectives (66). The Standpoint feminist researcher believes that women create and shape their beliefs, attitudes and values in relation to their everyday world within the broader patriarchal and capitalist context. To understand the women’s perspective, the researcher must sensitively enter that world. The focus for the Standpoint feminist is one of creating inter-subjectivity, which then creates meaning and realities shared between researcher and participant. The Standpoint researcher subsequently uses reflectivity to identify the causes of women’s disempowerment (66). Feminist Post-Modernism also called Post-Structuralism, is distinguished by rejecting epistemological assumptions of modernism by seeking to uncover the hidden power relations inherent in language (210).
All feminism research places value on women’s experiences. Feminism focuses the researcher to see and think about new perceptions and conceptual frameworks from women’s experiences (212). In feminist research, participants are no longer passive conduits for information as they are seen in standard scientific research. Rather, participants are active in co-constructing meaningful data (203). Through mutually agreed intimacy and reciprocity I strove to recognise and construct a shared “situated” understanding of the issues between the midwife participants” and me. This has been called “lived textuality by Denzin (142). In other words, both mine and the participant’s experiences are valid and valuable; therefore I needed to foster an equal relationship base. To facilitate this, researcher-participant power differentials need to be equal. A method to assist this is reflexivity. Skeggs (213) hypothesises reflexivity as a process and practice concerned with power, responsibility and accountability and positioning. Consequently, I needed to constantly reflect on the inter-subjective dynamics between myself and the participants (162, 214-217). Reflexive practices, Stanley and Wise (218) claim are needed in order to conduct political, morally responsible and accountable feminist epistemological research.

My aim was to gather individual experiences/stories to illuminate the ways in which midwives come to understand, act and manage their day-to-day situations and specifically how they enacted clinical decision-making during 2nd stage labour. I wanted to hear other midwives’ accounts of midwifery decision-making and to be able to respect and understand their stories within their social and cultural context. Yet I had my own stories to share. I had knowledge, judgments and everyday understanding of midwifery decision-making within various midwifery settings in two countries and I wanted to be true to my presuppositions, my ideas and my experiences related to midwifery decision-making as expressed in Chapter 1 (219). Feminist theory provided a means for me to declare my values at commencement of and throughout the study (65, 202, 203, 220-224). In other words, feminist researchers are required to state their premises rather than concealing them. By acknowledging my everyday knowledge, political knowledge, theoretical knowledge, social knowledge as well as reflecting and analysing myself, assisted me in relating to the participants.
So although the term feminism covers a wide range of meanings and activities, for the purpose of this research study and to be consistent with the broader feminist literature, feminism is defined as: that range of women-centred activities conducted with the aim of reducing the social and interpersonal factors that sustain women’s disempowerment (162, 202-204, 225, 226).

4.2.3 Feminist principles

Feminist epistemological assumptions and beliefs are reflected in diverse lists of what characterises feminist research principles (208-211). Nevertheless, Acker and Esseveld (151) postulate that feminist principles can guide feminist research if women's voices are heard. In the section that follows the feminist methodological principles guiding this study are described.

4.2.3.1 Women’s diversity of experiences are central to the research process and research outcomes

Early feminists made universal claims related to how, where and why all women were oppressed at all times (200). The complexities of women's individuality and culture were ignored (84). Research outcomes, they averred, should not be generalized, applied and/or distorted to fit the masculine ideology of gender (196). Neither should reasonableness, as claimed by man, be accepted as women's truth (200). Male stereotypes of women should not be accepted by women (200). Post-structuralism addresses this by giving validity and acceptance to each woman's personal experiential based knowledge, experiences, thoughts, social interactions and reactions. One's reactions and actions combined with existing knowledge are foundational in the development of and mastering of how the personal lived experiences of women and decision makers are constructed within midwifery (221). Irigaray (198) hypothesised, for women, this process was necessary in order to accumulate wisdom. To conceptualise each woman's culturally constructed reality and wisdom, it was vital that participants were centrally located within the research. Consequently this principle was honoured by the research focus, which is on a women's discipline: midwifery and decision-making.
with and for women during birth. It is acknowledged that Australian male midwives were participants, however the primary focus was on midwifery: of which both the national and international workforce is predominately made up of women whose practice focuses solely on childbearing women. In this study, women’s experiences mean the woman’s subjective experience of mind and body and its social entanglements with their perceived every day lived reality. It was recognised, that every participant and their experience is unique. Further, those experiences are moulded by external and internal influences.

4.2.3.2 Exploration and acknowledgement of how the researcher’s own values and previous experiences influence the research process

Keddy, Sims and Noerager Stern (226) state that being a successful feminist researcher is “…incumbent upon her philosophy… and her… application of the method” (p 449). This principle was respected by acknowledging the continuing need to explore the most appropriate ways to conceptualise and theorise about those factors influencing midwifery clinical decision-making during 2nd stage labour. „Becoming a feminist“ has inescapably led to changes in my attitudes, values and beliefs. It has heightened my awareness of sexual/gender differences causing reconceptualisation: what was once acceptable has become unacceptable and vice versa. Inevitably this has changed during the research process. These changes, in turn, have contributed to this study through reflexivity (203, 220, 221). This open-minded evolutionary approach to feminist research practice is well supported within methodological literature (64-68). Further, it matters that I am a woman, wife, mother and midwife. I have also worked as a nurse/midwifery academic and nurse. I acknowledge I have been shaped by these roles and my broader social background. I acknowledge I have my own theories, knowledge, values, experiences and biases, which were declared and examined throughout the research process. Several feminist researchers” state that declaration of the researcher's values should be made at commencement of and throughout a study (65, 202, 203, 220-224). In Chapter 1, for example: I outlined my biography, stated my current personal and professional values and explained why I chose this research topic. By using the „I“, I have not hidden my historical roots, my passions, or my conscious/unconscious motivations. I have not restricted or prevented the participants in any of their choices.
Neither have I misrepresented my intent to enlighten midwives to value their right to freedom of choice and decision-making. I have offered the power of speech to the midwives studied so they can become aware of their personal oppressions and individual oppressors and reconceptualise how to address them. The women and the readers must judge for themselves of my honesty, reliability and authority (227, 228).

4.2.3.3 The researcher is reflexive about her relationships with the women and these experiences may legitimately form part of the data

Reflexivity is defined by Fonow and Cook (215) as:

“feminists...reflecting upon, examine Consciousness Raising and explore analytically the nature of the research process…to gain insights into the underlying assumptions about gender relations underlying the conduct of the research” (p 2).

Reflexivity was honoured within this research as I critically explored and analysed my own identity as a woman, a feminist and a midwife and how these roles influenced each stage of the research process. Feminist post-structural interview techniques involved intimacy and reciprocity, shared knowledge and experience between the researcher (me) and the women through the development of a relationship based upon equality. This dialogic engagement allowed for greater understanding of shared meanings, interpretations, processes and theories (86, 229, 230). This construction of a shared “situated” understanding of the issues between the midwife and me has been called “lived textuality” by Denzin (142). Non-hierarchical interactive sharing required me to eliminate any preconceived role expectations and power imbalances between me as a researcher and the women/men as practising midwives (194). Both our experiences were valid and valuable; therefore I needed to foster an equal relationship base. Consequently, I reflected on the inter-subjective dynamics between myself and the midwife (162, 214-217). Articulations of my experiences and reflections have legitimately formed part of the data (221, 231).
4.2.3.4 The intrinsic power of what is and what is not verbalised is explored

Post-structuralism focuses on language and how it is used by women to define their lived reality (191). It shapes the content of one’s subjective experience. Potter and Wetherell (232) claim that any socio-psychological imagery of self is portrayed in the language one uses. Verbalisation of an experience contributes to the negativity or positivity of an experience. Language is a powerful force. Irigaray (233) hypothesised how the patriarchal tradition of language creation and usage controlled and suppressed women. It alienates and exploits women by enforcing its own configurations on one’s comprehension of society and one’s place within: it renders them silent and in an inferior position (198, 200, 225). This, claims De Beauvoir (234) is how men dominate, prove themselves right and ultimately speak for women. Language reveals biases and betrays feelings and emotions. It illuminates hidden or suppressed feelings of negativity and oppression or areas ripe for resisting pressures to conform and change. Therefore, it was important for me to listen and to hear the diversity of language used and what was omitted. However, if an experience fell outside women’s language, then it was lost; thus the absence of or silence of language was as important as that, which was voiced (185).

4.2.3.5 The researcher explicitly explores how power is operating and the women’s own participation in their disempowerment

The patriarchal sex-role stereotyping socialisation and processes are entrenched in large environmental cultures such as hospitals contributing to how one experiences and interprets lived reality (209, 228). These intrinsic strategies of oppression become invisible over time: they foster conformity of behaviour and become accepted as the dominant discourse (209, 221). Individuals (women) lose their own identity and place of being (198). As a result of societal (male) power/knowledge/gaze, over time awareness of such transformation disappears and to all intents and purposes it appears that women are unconstrained, thus obedience to male domination is successful (200). But men are not the only ones to oppress women; women are instrumental in proliferation of the
dominant discourse. Irigaray (198) argues, women alienate and/or constrain fellow women who choose to rebel against such oppression. In society today and indeed in the health care system today, this happens in one of two ways: the individual can be directly required to conform to change and comply with societal/health care norms or experience social discomfort until they leave. Alternatively, in seeking to attain peer approval and acceptance, individuals therefore conform and maintain societal/healthcare traditions of oppression (200).

As a midwife, I am aware that Australian midwives predominately practice in hospitals. Public and private hospitals are ruled by formal health administrators but at the actual level of practice, the male dominated medical profession is the dominant group under which all other health professionals are subordinated (63). The explicit exploration of power relationships required me to really look at, in detail, the practice of some midwives, why they sought to silence others who wished to claim an identity and place of being. Further, I needed to explore and understand how some midwives, as women, participated in their own disempowerment in decision-making. This encompassed the broader organisational and policy environment to see how power operated to compel and constrain decision-making by midwives (175, 209, 235). Through this exploration I raised the following options to the forefront of the midwives’ consciousness:

- To understand how the current situation arose;
- To see how the environmental systems and people within it function, and
- To make the midwives aware of their freedom to choose either to resist conforming pressures or not (162, 200, 215).

4.2.3.6 The research outcomes will provide knowledge for women, which they will find useful and will contribute to their daily lives.

Feminist Consciousness and Consciousness Raising are fundamental feminist beliefs. Feminist Consciousness is a method of exposing previously unexploited reservoirs of knowledge that leads to the woman discovering the meaning of being a woman, how
she views, constructs and negotiates the social world she inhabits (221). Consciousness Raising is a way of sharing individual experiences of oppression with other oppressed women, trying to understand and change them (84). This is important as Moss (223) notes, “…that which is experienced can be known; and that which is know can be changed” (p 48). Consciousness Raising consists of three stages:

- False consciousness;
- Partial consciousness, which includes Feminist Consciousness, and
- Revolutionary consciousness or feminist true consciousness (218).

It should be noted however, Consciousness Raising stages are not linear, but rather circular. Some feminists refute the notion of false and true consciousness as it denies validity of individuals” interpretation and understanding (218). Neither is it reasonable to assert Consciousness Raising alleviates women"s discontentment (177). Further, Consciousness Raising is dependent upon the notion; the male dominated culture of power will obligingly and willingly surrender its position, changing the existing social boundaries (236). Rather, this research offered midwives a way of commencing and/or moving within the Consciousness Raising stages by promoting awareness and/or enlightenment of the factors that generated and perpetuated the inequalities between the male dominated medical profession and midwives (237). It provided data about their decision-making abilities and their capacity to implement these decisions within the patriarchal birthing environment (65, 204, 237). By giving the power of speech to the midwives studied, it was hoped they would become aware of their personal oppressions and individual oppressors and reconceptualise how to address them. Consciousness Raising is a way of sharing individual experiences of oppression with other oppressed women, trying to understand and change them (84). Empowerment is constructed through and by midwives belief in their autonomy. For this reason, I needed to understand the lived reality of the midwives studied. From reciprocal exposure and understanding the midwives would be offered the opportunity to claim their right to be heard as midwives and decision-makers.
4.2.3.7 The research is guided and informed by feminist literature

Traditionally, women’s role in society was reproduction and to be of service to men. The underlying problems for women derived from males and their quest for domination and subversion (200). Over time women won roles in society that were predominately those of males, yet discrimination persists. Through understanding women’s historical struggles and how they survived, we can construct our daily lives (203, 208, 211). Basing this research on feminist literature helped me to frame the whole research process and to keep focused on the feminist philosophy of the fight against oppression and the disempowerment of women.

4.3 Research Design: Post-structural Feminist Interpretive Interactionism

Post-structural Feminist Interpretive Interactionism is the methodology used to guide this research. The methodology has been modified from critical post-structural interpretative interactionism methodology (178). Critical post-structural interpretative interactionism encompasses post-structural insights and the consideration of power imbalances inherent in interactions between people.

The political aim of feminism is to liberate the oppressed and to promote personal emancipation, but this is founded on the philosophical assumption of women’s value judgements and claims of truth (238). As a midwife/researcher my aim has been to understand and change the situation/condition of midwives” decision-making during labour.

The particular aspects of mutuality between, interpretive interaction, post-structuralism and feminism that impacted upon the philosophical framework of my study were: „docile-bodies” and autonomy, power and emancipation and the deconstruction of language as well as the constitutive and constraining social realms within which midwifery decision-making occurs (62, 87, 166, 198, 239-241).
The concept of the midwife/woman partnership is a feminist form of professional practice (242). The “Good Midwifery Practice” model acknowledges midwives as autonomous practitioners. Such an attribute is fundamental to midwifery’s claim that it is a feminist profession, challenging the biomedical model of birth (206, 242). In midwifery, in the absence of partnership and sound clinical decision-making, we see both women and midwives subordinating their voices and rights to medicine and their “power/knowledge”. Philosophically there is agreement within midwifery that midwifery clinical decision-making should involve the midwife in negotiating sensitively with the woman with consideration for the environment and the people within it (60). Further, midwives’ decision-making abilities and their capacity to implement these decisions within the patriarchal birthing environment are shaped and influenced by such things as: context, culture and the history of midwifery’s place within the hierarchy of health science (65, 204, 237). Post-structural Feminist Interpretive Interactionism facilitated the examination and explication of the supporting and constraining influences upon the midwifery best practice.

Using Denzin’s (1989) model, there were six phases to the interpretive process. With modification at several of these stages as outlined, the principles of Post-structural Feminist Interpretive Interactionism were incorporated into these steps to develop a design that allowed the aims of this study to be met. The first two steps of Post-structural Feminist Interpretive Interactionism outlined in the next section of the chapter illustrate if and how they have been modified for this study.

4.4. Post-Structural Feminist Interpretive Interactionism

4.4.1 Framing the Question

The development of the research question of this study was in accordance with guidelines from Denzin (243). The first requirement of this methodology was, for me as the researcher, to frame the question. This was done in such a way that I was prompted to think critically, historically and comparatively as I engaged with the research. The
question also encouraged me to examine issues from my own biography in relation to the research topic. The question focused on the process of interaction with particular attention given to the factors that were influencing the interactive process (243). I clarified how the phenomenon of interest (in this case decision-making during 2nd stage labour) related to a public issue that affects multiple lives, institutions and social groups. For this study, this primarily meant women and their families, midwives, maternity services and the health workforce.

4.4.2 Deconstructing and Critically Analysing Prior Conceptions of the Phenomenon of Interest

This step required me to locate previous conceptions of the phenomenon of interest in contemporary literature (243). Previous theories, observations and analysis of the phenomena under study were critically examined. Previous biases and possible misconceptions surrounding existing understanding were acknowledged. Essentially, this meant that a review of the contemporary literature was undertaken. This step required no modification for the Post-structural Feminist Interpretive Interactionism approach. Systematic review of relevant literature and theory were undertaken as highlighted in Chapters 2, and 3.

The next step of Post-structural Feminist Interpretive Interactionism has been placed under the heading Methods of Data Collection. This section outlines the third step: Capturing Instances of the Phenomenon from the World of Practice. This step required no modification for the Post-structural Feminist Interpretive Interactionism approach.

4.4.3 Methods of Data Collection: Capturing Instances of the Phenomenon from the World of Practice

Capture involved locating multiple cases of the phenomenon under examination. In this study I designed questions to elicit multiple cases on midwifery decision-making during 2nd stage labour. These cases were provided in narrative form by the participating
midwives. The midwives were asked to recall episodes from their practice that they felt reflected both a „positive“ and „negative“ clinical decision (an emic interpretation). Participants came from a variety of midwifery care settings within each State and Territory of Australia.

4.4.3.1 The Research Sites

In the interests of generalisability and validity I was anxious to access participants exhibiting diversity in both experience and practice location. I was able to access attendees at the bi-annual ACM conference held in Adelaide in September 2009. Another consideration was potential power differentials within in-depth interviewing. Locations for interviews were chosen by the participants upon the offer of several alternatives. Participants chose several locations including participants" homes and hotel accommodation, secluded coffee houses and cafes as well as private interview rooms at the convention centre. Conducting interviews at various locations assisted in diminishing potential power differentials (225).

4.4.3.2 Selection and Recruitment of Participants

4.4.3.2.1 Selection

Purposive, theoretical sampling was used to recruit midwives who had worked with birthing women within the past few months. Purposive sampling is the “…conscious selection by the researcher of certain subjects” with particular characteristics (244, 245). The following inclusion criteria were applied:

1. Registered with a Nursing and/or Midwifery Board/Council;

2. Had practiced midwifery during labour within the last month.

3. Cultural diversity;
4. Diversity in work place and location: metropolitan, rural, remote, independent, hospital (tertiary), midwifery led birth units (stand alone, attached to a hospital);

5. English speaking, and

6. Willing to sign the consent form.

Any participant who did not meet these selection criteria was respectfully excluded. I aimed to recruit midwives with diversity of age, race, class, experience levels, qualifications, gender and place of employment. Careful notes about who offered to participate using an excel spreadsheet were kept (245, 246).

4.4.3.2.2 Recruitment

4.4.3.2.2.1 Recruitment Strategy

To ensure wide recruitment, an advertisement was disseminated across Australia (Appendix 4). Sites included:

- A national on-line midwifery forum;
- The Australian College of Midwives membership email network of approximately 4,000 midwives;
- The Women’s Hospitals Australasia network (WHA) which represents many major women’s hospitals and health units throughout Australia and New Zealand, as well as on
- An international midwifery research on-line forum.

Personal acquaintances, known to the researcher, were contacted as a third party recruitment strategy and were a reference point for notifying potential participants of the study. A point of access to an array of diverse midwives practising in a variety of settings was offered by each acquaintance. Organisational approval was obtained within the health services/universities of each acquaintance. These included:
Greater Southern Area Health Service covering 14 rural maternity services in New South Wales (NSW);

Western Australia (WA);

Lyell McEwin Hospital, South Australia (SA), and

Winnunga Nimmityjah Aboriginal Health Services in the Australian Capital Territory (ACT) who have access to a network of midwives across Australia in a variety of settings.

The two main maternity hospitals, within the Australian Capital Territory of Australia (ACT), declined to post the advertisement on their notice boards.

I was granted permission to use the ACM exhibition stand at the ACM conference in Adelaide to provide information on the study to conference delegates and distributed the recruitment advertisement. Once a potential participant contacted me an information sheet (Appendix 5) and consent form (Appendix 6) was provided.

Seventy-two midwives contacted me in response to initial advertisement indicating a willingness to participate in the research. Of these, two fell outside the selection criteria: both midwives were from New Zealand and I did not have ethical approval for an international study. Consequently, the information sheet and the demographic questionnaire were sent to 70 midwives. Of these, 48 midwives completed and returned the questionnaire and signed consent form.

4.4.3.2.2 Recruitment Screening

Upon the consent form”s return a selection screening questionnaire (Appendix 7) was posted, emailed, faxed or hand delivered. The demographic questionnaire was used as a screening tool to maximise diversity of participants in terms of geographic location, level of education, length of experience, age etc. Consequently out of the 48 midwives recruited only 26 were invited to individual interviews. The selection of participants
based on diversity is a hallmark of quality feminist research. Further the aim of this selection process was to improve the validity and transferability of the study findings.

The possibility of conducting in-depth interviews with 48 midwives appeared overwhelming so I discussed the response rate with my academic supervisors. It was concluded that face-to-face, rather than telephone interviews were the preferred method of data collection. During the interview both the participant and I would reveal information about a positive and a negative decision-making experience during 2nd stage labour. There was, therefore, a slight risk the participant would feel uncomfortable and even vulnerable. Whilst a telephone interview permitted listening for implicit and explicit meanings within the data (247), I could potentially lack sensitivity to emotional elements displayed on a face. Face-to-face interviews provided an opportunity to observe and interpret body language and emotions of the participant (248). Consequently, I contacted the 48 midwives to establish if they anticipated attending the ACM conference in September 2009 or two other national midwifery conferences occurring within 2009. Twenty-three midwives would be attending the ACM conference and agreed to be interviewed whilst there. Three out of the 48 midwives lived within travelling distance of the researcher and agreed to be interviewed at home. Excluded were midwives who did not attend one of three national midwifery conferences in 2009. This means that midwives who are professionally engaged were the participants in this study. The findings, that the majority did not use a systematic approach to assessment and clinical reasoning is, therefore, all the starker.

The final 26 midwives who were interviewed represented every State and Territory in Australia, and worked in all of the models of care provided within Australia. This is summarised in the tables below.

**Tables 4.3 Demographic data of Participants**

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Interviewed</th>
<th>Location</th>
<th>Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>6</td>
<td>Rural</td>
<td>7</td>
</tr>
<tr>
<td>Victoria</td>
<td>2</td>
<td>Remote</td>
<td>3</td>
</tr>
<tr>
<td>Queensland</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Australia</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Australia</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tasmania</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major city</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Environment</td>
<td>Interviewed</td>
<td>Time Qualified as a Midwife</td>
<td>Interviewed</td>
</tr>
<tr>
<td>Consultant led private</td>
<td>3</td>
<td>&lt; 5 years qualified</td>
<td>5</td>
</tr>
<tr>
<td>Consultant led public</td>
<td>11</td>
<td>6-10 years</td>
<td>4</td>
</tr>
<tr>
<td>Birth unit attached</td>
<td>4</td>
<td>11-15 years</td>
<td>None</td>
</tr>
<tr>
<td>Birth Unit Unattached</td>
<td>1</td>
<td>16-20 years</td>
<td>3</td>
</tr>
<tr>
<td>Group midwifery practice</td>
<td>9</td>
<td>21-25 years</td>
<td>4</td>
</tr>
<tr>
<td>Self employed/Private Practice</td>
<td>4</td>
<td>26-30 years</td>
<td>2</td>
</tr>
<tr>
<td>General practitioner (GP) unit</td>
<td>2</td>
<td>31-40 years</td>
<td>6</td>
</tr>
</tbody>
</table>

The sample included practicing midwives from each State and Territory across Australia and from every model of midwifery care offered within Australia. Diversity of midwifery qualifications was sought and included: hospital certified, post graduate qualifications and direct entry Bachelor of Midwifery. Some midwifery qualifications were gained overseas. The length each midwife had been qualified ranged from 6 months to 40+ years. The study was not limited to Anglo-Saxon Australian female midwives.
4.4.3.2.3 Selection Screening Questionnaire

A selection screening questionnaire was used to elicit information such as: midwifery qualification, gender and place of employment (remote, rural, and metropolitan). A description of the sample’s characteristics was provided from correlation of this data (245). This data was used to select a diverse range of participants thus improving the validity and transferability of the study findings.

4.4.3.2.4 In-depth Interviewing

A pilot study was conducted to test both my interview skills and the interview schedule. For two reasons the interviews I undertook were unsuccessful. First, I knew one of the midwives professionally and personally. Second, these midwives were very reluctant to discuss a „negative decision-making” aspect of a birthing story. The interviewees might have perceived that they were placed in an emotionally vulnerable situation (230) exposing them to a perceived a risk of harm: thus hindering intimate dialogue and personal information being revealed (162, 209, 220, 222). Another potential contributing factor could be that I missed or mis-read non-verbal behaviour highlighting their discomfort. Consequently, I undertook a communication and negotiation workshop as well as an Emotional and Social Intelligence workshop. These workshops highlighted cues to be conscious of (being more in tuned with/observing non-verbal behaviour) and possible action required such as: halting or stopping the interview and/or referral to counselling or support services (229). After discussions with my supervisors it was decided not to change the Interview Preparation Sheet (Appendix 8). Neither did I change the Interview Schedule (Appendix 9).

An interview theme list of the potential discussion topic/concepts was given to selected participants prior to the in-depth interview. This allowed participants to be prepared and/or feel comfortable prior to the interview and thus be more likely to provide rich information. Further, an interview theme list provided a balance between the unplanned free flowing and an overly structured interview schedule. To ensure all participants were
asked the most relevant questions, the interview schedule acted as a prompt during the interview.

To align with the beliefs of some feminist researchers and to support shared control of the interview with the midwives I needed to create a non-hierarchical, non-manipulative relationship (220, 249). I was concerned about potential power imbalance inherent within research. To that end I consciously wore understated clothes, no make-up. Further, I began with two open-ended questions. Midwives were asked to discuss stories related to their recent experiences of decision-making during the birthing of a baby: both positive and negative. Through midwives” personal oral stories, unique and individualistic accounts related to their complex social reality and experiences were heard (229, 250). Throughout the interview, naturally occurring data of each participant”s non-verbal behaviour was observed. This helped me to contextualise or situate specific aspects of each unfolding story. Any observed body language and emotions of participants were incorporated into the analysis of the data by inductively establishing links between what was heard and what was observed. This aided in the accrual of richer, valid data.

Once interaction with the midwife occurred, as appropriate, I asked minimal probing questions which prompted unhindered narrative responses (64, 153, 214, 220, 225, 251-254). This dialogic engagement allowed for greater understanding of shared meanings, interpretations, processes and theories (229, 230). A major strength of in-depth interviewing is that I could carefully listen to what was being said in terms of: content, context, names, sequencing, relevance and emotions (229). In-depth interviewing also allowed me to be flexible in my line of enquiry, following up themes/concepts rather than relying on pre-determined structures (249, 250). Data collection continued until no new information was being gained and theoretical categories were saturated (229, 255).

Each interview was transcribed by a professional transcriber outside of Australia to promote confidentiality and anonymity. Where the transcriber was unsure of what was
heard, a reference to the exact point on the tape was recorded in the transcript. I listened to each interview in full whilst reading the written transcript multiple times. Missed words or misheard words were corrected; an example of this is the word: continuity.

The next step of Post-structural Feminist Interpretive Interactionism has been placed under the heading Methods of Data Analysis. This section outlines the next two steps:

- Focusing on Instances of the Phenomenon from the World of Practice and
- Constructing a Tentative Conceptual Model.

These steps required modification for the Post-structural Feminist Interpretive Interactionism approach for this study.

### 4.4.4 Methods of Data Analysis: Focusing on Instances of the Phenomenon from the World of Practice

After the in-depth interviews had been captured, the next step in Interpretive Interactionism, according to Denzin would be “Bracketing the Phenomenon”. In bracketing, the researcher holds the phenomenon up for serious inspection, removing it from the world to examine it in detail. Denzin exhorted the researcher to examine the phenomenon as a text: to deconstruct it. At this stage, previous understandings reached through earlier deconstruction of the literature were suspended and the participants’ narratives were inspected purely as examples of the midwives’ experiences for example: an entirely emic perspective.

This step required modification for the Post-structural Feminist Interpretive Interactionism approach because of the commitment to include my own understandings and values. Thus, I wanted my account of decision-making during 2nd stage labour to have both an emic and an etic perspective. I had knowledge, judgements and everyday understanding of midwifery decision-making derived from a variety of midwifery settings
in two countries. As a feminist researcher I critically explored and analysed my own identity as a woman, a feminist and a midwife and how these impacted upon my ability to bracket what I already knew or believed during analysis. I felt my voice and values should be included as part of this research (202, 203, 256). I had declared my values in Chapter 1 and again, within the feminist principles of this methodology chapter.

I used my reflective journal and discussed, at length, with my supervisors how to stay true to my feminist principles and comply with this stage of Denzin”s (243) model. It can be seen that Denzin”s term „bracketing” differs from the concept of bracketing one”s values and preconceptions during analysis. In light of this discussion and the post-structural critique of modernism, “Bracketing the Phenomenon” was renamed to “Focusing on Instances of the Phenomenon in the World of Practice”. Focusing on (or examination of) instances of the phenomenon involved several distinct yet inter-related steps:

1. **Finding examples of positive and negative decision-making in the stories from practice:**

   In this step the data was inspected for examples of the phenomenon within the midwives” broader narratives. In this midwifery decision-making study I listened to midwives” personal narratives in relation to making a decision that they determined as being a positive decision-making experience and a negative decision-making experience. This reflected an emic interpretation process.

2. **Locating the phenomena of interest within the larger story from practice:**

   At this point I limited my focus of attention to decision-making in the midwifery context. Previous understandings reached through deconstruction of the literature were suspended and the midwives” narratives were inspected and dissected purely as examples of their experiences of the phenomenon (178, 243). However, the heading was changed from Denzin”s „Bracketing the phenomena of interest within the larger story from practice” to „Locating on the phenomena of interest within the larger story from practice".
3. Examination of text or narratives for key phrases, silences or gaps which highlight and „locate” the critical processes for the decision-makers.

This step required searching the interview texts for recurrent phrases or meanings that seem to exemplify significant moments of the decision-making process of interest. Where a silence or gap was identified in the narrative a different font was used.

i) Interpreting the story as an informed reader/researcher through:

Interpretation of the identified key moments and their importance as an informed reader was undertaken. This was done by inserting my interpretations directly into the unfolding stories, using an Century Schoolbook font to make it clear to the reader when the researcher’s etic perspective was being added. During this stage of analysis, concept names were given to the factors identified, (brackets were placed around the named factor), in the key moments of interactions. The following paragraph illustrates how this etic perspective was integrated with the participant’s story:

I was starting to question if Kylie was fully [dilated] (DMP: Hypothesis 1 clarification) as it was a relatively slow second stage for a third time mother (MBP: Reflexive practice) (Cue). Often babies come out in 8 minutes or so (DMP: Knowledge and experience used to support hypothesis 1). Kylie’s second stage [at this point] was about 37 minutes (DMP: Evidence for ruling in hypothesis). My sense (hesitates) was that the membranes were quite bulgy and not close to the baby’s head (Cue) (Intuition: Hypothesis formation 2 based on intuition) and maybe if the membrane were close to the baby’s head, the baby would have slipped down a bit faster (DMP: Using knowledge to explain hypothesis 2). Because the baby’s head was progressing reasonably slowly (Cue) I wondered whether other midwives would consider rupturing the membranes just to speed things up (DMP: Evaluating treatment options). (MBP: Reflexive practice- taking in to consideration what other midwives might or should do?).
This step in analysis was considered part of the early “working through” stage where applications of concept names to identified factors were used. It should be noted, however that the versions of the stories presented in Chapter 5: Findings are more refined and this level of detracting detail has been removed.

This step of the methodology facilitates thick interpretation of the data by inserting an “informed” perspective into the midwives’ unfolding stories as I had become informed through:

a. The literature

As analysis unfolded and key phrases, gaps and silences developed into concepts, themes and an emerging model I returned to the literature. Literature was explored in relation to the analytical classifications in order to validate and further understand the emerging model in light of contemporary evidence and practice.

b. Critical reflection

As a researcher I have been shaped by my roles and broader social background, which must not overpower the narratives of the midwives. Consequently it was important that I undertook critical reflection in order to remain true to the phenomena under investigation and the analytical classifications. Critical reflection in this study took the form of a reflective journal and critical discussions, with supervisors. Critical reflections added to the data and shaped interpretation and model building as described below.

4. Identification of the core process

Initially there was one core process for example: decision-making. As the study progressed it became clear that in order to build a model of „optimal” midwifery decision-making, there was a need to be able to describe and justify what I meant by good
midwifery practice decision-making. Thus, I began to code for factors that represented either “good practice” or “poor practice”. These would later come together in my model.

**Decision-making process**: the process of making a decision and acting upon it. The decision-making process may or may not have been conscious and may or may not have used a systematic clinical reasoning process. The decision may or may not meet the criteria for best practice midwifery. My understanding of what constitutes Good Practice Midwifery Decision-Making is an outcome of the present research. It is described and explained in Chapter 5 Findings.

5. **Identification of factors that seem to be influencing the core process.**

In this step those key factors that were having an impact on the identified core process were isolated and identified. In this study I made the decision to categorise the factors (defined below) as an aid to ongoing analysis and theory development:

a. **Personal key factor = The midwife’s biographical, experiential and interpersonal factors** which can be seen to be affecting the midwife’s decision-making process and/or good midwifery practice.

b. **Contextual key factor = Refers to context within which the situation of interest occurred;** in this case the decision-making process and its relationship to Birth Territory. Contextual factors include the physical and organisational environment. Where relevant it can also include policies and procedures that are expected to be followed that emanate from inside/outside the particular organisational environment.
6. Tentative ordering of the core process and the influencing factors:

As described in detail below, during data analysis the core process and influencing factors began to become clear to me. As that happened, I developed an analytical framework and used that to ensure rigour in analysis by returning to all the stories until no new concepts emerged and all concepts could be meaningfully incorporated within the developing model. The development of the analytical framework was informed by reflection as the analysis progressed, by the literature chiefly related to Birth Territory Theory and Midwifery Guardianship (17), clinical reasoning (72-74, 103, 104), intuition (86) and legal/professional and ethical frameworks (14, 31, 32). These were placed within a table. Decisions about what was either good or bad practice was made on the basis of the words of the midwives compared with the guiding theoretical framework. The categories on the table are: birth territory, clinical reasoning and good midwifery practice. The factors under each category are the influencing variables which have been given a numerical value on a continuum from -3 (meaning absent or negative influence) through 0 meaning neither positive nor negative to +3 meaning very positive influence). The analytical framework provides a continuum ranging from –3 to +3, which acts as a rating scale. This is useful when behaviour or characteristics require precise measurement rather than merely being present or not (257). A decision about an accurate knowledge base was made based on what the midwife said, sometimes after prompting, against best available evidence which I checked as needed during analysis. The framework allows for Unsure or Not Applicable, so sometimes I did not have sufficient data for decision making. Where I could not substantiate a factor: „Not Known” (NK) is used. For example: NK was applied when the midwife referred to a policy as I accepted the midwife’s verbal interpretation of the facilities policies and it is not within the scope of this thesis to explore evidence of institutional policies. Where a factor is not applicable: „Not Applicable” (NA) is used. The application of this analytical framework facilitated the consideration of both emic and etic perspectives:

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<th>Table 4.4 Questions derived from Analysis</th>
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<tr>
<td>Re: BIRTH TERRITORY</td>
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<tr>
<td>-3 -2 -1 0 +1 +2 +3 Comment</td>
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<tr>
<td>1. The birthing environment warm, quiet and peaceful?</td>
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</table>
2. The standard model of care was midwifery caseload?

3. There are enough midwives to provide 1-to-1 care in labour?

4. The woman’s goals for labour/birth were respected by doctors or senior midwives?

5. Policies appeared to be evidence-based?

**Overall: This context represents a BIRTH SANCTUM**

**Re: CLINICAL REASONING?**

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<td>1. Accurate knowledge base in line with best evidence</td>
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<td>2. Cue acquisition – appears to be comprehensive</td>
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<td>3. Cue clustering – appears to be comprehensive</td>
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<td>4. Cue Interpretation – Generating multiple hypotheses – if relevant</td>
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<td>5. Focused cue acquisition – if needed and relevant to hypothesis</td>
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<td>6. Ruling in and Ruling out hypotheses – if relevant</td>
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<td>7. Making a diagnosis</td>
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<td>8. Evaluate treatment options relevant to the diagnosis – if relevant</td>
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<td>9. Prescribes and/or implements planned care</td>
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<td>10. Evaluates outcomes</td>
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<td>11. Uses intuition to aid decision-making</td>
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<td>12. Links intuition to cues and reasoning</td>
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**Overall: CLINICAL REASONING = GOOD**

**Re: MIDWIFERY PRACTICE**

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<td>1. Stays in the room with the woman in labour</td>
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<td>2. Shares a common, known goal with the woman</td>
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<td>3. Trust the woman and her body</td>
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<td>4. Maintains rapport with the woman appropriately</td>
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<td>5. Maintains rapport with the support people appropriately</td>
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<td>6. Appropriate assertion with the woman and support people</td>
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<td>7. Honest and complete information sharing with woman/partner</td>
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<td>8. Uses power integratively to promote the woman’s empowerment</td>
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<td>Accountability for own professional behaviour in accordance with professional frameworks</td>
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<td>10</td>
<td>Skills in negotiating with medical staff or senior midwifery staff</td>
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<td>11</td>
<td>Assumes appropriate responsibility for woman/baby’s well-being in labour</td>
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<td>12</td>
<td>To what extent does the midwife show reflexive practice</td>
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<td>13</td>
<td>When the woman and midwife disagree about care the midwife takes appropriate action (documentation and consultation)</td>
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<td>14</td>
<td>The woman is the final decision-maker</td>
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The midwife demonstrated GOOD MIDWIFERY PRACTICE

NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication

### 4.4.5 Constructing a Tentative Conceptual Model

This step involved the re-assemblage of the previously identified factors so that they could be conceptualised as theory (243). The “reconstructed "identified factors were placed into one model which theoretically explained the phenomenon under investigation, in this instance, midwifery decision-making during 2nd stage labour. "Construction" followed upon and yet integrated with analysis. Construction too, has a number of distinct sub-steps:

i) Listing and Tentative ordering of “focused” factors in process for individual:

In line with feminist principles already discussed above, the name of this step was modified from “Listing and Tentative ordering of „bracketed” factors in process for individual” to that of "Listing and Tentative ordering of „focused” factors in process for individual." At the end of each interpreted narrative, the key phrases, gaps and silences were listed together with tentative conceptualisations of the significance of each factor in the process of midwives” decision-making during 2nd stage labour. All factors listed at this stage were subsumed and organised under their analytical concepts to reflect a tentative temporal and semi-constructed process explaining midwives” decisions during 2nd stage labour:
1. Decision-making process

2. Midwifery Best Practice;

3. Personal and


At the end of each (midwives”) interpreted narrative the key factors were listed together under their analytical classifications. At this stage, it became apparent that some midwives” stories were not about their decision-making, but rather, about another midwife or a medical practitioner”s decision-making so these stories were not included as they did not answer the research question. One story was not included as I was not able to interpret it due to incongruent comments throughout the story. Another 11 stories were excluded as the stories were not about midwives” decision-making during 2\textsuperscript{nd} stage labour. Out of respect for the midwifery participants, if my gentle probing was not sufficient to ensure they kept on track, I allowed them to tell their stories even when they were not directly relevant to my study topic.

ii) Ordering of factors as they appeared within the process:

At the end of each (midwives”) interpreted narrative the key factors were listed together under their analytical classifications: Decision-making process, Midwifery Best Practice, Personal factors and Contextual factors. Factors were then sorted, subsumed and organised to reflect a tentative temporal and semi-constructed process explaining midwives” decisions during 2\textsuperscript{nd} stage labour. This was done by comparing factors with participants. Factors were examined for similarities and like factors were grouped together and given a conceptual label. Any factor that was not recurrently reported was examined for theoretical relevance and was either subsumed, eliminated or given a conceptual label.
During this process, similar reoccurring factors were highlighted as being significant in the midwives" decision-making. Researcher agreement was sought to the validity of the emerging concept and the decision was made to assign the following conceptual labels:

1. Midwifery Abdication;
2. Egoic Birth or Midwife Centred Birth:
3. Forced Birth, and

ii) Tentative development of temporal and contextual ordering of key factors in the interactional process for each sub-group:

Following "listing" of the "focused" factors and the assignment of conceptual labels, Denzin suggests that the various factors be examined for some indication of how they all interrelate with one another and the process being studied (243). In the present study, I examined the concepts and organised them into a tentative modelling of the process of midwifery decision-making during 2nd stage labour from each individual midwife"s perspective (emic interpretation). The tentative modelling yielded four categories:

1. Optimal Decision-Making and Optimal Midwifery Best Practice;
2. Optimal decision-making and Poor Midwifery Practice;
3. Poor Decision-Making and Optimal Midwifery Best Practice, and
4. Poor Decision-Making and Poor Midwifery Practice.

Each participant interprets and constructs their social reality based upon their own theories, knowledge, values and experiences and biases as well as social background, positioning and behaviour. Understanding and interpreting the participants" decision-
making processes during birth required insight into how they apply meaning to their contextual world (258). This uniqueness cannot be replicated, however similarities can be established by other researchers using comparable analytical procedures (153, 259). If this occurs, dependability increases. Dependability also encompasses confirmability and reflexivity. The emerging categories of the modelling were then compared and validated against two stories. This part of the analysis revealed that midwives’ emic interpretation on what constituted a positive and negative story was not consistent with the analytical classifications: Decision-making process, and Midwifery Best Practice, in other words, the etic interpretation. Two midwives told stories that they rated as positive experiences of clinical decision-making, which I analysed to be consistent with Poor Clinical Reasoning and Poor Midwifery Practice; Two midwives told stories that they rated as positive experiences of clinical decision-making, which I analysed to be consistent with Good Clinical Reasoning and Poor Midwifery Practice; one midwife told a story that she/he rated as positive experience of clinical decision-making which I analysed to be consistent with Poor Clinical Reasoning and Good Midwifery Practice. Consequently, I compared and validated the emerging categories of modelling against two stories: one which I felt represented a situation in which there was positive evidence of the necessary and sufficient conditions (a decision-making process and Midwifery Best Practice) for best practice decision-making: and one in which it was felt the midwife conveyed negative best practice decision-making (etic interpretation). My two supervisors validated this process and the outcome.

iv) Production of concise statement/ model of process

Finally, the researcher needs to produce a statement or model that indicates how the constituent analytical elements cohere into a totality (243). In the present study, the aim was to recreate and understand the process of decision-making during 2nd stage labour as represented by the participants. The present study developed a theoretical model for decision-making during 2nd stage labour that is consistent with best practice.
4.4.6 Contextualising the new Model in the World of Practice

Following construction of a theoretical explanation of the phenomenon of interest, contextualisation re-situates (and tests) this explanation within the context of the contemporary social world. In this midwifery decision-making study, contextualisation occurred in two phases. First, I developed a theoretical model for decision-making during 2nd stage labour that is consistent with best practice. During discussion of findings, examples were drawn from individual midwife’s narratives to illustrate concepts; highlight points made and thus embed findings in the data.

Contextualisation was Denzin’s final step in Interpretive Interactionism. Contextualisation adds depth of meaning to the constructed theory or model by finally laying aside the original „bracketing” or „focused” in the case of Post-structural Feminist Interpretive Interactionism. This occurred as the researcher compared and contrasted the new theoretical model with all the research data, with the contemporary literature and with her own midwifery experience.

4.4.7 Recommending of Actioning Change in Practice

It is imperative that critical research is designed to bring about change in the social world and I have incorporated this into this new step. The ultimate purpose of the midwifery decision-making study had been the discovery of the necessary and sufficient conditions for midwifery best practice decision-making processes during 2nd stage labour, and the development of a model for decision-making that is consistent with best practice.

4.5 Validation of Participant’s Story

Participant validation occurred at two points during the study: formal validation of the transcribed interview transcripts and validation of the researcher’s interpretations/emerging concepts arising from the data. Through the validation process the data was refined.
Formal validation of the transcribed interview stories involved mailing out documentation to each midwife. Validation focused on the midwives' confirmation of their interview transcript. Midwives were provided opportunity at this stage to remove or change any part of their story. Apart from two participants, very few changes, if any, were made by the midwives. Two midwives however, made major changes to their transcripts. The changes focused on language used that appeared to reflect paternalistic tendencies rather than caring, nurturing and/or partnership language: for example “I may have said just make but you know I would never “just make" a woman do anything - unfortunate phrase I used unintentionally”.

4.5.1 Validation Process

Six randomly selected participating midwives were chosen to assist within the validation process. I sent them copies of all the interviews, used within this study, which included my analysis and interpretation. I also sent them the tables with the emerging concepts. Two participants responded, offering minor changes, which were incorporated.

4.6 Research Methods and Ethics

4.6.1 Research Ethics

Ethical approval for this research was granted by the Newcastle University Human Research Ethics Committee on 1 June 2009 (Appendix 10a & 10b). As the proposal indicated that data would be collected in the „field,” approval was also granted from the Newcastle University's Health and Safety Team.

In the context of this study, autonomy means the right of the individual midwife to make a free choice to participate in the research. This includes the ability to choose to withdraw at any time, without giving any reason and without any detrimental effect to the participant. To honour these principles, once a potential participant had received the
information sheet, consent form and interview theme sheet, a period of 24-36 hours was given prior to the interview. Immediately prior to commencing the interview participants were verbally reminded that their involvement was voluntary, and they could withdraw at anytime.

To promote a feeling of safety, interviews were conducted at a time and place of their choosing. Some qualitative research participants who have been asked to explore negative personal experiences, Deery (260) and Pellat (261) claim, have become distressed. At commencement of each interview I offered to stop the interview/audio-tape if the midwife became upset. I also had the contact details for Dr Jenny Fothergill who was available should any participant wish to take up the option of debriefing or the option of referral for counselling as appropriate.

4.6.2 Consent, Confidentiality and Anonymity

Consent was undertaken using the National Health and Medical Research Council guidelines (262). As the researcher the following measures to respect an individual’s right to confidentiality and anonymity were undertaken:

- In order to protect the identity of the participants, and the processes involved in maintaining confidentiality and anonymity, each participant chose their own false name (pseudonym) (263). Pseudonyms ensure confidentiality and foster a feeling of safety throughout the research process. Further, as the researcher, I neither confirmed nor denied any individual midwife’s participation in the study. It was the choice of the individual midwife to disclose if they were a participant. Any identifiable data was changed. The responses from the six randomly selected midwives who were sent the data for validation purposes did not raise any concern that they could identify any peers as participants of the study

- With the midwives feeling safe and assured of their confidentiality, they would be able to retell their personal stories, honestly and openly, of good and negative
decision-making during 2\textsuperscript{nd} stage labour (264). When participants described their decision-making experiences, if any birthing woman and/or attending health professional names and/or specific birthing locations were inadvertently used: they were removed upon transcribing. Pseudonyms were used when direct quote(s) were used in the research findings ensuring anonymity.

- Midwives were asked to review and validate their own transcript, enhancing confidentiality and anonymity. All transcribed material was identified by pseudonym. Transcripts were returned by email or post to the individual participant in a plain envelope. This also confers validity on the study.

- Prior to data collection, participants were made aware that I was obliged to report any disclosed information, constituting unlawful or harmful conduct, that I had an obligation to report it in order to comply with the ANMC regulations (31, 32).

4.6.3 Confirmability and Reflexivity

Confirmability and reflexivity relate to “…examining the methodological and analytical „decision trails”” (259). Readers critiquing the research must be able to see the adequacy of the researcher”s decision-making throughout the research process: for example the inductive identification of codes or categories (265). To honour this, I have clearly discussed and demonstrated how these analytical decisions were made. This decision-making process has been laid out in the preceding chapters of this thesis. To strengthen this, I:

- Had frequent auditing of the decision-trail: One method of this was regular meetings with one or both supervisors where critical discussions occurred (259), and

- Kept a reflective journal where I explored issues of confusion or concern related to this study.
The use of a reflexive journal brings consciousness to the researcher’s own theories, knowledge, values, experiences and biases about the research issue and process (229). This can reveal constructive and interpretative knowledge about the researcher and the phenomena under study (203). Bracketing and explication of these values through reflection minimises the imposition of the researcher’s voice and own ideologies upon the research process ensuring the participants stories are clearly heard (203, 250, 265). I maintained a reflexive journal throughout the research data collection and analysis phases of the research. Entries were made pre and post interviews and as I undertook data analysis related to my feelings, thoughts and experiences as I moved through the research journey.

An example of these reflections occurred when I recognised, on listening to a particular midwife’s experience of negative decision-making, that I was thinking, “how could you have acted like that?” I was aware of this at the time of the interview and again, that night when I listened to the tape. Immediately post interview I discussed my feelings with my supervisor. From this discussion and later writing in my journal, I critically explored that it matters that I am a woman, wife, mother and midwife. I have also worked as a nurse/midwifery academic and nurse. I acknowledged how I have been shaped by these roles and my broader social background. I acknowledged the potential for my own beliefs and experiences to influence data collection and analysis (215, 222, 259). Incorporation and/or consideration of my reflections were considered as data to enrich the analysis and are incorporated in the study results (231).

The reflexive journal created a forum where all my thoughts, discussions with self and others were noted. The journal acted as an audit tool to document a trail of explanations for decisions I made and sometimes the reasoning behind those decisions. Further, the reader can follow my decision trail as codes are applied to transcripts and the multiple reiteration of analysis.
4.6.4 Credibility

Credibility is a measure of truth-value and related activities that increase credible results (258). The midwives must be able to recognise their voice in their contextual truth of the research data in order to achieve credible rigour within qualitative research (152, 153, 259, 266, 267). Further Lincoln and Guba (268) claim people unrelated to the research should understand it.

To achieve credibility and authenticity post interview, the participants had their transcripts returned to seek their feedback and validation that the transcripts were a true representation of their interview (210). Morse (269) hypothesises that confusion may result from seeking participant's feedback and validation due to them reflecting, post interview on their stories and wishing to amend them to reflect more considered responses. Two midwives did change their transcripts to portray more woman-centred language/actions. However, feminist post-structural interview techniques involve intimacy and reciprocity, the sharing of knowledge and experience between the women and myself through the development of a relationship based upon equality. This dialogic engagement allows for greater understanding of shared meanings, interpretations, processes and theories (86, 229, 230). I felt therefore it was important to maintain the feminist post-structural philosophy of reciprocity. The midwives were therefore able to see that data obtained reflects the researcher-participant constructed and reconstructed complex „lived textuality” of their shared situated understanding of the research phenomena (142, 152, 229, 230).

Several midwives found reading their transcripts challenging. Two midwives in particular felt embarrassed they had become upset during the interview. In order to validate and reassure the feelings and emotions expressed by these midwives during and post interview several further emails and a telephone call occurred. I also provided the contact details for Dr Jenny Fothergill who was available should they wish to take up the option of debriefing or the option of referral for counselling as appropriate.
The „final” data was not shared with the participants prior to submission of the final thesis. This approach is validated by Webb (210) who hypothesises, disagreement by participants does not equate to the researcher being wrong. Ultimately, it needs acknowledging, the power to include/exclude data in the final research report lies with the researcher (270-272). Nevertheless, the participants should be able to recognise their voice in their contextual truth of the research data (152, 153, 259, 266, 267).

Credibility will be further achieved by having midwives from every State and Territory across Australia. Also two feminist scholars, who are my supervisors, assessed the believability of the research process and subsequent findings (152).

4.6.5 Transferability

Transferability refers to the degree to which the findings of this research may fit into contexts outside the study (273). This research explored midwifery decision-making during 2\textsuperscript{nd} stage labour drawing on participants from all States and Territories across Australia. The findings are likely to be transferable to other maternity services within Australia but the decision about transferability is that of the person seeking to use these findings in their own context. Likewise, the finding may be transferable to other countries where the training and regulation of midwives are similar and where the laws and policies are similar.

4.6.6 Strengths of the study methodology

Recruitment strategies ensured demographically diverse practicing midwives from each State and Territory across Australia participated in the study. The diversity of participants enriched data collection of decision-making during 2\textsuperscript{nd} stage labour and enhanced the possibility of confirmability of the findings for all Australian settings.
Each midwife’s culturally constructed reality and wisdom was centrally located within the study. Solicitation and validation of the data and interpretation of the data was sought from the participants. These strategies enhanced the credibility, dependability and transferability of the study.

As a post-structural feminist I have used reflexivity to explore and acknowledge that I am a woman, wife, mother and midwife. I have also worked as a nurse/midwife academic and nurse. These roles and my broader social background have influenced and shaped my values, beliefs knowledge and biases. I have not hidden this fact, neither have I restricted or prevented the participants in any of their choices or language used. I have used „me“ to form intimate, reciprocal and equal partnerships between the participants and myself as researcher.

4.6.7 Limitations of the study methodology

A limitation of this study is that the data derives only from the midwives” recollection of their decision-making during 2\textsuperscript{nd} stage labour. This study does not include data from the women highlighted within the midwives stories; consequently I have no way of checking the truthfulness of the midwives” statements or cross referencing it against the women”s perceptions. Although it was beyond the scope of this study, the research could have been strengthened if the women”s perceptions had been taken into consideration.

I acknowledge that I am a woman, wife, mother, midwife and academic. I acknowledge I have my own theories, knowledge, values, experiences and babies. Collectively, the subjectiveness of my decisions/judgements may have influenced the data analysis and interpretation. I have provided a rationale in the analysis framework and interpretation and I have had consensual agreement for my judgements/decisions from supervisors throughout this study. In conjunction with this, I sought validation of the analysis and interpretation from six participants.
4.7 Conclusion

This chapter has described how Post-Structural Feminist Interpretative Interactionism was developed from Denzin"s original Interpretive Interactionism methodology. I used this revised methodology to create a model of optimal midwifery decision-making during 2nd stage labour. The feminist methodological principles underpinning this research were presented and discussed. The chapter outlined the research ethics for this study including research sites, participant selection and recruitment. Methods of data collection, data analysis, interpretation and theorising and model building have been described. Finally, this chapter highlighted the strengths and limitations of this new methodology by detailing how the standards for scientific rigour in qualitative research for example: confirmability and reflexivity, credibility and transferability were honoured (151-153). The chapter that follows focuses on the research findings and model development.
Chapter Five

Findings

Introduction

This chapter presents findings, which contribute to answering the research question:

“What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?”

Within this chapter I present the analysis and interpretation of stories told by midwives. Each story begins with an introductory background to the midwife. The words used are mostly those of the midwife but sometimes I summarised and re-organised words and sentences for clarity. The decision-making vignette (a section of the midwife’s story directly describing decision-making during 2nd stage) and the final outcome of the decision are provided. Where appropriate the individual midwife’s reflection is also presented. The in-text analytical notations that I used in the beginning stages of analysis are provided along with the corresponding analytical table in Appendices 11-26. These appendices are included to provide an audit trail (274). The in-text notations demonstrate which of the concepts in the developing model were grounded in the data. For reasons of parsimony removal of these notations from the findings chapter occurred. As far as possible, my interpretive comments have been kept to a minimum. The chapter concludes by using the major findings to support the thesis that: *Good clinical reasoning and good midwifery practice are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour.*

The methods used for data analysis and interpretation are described and justified in Chapter 4: Methodology. As described in the Methodology chapter, a framework for analysis was commenced during the early stages of analysis. The analytical table continued to be refined throughout data analysis and interpretation. Each time this
happened, all the stories were re-considered in relation to the changed elements. This degree of analytical precision involving multiple crosschecking, which is recommended as a strategy in rigorous qualitative data analysis (275). At the end of each vignette I include and justify my evaluative decisions about the extent to which each particular story does (or does not) represent one of the two core concepts that had developed during multiple iterations of analysis.

The core concepts are:

1) Good Clinical Reasoning and

2) Good Midwifery Practice.

Major concepts that developed during multiple iterations of analysis are:

1) Birth Sanctum and

2) Birth Outcome.

The research question required that each story be analysed in terms of both the clinical reasoning process (good or otherwise) and the midwifery practice process (good practice or otherwise). The stories therefore are organised by these headings:

1) Good Clinical Reasoning and Good Midwifery Practice;

2) Good Clinical Reasoning and Poor Midwifery Practice;

3) Poor Clinical Reasoning and Good Midwifery Practice, and

4) Poor Clinical Reasoning and Poor Midwifery Practice.

Each healthcare facility has a governance structure through which policies are developed, implemented and evaluated. As I did not visualise the actual policy referred to by the midwife I am unable to see what evidence it is based upon. I accepted the
midwife’s verbal interpretation of the facilities policies and it was not within the scope of this thesis to explore evidence of institutional policies.

5.1 Good Clinical Reasoning and Good Midwifery Practice

5.1.1 GRACE

Background to Grace’s Story

Grace has been midwife for 30 years. She is currently working in Group Midwifery practice in a major city.

Grace story occurred when she was providing continuity of care for Katie, a 44-year-old multigravida. Grace had been the midwife for Katie’s first birth. Katie had watched both her sisters have natural births at home and she wanted the same experience. Grace had spent this pregnancy debriefing Katie about her previous birthing experience. She had been terrified about the potential pain and would often cry but was determined that she didn’t want any pain relief; just a natural birth with no intervention. However, as her pregnancy progressed, Katie became fixated on the birth and potential complications that could arise. She also felt that she did not have the confidence that she perceived that her sister’s had during their births. She found the actual labour very painful and frightening. Katie decided, after two-three hours of labour to go to the birth centre. She was accompanied by her two sisters and was disappointed in herself that she went to the birth centre. Grace spent time talking about this pregnancy and labour with Katie.

One week before Katie’s due date, for this pregnancy, she went into spontaneous labour.

Grace’s Story

When Katie arrived at the birth centre I was there to meet her. After only a few contractions I guessed she was either in transition or 2nd stage. The contractions were coming really strong and really, really close together. I could see there was pressure on her perineum as it was starting to stretch and expand which indicates the baby’s head is
moving down. Also Katie changed the way she was pushing and the noises she was making: becoming more vocal. Katie was just so scared; frightened the pain she was experiencing was going to go on forever. Katie didn’t realise she was transitioning and her body was preparing to actually deliver her baby. I listened to the fetal heart rate and it was fine.

The birth centre policy says you must do a vaginal examination to make sure the woman is fully dilated before you allow (emphasis) her to push her baby out. But I believe the body knows what it’s doing. I (emphasis) trust women’s bodies and their power to birth. I trust their intuition or their feeling that birth is going to happen. This trust comes from years of experience and I think it makes it easier in the continuity of care model because I really got to know Katie before labour. I guess (hesitation) knowing Katie’s whole family and her two sisters and the whole family dynamics helped. We had talked about what Katie wanted, her fears and her concerns and how she thought she could get through them. So I knew (emphasis) how to make Katie feel comfortable and relaxed. I knew she needed encouragement to believe in herself, that the pain would not last and the support and love of her two sisters.

Katie asked me, “how do you know what I’m doing and do you think you need to examine me?” Katie was being supported and encouraged beautifully by her two sisters and that was exactly what she had said she wanted. This dynamic contributed to make me feel like I didn’t have to do anything here but wait and watch. I decided I didn’t need to examine Katie to determine if her cervix was actually fully dilated. She was showing the signs and I just knew she would birth soon. It’s intuition I think: just a feeling, something that you know but you don’t know really or how you know it. So I just reassured her that I knew she was progressing really well and would soon have her baby. I said, “no, no it’s all fine. Just go with it, just keep breathing, push if you want to, listen to your body let it tell you what to do, believe you can birth this baby just like you did the last one.” I listened to the fetal heart just to make sure it was fine.

**Outcome**

Katie’s sisters and I talked Katie through her labour until the baby’s head was on view. We helped her believe in herself. Katie birthed her baby absolutely beautifully, totally
shocked and wonderfully surprised that she had found the power and belief in herself 15 minutes later.

### Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a BIRTH SANCTUM</td>
<td>I categorised this as a birth sanctuary because it was a hospital birth unit where the environment resembled a birth sanctum (276) and optimised privacy, ease and comfort of the woman and the power remained with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD CLINICAL REASONING</td>
<td>The midwife said she used intuition and then collected empirical cues to strengthen her decision to not intervene. But she did not consciously link the empirical cues with her intuition.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
<td>The relationship of trust and knowing that is evident between midwife and woman was an outcome of the continuity of care model. As the woman’s labour progressed rapidly, the woman’s two sisters and the midwife used their power integratively and engaged in facilitative empowering practices: collectively they asked the woman to, consciously, draw on her inner power to sustain her through her labour and birthing pain. At all times the midwife worked within the professional framework.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth outcome was a GENIUS BIRTH</td>
<td>The woman effectively activated her hidden capacities deep within her embodied self in order to achieve what Parratt terms a „Genius Birth” (26). I began to see that „Genius Birth” was a likely outcome of Good Clinical Reasoning and Good Midwifery Practice.</td>
</tr>
</tbody>
</table>

### 5.1.2 ANDI

#### Background to Andi’s Story

*Andi has been a midwife for 25 years. She has two jobs in rural Australia: one as an independent midwife, and the other as a midwife in a GP-led unit of a public hospital.*

*Andi’s story occurred at the GP-led unit when Andi was working with Narelle, an RN student midwife. They were caring for Paula, a multigravida, whom they had met for the first time when she arrived in early labour. Paula was in 1st stage labour for*
approximately six hours prior to entering 2nd stage, which Andi confirmed on vaginal examination in accordance with the GP birth unit policy.

Andi’s Story

At this point in the story, Paula was in a standing position. She had been pushing well with each contraction for approximately 30 minutes but there were no obvious signs of progress happening, such as visible [fetal] head, which, for a multigravidia woman was strange. I was beginning to wonder what was happening. I was checking the fetal heart rate and it was fine. Paula said to me, pointing at her tummy, “something is wrong, nothing’s happening: when I push there’s nothing to push against”.

I actively listened to Paula, sensing what she meant. She was feeling her tummy muscles were not creating enough resistance for her to feel like she had something to push against, which women need to aid in pushing. I palpated Paula’s abdomen when she had a contraction and the abdominal wall did not appear to feel tight and strong. I wondered if she had a pronounced extended separation of the abdominal muscle [rectus diastasis] that was affecting her ability to push.

I had read about “muscle draws” and how Mexican midwives often use a shawl or something to put around a woman’s abdomen to assist her in pushing. So I decided I needed to do something similar to help create a false sense of a tummy wall; creating something for Paula to push against. I was thinking that if the tummy wrap made a difference to Paula, it could stop her pushing for ages with nothing happening and perhaps prevent unnecessary [medical] intervention.

I talked to Paula, suggesting what I had in mind and how it would work, asking what she thought about the idea. Paula agreed to try the “muscle draw”. Narelle and I got a single sheet, which was fairly stiff, folded it up and holding one end each put it around Paula’s back and across her abdomen. During a contraction Narelle and I pulled the sheet quite hard and tight around Paula’s abdomen, keeping the pressure on until the contraction passed. After the first contract I asked Paula how she felt and she said it was a lot better as it gave her something to push against.
Outcome

Paula gave birth to her baby in the standing position four contractions later.

Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a <strong>BIRTH SANCTUM</strong></td>
<td>I categorised this as a birth sanctuary because it was a GP birth unit where the environment resembled a birth sanctum. It optimised privacy, ease and comfort of the woman and the power remained with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>GOOD CLINICAL REASONING</strong></td>
<td>The midwife said she used intuition and linked it to collected empirical cues and literature to strengthen her decision to intervene with the woman’s informed consent.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>GOOD MIDWIFERY PRACTICE</strong></td>
<td>The midwife worked in a fragmented model of care but chose to listen to the woman. The midwife used her power integratively, through open and honest information sharing, facilitating the woman’s empowerment. At all times the midwife worked within the professional framework.</td>
</tr>
</tbody>
</table>

**JUSTIFICATION**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth outcome was a <strong>GENIUS BIRTH</strong></td>
<td>The woman effectively responded to her innate sense of knowing her own body in order to highlight something was wrong. She actualised a solution to achieve a „Genius Birth” (26).</td>
</tr>
</tbody>
</table>

5.1.3 **JANE(2)**

**Background to Jane (2)’s Story**

_Jane(2) has been a midwife for 25 years. She works in a consultant-led hospital that is both private and public in rural Australia. The rural setting seems to have been conducive to forming a collaborative agreement between a private obstetrician and Jane(2) that allows for a continuity of care model with a midwife. This is on the mutual understanding that this midwife keeps the private obstetrician fully informed. Jane(2)’s story occurred when caring for Lisa, a primigravida, who was a private patient of Jane(2)’s. Lisa had been in labour approximately 12-14 hours and wanted a natural childbirth._
Jane (2)’s Story

It was very obvious to me that Lisa was in 2nd stage. She had the predictive signs of a show and having the urge to push. Lisa was working hard with her contractions, trying a variety of positions: squatting, kneeling, and hanging over the basin in the bathroom. I monitored the fetal heart rate, not after every contraction but certainly after every two or three, with a Doppler and it was fine. After an hour, I could just see the fetal head so I was happy that there was some progress. After another two hours of pushing I probably could see fifty cents worth (laughter in voice). The fetal heart rate was still good. At this time, I decided to let the private obstetrician know [via telephone] that Lisa had been pushing for two hours and yes, we could see the baby but it was still a little way off.

Lisa kept trying different positions and the baby came down to where we could probably see a reasonable amount of fetal head, more than fifty cents worth certainly. After another 30-40 minutes the obstetrician rang me and said, “So what’s happening?” and I said, “Well we’re making progress, slow, fetal heart’s fine, clear liquor and that Lisa was determined to keep going and achieve a natural birth. I did discuss with Lisa the fact that the obstetrician was becoming anxious about the length of time she had been in 2nd stage and there are generally limitations on the time of 2nd stage but as long as everything was going fine and Lisa was willing to continue we would do that, but she had to understand the potential implications: he (obstetrician) may want to do an assisted birth. Lisa said she didn’t want an assisted birth and didn’t really want an episiotomy. (Jane(2) does not share with Lisa that there is general acceptance in the obstetric community that perinatal mortality/morbidity rates are higher in primiparous births if 2nd stage goes beyond two hours. The research around this, however, is contested).

A bit over three and a half hours from when I could first see the fetal head, the obstetrician knocked and came in to the birthing room. He reintroduced himself to Lisa and then made himself a cup of tea, sat in the corner and watched. By this stage, I was listening to the fetal heart rate after a contraction and during a couple too just to see what was happening, which is not in accordance with policy. There were no decelerations; the fetal heart rate was fine.
After four hours of being in 2\textsuperscript{nd} stage and active pushing, the obstetrician got up, walked over to Lisa and encouraged her with each contraction. He was respectful, not ordering, just encouraging. He said to me, “Have you got the scissors and the local anaesthetic?” I turned my back to Lisa while I got everything ready and he prepared himself, but Lisa saw me (\textit{Jane(2) showed disappointment}). Somehow Lisa found the strength to give a few huge pushes, and the fetal head advanced.

**Outcome**

Four and half hours after entering 2\textsuperscript{nd} stage Lisa gave birth to her baby with an intact perineum. The obstetrician sat and watched.

**Analytical Outcomes and Justifications**

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a BIRTH SANCTUM and a SURVEILLANCE ROOM</td>
<td>This environment resembled a birth sanctum but changed in to surveillance room (276) when the obstetrician arrived to observe the woman and intervene if necessary.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD CLINICAL REASONING</td>
<td>The midwife used 10 stages of clinical reasoning but I do not have the data to determine if intuition was used.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
<td>The midwife/woman relationship, fostered by the continuity of care model, promoted trust and knowledge. The midwife used her power integratively to facilitate a vaginal birth. This story also shows good midwife/doctor/woman collaboration until the doctor seems to make a unilateral decision to perform an episiotomy. The midwife worked within the professional framework most of the time, but did not follow protocol in listening to the fetal heart rate for one full minute during and after a contraction in 2\textsuperscript{nd} stage.</td>
</tr>
<tr>
<td>OUTCOME</td>
<td>Justification</td>
</tr>
<tr>
<td>The birth outcome was a VAGINAL BIRTH</td>
<td>Although this is a vaginal birth, I can’t tell if it was a „Genius Birth”. The following stories also lack data to determine if Genius Birth occurred.</td>
</tr>
</tbody>
</table>
5.1.4 SARAH

Background to Sarah’s Story

Sarah is a nurse and midwife with one year of post-graduate midwifery experience. She currently works shift-work in a consultant-led public and private hospital in a major city. Sarah’s story occurred in the public delivery suite when she arrived to commence a night shift. Sarah first met Kylie (a multigravida) and Tom when entering their birthing room to provide one-to-one care.

Sarah’s Story

Prior to 2\textsuperscript{nd} stage, Kylie said (hesitates) her membranes were still intact as if that was a problem [which meant] and she couldn’t have the baby. So we discussed this and the possibilities of maybe and maybe not rupturing them.

Kylie was starting to say she felt she needed to push, so my sense was that she was fully dilated. There was a very clear change from what I would guess to be transition to when she is fully [dilated]. Kylie became very internalised, less aware of what was going on around her and very focused on the job of having her baby. I think whenever I see a woman become like that [internalised] I err on the side of saying as little as possible so as not to distract the mother.

I was starting to question if Kylie was fully dilated, as it was a relatively slow 2\textsuperscript{nd} stage for a third time mother. Often babies come out in eight minutes or so. Kylie’s 2\textsuperscript{nd} stage [at this point] was about 37 minutes. My sense (hesitates) was that the membranes were quite bulgy and not close to the baby’s head and maybe if the membranes were close to the baby’s head, the baby would have slipped down a bit faster. Because the baby’s head was progressing reasonably slowly, I wondered whether other midwives would consider rupturing the membranes just to speed things up. I was asking myself, „well do we need to hurry this birth up for any reason?“ I (slight hesitation) couldn’t really think of any convincing reasons to rupture the membranes at that point. I was checking the baby’s heart rate after every contraction and it was perfectly good. I could see fetal
descent [membranes bulging at perineum] and obviously Kylie was now fully dilated because the baby’s head was coming.

Outcome

Kylie gave birth to her baby „in the caul” and Sandra gently broke the membranes.

Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a</td>
<td>Although this was a hospital environment, I categorised this as a birth sanctum because the environment created by the midwife optimised privacy, ease and comfort of the woman and the power remained with the woman.</td>
</tr>
<tr>
<td>BIRTH SANCTUM</td>
<td></td>
</tr>
<tr>
<td>The midwife demonstrated</td>
<td>The midwife used intuition and then collected empirical cues to strengthen her decision. When the midwife began to doubt herself she used clinical reasoning and an accurate knowledge base to confirm the rightness of her decision.</td>
</tr>
<tr>
<td>GOOD CLINICAL REASONING</td>
<td></td>
</tr>
<tr>
<td>The midwife demonstrated</td>
<td>Although this midwife does not practise in a continuity of care model, she used the 1st stage of labour to establish a rapport with the woman. This rapport was essential for information sharing and deciding when to stay silent and not distract the woman’s energy from the task of birthing, which empowered her to birth spontaneously. At all times the midwife worked within the professional framework.</td>
</tr>
<tr>
<td>GOOD MIDWIFERY PRACTICE</td>
<td></td>
</tr>
<tr>
<td>OUTCOME</td>
<td>Justification</td>
</tr>
<tr>
<td>The birth outcome was a</td>
<td>Although this is a vaginal birth, I can’t tell if it was a „Genius Birth” (26) as I do not have enough data.</td>
</tr>
<tr>
<td>VAGINAL BIRTH</td>
<td></td>
</tr>
</tbody>
</table>

5.1.5 DAISY

Background to Daisy’s Story

*Daisy is a direct entry midwife and has been a midwife for four and half years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives in this practice also provide a home birth service for selected women.*

Daisy was the primary midwife for Ella, a multigravida woman. Ella’s first birth was by emergency caesarean. This pregnancy, Ella wanted a vaginal birth and continuity of care so chose the group midwifery practice. At 25 weeks Ella contacted Daisy to say she
had not felt the baby move for a day. Fetal death was diagnosed. Ella was admitted the
next morning; under the care of an obstetrician to the local hospital delivery suite to have
her labour induced using misoprostal. The hospital agreed to support Daisy, as this was
her first fetal death, so she could continue to care for Ella. Ella had had 4 misoprostal
tablets and her membranes were still intact.

**Daisy's Story**

I spent many hours with Ella, before she went in to hospital, talking about what she
wanted, her options for things such as how she wanted to deal with the labour pains she
would experience and what would happen throughout the whole process.

Early evening Ella’s behaviour changed and there wasn’t another midwife in the room to
ask. The pain Ella was experiencing was increasing. I asked if she wanted any pain
relief as previously discussed but she declined. Then Ella started to make some different
noises, which I thought were similar to the grunting women do when they’re in 2nd stage
or getting ready to push and to birth. Ella’s agitation level was different too. She was
quite emotional, which she could be in any stage, but her agitation level accelerated a
little. I had never been in this situation [where there is fetal death] before and I wasn’t
sure what to expect. My instinct was telling me something was happening but I wasn’t
sure what. The signs Ella was showing made me think maybe she was in transition or
2nd stage.

Ella said she wanted to use the bathroom. I thought maybe Ella wanted the privacy the
bathroom could offer her but then again maybe she just wanted to use the toilet. But Ella
was definitely showing signs of being in transition or 2nd stage. Then I started to think,
this baby, when it’s born, is going to be small so the cervix won’t need to be fully dilated
for her to birth. I thought, if Ella needs to open her bowels, it is possible it would not take
too much effort for her to birth her baby whilst using the toilet. This would be terrible for
Ella, to not only suffer the death of her child but also to birth it down the toilet.

Something told me, with all the signs Ella was showing and the size of her baby, that I
should take some action. I decided the right thing to do was to ask Ella if she would mind
if I put a bedpan over the toilet. I didn’t tell Ella why I suggested this or my thinking as she was emotional enough without me adding extra stress. Ella agreed.

**Outcome**

As Ella opened her bowels her membranes broke and she birthed her baby into the bedpan rather than into the toilet. It was the right thing to do; I made the right decision.

**Analytical Outcomes and Justifications**

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a BIRTH SANCTUM</td>
<td>Although this is a hospital environment, I categorise it as a birth sanctum because the midwife created a space where the woman was safe, warm and quiet despite the circumstances. The power remained with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD CLINICAL REASONING</td>
<td>The midwife used intuition and then collected empirical cues, which she used to mirror „normal birth“ to reach and strengthen her decision.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
<td>The midwife/woman relationship was an outcome of a continuity of care model. As the woman’s labour progressed the midwife made the decision to act as „gate-keeper“, not for personal control but to prevent any further negative emotional repercussions for the woman who had been robbed of a desired birthing experience and outcome. At all times the midwife worked within the professional framework.</td>
</tr>
</tbody>
</table>

**OUTCOME**

| The birth outcome was VAGINAL BIRTH | Although this is a vaginal birth, I can’t tell if it was a „Genius Birth“ (26) as I do not have enough data. |

**5.2 Good Clinical Reasoning and Poor Midwifery Practice**

**5.2.1 ADELAIDE**

**Background to Adelaide’s Story**

*Adelaide has worked for 33 years as a midwife. She is currently working in a birth centre attached to a consultant-led public hospital located in a major city. When the birth unit is quiet, Adelaide is required to work on the hospital’s delivery unit where this story occurred.*
Adelaide arrived at 7 am and began caring for Rosalie, a primigravida. Rosalie had laboured all through the night and had been diagnosed, two hours previously, as being in 2nd stage labour. Rosalie had an epidural, a CTG and had been actively pushing following verbal cues from the midwives since full dilation. The whole family were aware that the doctors were planning to conduct an assisted birth shortly.

Adelaide’s Story

When I entered Rosalie’s birthing room, I spent a few minutes getting to know Rosalie, Mike and Joan. I tried to engage them in conversation and basically get a feel of how Rosalie was feeling about the way her labour and birth was progressing. Whilst this was happening, I used all my senses and assessed everything. I looked at Rosalie’s position on the bed, her colour, whether she was perspiring, whether she was exhausted or was she happy or sad? In essence, I assessed her general well being and her mental state. I looked at the support people and asked myself, are they in a chair snoring? Are they exhausted from supporting Rosalie all night? I also assessed the room for clutter or whether it was disorganised.

I saw, when Rosalie was pushing, there was a tiniest little bit (emphasis) of fetal head on view, but Rosalie was so exhausted after labouring all night that her pushing was not effective at progressing delivery of her baby. I knew the doctors, [once the shift changed in approximately 30 minutes], would come and do an assisted birth.

As Rosalie was pushing with each contraction, I sensed Rosalie did not want to throw the towel in and have an assisted birth. I thought, in this instance, I had to do something; we (emphasis) somehow had to push this baby out unassisted. I knew that if I got the lithotomy poles adjusted to suit Rosalie’s anatomy and she could just let her knees flop whilst supporting behind the back of her legs she would be able to get much more „push” into her bottom and get this baby round the bend of the pelvis. My decision was based on looking at the whole picture of Rosalie and my knowledge of the body. I’ve observed placing the woman in the lithotomy position worked quite a few times in my experience and from observing other midwives. Once I’d made my decision, I actually said to Rosalie, “would you mind very much if I put your legs into a lithotomy? I explained to her what I wanted to do.
Outcome

Within twenty minutes of Rosalie agreeing to use the lithotomy poles she birthed her child unassisted.

Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a SURVEILLANCE ROOM</td>
<td>I categorise this environment as a surveillance room because it optimised the ease and comfort of the staff and was an environment where staff where waiting to intervene. The power was being removed from the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD CLINICAL REASONING</td>
<td>The midwife used sound clinical reasoning skills.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR MIDWIFERY PRACTICE</td>
<td>Working within this fragmented model of care, where a new midwife is introduced to the woman and her family during 2nd stage labour, does not allow a relationship of trust and knowing to develop between the woman and the midwife. The midwife used her power disintegratively, assuming the woman did not want an assisted birth, informing the woman once she had made her decision, thus facilitating disempowerment of the woman. The midwife did not, therefore, work within the professional framework at all times.</td>
</tr>
</tbody>
</table>

OUTCOME

<table>
<thead>
<tr>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth outcome was an EGOIC BIRTH AND FORCED BIRTH</td>
</tr>
</tbody>
</table>

5.2.2 NICOLI

Background to Nicoli’s Story

Nicoli has been a midwife for 10 years. He works in a consultant-led public hospital in a major city.

Madj, a RN who was a senior student midwife, and Nicoli were caring for Jane, a multigravida woman, throughout the morning shift. During that time he had established a rapport with Jane who was now in late 1st stage labour with a CTG in-situ. Nicoli left Madja and Jane in the birthing room to give handover to the midwives who had arrived
to start the late shift. When he returned to the room he found a doctor preparing to take a fetal blood sample. Apparently Madja had consulted the doctor because the CTG printout was showing decelerations suggesting the baby was experiencing some distress. This doctor was not covering birth suite but happened to be passing when Madja was looking for some support. Once the fetal blood sampling had been completed, Nicoli left the room a second time to complete the clinical handover. When he returned to the birthing room the medical practitioner was still present.

**Nicoli's story**

I finished the handover and went straight back to the birthing room [for the second time]. The doctor wanted to do a vacuum extraction. A second doctor, who was on for birth suite, came into the birthing room seeking clarification of what was happening. The second doctor was junior to the first doctor, so once the situation had been explained, the junior doctor deferred to the senior doctor’s decision. When I heard the first doctor repeat that he was going to do a vacuum extraction I asked him if Jane’s cervix was fully dilated. He said, “Yes.”

Jane had only been in 2nd stage for no more than 15 minutes at this point. I was thinking several things: the CTG that I had looked at before I left the birthing room wasn’t that bad there had been early decelerations from a baseline of around 140bpm to 115bpm lasting around 15-30seconds; the fetal blood sampling test had shown the baby was coping as the pH was within normal limits (result was 7.35(277)); the fetal head was low; Jane did not have an epidural and had birthed vaginally before so I could see no reason why she could not push this baby out vaginally.

I made the decision Jane did not need a vacuum extraction and that she could have a vaginal birth. I physically pushed the senior doctor out the way, turned to Jane ignoring the junior doctor, and said, “*We (emphasis) need to push this baby out now before these doctors pull it out.*” The two doctors just looked at me but kept silent. I was forceful in encouraging Jane to push as she had to push out this baby with the threat of these two doctors wanting to do a vacuum extraction hanging over her. Also the two doctors stayed in Jane’s birthing room to watch.
Outcome

Fetal decelerations persisted, although they had changed to late decelerations, throughout the time it took Jane to push her baby out vaginally. The baby was fine at birth with good Apgars. The doctors left once the birth was over.

Nicol’s Reflection

This normal birth was being taken away from Jane and I thought that wasn’t fair. I (hesitation) felt bad in that if I had stayed in the room I might have been able to avoid the doctors being made aware of anything. But the doctors were trying to take the delivery away from me (emphasis) and Madja. I had to take back control of the birth.

Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a SURVEILLANCE ROOM</td>
<td>The birth environment was one of a surveillance room. It optimised the ease and comfort of the staff and was an environment where staff were waiting to intervene. The power was firstly with the doctors and then with the midwife.</td>
</tr>
<tr>
<td>The midwife demonstrated good CLINICAL REASONING</td>
<td>The midwife demonstrated good clinical reasoning when he was in the birthing room immediately prior to the woman birthing her baby however twice he chose to leave the birthing woman.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR MIDWIFERY PRACTICE</td>
<td>The fragmented model of care resulted in a limited rapport with the woman. The midwife failed to disclose information to the woman which prevented her from being an informed decision-maker in her own care. The midwife used his power disintegratively to achieve what he wanted: a vaginal birth for himself and the student. His aggression and lack of appropriate collaboration with the doctors was unacceptable in terms of midwifery partnership. He did not work within the professional framework at all times.</td>
</tr>
<tr>
<td>OUTCOME</td>
<td>Justification</td>
</tr>
<tr>
<td>The birth outcome was an EGOIC AND FORCED BIRTH</td>
<td>The midwife employed „Egoic (Midwife Centred) Birth and Forced Birth” (26) behaviour where his egoic power was used to manipulate the doctors and woman, and he was determined to block out all other possibilities to force a particular birth.</td>
</tr>
</tbody>
</table>
5.3 Poor Clinical Reasoning and Good Midwifery Practice

5.3.1 MAGGIE

Background to Maggie’s Story

Maggie has been a midwife for 28 years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from this practice also provide a home birth service for selected women. Maggie was the primary midwife for Carla, (a multigravida) who is a personal friend and a midwife. Carla doubted her body’s ability to give birth throughout labour. Alison, a midwife and a friend of Carla and Maggie’s accompanied her. Maggie mentored Carla and Alison through their midwifery training.

Maggie’s Story

I just knew Carla had gone through the transition stage because she’d been really distressed and very unsure of herself, and I could hear she was occasionally grunting at the height of her contractions. Carla became agitated thinking she wasn’t in 2nd stage or ready to birth and asked if I should [vaginally] examine her to see where she was.

My first thought was: I normally trust a woman’s judgement and when the woman says to me “I’m concerned I don’t think it’s time”, I normally trust them and often they are right. But in my experience, particularly with midwives in labour, they often second-guess themselves and often misread their body signs. I wasn’t looking closely at Carla so I don’t know whether there were any other physical signs of 2nd stage to be seen such as: fetal descent or perineal bulging and anal pouting. To me it was very obvious Carla was in 2nd stage. Carla was saying she was getting a lot of perineal pressure. I expected her to birth well because she had birthed well twice before.

My dilemma was: should I examine Carla to check if she was in 2nd stage or not? I was aware that Carla would have performed a vaginal examination on a woman to establish 2nd stage so I was questioning myself whether I needed to act, as she would have done. I was the senior midwife [in the room] so I felt there was more pressure to get it [the diagnosis] right (emphasis). I suppose I didn’t want to make a mistake so, I guess I was questioning my thinking carefully and looking at what decisions I was making. I started to
ask myself, is the baby in a mal-presentation? Is the cervix not fully dilated? Do I need to diagnose that there is something holding the birth of the baby up? Can I wait a little while longer as Carla has only [potentially] been in 2nd stage 15-20 minutes? I knew there was no reason to suspect these as I had done a palpation at the beginning of labour; I had seen the [emotional] signs of 2nd stage. Maybe if I could get Carla to relax enough the [fetal] head would come down deep enough, the baby would rotate and the cervix would fully dilate around the head naturally and birth would happen, especially in a woman who has had two children before. I knew I didn’t need to examine her; I felt (emphasis) she was ready to birth. I told Carla I didn’t need to and would not examine her.

As I know Carla very well, I just held her close to me, telling her to trust her body, let go of negative thoughts, feel the baby coming down and just let the birth happen.

Outcome

Carla gained the strength and belief that she could birth her baby, which she did very shortly after. Carla said that having me talk to her in such a calm and knowing way empowered her to believe in herself again and that she could trust her body to let the baby be born just like her body had for her previous babies.

Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a BIRTH SANCTUM</td>
<td>I categorised this as a birth sanctuary because it was a hospital birth unit where the environment resembled a birth sanctum. It optimised privacy, ease and comfort of the woman and the power remained with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR CLINICAL REASONING</td>
<td>The midwife’s clinical reasoning process and final diagnosis was based upon intuition or guesswork. She rules in and rules out potential hypotheses but did not collect comprehensive empirical cues to refute or confirm her hypotheses. She remained anchored to her intuitive decision.</td>
</tr>
<tr>
<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
<td>The relationship of trust and knowing was evident between midwife and the woman and was an outcome of the continuity of care model as well as their personal and professional friendship. However, this raises ethical and professional questions/dilemmas associated with caring for friends and colleagues and the vulnerability of one’s own internal and external boundaries. The midwife used the power of touch integratively; holding the woman close whilst repetitively providing in-the-moment empowering words. At all times she</td>
</tr>
</tbody>
</table>
worked within the professional framework.

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth outcome was a</td>
<td>The woman accessed her inner power, reinforced her sense of self-trust that gave her-self the courage to embrace her body’s ability to birth: thus achieving a „Genius Birth”. I began to see that „Genius Birth” was also an outcome of Poor Clinical Reasoning and Good Midwifery Practice.</td>
</tr>
<tr>
<td>GENIUS BIRTH</td>
<td></td>
</tr>
</tbody>
</table>

### 5.3.2 RENE

**Background to Rene’s Story**

*Rene is a direct entry midwife and has been qualified for two years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from this practice also provide a home birth service for selected women. Rene was primary midwife for Dimity, a primigravida. Throughout Dimity’s pregnancy they discussed her history of sexual abuse and the request that vaginal examinations not be performed by male doctors. The consultant male obstetrician, Mohammed, was notified antenatally.*

**Rene’s story**

At this point in the story, Dimity was labouring in a quiet, calm and semi dark environment with Keith massaging her back. I sensed by the way Dimity’s behaviour was changing she was either in transition or 2\textsuperscript{nd} stage. Dimity was restless, her vocalisations were changing and occasionally she was grunting. I listened to the fetal heart rate using a Pinard and it was fine.

Suddenly Mohammed [obstetrician] opened the birthing room door and walked in, flooding the room with bright light. Mohammed told Dimity she was taking a long time to birth so he wanted to examine her to see what was happening. Dimity had only been in labour approximately eight to nine hours. Dimity looked frightened but said, „no”. Mohammed repeated his need to do an examination but this time turned his back on Dimity and prepared to put on some gloves. Dimity looked at me and started to become upset. Keith looked at me too. I felt they were looking for me to advocate for them, to stop something happening they did not want.
I told Mohammed I did not think Dimity needed to be examined as the fetal heart rate was fine, the liquor draining was clear and I thought she was in 2\textsuperscript{nd} stage. Mohammed said he could confirm if Dimity was fully dilated or not by doing the examination. For the third time I said the vaginal examination was not necessary but Mohammed ignored me and walked towards Dimity asking her to move from the floor mat on to the bed. By this time both Dimity and Keith were visibly distressed and anxious. So I knelt on the floor mat with Dimity and Keith and I said, “Dimity it basically comes down to your choice, you can say „no“ if you don’t want to be examined”.

**Outcome**

Dimity turned to Mohammed and said „No! (emphasis) I don’t want to be examined.” Mohammed threw his gloves off and stormed out of the room. Approximately 45 minutes after Mohammed left, Dimity birthed her baby on the floor mat.

**Analytical Outcomes and Justifications**

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a <strong>BIRTH SANCTUM AND A SURVEILLANCE ROOM</strong></td>
<td>The environment was a birth sanctum but it became a surveillance room when the obstetrician entered with the aim of intervening. It returned back to a birth sanctum when he left and the power was restored to the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>POOR CLINICAL REASONING</strong></td>
<td>The midwife’s clinical reasoning skills were limited. She used intuition to make the diagnosis of 2\textsuperscript{nd} stage. She collected some empirical cues, interpreted them and made a diagnosis: the baby was fine.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>GOOD MIDWIFERY PRACTICE</strong></td>
<td>The midwife used her power integratively, which facilitated the woman’s empowerment because she, the woman and her partner had known, shared goals within a continuity of care model. The doctor used his power disintegratively when he placed himself as „the expert” who needed to confirm normal progression of labour to birth via an invasive examination. The midwife located herself as the healthcare professional that was the „guardian of normal” that emphasises the legitimacy of normality in labour and birth. At all times she worked within the professional framework.</td>
</tr>
<tr>
<td><strong>OUTCOME</strong></td>
<td><strong>Justification</strong></td>
</tr>
</tbody>
</table>
| The birth outcome was a **GENIUS BIRTH** | The woman took back control and power of her birthing experience; trusting her personal knowledge or innate sense that her body could birth her baby to achieve a „Genius Birth”.


5.4 Poor Clinical Reasoning and Poor Midwifery Practice

5.4.1 ROSE

Background to Rose’s Story

Rose has been a midwife for 10 years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from the practice also provide a home birth service for selected women.

Rose’s story occurred when, as primary carer for Tia, (a primigravida), an epidural was requested. Tia was given information what having an epidural would involve, the positive and potential negative implications. As per birth centre policy, Tia was to be transferred to the hospital delivery suite. The transfer took approximately 30 minutes to arrange. Rose continued to care for Tia once she was transferred to the delivery suite. At this point in the story, as per protocol prior to an epidural, the CTG had been commenced and Rose had performed a vaginal examination (VE). The VE showed Tia’s cervix was fully dilated and that the fetal head was really low in the pelvis.

Rose’s Story

I explained the [VE] findings to Tia and Rod and the different options she had. After we had talked each option through, Tia decided that she would forego the epidural now that she was fully [dilated]. I decided I needed to let the labour staff and the anaesthetist know my findings and Tia’s decision so I left the delivery suite room. Also, I decided that I needed to ask another midwife from my team to come and take over from me as I had now reached 12 hours of practice. Hospital policy states we must be relieved after 12 hours. I knew the baby would be born soon but I was absolutely shattered and felt I needed some help. To make the phone calls and let the labour staff know took me around 5-10 minutes.

When I came back into the room, Tia was involuntary pushing with the contractions and there was about 20 cents worth of fetal head on view. I looked at the CTG and it was showing fetal brachycardia of around 70 beats per minute [bpm] and it was not returning to its previous baseline of around 110 bpm. The bradycardia was about two–two and half minutes long. I pulled the emergency buzzer requesting urgent help.
As I was opening the pack to get the episiotomy scissors, a junior labour staff midwife came in. She helped me prepare the episiotomy equipment as I was trying to explain to Tia that the baby was not coping very well with the pushing and needed to be born now and that I was going to cut an episiotomy. I infiltrated and cut the episiotomy. The baby slipped out with the next contraction (*begins to become upset*).

**Outcome**

The baby was born very „flat”. Apgars around 1-2. I initiated resuscitation, whilst the junior midwife watched asking, „what should she do?” I asked her to get a neonatologist. Approximately two minutes later a neonatologist arrived and the baby was intubated and transferred to the Special Care Nursery. The cord blood showed the baby was acidotic (ph <7.2). The baby suffered two fits the next day and remained in the Special Care Nursery for six days (*becomes quite upset*).

**Rose’s Reflection**

I should have not left the room to speak to the labour ward staff or to phone to ask for someone from my team to take over from me. If I had stayed in the room I would have seen the bradycardia sooner and could have acted straight away. I could have called for help sooner and the neonatologist could have been there at the birth. It was a lapse in judgement, maybe because I was so shattered. I regret my decision especially as I knew the baby was going to be born soon (*starts to become tearful*).

**Analytical Outcomes and Justifications**

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This context represented a BIRTH SANCTUM AND A SURVEILLANCE ROOM</strong></td>
<td>Prior to transfer to the hospital delivery suite the environment was a birth sanctuary because it was a hospital birth unit and the environment resembled a birth sanctum. Upon transfer to the hospital the environment became a surveillance room that optimised the ease and comfort of the staff.</td>
</tr>
<tr>
<td><strong>The midwife demonstrated POOR CLINICAL REASONING</strong></td>
<td>The midwife&quot;s clinical reasoning skills were limited, influenced by organisational needs, which resulted in a poor decision. However, when fetal distress was noted, the perceptions of risk shaped her clinical reasoning that ensured she took</td>
</tr>
</tbody>
</table>
The midwife demonstrated **POOR MIDWIFERY PRACTICE**. The trust made possible by the continuity of care model facilitated reciprocal sharing of information and knowledge. This enabled the midwife to use her power integratively so that the woman felt empowered to make informed choices about her method of pain relief including its technological and environmental implications. The midwife chose to abdicate her professional role and leave the room at a critical time rather than use her mobile within the room. Once situated in the medical environment, the woman was unquestioning of the expert midwife’s decisions when the emergency situation necessitated intervention. However, she worked within the professional framework.

**OUTCOME**

<table>
<thead>
<tr>
<th>The birth outcome was a VAGINAL BIRTH</th>
<th>The midwife abdicated her professional midwifery knowledge and skills, in order to fulfil organisational requirements. I began to see that „Midwifery Abdication” was a possible outcome from Poor Clinical Reasoning and Poor Midwifery Practice.</th>
</tr>
</thead>
</table>

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5.4.2 MAGGIE

**Background to Maggie’s Story**

*Maggie has been a midwife for 28 years. She is currently working within a group midwifery practice as part of an attached birth centre in a major city. The group midwives also provide a home birth service for selected women. Maggies was the primary midwife for an Afghani woman Raja a primigravida. Raja and Mohammed, her partner speaks quite good English. Raja and Mohammed deferred to Zita: Raja’s, non-English speaking, Mother-in-law who accompanied them to the birth centre.*

**Maggie’s Story**

I had discussed labouring and birthing positions with Raja ante-natally. In the Afghan culture women believe a birthing stool is quite a good place to labour. Raja used the birthing stool in first stage and 2nd stage labour. She found it a very comfortable position to be in and to cope with labour [pains] and pushing. Raja was pushing for quite a long time.
I felt unhappy with Raja being on the birthing stool for so long [approximately a total of 4-6 hours] because research has shown that in 2nd stage you really shouldn’t sit on birth stool for a very long time because of the risk of perineal oedema and that’s what I’ve found in practice. I could see in the mirror under the birthing stool that Raja’s perineum was becoming quite oedematous. I tried to encourage Raja to come off the birth stool and go forward and kneel, but she didn’t want to move. There was much discussion between Raja, Mohammed and Zita. Mohammed told me his Mother says “Raja needs to stay there [on the birthing stool] because the baby needs to come.” Zita was continuously touching Raja encouraging her to stay on the birth stool.

It was very difficult for me, I felt challenged and questioned in my practice and my knowledge and my decision-making but I didn’t want to be disrespectful towards Zita because the dynamics in the room were: Zita was very much managing the labour and where Raja should be in labour: on the birthing stool. To me culture is very important, especially as Raja has only Mohammed’s family in Australia and Raja has to go home with that family. For me to cause Zita to lose face in front of her family was not something I was prepared to do. So I left Raja on the birth stool.

**Outcome**

Raj birthed on the birthing stool and experienced severe perineal trauma which required medical suturing in theatre.

**Analytical Outcomes and Justifications**

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a</td>
<td>I categorise this as a birth surveillance despite being a quiet,</td>
</tr>
<tr>
<td>BIRTH SANCTUM</td>
<td>warm environment because the power was with the Mother-in-law rather than</td>
</tr>
<tr>
<td></td>
<td>with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated</td>
<td>The midwife’s cultural perceptions influenced and limited her</td>
</tr>
<tr>
<td>POOR CLINICAL REASONING</td>
<td>clinical reasoning skills, which resulted in a poor decision.</td>
</tr>
<tr>
<td>The midwife demonstrated</td>
<td>The trust facilitated by the continuity of care model was</td>
</tr>
<tr>
<td>POOR MIDWIFERY PRACTICE</td>
<td>overridden by cultural safety. Maggie used her power dis-</td>
</tr>
<tr>
<td></td>
<td>integratively, withholding information and her concerns. The midwife</td>
</tr>
<tr>
<td></td>
<td>abdicated her professional, ethical and legal</td>
</tr>
<tr>
<td></td>
<td>responsibility/accountability.</td>
</tr>
<tr>
<td>OUTCOME</td>
<td></td>
</tr>
<tr>
<td>The birth outcome was a</td>
<td>The midwife abdicated her professional midwifery knowledge and skills,</td>
</tr>
<tr>
<td>VAGINAL BIRTH</td>
<td>using cultural safety as a disclaimer, to the Mother-in-law.</td>
</tr>
</tbody>
</table>
5.4.3 HANNAH

Background to Hannah’s Story

Hannah has been a midwife for four years. She has two jobs: one as an independent midwife, and the other as a midwife in a consultant-led private hospital in a major city.

Hannah was the independent midwife for Karma who lived in a temporary structure three quarters an hour inland from the nearest town. Karma had free birthed her four children with her partner Jed. The last birth had been difficult so Karma and Jed wanted a midwife to assess, antenatally, that the baby was in a good position for birth. Hannah agreed. Hannah met Karma, Jed and the four children a couple of times in the antenatal period. At the antenatal appointments Jed always listened to the fetal heart rate using his ear. Hannah respected this and did not listen to the fetal heart rate. Hannah would only attend this birth if Karma and Jed felt it was necessary. At four in the morning Jed phoned asking Hannah to come as Karma had been in labour and pushing for an hour or two. Jed could see some fetal head at Karma’s perineum which had become swollen. They thought the baby was somehow stuck and they were worried Karma was going to suffer a prolapse.

Hannah’s Story

When Jed phoned and I was on my way to their home, I was actually having palpitations. I hadn’t thought ahead that something awful could happen as I was supposed to just be a kind of back-up person. The baby must have been sitting on Karma’s perineum at least for one –two hours plus the three quarters of an hour it took me to arrive, if not longer.

As Karma had free birthed all her other children, I wanted to be careful not to take any control away from her or Jed because I felt control was a big issue for this family and they were worried what a midwife might do. Karma and Jed were obviously not going to be interested in going to hospital anyway (laughs).
When I got to the location where they lived, Karma and Jed were both naked and I felt like the whole labour and birth, was an intimate experience between them, their relationship and their family. So, obviously, they felt a person coming in, as friendly as I could try to be and staying in the background as often as I could, was still an intruder. I sensed the tension in the air which made me feel like I wasn’t welcome in their space but in a way, having known Karma and Jed all the way through their pregnancy, I understood a bit about what they wanted and where they were coming from. What I did do was sit at the other side of the tent for that whole birth wondering how could I be less intrusive?

Jed said he had just listened to the fetal heart rate, using his ear, and it was fine. I took that to mean, „don’t listen to the fetal heart,” so I didn’t. Part of my decision not to listen to the fetal heart was that I could see the baby’s head sitting on Karma’s swollen perineum. I felt the baby was going to come out any second but I sensed there was some kind of fear stopping the baby from birthing. I sat on the floor at the other side of the tent and gently said to Karma, “your baby is about to be born. Don’t be scared. You can push, don’t worry. You don’t need to be worried about a prolapse.” I gave Karma the emotional reassurance she needed to let go and birth her baby. I actually never put my hand on the mother or a hand on the baby or listened to the baby’s heart rate at all.

**Outcome**

Karma free birthed her baby into Jed’s hands whilst Hannah sat against the opposite side of the tent.

**Hannah’s Reflection**

I work within the Australian College of Midwives Consultation and Referral guidelines knowing the woman can choose her birthing path. Jed and Karma wanted a midwife not to intervene or interfere but for me to sit on my hands and do nothing which all great midwives need to learn to do (*laughs confidently*). I thought this is what a midwife is supposed to do (*laughs confidently*) just to be a security blanket in a way and for the woman to feel that she did give birth herself. I felt I did a good job.
## Analytical Outcomes and Justifications

<table>
<thead>
<tr>
<th>Major Concept</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This context represented a BIRTH SANCTUM</td>
<td>This was as a birth sanctuary because it was a home birth and the environment resembled a birth sanctum. The privacy and power remained with the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR CLINICAL REASONING</td>
<td>The midwife used experiential and intuitive knowledge and displayed poor clinical reasoning skills.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR MIDWIFERY PRACTICE</td>
<td>This model of continuity of care provided a forum for the midwife and woman to form a reciprocal relationship that explored and clarified the midwife’s professional responsibility and accountability. However, what the woman (and her partner) were responsible for and what she would do on her own behalf, should have been negotiated. The midwife failed to do this. The woman feared about the safety of her baby and herself and ensured an „expert” midwife attended the birth, albeit late in 2nd stage, to necessitate surveillance and/or potential intervention. The midwife abdicated her professional, ethical and legal responsibility/accountability.</td>
</tr>
</tbody>
</table>

### OUTCOME

<table>
<thead>
<tr>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth outcome was a FORCED BIRTH</td>
</tr>
<tr>
<td>The woman consciously employed „Forced Birth” (26) where power was used by a person, in this case the woman, to force a particular birth as well. The midwife used Midwifery Abdication behaviour. I began to see that a „Forced Birth” combined with „Midwifery Abdication” was a possible outcome of Poor Clinical Reasoning and Poor Midwifery Practice.</td>
</tr>
</tbody>
</table>

### 5.4.4 HELEN

#### Background to Helen’s Story

_Helen has been a midwife for 24 years. She currently works in a consultant-led public hospital in a regional city. Helen’s story occurred when she arrived on a morning shift. Jacqui (multigravidia) had been labouring all night, and was draining meconium stained liquor. The night staff had minimal contact with Jacqui. Jacqui wanted a vaginal birth and intermittent fetal auscultation. Helen first met Jacqui, (whose first birth was by emergency caesarean section) during 2nd stage labour._

#### Helen’s story

I introduced myself to Jacqui and she made it clear that she was annoyed she had been left alone most of the night and now there was another new person involved in her care.
I felt there was animosity towards me. I certainly didn’t want to do anything that was in contravention to her birth plan, so I retreated into my little cupboard where I made sure I had everything ready in case something didn’t go quite right. While I was hiding in the cupboard trying to work out how I was going to find some common ground with this girl, Jacqui went and sat in the dark on the toilet. I entered the toilet space and stood in the dark. I asked Jacqui if I could assess her progress by performing a vaginal examination and listen to the fetal heart rate, as I was new on the scene and really needed to know what was happening. Jacqui returned to the bed. The fetal heart rate was normal, but I had concerns as I could not determine on VE whether she was fully dilated or not, so I left the birthing room to report my findings to my colleagues and the registrar. As I walked out the birthing room, I noticed the bath was full. At our hospital, the policy states if you are a vaginal birth after caesarean section you are not allowed to have a water birth.

I came back into the room a few minutes later, and Jacqui was in the bath with the lights turned off. Jacqui had a contraction, she wasn’t expulsive but her breathing had changed and I thought, we’re going to have a baby. She had another contraction; it was a little bit more expulsive. When the contraction was over, I put my hand on Jacqui’s shoulder and asked, “Would you like to get out the bath?” Jacqui answered, “No, I’m quite comfortable here thank-you.” There was nothing else I could say but I was squirming inside, as I am not water birth accredited.

I knew I had a mother who had a previous caesarean section; there was meconium-stained liquor, which requires continuous fetal monitoring as per policy. I was thinking there had been no deviations in the fetal heart rates; Jacqui had had no analgesia. I decided I was just going to go with it, let Jacqui have a water birth if that’s what she wanted. I just thought if the birth goes well, all well and good, if the birth goes pear-shaped I have to wear it. I could even lose my registration over this. I honestly thought about it in those seconds: I had to make a decision. My decision was made in that I was doing something that was against hospital policy. I know I did the wrong thing but I very much did the right thing as I wanted the best thing for Jacqui and Jacqui wanted a water birth.
Outcome

Helen did not call a second midwife as per hospital policy knowing she was working outside her scope of practice and did not want another midwife to be part of this. Jacqui gave birth in the water several contractions later.

Analytical Outcomes and Justifications

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</thead>
<tbody>
<tr>
<td>This context represented a <strong>BIRTH SANCTUM</strong></td>
<td>Although this environment is a birth sanctuary in that it resembles, warmth, quiet, peaceful and the power remains with the woman. The woman created it rather than the midwife.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>POOR CLINICAL REASONING</strong></td>
<td>The midwife employed some clinical reasoning skills but, at the crucial point, made a poor diagnosis (decision).</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>POOR MIDWIFERY PRACTICE</strong></td>
<td>As a result of the fragmented model of care, the midwife could not establish a trusting, knowing relationship. The midwife used her integrative power, in a limited way, through the beginnings of some communication/negotiating skills. She provided the rationale for her request to perform a vaginal examination so the woman could make an informed decision. However, she used her power disintegratively and remained silent; failing to tell the woman she was not accredited to conduct a water birth or the potential safety implications for the woman or her baby. The midwife abdicated her professional, ethical and legal responsibility/accountability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth the was a <strong>EGOIC BIRTH AND FORCED BIRTH</strong></td>
<td>The midwife employed Egoic (midwife-centred) and „Midwifery Abdication“ behaviour failing to fulfil and be accountable for her own professional behaviour. The woman forced the water birth. I began to see that a „Forced Birth“ combined with „Midwifery Abdication“ and „Egoic (midwife centred) Birth“ was a possible outcome of Poor Clinical Reasoning and Poor Midwifery Practice</td>
</tr>
</tbody>
</table>

5.4.5 GRACE

**Background to Grace’s Story**

Grace has been a midwife for 30 years. She is currently working in Group Midwifery practice as part of an attached birth centre in a major city. Grace’s story begins when a colleague within the team called her into take over the care of Siobhan, a 17 year old primigravida. Siobhan had been in the 2nd stage labour and actively pushing for
approximately 30 minutes. As the other midwife [Jade] was leaving, she said she had heard the fetal heart rate drop from around 120 beats per minute (bpm) to 80bpm using a Sonicaid and that it took approximately a minute-minute and a half to return to the baseline. As per policy, she had thought of transferring Siobhan to the hospital delivery suite but had not.

Grace’s Story

I re-introduced myself to Siobhan and Shayne. I asked if I could listen to the fetal heart rate which I did using a Sonicaid. I heard no deceleration so I was thinking, in the 2nd stage sometimes you get decelerations in fetal heart as the baby comes through the pelvis or as the baby’s head is crashing down onto the perineum and then the heart rate will recover and be fine. So, I was thinking, the deceleration heard by Jade [previous midwife] was probably more mechanical, it was probably just a one-off and this baby is fine. I was also reassured by the colour of the liquor draining, as it was clear. If the liquor had been meconium-stained, that probably would have concerned me more because then I would have had another sign of fetal distress. I listened intensely (emphasis) to the fetal heart rate probably for about another half an hour intermittently but not continuously. There were no more decelerations that I heard: it sounded really fine.

I trusted and believed Siobhan could push her baby out and that she could do it without any problems. The labour was progressing well. I could see fetal descent so I knew the baby was going to be born soon, perhaps another half an hour, which is an okay time for a primigravida. I also didn’t want to traumatise Siobhan by moving her from the birth centre to the hospital delivery suite because we would have had to move at a really crucial time in her labour and that has all sorts of implications such as: maybe stalling her ability to push the baby out or emotionally distressing her or incurring a whole lot of really aggressive medical intervention. I didn’t want to bring in all those extra people, all the bright lights, all the noise, all the instruments and disturb her whole sort of psyche of being.

In my thoughts was also my own need to create a wonderful birth experience for all women and if we moved, it could be destroyed. I was thinking I could help Siobhan get
her baby out. I made the choice to ignore the other midwife’s concerns and her intuition which was telling her that the fetal deceleration was out of context. I thought,” no, Siobhan and her baby will be all right here in the birth centre,” and I decided not to transfer Siobhan to the hospital delivery suite (becomes quiet).

**Outcome**

Siobhan’s baby was born approximately an hour and fifteen minutes from when Grace took over the care of Siobhan. At birth the baby was very sick (becomes upset) and the baby didn’t breathe. The baby needed resuscitating. A neonatologist, the nursery staff and another midwife were called. The baby remained in intensive care for several days, but appears alright now.

**Grace’s Reflection**

The outcome has led me to really question what I did. It was my responsibility to listen to what the other midwife was telling me. She knew the deceleration was out of context and was questioning it. When I walked in on the situation I didn’t have that sort of feeling. I was thinking and more focused on the fact that I could help this woman get this baby out naturally without any problem.

**Analytical Outcomes and Justifications**

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<th>Major Concept</th>
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<tbody>
<tr>
<td>This context represented a <strong>BIRTH SURVEILLANCE</strong></td>
<td>I categorise this as a surveillance room despite it being a hospital birth unit despite the environment being warm, quiet and peaceful; because the power was with the midwife not the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>POOR CLINICAL REASONING</strong></td>
<td>The midwife employed intuitive “guesswork” and remained anchored to her original diagnosis (decision): the baby would be fine. She did collect some empirical cues to help strengthen her intuitive decision, however this was limited.</td>
</tr>
<tr>
<td>The midwife demonstrated <strong>POOR MIDWIFERY PRACTICE</strong></td>
<td>Although this was a continuity of care model, the midwife did not re-engage with the woman until late in 2nd stage. This limited re-establishing a trusting, knowing relationship. The midwife prioritised her own need to create a „perfect“ birth for the woman over the safety of the woman and baby. The midwife’s decision to remain silent and inactive was justified by her as she saw herself acting as the „guardian“ of normal birth. She worked outside the professional framework.</td>
</tr>
</tbody>
</table>
The birth was a **FORCED AND A EGOIC BIRTH**

The midwife employed her egoic power to ensure that an „Egoic (Midwife Centred)” and „Forced Birth” occurred. This implicit determined and influential egoic power diminished the well being of the woman and her baby and the woman experienced emotional distress and there was physical harm to her baby.

### 5.4.6 ORCHID

#### Background to Orchid’s Story

*Orchid has been a midwife for 36 years. She works in a consultant-led public unit located in a regional city. The midwives see the women at various times throughout their birthing journey but on an ad hoc basis. Orchid had met Sharma once antenatally, Sharma revealed she had been raped and requested that no men were to be involved in her care. The medical staff were advised. Orchid arrived to take over care for Sharma, a grand-multigravida, who had been in labour for several hours. The obstetrician and registrar on call this day were males.*

#### Orchid’s Story

At this point in the story, Sharma was lying over a beanbag and appeared to be coping very well with labour. I listened to the fetal heart rate using a Sonicaid and it was fine. For approximately an hour I just observed Sharma because I did not want to disturb her as she appeared to be very much focused on her labour and preparing to birth. After another 10-15 minutes Sharma said she had a strong urge to push and started pushing.

I didn’t want to perform a vaginal examination to confirm 2\textsuperscript{nd} stage, as per our hospital policy, as this was Sharma’s sixth birth and her previous history noted that the other five were relatively quick with 2\textsuperscript{nd} stages of about 5-15 minutes. Also, I was concerned for her emotional well being: I didn’t want to do a vaginal examination on a rape victim unnecessarily. Plus, to do a vaginal examination effectively, I would have had to relocate her from the beanbag to the bed and I was reluctant to do that. It was a conscious decision not to perform a vaginal examination.

After approximately half an hour of active pushing, the fetal head was not on view, but I also didn’t care if she was fully dilated, thinking that she would push any remaining
cervix away. I believed she would birth the baby soon and the fetal heart rate was fine. Another half hour of active pushing passed and there was still no sign of the fetal head, no evidence of any anal pouting or perineal distension, so I changed the plan and decided to perform a vaginal examination. The findings were: Sharma had a very thick oedematous anterior lip of cervix and was in a great deal of discomfort. I told Sharma I now needed to involve the medical team and they were all males. Sharma verbalised she was quite anxious about a male doctor coming in and became very distressed.

**Outcome**

The male doctor arrived and was very respectful towards Sharma. He repeated the vaginal examination with her consent. Sharma had an assisted birth.

**Orchid’s Reflection**

I should have kept the clinical assessment cap to the fore-front realising it was Sharma’s sixth birth and she had been pushing for an hour and I was not seeing any descent; no visible signs of progress. There had to be a reason. I should have checked rather than leave Sharma for a full hour of active pushing (*voice soft*). Instead I was guided by the „emotional health cap“ and I showed a bit of a maternalistic attitude, which was disrespectful of Sharma’s ability to actually make the decision that a vaginal examination after half an hour was needed. By acting maternalistically I actually made Sharma more vulnerable to something she verbalised she was quite anxious about: involving male members of the medical team.

**Analytical Outcomes and Justifications**

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<tbody>
<tr>
<td>This context represented a SURVEILLANCE ROOM</td>
<td>This was as a surveillance room; Although it was warm, quiet and peaceful, the power was with the midwife not the woman.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR CLINICAL REASONING</td>
<td>The midwife used experiential knowledge and intuition. She collected cues but failed to interpret them in line with an accurate knowledge base and best evidence. The midwife’s intuitive hypothesis and resultant diagnosis (decision) were surreptitiously influenced by her need to protect the woman from an invasive intervention. This influence resulted in poor clinical reasoning.</td>
</tr>
</tbody>
</table>
The midwife demonstrated **POOR MIDWIFERY PRACTICE**. Although not a structured continuity of care model, this model allowed the midwife to meet the woman in the antenatal period. During this period the woman felt empowered to take ownership of her individual needs. The midwife used disintegrative power which reinforced the role of an „expert“ in retaining power over a vulnerable woman’s care. She worked outside the professional framework.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>The birth outcome was a <strong>EGOIC BIRTH AND FORCED BIRTH</strong></td>
<td>The midwife used her egoic power manipulating others to try and force a specific type of birth: „Egoic (midwife centred)” and a „Forced Birth”, which did not happen.</td>
</tr>
</tbody>
</table>

### 5.4.7 HENRI

**Background to Henri’s Story**

*Henri has been a midwife for 16 years but works primarily in administration. Henri was primary carer for Lyn, a primigravida, but a colleague [Lillian] had cared for Lyn for approximately 12 hours. During this time, Lyn had been transferred to the local consultant-led delivery suite because she was draining meconium stained liquor. A vaginal examination (done by medical staff) had determined Lyn’s cervix was fully dilated. When Henri and Amy entered the birthing room, Lyn had continuous fetal monitoring (CTG) in-situ and was being actively coached to push on the bed by Lillian. Amy was a new doula and a personal friend of Henri’s.*

**Henri’s story**

We re-introduced ourselves to Lyn and Tom (her partner) and Lillian left. The atmosphere in the birthing room was like a train wreck, because labour hadn’t been going as Lyn wanted. Lyn and Tom were obviously fed up and it was almost like (hesitation) they had given up fighting for what they wanted. Approximately an hour after we arrived, Lyn felt the natural urge to push and was pushing really well. There’s a hospital policy, which states that following an hour of active pushing, if there is no progress, medical assessment and possible intervention is required.

I saw Lyn’s labia and vagina were becoming more oedematous as time was passing and she had been fully dilated and pushing for well over an hour and half and there seemed to be little visible evidence of fetal decent. Lyn was really tired and had really low energy...
reserves. But she was having [intravenous] fluids and was moving around and changing positions. Meconium stained liquor was still draining but the CTG was good. Despite these things, I knew from when I saw her antenatally, that first and foremost, Lyn didn’t want any intervention or any drugs. I thought, we can really push the hospital policy time limits further to achieve this for Lyn. I was being sensitive around what Lyn wanted. There is also definite research around the benefits of intervention and drug-free births for the woman and the baby, long-term, short-term and postnatal depression.

I decided to try and collaborate with the doctors and get them to agree to do what Lyn wanted: wait longer. My communication style with the doctor and midwifery staff was pushy. I was telling them what I wanted: to birth without any help or intervention. The [midwife/doctor] collaboration went downhill from that. The doctor said Lyn needed assessing and possible intervention. I made the decision to ignore the policy, the time limits, the doctor and the midwives and get Lyn to push the baby out in her own time. The doctor and the labour midwifery staff were unhappy with my decision and I was [verbally] fighting everyone not to intervene because I knew Lyn wanted a drug and intervention free birth (silence). I was also conscious that I felt pressure to make that decision because I had Amy with me. She was a new doula and very excited as it was our first birth together and it was all going to crap (laughs). I was thinking, how come I’m not showing myself as a good midwife here at all (laughs)?

As I had stopped the doctor or midwifery staff coming in the birthing room by my [verbal] interaction, I went back into the birthing room. By the time three hours had passed, post the diagnosis of full dilation, Lyn”s labia and vagina became more oedematous than I”ve ever seen before or since. It was like all the intravenous fluid had just gone straight to her perineum. It was horrible. By this time Lyn had become bothered and very distressed although the fetal heart rate remained normal.

**Outcome**

I talked with Lyn and we agreed that we needed medical help now, as the baby was just not birthing. I then had to ask the same doctors who I had been fighting with for over three hours to help. Lyn had a drug free ventouse delivery and was discharged a short time later under my care.
Henri’s Reflection
It was just a really awful situation that I couldn’t rescue and Lyn was really traumatised by her birth and how it ended.

Analytical Outcomes and Justifications

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<tr>
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<td>I categorise this as a surveillance room that optimised the ease and comfort of the staff. The power was with the midwife.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR CLINICAL REASONING</td>
<td>The midwife collected some cues, interpreted them and made a diagnosis: a vaginal birth was possible. However she omitted other cues such as perineal oedema, length of the 2nd stage and no progress of fetal descent. She was anchored to her original decision, which resulted in poor clinical reasoning.</td>
</tr>
<tr>
<td>The midwife demonstrated POOR MIDWIFERY PRACTICE</td>
<td>The midwife and woman shared a common, known goal pre-labour but the midwife did not re-check with the woman if this had changed. The trusting, honest and sharing midwife/woman relationship developed via the continuity of care model was relegated to midwifery domination. The midwife employed her egoic power to show herself to her friend, the doula, as a midwife who could rescue the woman being identified by the medical experts as a maternity patient who required intervention. The midwife disregarded her professional colleagues and her professional boundaries. She worked outside the professional framework.</td>
</tr>
</tbody>
</table>

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5.5 Interpretation of Data

The major decision-making theories reviewed in Chapter 2, are not adequate to describe optimal midwifery decision-making during 2nd stage labour. Optimal midwifery decision-making, however, cannot occur without good clinical reasoning: it is, therefore, an essential condition. But what should be taken to mean „good clinical reasoning”? The model of good clinical reasoning I have developed from this study includes the following steps:

- Cue acquisition;
- Cue clustering;
• Cue interpretation;
• Generating multiple hypotheses;
• Focused cue acquisition;
• Ruling in and Ruling out hypotheses;
• Making a diagnosis;
• Evaluate treatment options relevant to the diagnosis;
• Prescribe and/or Implement treatment plan, and
• Evaluate treatment outcomes.

These explicit steps provide a systematic approach to making a diagnosis and deciding which action is best (77). For example, in Andi’s story (No: 5.1.2). First, Andi undertook the foundation step of clinical reasoning: the **Collection of Cues**:

> “the woman had „been pushing well” with each contraction for approximately 30 minutes but there were no obvious signs of progress happening”.

There are no prescribed number of cues required to form an hypothesis and, at times, additional cues may be redundant if there is enough information to generate an hypothesis (73). Consequently, the next step of clinical reasoning, which is **Focused Cue Acquisition**, may or may not be utilised. In this particular case once Andi had **Clustered and Interpreted the Cues** she decided to seek focused cues:

> “the woman”s abdominal wall did not appear to be tight and strong.”

To ultimately decide on a preferred hypothesis required Andi to relate the cues she had collected, clustered and/or focused on to her knowledge base:

> “maybe the woman had a rectus diastasis”.
Andi made the (Provisional) Diagnosis about the abdominal muscles. Andi then suggested (Prescribed) a treatment for example: using a sheet to create “a false abdominal wall”. This gave the woman the option to apply her individual values and norms to the proposed strategy and choose an option that maximised her preferences. Andi demonstrated through further cue acquisition and interpretation that she had made a correct diagnosis because the woman was able to push effectively therefore:

“...the woman indeed had a rectus diastasis”.

These steps of clinical reasoning are consistent with a large number of influential theorists in the field (72-75, 103, 104). The strength of the steps is that they can be taught and tested (72-75, 103, 104). Further, having a clear and agreed decision-making process promotes transparency and allows for consensual checking of knowledge and reasoning (4). Likewise, a consensual decision can be made and justified against the data (70-77). However, midwifery, as a woman-centred discipline, needs more than cognitive clinical reasoning to reach best-practice clinical decisions. Consequently the model of good clinical reasoning I have developed from this study includes intuition.

Relying upon intuition alone is insufficient for good decision-making and (as demonstrated in this study) can actually undermine good clinical reasoning. Intuition is a useful aid to good clinical reasoning when used in conjunction with the steps of clinical reasoning noted earlier. For example: Sarah (No: 5.1.4) used intuition to make a tentative hypothesis:

“...my sense was that she was fully dilated...”

Sarah then linked knowledge to her intuitive hypotheses:

“...Often they [babies] come out in 8 minutes or so [in third time mothers]...”

As Sarah began to doubt her intuition she collected empirical cues and interpreted them in order to confirm or refute her intuitive hypothesis. She then continued along the
path of clinical reasoning interpreting the cues in order to rule in (or rule out) a hypothesis:

“I was checking the baby”s heart rate after every contraction and it was perfectly good. I could see fetal descent [membranes bulging at perineum] and obviously Kylie was now fully dilated because the baby”s head was coming”.

One reason my new model for midwifery decision-making and in particular the clinical reasoning aspect is preferable to its alternatives, is that the model incorporates but does not privilege „intuition” over rationale clinical reasoning. This incorporation is consistent with the post-structural methodological foundations of the study in that both thinking and feeling are important in understanding human motivation and behaviour.

Contemporary best midwifery practice in Australia is based upon the ICM (61, 126, 278, 279) philosophy and the ACM (20, 56) philosophy. These philosophies align with the „Framework” as noted in Chapter 1. These documents both define the midwife”s scope of practice and prescribe the requirements that midwives must meet and uphold to remain on the professional register. Good midwifery practice though, encompasses more than adherence to the scope and code of practice.

The model of optimal midwifery decision-making and in particular the aspect of good midwifery practice I have used for this study is drawn from these sources but also includes a theoretical understanding of birth, from a woman-centred midwifery perspective. This is offered by the theory of Birth Territory. This theory draws upon post-structural research exploring the factors influencing a woman”s changing embodied self during the childbearing journey (26, 280). The profound impact of the environment on the psychophysiology of the woman in reaching a feeling of security with her environment for herself and her baby is emphasised. In recognising and optimising psychophysiology the midwife creates the contextual conditions where the interconnections between mind, body, spirit, child, family, community and environment
can function optimally. Midwives must pay attention to women’s invisible energy flows, obstacles and liberation. Through this connection with the woman and by providing them space to experience and value pregnancy and birth, women can achieve a “Genius Birth” (26, 60).

Forced Birth and/or “Egoic Birth” are the opposite of “Genius Birth”. “Forced Birth” is defined as “...using energy that is hard, determined or manipulative of others to get what she/he wants and to block out other knowledge or possibilities” (11). “Egoic Birth” occurs when “...power is used to try and force a particular type of birth” (12 p234) which may or may not be a normal birth. With a Forced Birth and/or an Egoic Birth, power is used disintegratively to impose a self-serving goal. Disintegrative power may be used by the woman, the midwife and/or any other person in the birthing environment. It may be suggested that medical disciplinary knowledge wielded power over midwives (281), and the years of subjugation has resulted in midwives mirroring the same behaviour to others. The examples drawn from the data demonstrate some midwives used their dominating power to disintegrate the woman’s power or any other person’s power within the birthing environment. In their pursuit of a “Forced Birth or an “Egoic Birth” some of the midwives abandoned good midwifery practice and/or good clinical reasoning. An example of a “Forced Birth” and an “Egoic Birth” and thus abandonment of good midwifery practice are reflected by Nicoli (No: 5.2.2). Nicoli chose to ignore the woman and the two medical professionals in order to (attempt) to obtain a normal birth:

“...I made the decision [the woman] did not need a vacuum extraction and that she could have a vaginal birth...I was forceful in encouraging [the woman] to push out this baby...”

Nici manipulated everyone to achieve what he wanted: a vaginal birth. In essence he controlled everyone’s choices. He acted paternalistically towards the woman, using his midwife status as a form of authority dictating his decision as the only viable option, thus effectively blocking out other knowledge or possibilities. Nicoli controlled the woman. Interesting the two male doctors in the room detached themselves from the unfolding situation or became docile. As result of the doctors recognising male domination, they
were happy to act docile. In doing so, the doctor’s upheld the conformity of male power within the (midwifery) environment.

An insidious form of social control within midwifery is that of (female) midwives. An example of this is offered within Adelaide’s story (No: 5.2.1). Although it could be suggested that Adelaide’s (No: 5.2.1) focus was on the woman, her motivation to get a normal birth outcome may or may not have been self serving. Adelaide used her power in a maternalistic and disintegrative manner. The midwife made the decision the woman wanted a vaginal delivery and would welcome her diagnosis (decision) and intervention of lithotomy poles:

“I sensed [the woman] did not want to throw the towel in and have an assisted birth….I had to do something...we (participant’s emphasis) somehow had to push this baby out…”

Consequently the midwife did not facilitate an informed and considered choice for the woman, rather the woman ceded to the midwife’s authoritative knowledge (282). Adelaide’s power came as a result of her culturally-accepted knowledge and expertise that the lithotomy poles were the best way to ensure a successful birth, rather than what is necessarily right. Adelaide justified her actions on previous experiences.

Forced Birth and/or Egoic Birth are inconsistent with the post-structural methodological foundations of this study in that they oppress women (and males). These types of birth work to undermine the woman’s empowerment and are counterproductive to good midwifery practice. Forced Birth and/or Egoic Birth decreases the likelihood of achieving the best birth possible in her unique circumstances: a Genius Birth.

The model of optimal midwifery decision-making during 2nd stage labour I have developed from this study includes the concept of birth sanctum, which derives from the theory of Birth Territory. A birth sanctum is a subtly lit room that promotes the comfort,
safety and privacy of the woman (283). A woman feels supported and safe within a birth sanctum. Further, this feeling of safety enhances the woman’s embodied sense of self (3, 284-286). In such an environment the woman, if left undisturbed, becomes internalised promoting the normal neurohormonal cascades of labour to unfold and birth to occur promoting her integrative power (287). „Power remains with the woman” is a new element of birth sanctum derived from this study. „Power remains with the woman” when the woman connects with the contextual conditions and the interconnections between mind, body, spirit and retains ownership of her birthing experience. The woman uses her innate sense of self to determine her power within her birthing sanctum. Therefore, a birth sanctum, within this study, is defined as an „environment that optimises privacy, ease and comfort of the woman and the power remains with the woman”. A birth sanctum can be created by either the woman or the midwife irrespective of the location: a hospital, a birth centre, a GP unit or at home.

The opposite concept to birth sanctum is the surveillance room. A birth surveillance environment is designed to optimise the ease and comfort of the staff, denotes a clinical environment and is rationalised as promoting the safety of mother and babies (12). I have chosen to add the element: „power remains with either the midwife or the doctor” to the concept of surveillance room.

A birth sanctum is a desirable condition which may promote optimal midwifery decision-making but data from this study illustrated that it is neither a necessary nor sufficient condition for optimal midwifery decision-making.

The woman as the decision-maker within her own care is a fundamental concept within midwifery (31). The midwife works in partnership with the woman to exchange information in order that the woman can make an informed choice and remain in control (288). The evidence surrounding the issue of the woman making decisions whilst in active labour is conflicting. Saxell (289) hypothesises that decision-making during labour is problematic due to the woman experiencing contractions and pain. The woman must be calm and reasonable in order to negotiate her inner needs and values to achieve her
genius birth within the medical discourse of birth (290). During labour the woman may or may not be in an altered state of consciousness from which she should not be disturbed. Consequently, in such instances the woman should not be the final decision-maker in her own care. Research has found that the quality of the woman’s choices and the variability of the woman’s responses is decreased during labour (291). A study by Anderson however, found that women equated an altered state of consciousness as being in control (292). This suggests then that the woman should be able to make the final decision about her care whilst in labour.

The data within my study illustrates that when the two components required for optional midwifery decision-making (good clinical reasoning and good midwifery practice) are present the woman may or may not be the final decision-maker. Analysis of the midwives’ stories demonstrates that four of the five midwives worked within a continuity of care model within the category of good clinical reasoning and good midwifery practice. As a result, the decisions about care during labour were made by these women antenatally within the supporting structure of a continuity of care model of midwifery.

The woman as final decision-maker was not evidenced in Grace’s story (No: 5.1.1) despite occurring within a continuity of care model. The woman had negotiated her needs and values in order to achieve her genius birth during her pregnancy with Grace:

“...[the woman] was adamant throughout this pregnancy that she would birth naturally in the birth centre...”

Despite being attuned to the woman’s needs throughout her pregnancy, when the woman asked to be examined during labour Grace declined. Grace used good clinical reasoning skills and good midwifery practice to guide her decision-making, which proved to be correct, but never discussed her reasoning with the woman. Therefore, the woman was not the final decision-maker within her care.
One woman’s choices were honoured within a fragmented model of care. Sarah (No: 5.1.4) established a rapport with the woman during first stage of labour. The rapport led to a discussion about the woman’s membranes and if it would hinder the birth if they remained intact. Being informed gave the power and control to the woman preventing unnecessary anxiety and fear. The woman decided to leave her membranes intact.

Other data within this study shows that, in some instances, reconfirmation of the woman’s decisions did not occur when unanticipated events happened. This seems to happen most commonly when the midwife prioritised the goal to ensure a normal vaginal birth, whether that goal was the midwife’s or the woman’s. In such instances the midwife ignored the empirical cues and the ensuing risks thus creating a Forced Birth. This is evidenced in Henri’s story (5.4.7):

“...I knew from when I saw [the woman] ante-natally that first and foremost [the woman] did not want any intervention or drugs...I thought we can really push this to achieve this.”

For three hours Henri did not discuss the woman’s original choice. Henri did not inform the woman of the prolonged 2nd stage of labour, swelling labia and perineum and no fetal descent. Without this information the woman was prevented from realigning her needs with the unfolding situation.

The woman as the final decision-maker is a desirable condition which may promote optimal midwifery decision-making but it is neither a necessary nor sufficient condition for optimal decision-making during 2nd stage of labour. The findings from my study demonstrate that clinical reasoning and the woman being the sole final decision-maker is never a sufficient condition for optimal midwifery decision-making during 2nd stage labour. Rather, decision-making should be shared and renegotiated as appropriate to the woman’s cognitive and emotional state at the time.
Midwifery Abdication is a new concept that derived from this study. Midwifery Abdication occurs when a midwife consciously (or unconsciously) renounces her midwifery skills and/or knowledge: she loses her professional voice. The midwife ultimately fails to fulfil and be accountable for her own professional behaviour in accordance with the midwifery „Framework” (14, 30-32).

Midwifery Abdication occurred most often when the midwife abdicated her responsibility for decision-making due to fear of conflict with the woman and/or her support people. For example: Maggie (No: 5.4.2) abdicated her professional, legal and ethical accountability/responsibility to a support person:

“…I didn’t want to be disrespectful towards Zita because the dynamics in the room was: Zita was very much managing the labour and where Raja should be in labour: on the birthing stool…”

The data demonstrates that Midwifery Abdication to a support person is also evidenced in Hannah’s story (No: 5.4.3):

“Jed said he had listened to the fetal heart rate, using his ear, and it was fine. I took that to mean „don’t listen to the fetal heart rate” so I didn”t….I actually never put a hand on the mother or a hand on the baby…”.

It is essential that the midwife (in this case Hannah) ensure the woman is provided with balanced clinical information so that the woman understands the risks that threaten the safety of her and/or her baby (293). Complete safety and elimination of all risk within midwifery however, is impossible (294). Nevertheless the midwife needs to accept her professional accountability in order to justify her decision-making and actions and support safe practice (295). Further, Guilliland and Pairman (296) acknowledge that decisions rest with the woman, however, midwives cannot use this as an excuse for not using midwifery judgement/decisions when appropriate.
An accurate knowledge base and sound clinical skills are key concepts of accountability (58). Midwifery accountability was accepted and assumed by Maggie and Hannah when they agreed to become the primary carer for the women throughout their respective childbearing journeys. Yet both Maggie and Hannah abdicated their professional accountability and responsibility including their decision-making to others.

Midwifery Abdication through uneven power differential is further evidenced in Helen’s story (No: 5.4.4). Helen abdicated her professional role despite being aware that the woman had had a previous caesarean section and was draining meconium stained liquor, that she was not accredited to perform a water birth and that a water birth with such predisposing factors was against hospital policy.

“...I decided I was just going to go with it, let [the woman] have a water birth if that’s what she wanted. I just thought if the birth goes well, all well and good, if the birth goes pear-shaped I have to wear it”.

The mother, the baby and the midwife could have experienced a very different outcome to the successful one that transpired: the woman gave birth to a live health baby in the water.

Midwifery Abdication and poor clinical reasoning is also reflected by Henri (No: 5.4.7) who works in a continuity of care model. Henri failed to search for cues or ignored clinical cues to rule in or rule out her hypotheses that the birth was not proceeding normally and that the baby may be at risk or the woman was now to be classified as “high risk”. Henri chose to ignore several cues in order to (attempt) obtain a normal vaginal birth:

“...Lyn’s labia and vagina were becoming more oedematous as time was passing...there was little evidence of fetal descent...meconium liquor was still draining...the CTG was good...three hours had past post full dilation...been actively pushing...I was telling the doctors what I wanted: to birth without any help or intervention”. 
As a result of Henri’s abdication and poor clinical reasoning skills, the woman had a poor outcome: a forceps delivery and feelings of enduring a trauma.

Power/knowledge in a hospital is governed through policies and procedures. Policies and procedures become a means of surveillance, regulation and/or discipline for midwives rather than a vehicle of emancipation. Over time the midwives’ awareness of being observed (and measured against policies and procedures) is hypothesised as being fundamental to inducing self-surveillance which can lead midwives to take wrong action for fear of the consequences of making a woman-centred decision (166). Rose (5.4.1) abdicated her midwifery role when caring for a woman during 2nd stage labour when the needs to adhere to organisational policies and procedures superseded those of the labouring woman.

Nicoli (No: 5.2.2) also left a birthing woman twice to give handover to the midwives who had arrived to start the late shift. Nicoli rationalised his behaviour by stating the organisational routine of “handover” had to take place irrespective that the woman he was caring for was in labour:

“…There are rules. I thought I’d get into trouble if I didn’t go… to handover, which sounds (hesitation) immature in a way… I didn’t have the confidence that my boss would accept that decision and think that “Oh, it’s okay. Handover can delay or the other staff can fill us in on the gaps and we’ll catch up”.

By referencing the organisational “rules” and the climate of blame, Nicoli justifies his behaviour and decision-making, claiming there was little or no choice to resist. The fear of getting in trouble overrode his care for the woman, his decision-making and the quality of his decision-making.
Although not drawn from the data of this study, an example of Midwifery Abdication and poor clinical reasoning was noted in a recent Coroner’s case concerning the death of Baby Samara Lee Hoy (35) after a prolonged 2nd stage. Three responsible midwives involved in Mrs Hoy’s care over a period of five and a half hours failed to interpret the increasing fetal heart rate (125-170 bpm) as a serious sign of fetal distress (297). They also ignored fresh meconium stained liquor and did not apply electronic fetal monitor in contravention of hospital policy, ACM Consultation and Referral Guidelines (14) and the RANZCOG guidelines (297). The midwife who cared for Mrs. Hoy during the final hours of her prolonged 2nd stage has been referred to the Australian Nursing and Midwifery Board and the Director of Public Prosecutions for consideration.

The findings from my study and the Coroner’s case above demonstrate that clinical reasoning is a necessary condition for optimal midwifery decision-making, but it is not sufficient to ensure optimal decision-making ensues. Midwives have to take more into account than just empirical data when making optimal midwifery decisions. Midwifery is a midwife/woman partnership model of care which is woman-centred. Midwifery considers the safety of the woman and the baby, and other factors such as the family, the community and the environment. For these reasons, optimal midwifery decision-making requires good midwifery practice. Midwives have to take more into account when making optimal decisions which is why I added a measure of the quality of midwifery practice to my enlarged construct of „optimal midwifery decision-making”.

In summary, I have posed a series of questions of the data. Please note, in the section that follows, for reasons of brevity I have shortened „optimal midwifery decision-making during 2nd stage labour” to „optimal midwifery decision-making”.

Q. 1. Is good clinical reasoning a necessary condition for optimal midwifery decision-making?

Yes, the stories demonstrated that good clinical reasoning is a pre-condition in all cases of optimal midwifery decision-making. Equally, the stories demonstrated that there were no stories of optimal decision-making where there was poor clinical reasoning. This
means that clinical reasoning is a necessary condition for optimal midwifery decision-making during 2nd labour.

Q. 2. Is good clinical reasoning a sufficient condition for optimal midwifery decision-making?

No, although good clinical reasoning is a necessary condition for optimal midwifery decision-making; by itself, it is not sufficient. This is evidenced by there being no examples that I evaluated as optimal midwifery decision-making where good clinical reasoning was present but good midwifery practice was absent. Good clinical reasoning, therefore, is not a sufficient condition for optimal midwifery decision-making.

Q. 3. Is good midwifery practice a necessary condition for optimal midwifery decision-making?

Yes. The stories demonstrated that all cases of optimal midwifery decision-making had good midwifery practice as a pre-condition. Equally, the stories demonstrated that there were no stories of optimal midwifery decision-making where there was poor midwifery practice. This means that good midwifery practice is a necessary condition for optimal midwifery decision-making during 2nd stage labour.

Q. 4. Is good midwifery practice a sufficient condition for optimal midwifery decision-making?

No, although good midwifery practice is a necessary condition for optimal midwifery decision-making, by itself it is not sufficient. This is evidenced by there being no examples that I evaluated as optimal midwifery decision-making where good midwifery practice was present but good clinical reasoning was absent. Good midwifery practice, therefore, is not a sufficient condition for optimal midwifery decision-making.
Q. 5. Is a sanctum a necessary condition for optimal midwifery decision-making?

I thought at the beginning of the study that a birth sanctum might be a necessary condition for optimal midwifery decision-making. My thinking was based on Birth Territory Theory and other literature (12, 173, 298, 299), which hypothesises the importance of the environment on birth. The data, however, demonstrated that, a birth sanctum is neither a necessary nor sufficient condition for good midwifery practice.

Q. 6. For optimal midwifery decision-making is it a necessary condition that the woman is the final decision-maker in her care?

Before data collection commenced, I thought that the woman being the final decision-maker in her own care, would probably be a necessary condition for optimal midwifery decision-making. My thinking was based on the dominant view in midwifery that the woman should be the final decision-maker in her own care (20, 31). The data, however, showed me examples of optimal midwifery decision-making during 2nd stage labour where the woman was not consulted about a midwife’s decision and I evaluated the midwife’s actions as appropriate. Not including the woman as the decision-maker during 2nd stage labour is contentious.

Q. 7. Is Optimal Midwifery Decision-Making a necessary condition for genius birth?

No, optimal midwifery decision-making is not a necessary condition for a genius birth. This is evidenced by two stories where I evaluated the outcome to be a genius birth where good midwifery practice was present but good clinical reasoning was absent. Genius birth, therefore, is not a necessary condition for optimal midwifery decision-making.
5.6 Summary

This chapter has presented the analysis and interpretation of stories told by midwives in order to contribute to answering the research question noted previously. The chapter presents 15 stories from midwives in their own words. As described in the methodology chapter, these stories were chosen from 52 as clear examples of the main concepts under consideration; for example, clinical reasoning (both good and poor); midwifery practice (both good and poor) and birth territory (both sanctum and surveillance room). The finding supports my thesis that: *The necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour are good clinical reasoning and good midwifery practice.*

In the final chapter of this thesis: I will draw the threads of evidence from all the chapters to support my thesis above. I will return to the introduction and the literature reviews to consider further support for the thesis as well as considering alternative explanations for my findings and interpretations. I will make clear the new knowledge that I have created as part of this research and highlight the key implications for practice, research, theory and policy.
Chapter Six

Conclusion

Introduction

This conclusion chapter represents the final „actioning change in practice” step in the methodology as discussed in Chapter 4 section 4.5.7. Briefly, in the „actioning change in practice” step, the researcher aims to bring about change within the context that the research occurred. The aim of my research was to gain understanding about how midwives currently make decisions and to discover what the necessary and sufficient conditions were for optimal midwifery decision-making during 2nd stage labour.

The thesis explored the following:

*Good clinical reasoning and good midwifery practice are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour.*

In support of the statement above, a brief synopsis of each chapter and make clear how the chapter is presented first to outline the chapter’s contribution. Next the significance of the study is organised into three sub-sections:

1) Safety and quality and midwifery decision-making;

2) Theoretical contribution of this study to the discipline of midwifery, and

3) Teaching and testing of optimal decision-making in midwifery.

The next section presents recommendations drawn from this study including those for practice, education and research and finally the strengths and limitations of this study are discussed.
6.1 Contributions of Each Chapter

Chapter 1 introduced the research question, defined key terms and provided the background to the research question. I argued that existing theories and models for midwifery decision-making often follow a modified nursing process model. Both nursing and medical models of decision-making diminish the role of the woman or the patient. In contrast, models of midwifery decision-making seek to make the woman the decision-maker in her own care, placing the woman as the sole decision-maker. However, positioning the woman alone as the decision-maker diminishes the critical importance of the midwife's clinical knowledge and reasoning skills necessary to talk through decisions with the woman. Whilst the woman as the final decision-maker is generally laudable, it is not always possible. Birth, a time where rapid decisions are required in a complex, fast changing situation where decision-making is influenced by the environment and the people within it.

Answering the research question is important as it could contribute to quality and safety in maternity care. Contemporary health care is complex. Health service managers are rightly concerned about risk, uncertainty and diagnostic errors by clinicians (40, 41). Optimal midwifery decision-making is a central component of quality and safety in maternity care. The aim of the study was to seek a greater understanding of the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour so as to be able to develop a teachable, testable model of good clinical reasoning and, more broadly, good midwifery decision-making during 2nd stage labour.

Chapter 2 presented professional regulations and philosophy since midwifery decision-making occurs within this professional framework, thus providing the philosophical foundations for this study. In addition, two types of theories: Birth Territory Theory and Decision-Making theory were introduced. These provided the theoretical foundations for this study and ultimately aided conceptualisation of the interview questions and the analysis and interpretation of data. Concepts from Birth Territory Theory were used to enhance my understanding of the subtleties of what constitutes „Good Midwifery Practice”. Next, decision-making theories were explored in order to answer the question:
How adequate are existing decision-making theories as a basis for guiding good practice midwifery clinical decision-making?

The decision-making theories considered were: Hypothetico-Deductive Theory, the nursing Clinical Reasoning Cycle, Intuitive-Humanistic Theory, Dual Processing Theory, the ICM Clinical Decision-Making Framework in Midwifery Care and the ANMC Midwifery Practice Decisions Flowchart and Midwifery Decision Summary Guide.

Clinical Reasoning is an example of Hypothetico-Deductive Theory used by Medicine. Rational application of thinking is promoted by applying the explicit and clear steps of clinical reasoning. Meeting the emotional or contextual needs of individuals is not part of the clinical reasoning process. The person is acknowledged within the nursing Clinical Reasoning Cycle. Although some of the steps from clinical reasoning are within the cycle, several steps are opaque. This lack of clarity may lead to poor decision-making. Poor decision-making may also result from using Intuitive-Humanistic Theory as the decision-maker relies on automatic rather than rational processes. Speed of decision-making, however, is a strength of Intuitive-Humanistic Theory. This is particularly important in situations where rapid decisions are required. Dual Processing Theory is a combination of two systems: intuition and analysis. A weakness of this theory is that it predominately relies on pattern recognition. Accurate knowledge base and experience are a pre-requisite for pattern recognition.

The ICM Clinical Decision-Making Framework in Midwifery Care has five explicit, linear steps. However it is not woman-centred. The woman is only involved in two steps. The ANMC Midwifery Practice Decisions Flowchart and Midwifery Decision Summary Guide does not claim to be a decision-making model. This model is actually a set of principles upon which future decision-making models may be based. The conclusion drawn from this chapter was that a midwifery specific decision-making model is required. This conclusion has been addressed by the development of the optimal midwifery decision-making model from this study.
Chapter 3 reviewed the related research literature. A systematic literature search was conducted on three occasions in three different years; only five research articles were directly relevant to the research question. Overall the findings of the reviewed studies showed that, in general, decision-making, for the midwife is not usually an autonomous process and frequently the woman was the recipient of decisions made by doctors or managers following medical orders that have been encoded in unit policies. Support for the need for this study was provided by the extremely limited research. None of the extant research has addressed midwifery clinical reasoning during 2nd stage labour. None of the previous research has addressed in detail, the complexities for the midwife of trying to keep the woman as the decision-maker in her own care whilst working within the professional regulatory frameworks and/or the predominant medically dominated environment.

Chapter 4 presented the research methodology that underpinned this study: Post-Structural Feminist Interpretative Interactionism. The philosophical foundations for this study were discussed for example: Post-Structuralism, Feminism and Interpretative Interactionism. The Feminist methodological principles guiding this study were articulated before considering the research participants ethics. Each State and Territory across Australia and every model of midwifery care within Australia was represented by at least one midwife participant. The method of data collection was a semi-structured, opened ended interview with additional probing questions if required. The process of data analysis was described culminating in the creation of an analytical framework. This framework was used to review the data multiple times. During this iterative process of analysis and creation of the framework, data saturation for the concepts within the analytical table was achieved. This rigorous, transparent process of analysis demonstrates reflexivity and enhances the study’s claim of conformability, credibility and transferability.

Chapter 5 provided the findings of this study, which was derived from each midwife’s unique decision-making experiences. From the findings a new concept arose: Midwifery Abdication. Midwifery Abdication happens when a midwife, consciously (or unconsciously) abdicates her professional skills and/or knowledge. The midwife
ultimately relinquishes her professional “voice” to others. The woman’s empowerment is undermined and there is decreased likelihood of her achieving a “Genius Birth” if “Midwifery Abdication” and disintegrative power are used by the midwife and/or doctor.

Specific questions are asked of the findings in this chapter. The answers demonstrated that good clinical reasoning was a necessary condition for optimal midwifery decision-making during 2nd stage labour. Good clinical reasoning was not, however, a sufficient condition for optimal midwifery decision-making. Further, good midwifery practice was a necessary condition for optimal midwifery decision-making during 2nd stage labour. Good midwifery practice was not, however, a sufficient condition for optimal midwifery decision-making.

The evidence, which supports my analysis and interpretation, is based upon the theories that underpin this study:

**Good Midwifery Practice**

The midwifery philosophies and regulatory documentation used were: the Australian Nursing and Midwifery Council (ANMC) Code of Professional Conduct for Midwives in Australia (30), the ANMC National Competency Standards for the Midwife (31), the ANMC Code of Ethics for Midwives (32) and the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (14). The midwifery theory was Birth Territory (17)

**Good Clinical Reasoning**

The clinical reasoning/decision-making theories used were based on several authors and consistent with a large number of influential theorists in the field: (72-74, 103, 104).The decision-making theories were: Hypothetico-Deductive theory (99-101) and Intuitive Humanistic (86) (112)

The next section of this chapter addresses the significance of the study and makes recommendations.
6.2. Significance of the Study

This research has implications for midwives, women and babies, the organisation and midwifery education, midwifery practice and the midwifery profession.

6.2.1 Theoretical Contribution to the Midwifery Profession

The model of optimal midwifery decision-making during 2nd stage labour, derived from this study, makes a theoretical contribution to the midwifery profession. The model is grounded in clinical reasoning theory, midwives’ clinical practice and contemporary midwifery philosophy and midwifery regulations (see Chapter 2). Key elements of good midwifery practice and good clinical reasoning are brought together within an optimal birthing environment to create the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour. This conceptualisation is offered on a single page below (figure 6.2.1.1 Model Developed for Optimal Midwifery Decision-Making during 2nd Stage Labour).

Figure 6.2.1.1 Model Developed for Optimal Midwifery Decision-Making during 2nd Stage Labour
Optimal Midwifery Decision-Making during 2nd stage labour

The midwife and woman
- Have an established relationship
- Share a known common goal
- Focus on the woman and her health
- Work within an agreed scope of practice
- Encourage the woman to trust her body
- Assume appropriate responsibility for the woman/baby's health
- Maintain rapport with the woman and support people
- Is appropriately assertive to avoid abdicating responsibility for clinical decisions
- Consults and refers appropriately
- Acts to facilitate the woman's informed decision making
- Supports the woman and documents and/or consults if the woman and midwife disagree about best decision
- Uses effective skills in negotiating with medical or senior midwifery staff
- Accepts accountability for own professional behaviour

The birthing environment: Woman-centred
- The birthing environment is warm, quiet and peaceful
- The midwife is the guardian of the birth space (no unwanted intrusions)
- The woman receives 1-to-1 continuous care in labour
- Unit policies and evidence-based
- Women have the right to informed choice with no coercion to comply with policies
One hallmark of rigor in qualitative research is „transferability“ which means the degree to which the findings of this research may fit into contexts that are similar to the context in which the study was conducted (273). Data of midwives’ decision-making processes for this study was drawn from clinical midwives in diverse clinical environments across all States and Territories of Australia. Thus the model of optimal midwifery decision-making should be transferable to many maternity settings. The model of optimal midwifery decision-making during 2nd stage labour provides midwives with a framework for decision-making that can be taught, used as an aide-memoir and used to facilitate joint decision-making with other maternity care providers.

6.2.2 Midwifery Decision-Making and Safety and Quality

Uncertainty and health care provision are inseparable. The quality of the midwife’s clinical decision-making directly affects the safety and quality of midwifery care for the woman and baby. Decision-making during 2nd stage labour is often different from that which occurs during pregnancy and the postpartum where the woman has time to ask questions, weigh up the risks and benefits and make her own decision. During 2nd stage labour a midwife may have to make a decision that has risk and safety implications in an environment where the power of the institution, (the obstetrician) is dominant but the woman’s needs and wishes are the midwife’s primary concern. To optimise the safety and quality of midwifery care to women, it is imperative that midwives make optimal decisions during 2nd stage labour. In addition, in order to fulfil his/her obligations of professional accountability, the midwife must be able to able to explain and justify her clinical decision-making, not just to the woman, but to other maternity care providers.

The research found that good clinical reasoning is a necessary condition for optimal midwifery decision-making during 2nd stage labour. Some of the midwives stories highlight that dependence on clinical reasoning is not, by itself, a sufficient condition for optimal midwifery decision-making. Further, this study demonstrates that good midwifery practice is a necessary condition for optimal midwifery decision-making during 2nd stage labour. Some of the midwives’ stories highlight, however that dependence on good
midwifery practice is not by itself a sufficient condition for optimal midwifery decision-making. To promote safety and quality of midwifery care for the woman and baby, this study strongly indicates that two indivisible halves: good clinical decision-making and good midwifery practice create the model of optimal midwifery decision-making during 2\textsuperscript{nd} stage labour. Using a systematic model of optimal decision-making during 2\textsuperscript{nd} stage labour, there is the potential to promote intra and inter-professional consensus decision-making and simultaneously improve decisions and reduce the risk of the midwife being reported to ANMC. By combining good clinical reasoning with good midwifery practice, this model supports midwives to provide high quality decisions and improve the safety of midwifery care. By using the model developed in this thesis, a midwife will be able to fully embrace her autonomy and accountability in her clinical decision-making.

6.2.3 Improved Teaching and Testing of Decision-Making in Midwifery

The detailed and specific steps of clinical reasoning, which are revealed from the work of this thesis can be used for teaching and learning. Real clinical cases can be used in the classroom. Teachers can use a problem-based learning approach so that midwifery students can practice the steps in clinical reasoning. When teaching decision-making in midwifery it is essential that the underpinning philosophy of midwifery, on which the element of good midwifery practice is based, is always included because clinical reasoning alone is not sufficient for optimal decision-making.

6.3 Recommendations

The recommendations from this study are presented under three specific headings: Practice, Education and Research.
6.3.1 Practice

- Clinical midwives would benefit from using this decision-making framework to guide and explain their clinical decision-making to women and other care providers.

6.3.2 Education

- The model for optimal decision-making during 2\textsuperscript{nd} stage labour is clear, concise and teachable.

- The model also provides the criteria against which to judge the validity and professional appropriateness of midwifery decision-making: both in the classroom and in practice

6.3.3 Research

- The model for optimal decision-making during 2\textsuperscript{nd} stage labour has been designed to be clear, concise and useful. To validate for research would require for example to use it when observing expert midwifery clinicians who have been peer-reviewed by other midwives as being excellent role models for midwifery practice and clinical reasoning. An outcome of further research may be that the model is modified or extended.

6.4 Strengths of this Study

The rigorous methodology of this study is its strength. This qualitatively-focused study including its design, analysis and interpretation were guided by feminist principles and post-structural interpretative interactionism methods as noted in Chapter 4. The feminist post-structural framework supported the receptiveness to the emerging concepts arising from the midwives" stories. The methods used in this study value the “emic” perspectives
of the midwives who participated. The interviews specifically explored the midwives' stories and made explicit how their experiences were embedded within real world of Australian maternity care services. However, the etic, theoretically informed perspective of the researcher is also presented. This is consistent with feminist and critical research in general. The framework facilitated the gathering of data: probing in-depth interviews which continued to a point of redundancy. Validity of the interviews was sought from each participant prior to analysis. Clarification was sought if uncertainty about the stories or emerging concepts occurred by recontacting the participants. The framework also supported the multiple reiterative process of data analysis as new concepts arose to the point of redundancy. Truth and completeness of theoretical interpretations of the data was sought by sending four analysed stories to six participants for validation. This validation process lends strength to the study.

The reality of each midwife's lived experiences of clinical reasoning during 2nd stage labour within the contexts of their practice environments is a substantial strength of this study. In the interest of transferability and validity the midwives were drawn from every State and Territory across Australia and from every model of midwifery care offered within Australia. Diversity of midwifery qualifications was sought and included: hospital certified, post graduate qualifications and direct entry Bachelor of Midwifery. Some midwifery qualifications were gained overseas. The length each midwife had been qualified ranged from 6 months to 40+ years. The study was not limited to Anglo-Saxon Australian midwives. The diversity of midwifery practice, education, experience and location led to theorising that illuminated the multiplicity of midwives' experiences of clinical reasoning and decision-making during 2nd stage labour.

6.5 Limitations of this Study

A limitation of this study is that the data derives only from the midwives' recollections of their decision-making during 2nd stage labour. Participants may be selective about what they remember and not be completely honest. Against this concern, however, there
were a number of examples of midwifery decision-making where the midwife telling the story thought was an example of good decision-making when, on analysis, the midwife’s behaviours was actually deficient in some significant way. There was no way of checking the truthfulness of the midwives’ statements because this study did not include data from the women. Although it was beyond the scope of this study, the research could have been strengthened if the women’s perceptions had been taken into consideration.

I acknowledge that I am a woman, wife, mother, midwife and academic. These roles and my broader social background have shaped me. I acknowledge I have my own theories, knowledge, values experiences and babies. Collectively, the subjectiveness of my decisions/judgements may have influenced the data analysis and interpretation. However, rationales in the analysis framework and interpretation have been provided and consensual agreement for my judgements/decisions has been obtained from supervisors throughout this study. In conjunction with this, validation of the midwives’ transcribed interviews as well as validation of my analysis and interpretation from six participants was sought.

6.6 The Overall Summary

This study has answered the research question:

„What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?“

The study has explored the complexities of decision-making within diverse midwifery contexts and models of care within Australia. It has examined the interactions between midwives, women and doctors and those aspects of the processes that resulted in optimal midwifery decision-making. The findings of this study have highlighted that good midwifery practice is a necessary condition for optimal midwifery decision-making.
There were no stories of optimal midwifery decision-making where there was poor midwifery practice. The findings also show that good clinical reasoning is a necessary condition for optimal midwifery decision-making. There were no stories of optimal midwifery practice where poor clinical reasoning was present. Further, the study has shown that a woman can achieve a „Genius Birth” within the framework of optimal midwifery decision-making and the types of births/outcomes that can occur when optimal midwifery decision-making does not happen. Further, this study has demonstrated that a midwife may (un)consciously abdicate her role as a professional.

The ultimate purpose of this midwifery decision-making study has been the discovery of the necessary and sufficient conditions for optimal midwifery decision-making processes during 2nd stage labour: and the development of a model for decision-making that is consistent with best practice. The work carried out supports the overall thesis that:

**Good clinical reasoning and good midwifery practice are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour.**

The thesis has shown that the relationships between the concepts of optimal decision-making during 2nd stage labour are interconnected. This can best be represented by the model for optimal midwifery decision-making during 2nd stage labour depicted in figure 6.2.2.1.
Appendix 1

Australian College of Midwives: Philosophy Statement for Midwifery

Midwife means “with woman”. This meaning shapes midwifery’s philosophy, work and relationships.

Midwifery is founded on respect for women and on a strong belief in the value of women’s work of bearing and rearing each generation.

Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman’s life. These events are also seen as inherently important to society as a whole.

Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and well-being of society.

Midwifery is a woman centred, political, primary health care discipline founded on the relationships between women and their midwives. Midwifery: focuses on a woman’s health needs, her expectations and aspirations, encompasses the needs of the woman’s baby, and includes the woman’s family, her other important relationships and community, as identified and negotiated by the woman herself and is holistic in its approach and recognises each woman’s social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself. Midwifery

• recognises every woman’s right to self-determination in attaining choice, control and continuity of care from one or more known caregivers;

• recognises every woman’s responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals;

• is informed by scientific evidence, by collective and individual experience and by intuition;

• aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems;

• the focus is on the woman, not on the institutions or the professionals involved, and

• includes collaboration and consultation between health professionals (1).

Appendix 3

On-Line searching: Search Strategy

Research question: *What factors influence the midwife’s clinical decision-making during birth?*

To assist in refining the electronic literature search, key concepts and words within the research question were identified prior to commencing:

**Phase 1**
Identifying keyword strings, synonyms and truncations.

1\textsuperscript{st} keyword string: Decision-making OR reasoning OR judgement
2\textsuperscript{nd} keyword string: clinical OR practice OR labor$\$, OR birth OR second stage
3\textsuperscript{rd} keyword string: Midwives OR midwife$\$ OR nurse$\$
4\textsuperscript{th} keyword string: Research OR random$^*$ OR trial OR qualitative OR literature review

The initial literature search encompassed the following data bases: PubMed, CINAHL, and Cochrane. The Cochrane Library, PubMed and CINAHL does not allow keyword string searches and forces a decision about which MeSH term is most appropriate. The search terms used for these databases are given below.

**PubMed:**
The words used in this search were matched to the MeSH headings dictated by the search engine and therefore differ from those noted below.

1\textsuperscript{st} keyword string: Decision-making OR logic OR judgement
2\textsuperscript{nd} keyword string: clinical competence OR professional practice OR labo(u)r stage, second, OR parturition.
3\textsuperscript{rd} keyword string: Midwives OR midwife OR nurse OR „nurse midwives”.
4\textsuperscript{th} keyword string: Research OR Randomised Controlled Trials as a topic OR qualitative research OR literature review as a topic

**CINAHL:**

1\textsuperscript{st} keyword string: Decision-making OR reasoning OR judgement
2\textsuperscript{nd} keyword string: clinical OR practice as a key word OR labo(u)r stage, second OR birth.
3\textsuperscript{rd} keyword string: Midwives OR midwife OR nurse
4\textsuperscript{th} keyword string: Research OR random, OR trials OR qualitative studies OR literature review.
Cochrane:

1\textsuperscript{st} keyword string: Decision-making (includes judgment) OR reasoning
2\textsuperscript{nd} keyword string: clinical competence OR professional practice OR labo(u)r stage, second OR parturition.
3\textsuperscript{rd} keyword string: Midwifery OR midwife OR nurse OR „nurse midwives‟.
4\textsuperscript{th} keyword string: Peer review OR Research OR Randomised Controlled Trials OR qualitative research OR literature.

Phase 2
Search by keyword word string: The results are indicated below

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>PubMed meSH</th>
<th>Cochrane meSH</th>
<th>CINAHL meSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} keyword string related to decision-making</td>
<td>88, 814</td>
<td>4,259</td>
<td>37,981</td>
</tr>
<tr>
<td>2\textsuperscript{nd} keyword string related to Clinical</td>
<td>226,473</td>
<td>4,206</td>
<td>396,940</td>
</tr>
<tr>
<td>3\textsuperscript{rd} keyword string related to midwife</td>
<td>67,098</td>
<td>11,029</td>
<td>120,871</td>
</tr>
<tr>
<td>4\textsuperscript{th} keyword string related to research</td>
<td>704,908</td>
<td>41,361</td>
<td>98,053</td>
</tr>
</tbody>
</table>

Phase 3
In phase 3, the key word strings were combined. The results are shown below.

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>PubMed meSH</th>
<th>Cochrane</th>
<th>CINAHL meSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} keyword string AND 2\textsuperscript{nd} keyword string</td>
<td>170</td>
<td>154,</td>
<td>18,385</td>
</tr>
<tr>
<td>3\textsuperscript{rd} keyword string AND 4\textsuperscript{th} keyword string</td>
<td>0</td>
<td>3,254</td>
<td>19,439</td>
</tr>
<tr>
<td>1, 2, 3 and 4\textsuperscript{th} keyword string combined</td>
<td>2</td>
<td>20</td>
<td>1,936</td>
</tr>
</tbody>
</table>

Phase 4
The following limits were applied to the search combining 1, 2, 3 and 4\textsuperscript{th} keyword strings.

- Humans;
- English;
- 10 years;
- Journals that were peer reviewed, and
- All fields.

No limits were applied to the 2 retrieved from PubMed.
The results are indicated below.

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>PubMed meSH</th>
<th>Cochrane</th>
<th>CINAHL meSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits applied to 1, 2, 3 and 4th keyword string combined</td>
<td>2</td>
<td>13</td>
<td>520</td>
</tr>
</tbody>
</table>

**Phase 5**

Retrieved results were cross referenced to exclude duplication. Abstracts were read to eliminate any literature that was not relevant. Studies that pertained to the nursing profession were eliminated. Studies were eliminated if they were conducted in the developing world. Studies involving women’s decision-making were also excluded. Included studies were randomised controlled trials and qualitative studies concerned with decision-making during birth irrespective of birth location. Also included were studies that related to midwives or student midwives and those professionals who practice within the field of midwifery, but are classified as midwives/nurses within their country. Four research studies met these criteria.
Appendix 4

Advert

Dear Midwives

Invitation
I would like to invite currently practicing midwives to take part in a research study designed to explore midwives decision-making during the birth of a baby.

Background
Clinical decision-making in midwifery has been under-researched. It is not the same as either nursing or medical decision-making because of the unique nature of the woman-midwife relationship.

The purpose
The study aims to describe, explain and predict midwives decision-making during the birth of a baby with an emphasis on the factors that either enhance or inhibit optimal decision-making in practice. The knowledge created by this study will allow the researcher to recommend changes in midwifery policy, practice and education to improve the experiences and outcomes for birthing women, babies and midwives.

If you would like to find out more then please contact me
Elaine Jefford
PhD Candidate - Midwifery
The University of Newcastle
Tel: 02 4921 5966
Work: 02 6205 1084 Mobile 0405374536
Fax: 02 6205 3300
Email: Elaine.Jefford@studentmail.newcastle.edu.au

Principle Researcher and Research Supervisor
Dr. Kathleen Fahy, Professor of Midwifery
School of Nursing and Midwifery,
The University of Newcastle,
Callaghan, NSW 2308 Australia
Tel: 02 492 15966;
Email: Kathleen.Fahy@newcastle.edu.au

This project has been approved by the University of Newcastle’s Human Research Ethics Committee, Approval No. H-2009-0163
Appendix 5

Principal Researcher and Research Supervisor

Dr. Kathleen Fahy, Professor of Midwifery  
School of Nursing and Midwifery,  
The University of Newcastle,  
Callaghan, NSW 2308 Australia  
Tel: 02 492 15966;  
Email: Kathleen.Fahy@newcastle.edu.au

Information Sheet

Research concerning factors affecting midwives decision-making during birth  
Document Version [1]; dated [01/07/09]

As a practising midwife who is regularly involved in birth you are invited to take part in a research study. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The research is being conducted by Mrs. Elaine Jefford, a midwife, a nurse and PhD student from the school of Nursing and Midwifery, Faculty of Health at the University of Newcastle. I am being supervised by Dr. Kathleen Fahy, Professor of Midwifery; the second supervisor is Dr. Deborah Sundin. Both supervisors are in School of Nursing and Midwifery at the University of Newcastle.

Why is the research being done?  
Decision-making in medicine and nursing has been the focus of much research in recent years. Decision-making in midwifery has received little attention. The purpose of studying midwives’ professional decision-making processes during the birthing of a baby is to learn and understand what factors may influence decision-making and decision implementation. The significance of this study is that it will focus not just on the thinking part of decision-making but also on the people and environmental factors, which affect what decisions are made and implemented. The ultimate aim of the research is to be able to describe, explain and predict how midwives can best make informed decisions with women that are actually implemented and evaluated. Recommendations will be made for midwifery policy, practice and education so as to improve the experiences and outcomes for birthing women, babies and midwives.

Who can participate in the research?  
Any midwife can participate in the research if they have practiced midwifery by working with a woman in labour within the last month.
What is required of you in this research study?
If you agree to be considered for participation the following will happen:

Stage 1 Selection Screening Questionnaire & Information Sheet
1. Read the information sheet;
2. Complete the questionnaire you receive either by email, fax and post or by hand, and
3. Return the questionnaire to the researcher either by email, fax and post (in the pre-paid envelope) or by hand,

The purpose of this questionnaire is to gain information such as: midwifery qualification, gender and place of employment (remote, rural, and metropolitan). I will use the result of this questionnaire to select a diverse range of participants, who will be invited to individual interviews. The aim of this selection process is to ensure a diversity of midwives are interviewed, which in turn improves the validity and transferability of the study findings. If you would be willing to be considered for an individual interview, please answer the questions and return the questionnaire to the researcher in the pre-paid envelope, or by fax, email or by hand.

Stage 2 Individual Interviews with the Researcher.
If you are invited to participate in an individual interview with the researcher you will:
4. Be sent a consent form and an interview preparation sheet either by email, fax and post or by hand;
5. Asked to sign and return the consent form to the researcher prior to the interview either by email, fax and post (in the pre-paid envelope) or by hand;
6. The interview will be either face-to-face or by telephone. It should be at a time and place convenient to you and me. The interview should approximately last 40 to 80 minutes. The interview will be digitally audio recorded and transcribed verbatim;
7. At the beginning of the interview you will be verbally reminded, you have signed a consent form and participation is voluntary. Also you are free to withdraw at any time, without giving any reason and without any detrimental affect to yourself;
8. In the interview you will be asked to discuss both positive and negative stories related to your professional experiences of decision-making as a midwife during the birthing of a baby, and
9. You will be offered an opportunity to read and edit the transcript as you wish. You also have the right to withdraw any data provided.

Stage 3 Validation of findings
10. At the end of the interview the researcher will gain verbal confirmation you are willing, at a later stage, to be recontacted asking you to review and validate your own transcript. You may also be invited to review and comment upon the researcher’s analysis and interpretations of data. This can be arranged to be in that is most convenient to you such as: by telephone, face-to-face by email or letter. If your feedback on the interpretation of the data does not validate the researcher’s, then exploratory discussions may take place to seek further clarification. However, the researcher will not coerce you to provide validation.
11. At the time of recontacting, by either meeting face-to-face or telephone, you will be verbally reminded you signed a consent form and participation is voluntary. Also you are free to withdraw at any time, without giving any reason and without any detrimental affect to yourself. You also have the right to withdraw any data provided.

**What are the risks and benefits of participating?**
As the methodology chosen for this research study is feminist theory, it is anticipated that you and I will develop an interactive relationship based on mutual respect. During the interview both of us may reveal information; there is however a slight risk you may feel uncomfortable and even vulnerable. As a health professional I have learned basic communication and counseling skills. If you become upset, I will provide support and offer to terminate the interview. I will discuss with you the option of referral for counseling as appropriate. I will provide you with the contact details for Dr Jenny Fothergill who will be available to you should you wish to take up the option of debriefing or counseling. You may also withdraw from the study at any time at no detrimental effect to yourself. You also have the right to withdraw any data provided.

**How will your privacy be protected?**
False names (pseudonyms) will be used ensuring your confidentiality throughout the research process and future publications. You may select your own false name if you wish. These false names will be used when any direct quote(s) is used in the research findings. Your signed consent form will be stored securely in a locked cabinet at the researcher’s home and kept separate from the remainder of the data. Should you inadvertently use the names of any birthing woman and/or attending health professional when describing your decision-making experiences, these will be removed during transcription of the interviews thus ensuring their privacy within the study. Data collected throughout the study will be securely stored in a locked filing cabinet at the researcher’s home and/or an office in the Faculty of Nursing and Midwifery at the University of Newcastle. Further, any information kept on computer will be password protected. Upon completion of the research study all information collected will be securely stored at the School of Nursing and Midwifery at the University of Newcastle. It will be kept for a period of 5 years to comply with ethical standards.

As a midwife you understand, in order to comply with the Australian Nursing and Midwifery Council (ANMC) regulations, if you chose to disclose serious information, which constitutes unlawful or harmful conduct I may have an obligation to report it

**How will the information collected be used?**
- The midwives who participate in the individual interviews will be sent a summary of the findings.
- Results from this research will be written up in a thesis and submitted to the University of Newcastle.
- Results from this research will be disseminated in conference presentations and journal publications and/or book (chapters).
What do you need to do to participate?
You can participate in this research study by completing the selection screening questionnaire and returning it to the researcher Elaine Jefford in the pre-paid envelope, or by fax, email or by hand (details below).

Complaints about this research
This project has been approved by the University of Newcastle’s Human Research Ethics Committee, Approval No. H-2009-0163

If you have any concerns related to the ethical conduct of the research you may contact:

➢ The researcher;
➢ The Principal Researcher and Research Supervisor, and/or
➢ The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, Email: Human-Ethics@newcastle.edu.au

Elaine Jefford
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The University of Newcastle
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Work: 02 6205 1084 Mobile 0405374536
Fax: 02 6205 3300
Email: Elaine.Jefford@studentmail.newcastle.edu.au
Appendix 6

Principal Researcher and Research Supervisor

Dr. Kathleen Fahy, Professor of Midwifery
School of Nursing and Midwifery,
The University of Newcastle,
Callaghan, NSW 2308 Australia
Tel: 02 492 15966;

Document Version 1; dated [01/07/09]

Consent Form
Research concerning factors affecting midwives decision-making during birth

I confirm I have read and understood the information sheet dated .................

☐ for the above study (which I have retained) and have had the opportunity to ask questions.

I understand my participation is voluntary and I am free to withdraw at any time, without giving any reason and without any detrimental affect to myself.

☐ I agree to take part in the above study by participating in an individual interview, which will be digitally audio recorded and that at a later stage the researcher will

☐ re-contact me either meeting face-to-face or by telephone, seeking me to review and validate the researcher’s interpretations arising from the data.

I understand the steps being taken to protect my confidentiality and that a false

☐ name, which I may chose, will be used at all times and when any direct quote(s) is used in the research findings.

Name: ________________________________________________________

Signature: ________________________________________________________

Date: ____________________________________________________________

Contact details: Phone ________________________ Email ________________________
Complaints about this research

This project has been approved by the University of Newcastle’s Human Research Ethics Committee, Approval No. H-2009-0162

If you have any concerns related to the ethical conduct of the research you may contact:

- The researcher;
- The Principal Researcher and Research Supervisor and/or
- Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au

Elaine Jefford
PhD Candidate - Midwifery
The University of Newcastle
Tel: 02 4921 5966
Work: 02 6205 1084 Mobile 0405374536
Fax: 02 6205 3300
Email: Elaine.Jefford@studentmail.newcastle.edu.au
Selection Screening Questionnaire

Research Question:
*What factors influence midwives' decision-making processes during birth?*

The purpose of this questionnaire is to gain information such as: midwifery qualification, gender and place of employment (remote, rural, and metropolitan). I will use the result of this questionnaire to select a diverse range of participants, who will be invited to individual interviews. The aim of this selection process is to improve the validity and transferability of the study findings. If you would be willing to be considered for an individual interview about your clinical decision-making related to the birthing of a baby, please answer the following questions and return them to me in the pre-paid envelope, by fax, email or by hand (see below for details).

1. **Have you practised midwifery during labour and birth within the last month?**
   Please tick
   - a) Yes  
   - b) No  

2. **Are you a ....?** Please tick
   - a) Female  
   - b) Male  

2. **Do you identify as an?** Please tick if YES
   - a) Aboriginal or  
   - b) Torres Strait Islander  
   - c) Both the above  

3. **Which qualification did you complete to be eligible for initial registration as a MIDWIFE?**
   Please tick
   - a) Hospital certificate in Midwifery  
   - b) Bachelor Midwifery  
   - c) Graduate Diploma or Master of Midwifery  

4. **In what State or Territory do you practice?** Please write the name

5. **Do you consider your place of practice to be located in...?** Please tick only one
   - a) Major city  
   - b) Regional city  
   - c) Rural  
   - e) Remote  

6. In total, how long have you been in midwifery practice (years/months)?

☐ Years  ☐ Months

7. Are you involved in the following settings? Please tick as many as apply
   a) Consultant-led unit in a private hospital ☐
   b) Consultant-led unit in a public hospital ☐
   c) Birth Unit (Stand alone) ☐
   d) Birth Unit (attached to a hospital) ☐
   e) Group Midwifery practice ☐
   f) Self-employed midwife in private practice ☐
   h) Another please state

8. Do you work in a continuity of carer model (i.e. you do not work regular shifts and are on call for a set number of women)?
   a) Yes ☐
   b) No ☐

9. Do you hold a current certificate in? Please tick more that 1 if appropriate
   a) Advanced Life Support Obstetrics ☐
   b) Birth-Sprit ☐
   c) Another please state ☐

Thank you for your willingness to take the time to engage with this research project. I am looking for approximately 20-25 midwives who offer diversity of practice and experience. If you are selected to participate in an interview, would you also be willing a later stage for the researcher to re-contact you either meeting you face-to-face or by telephone to review and validate the researcher’s interpretations arising from the data? If YES please would you provide your name, address and/or phone number.

Is there anything else you would like me to know?
Please return this questionnaire either by: hand, email, fax or in the postage paid envelope to:

Elaine Jefford
PhD Candidate at University of Newcastle
Tel: 02 4921 5966
Postal address: 16 Kettlewell Crescent, Banks, ACT, 2906
Work: 02 6205 1084
Mobile: 0405374536
Fax: 02 6205 3300
Email: Elaine.Jefford@studentmail.newcastle.edu.au
Appendix 8

Interview Preparation Sheet

Thank you for your willingness to take the time to engage with this research project and completing and returning the Selection Screening Questionnaire. You have been selected to participate in an individual interview. I will contact you to arrange a time for the interview either by meeting you face-to-face or by telephone. The interview should approximately last 40 to 80 minutes and will be digitally audio recorded and will then be transcribed verbatim. At the beginning of the interview you will be verbally reminded, you have signed a consent form and participation is voluntary. Also you are free to withdraw at any time, without giving any reason and without any detrimental affect to yourself.

Please take time to read the following information as it will help you prepare for the interview. Ask me if there is anything that is not clear or if you would like more information.

Preparation
I will be asking you to think, of times within the last month, when you were with a woman during the birthing of her baby. I would like you to tell me two stories with reference to your decision-making during those births: One should be a positive experience, the other a negative one. You decide what is positive and negative, but I will want to understand why you made that choice. It can be a simple, everyday situation. The following common clinical decisions related to the birthing of a baby may help you, but please don’t be limited by them:

- What is your usual practice that lets you know when a woman is in the 2\textsuperscript{nd} stage of labour?
- What is your usual practice in relation to pushing in 2\textsuperscript{nd} stage of labour?
- How and when, do you talk to women about birthing positions?
- What is your usual practice when the head is advancing: do you have hands on/off approach?
- How and when, do you talk to women about protecting the perineum during birth?
- Do you actively protect or manage the perineum during birth?
- How and when, do you monitor fetal wellbeing during 2\textsuperscript{nd} stage?
- How do you respond to fetal heart rate changes?
- What is your usual practice in relation to the nuchal cord?
- How do you recognise and respond to shoulder dystocia?
- What is your usual practice immediately after the baby is born into your hands?
- What is your usual practice in the 3\textsuperscript{rd} stage or labour?
- How do you engage with the woman (and her family) during the birthing of a baby?

Main Question
*What factors influence midwives’ decision-making processes during birth?*

Please describe a situation with as much detail as necessary for me to fully understand the whole context of decision-making as well as what you were thinking?
Follow up Questions
I might ask some follow-up questions so I can fully understand the factors that affected you when making that decision and why. Examples of potential follow-up questions that I may ask are:

- Why did you choose this event as a positive/negative example?
- As the event was happening how were you feeling?
- Was there any communication between you and the women about this decision either before, during or this experience?
- How do you think the woman was feeling? What makes you say that?
- How do you think other people in the room were feeling? What makes you say that?
- Can you describe what was happening at that time and tell me what factors may have affected the decision that you made and the actions that you took?
- To what degree do you think the factors you have mentioned were important?
- Why do you think these factors were important?
- Do you feel any other staff member influenced your decision? What makes you say that? How do you feel about that?
- Please can you explain why you think this decision was a positive one?
- Looking back, how empowered did you feel to be professionally autonomous in your decision-making?
- Did you feel free to implement your decision or were their constraints?
Appendix 9

Interview Themes

Introduction
This part will not be digitally recorded

- Greeting and introductions;
- Explanation of research and the selection screening questionnaire – answer any questions;
- Revisit the issue of consent and their ability to withdraw at any time;
- Discuss digital audio-taping - answer any questions;
- Selection of a false name (pseudonym), and
- Discussion how the interview will unfold - answer any questions.

- Before we start please allow me to introduce myself more fully

This part will be digitally recorded
I would like you to talk about two stories with reference to your decision-making during the birthing of a baby: One should be a positive experience the other a negative one. You decide what is positive and negative but I will want to understand why you say that: ok?

I might ask some follow-up questions so I can fully understand the factors that affected you when making that decision and why.

Let's Start with the Positive Experience
Please think of a time within the last month when you were with a woman during a birthing of a baby, where you made a decision that was a positive experience. It can be a simple, everyday decision.

Main Question
What factors influence midwives’ decision-making processes during birth?

Please describe a situation with as much detail as necessary for me to fully understand the whole context of decision-making as well as what you were thinking?

Follow-up Questions that may be asked if not addressed by the midwife in her stories:

- Why did you choose this event as a positive example?
- As the event was happening how were you feeling?
- Was there any communication between you and the women about this decision either before, during or this experience? (partnership)
- How do you think the woman was feeling? What makes you say that?
- How do you think other people in the room were feeling? What makes you say that?
- Can you describe what was happening at that time and tell me what factors may have affected the decision that you made and the actions that you took?
- To what degree do you think the factors you have mentioned were important?
Why do you think these factors were important?
Do you feel any other staff member influenced your decision? What makes you say that? How do you feel about that?
Please can you explain why you think this decision was a positive one?
Looking back how empowered did you feel to be autonomous in your decision-making?

**Negative Experience**
The same base questions will be used but framed within the negative view.

**Conclusion**
Thank you for your time: I have really been fascinated by your stories.

Are there any questions or comments you wish to make?

What are your plans now, for the rest of the day? (This will assist the person to ground back into the reality of the present time)

Any reminders and follow ups that need to be mentions.
Appendix 10a

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor: Professor Kathleen Fahy
Cc Co-investigators / Research Students: Mrs Elaine Jefford, Dr Deborah Sundin
Re Protocol: Midwives professional decision-making during birth
Date: 01-Jul-2009
Reference No: H-2009-0163
Date of Initial Approval: 01-Jul-2009
Approved To: 30-Jun-2012

Thank you for your Response to Conditional Approval submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under Expedited review by the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is Approved effective 01-Jul-2009.

Please add the Chief Investigator's letterhead to the top of the Information Sheet and the Consent Form prior to distribution of the documents.

Approval is granted to the date indicated above or until the project is completed, whichever occurs first. If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request. Your approval number is H-2009-0163.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants. You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved
Protocol as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- Monitoring of Progress

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. You will be advised when a report is due.

- Reporting of Adverse Events

1. It is the responsibility of the person first named on this Approval Advice to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
   - Causing death, life threatening or serious disability.
   - Causing or prolonging hospitalisation.
   - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
   - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
   - Any other event which might affect the continued ethical acceptability of the project.
5. Reports of adverse events must include:
   - Participant's study identification number;
   - date of birth;
   - date of entry into the study;
   - treatment arm (if applicable);
   - date of event;
   - details of event;
   - the investigator's opinion as to whether the event is related to the
research procedures; and
  o action taken in response to the event.
6. Adverse events which do not fall within the definition of serious, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- Variations to approved protocol

If you wish to change, or deviate from, the approved protocol, you will need to submit an Application for Variation to Approved Human Research. Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

**Linkage of ethics approval to a new Grant**

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Associate Professor Alison Ferguson  
Chair, Human Research Ethics Committee

*For communications and enquiries:*
Human Research Ethics Administration

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F +61 2 492 17164  
Human-Ethics@newcastle.edu.au
Appendix 10b

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor: Professor Kathleen Fahy
Cc Co-investigators / Research Students: Mrs Elaine Jefford
 Doctor Deborah Sundin
Re Protocol: Midwives professional decision-making during birth
Date: 23-Apr-2010
Reference No: H-2009-0163

Thank you for your Variation submission to the Human Research Ethics Committee (HREC) seeking approval in relation to a variation to the above protocol.

Variation to change the research question from "What factors influence midwives' decision-making process during birth?" to "What are the necessary and sufficient conditions for optimal midwifery decision-making during 2nd stage labour?" to facilitate more appropriate analyses of the data collected.

Your submission was considered under Expedited review by the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is Approved effective 16-Apr-2010.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request.

Associate Professor Alison Ferguson Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration
Research Services
Research Office
The University of Newcastle
Callaghan NSW 2308 T +61 2 492 18999 F +61 2 492 17164
Human-Ethics@newcastle.edu.au
Appendix 11

Background to Grace’s Story (5.1.1.)

Grace has been midwife for 30 years. She is currently working in Group Midwifery practice in a major city.

Grace story occurred when she was providing continuity of care for Katie, a 44-year-old multigravida. Grace had been the midwife for Katie’s first birth. Katie had watched both her sisters have natural births at home and she wanted the same experience. Grace had spent this pregnancy debriefing Katie about her previous birthing experience. She had been terrified about the potential pain and would often cry but was determined that she didn’t want any pain relief; just a natural birth with no intervention. However, as her pregnancy progressed, Katie became fixated on the birth and potential complications that could arise. She also felt that she did not have the confidence that she perceived that her sister’s had during their births. She found the actual labour very painful and frightening. Katie decided, after two-three hours of labour to go to the birth centre. She was accompanied by her two sisters and was disappointed in herself that she went to the birth centre. Grace spent time talking about this pregnancy and labour with Katie.

Grace’s Story and Analysis

When Katie arrived at the birth centre I was there to meet her (CF: Continuity of care) (MBP: Established midwife/woman relationship where shared known goals were reconfirmed). After only a few contractions I guessed she was either in transition or 2nd stage (Intuition: uses intuition to form a hypothesis and then seeks cues). The contractions were coming really strong (Cue) and really, really close together (Cue). I could see there was pressure on her perineum as it was starting to stretch and expand which indicates the baby’s head is moving down (Cues) (DMP: Accurate knowledge base -diagnosis). Also Katie changed the way she was pushing and the noises she was making: becoming more vocal (Cue) (DMP: Focused cue acquisition, clustering and interpretation to support intuitive hypothesis). Katie was just so scared; frightened the pain she was experiencing was going to go on forever (Cue). Katie didn’t realise she was transitioning and her body was preparing to actually deliver her baby (Intuition: Using intuition to make a diagnosis). I listened to the fetal heart rate and it was fine (Cue) (DMP: Cue acquisition, interpretation to make a diagnosis) (MBP: Assumed responsibility for fetal wellbeing).

The birth centre policy says you must do a vaginal examination to make sure the woman is, fully dilated before you allow (emphasis) her to push her baby out (CF: Organisational policy governance). But I believe the body knows what it’s doing (Cue). I (emphasis) trust the women’s bodies and their power to birth (Cue). I trust their intuition
or their feeling that birth is going to happen (Cue) (MBP: Trusts Katie to birth her baby). This trust comes from years of experience and I think that it makes it easier in the continuity of care model because I really got to know Katie before labour (Cue). I guess (hesitation) knowing Katie’s whole family and her two sisters and the whole family dynamics helped. We talked about what Katie wanted, her fears and her concerns and how she thought she could get through them (CF: Continuity of care) (MBP: Shared known goal). So I knew (emphasis) how to make Katie feel comfortable and relaxed (Uses power integratively). I knew she needed encouragement to believe in herself, that the pain would not last and the support and love of her two sisters (CF: Continuity of care) (MBP: Understands family dynamics and how it was having a positive effect on Katie –shared known goal).

Katie asked me “how do you know what I’m doing and do you think you need to examine me?” (Cue) Katie was being supported and encouraged beautifully by her two sisters and that was exactly what she had said she wanted (Cue). This dynamic contributed to make me feel like I didn’t have to do anything here but wait and watch (DMP: Evaluates treatment options, makes a decision and implements that decision). I decided I didn’t need to examine Katie to determine if her cervix was actually fully dilated (MBP: Trusts Katie’s body to birth her baby). She was showing the signs and I just knew she would birth soon (Intuition: Uses intuition based upon earlier cues to make a diagnosis and decision –Does not look for new cues or reconfirmation of previous cues). Its intuition I think: just a feeling, something that you know but you don’t know really or how you know it (Cue) (Intuition or guesswork?). So I just reassured her that I knew she was progressing really well and would soon birth her baby. So I said “no, no it’s all fine. Just go with it, just keep breathing, push if you want to., listen to your body let it tell you what to so, believe you can birth this baby just like you did the last one” (MBP: Appropriate assertion with Katie). I think I listened to the fetal heart once just to make sure it was fine (DMP: Cue acquisition, interpretation to form a hypothesis).

Outcome

Katie’s sisters and I talked Katie through her labour until the baby’s head was on view. We helped her believe in herself. Katie birthed her baby absolutely beautifully, totally shocked and wonderfully surprised that she had found the power and belief in herself 15 minutes later.
### QUESTIONS DERIVED FROM ANALYSIS

#### 5.1.1 GRACE

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<td>1. The birthing environment warm, quiet and peaceful?</td>
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<td>2. The standard model of care was midwifery caseload?</td>
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<td>3. There are enough midwives to provide 1-to-1 care in labour?</td>
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<td>4. The woman’s goals for labour/birth were respected by doctors or senior midwives</td>
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<td>5. Policies appeared to be evidence-based?</td>
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<td>Overall: This context represents a BIRTH SANCTUM</td>
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<td>1. Accurate knowledge base in line with best evidence</td>
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<td>2. Cue acquisition – appears to be comprehensive</td>
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<td>3. Cue clustering – appears to be comprehensive</td>
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<td>4. Cue Interpretation – Generating multiple hypotheses – if relevant</td>
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<td>5. Focused cue acquisition – if needed and relevant to hypothesis</td>
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<td>6. Ruling in and Ruling out hypotheses – if relevant</td>
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<td>7. Making a diagnosis</td>
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<td>8. Evaluate treatment options relevant to the diagnosis – if relevant</td>
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<td>9. Prescribes and/or implements planned care</td>
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<td>10. Evaluates outcomes</td>
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<td>11. Uses intuition to aid decision-making</td>
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<td>1. Stays in the room with the woman in labour</td>
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<td>2. Shares a common, known goal with the woman</td>
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<td>3. Trust the woman and her body</td>
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<td>4. Maintains rapport with the woman appropriately</td>
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<td>5. Maintains rapport with the support people appropriately</td>
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<td>6. Appropriate assertion with the woman and support people</td>
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<td>7. Honest and complete information sharing with woman/partner</td>
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<td>8. Uses power integratively to promote the woman’s empowerment</td>
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<td>9. Accountability for own professional behaviour in accordance with professional frameworks</td>
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<td>10. Skills in negotiating with medical staff or senior midwifery staff</td>
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<td>11. Assumes appropriate responsibility for woman/baby’s well-being in labour</td>
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<td>Only checked fetal heart once</td>
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<td>12. To what extent does the midwife show reflexive practice</td>
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<td>13. When the woman and midwife disagree about care the midwife takes appropriate action (documentation and consultation)</td>
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<td>14. The woman is the final decision-maker</td>
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<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
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**NA** = Not applicable, **NK** = Not known, **MG** = Midwifery guardian, **MD** = Midwifery domination, **MA** = Midwifery abdication
Appendix 12

Background to Andi’s Story (5.1.2)

Andi has been a midwife for 25 years. She has two jobs in rural Australia: one as an independent midwife, and the other as a midwife in a GP-led unit of a public hospital. Andi’s story occurred at the GP-led unit when Andi was working with Narelle, an RN student midwife. They were caring for Paula, a multigravida, whom they had met for the first time when she arrived in early labour. Paula was in 1st stage labour for approximately six hours prior to entering 2nd stage, which Andi confirmed on vaginal examination in accordance with the GP birth unit policy.

Andi’s Story and Analysis

At this point in the story Paula was in a standing position (Cue). She had been pushing well (Cue) with each contraction for approximately 30 minutes (Cue) but there were no obvious signs of progress happening (Cue), such as visible [fetal] head (Cue), which for a multigravida woman was strange (Cue) (DMP: Cue acquisition and interpretation to ruling in a hypothesis). I was checking the fetal heart rate and it was fine (Cue) (DMP: Cue acquisition, interpretation to make a diagnosis) (MBP: Assumed responsibility for fetal wellbeing). Paula said to me, pointing to her tummy (Cue), “something is wrong, (Cue) nothing’s happening (Cue), when I push there’s nothing to push against” (Cue).

I actively listened to Paula (Cue) sensing what she meant. She was feeling her tummy muscles were not creating enough resistance for her to feel like she had something to push against (Intuition: Uses intuition to rule in a hypothesis), which women need to aid their pushing (DMP: Accurate knowledge base).

I had read (Cue) about “muscle draws” and how some Mexican midwives often use a shawl or something to put around the women to assist her in pushing (Cue) (DMP: Using empirical knowledge). So I decided I needed to do something similar to help create a false sense of a tummy wall; creating something for Paula to push against (DMP: Makes a decision). I was thinking that if the tummy wrap made a difference to Paula it could stop her pushing for ages with nothing happening and perhaps prevent unnecessary [medical] intervention (DMP: Using empirical evidence to support treatment options and evaluate potential outcomes) (MBP: Understanding optimising psychophysiology and trusting Paula’s body to birth her baby).

I talked to Paula suggesting what I had in mind, how it would work asking what she thought about the idea (MBP: Uses power integratively sharing thoughts, information so that Paula is empowered to make an informed decision). Paula agreed to try the „muscle draw”. Narelle and I got a single sheet which was fairly stiff, folded it up and holding one end each put it around Paula’s back and across her
abdomen. During a contraction Narelle and I pulled the sheet quite hard and tight around Paula’s abdomen, keeping the pressure on until the contraction passed (MBP: Optimising psychophysiology, listening to woman’s needs and acting accordingly) (DMP: Implements planned care). After the first contraction I asked Paula how she felt and she said it was a lot better as it gave her something to push against.

**Outcome**

Paula gave birth to her baby in the standing position four contractions later.

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<td><strong>Overall: This context represents a BIRTH SANCTUM</strong></td>
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<p>| <strong>Re: CLINICAL REASONING?</strong> | <img src="chart.png" alt="Chart" /> |
| 1. Accurate knowledge base in line with best evidence | X |
| 2. Cue acquisition – appears to be comprehensive | X |
| 3. Cue clustering – appears to be comprehensive | X |
| 4. Cue Interpretation – Generating multiple hypotheses – if relevant | X |
| 5. Focused cue acquisition – if needed and relevant to hypothesis | X |
| 6. Ruling in and Ruling out hypotheses – if relevant | X |
| 7. Making a diagnosis | X |
| 8. Evaluate treatment options relevant to the diagnosis – if relevant | X |
| 9. Prescribes and/or implements planned care | X |
| 10. Evaluates outcomes | X |
| 11. Uses intuition to aid decision-making | X |
| 12. Links intuition to cues and reasoning | X |
| <strong>Overall: CLINICAL REASONING =GOOD</strong> | X |</p>
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**The midwife demonstrated GOOD MIDWIFERY PRACTICE**

X MG

NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 13

**Background to Jane (2)’s Story (5.1.3)**

Jane(2) has been a midwife for 25 years. She works in a consultant-led hospital that is both private and public in rural Australia. The rural setting seems to have been conducive to forming a collaborative agreement between a private obstetrician and Jane(2) that allows for a continuity of care model with a midwife. This is on the mutual understanding that this midwife keeps the private obstetrician fully informed. Jane(2)’s story occurred when caring for Lisa, a primigravida, who was a private patient of Jane(2)’s. Lisa had been in labour approximately 12-14 hours and wanted a natural childbirth.

**Jane (2)’s Story and Analysis**

It was very obvious to me that Lisa was in 2nd stage (Intuition: uses intuition to form a hypothesis). She had the predictive signs of a show (Cue) and having the urge to push as she felt the need (Cue). Lisa was working hard with her contractions, trying a variety of positions: squatting, kneeling, hanging over the basin in the bathroom (Cue). I monitored the fetal heart rate, not after every contraction but certainly after every two or three, with a Doppler and it was fine (DMP: Cue acquisition, interpretation to rule in a diagnosis). After an hour (Cue), I could just see the fetal head so I was happy that there was some progress (DMP: Focused cue acquisition to form a hypothesis). After another two hours of pushing I probably could see fifty cents worth (*laughter in voice*), (Cue) (DMP: Focused cue acquisition to support hypothesis). The fetal heart rate was still good (DMP: Cue acquisition, interpretation to support diagnosis). At this time I decided to let the private obstetrician know [via telephone] that Lisa had been pushing for two hours and yes we could see the baby but it was still a little way off (MBP: Accountable for professional behaviour –consultation – negotiating with medical practitioner). The Obstetrician was happy to let Lisa keep going (DMP: Decision).

Lisa kept trying different positions and the baby came down to where we could probably see a reasonable amount of fetal head, more than fifty cents worth certainly (Cue) (MBP: Shared known goal). After another 30-40 minutes the obstetrician rang me and said, “So what’s happening?” and I said, “Well we’re making progress, slow, fetal heart’s fine,” clear liquor and that Lisa was determined to keep going and achieve a natural birth (Cue) (DMP: Focused cue acquisition to support hypothesis and evaluate treatment options) (MBP: Shared known goal – accountable for professional behaviour). I did discuss with Lisa the fact that the obstetrician was becoming anxious about the length of time in 2nd stage and there are generally limitations on the time of 2nd stage but as long as everything was going fine and Lisa was willing to continue we would do that, but she had to understand the potential implications: he (obstetrician) may want to do an assisted birth (Cues) (MBP: Uses power integratively to empower
Lisa to make an informed decision via open and honest information sharing). Lisa said she didn’t want an assisted birth and didn’t really want an episiotomy (Cue).

A bit over three and a half hours from when I could first see the fetal head the obstetrician knocked and came in to the birthing room (CF: Respects birthing environment). He re-introduced himself to Lisa (Cue) and then made himself a cup of tea, sat in the corner and watched (CF: Continuity of care – woman’s goals for labour/birth respected). By this stage I was listening to the fetal heart rate after a contraction and during a couple too just to see what was happening, which is not in accordance with policy. There were no decelerations, the fetal heart rate was fine (DMP: Focused cue acquisition, interpretation to support diagnosis).

After four hours of being in 2nd stage and active pushing, the obstetrician got up, walked over to Lisa and encouraged her with each contraction. He was respectful, not ordering just encouraging (Cue) (CF: woman’s goals for labour/birth respected). He said to me, “Have you got the scissors and the local anaesthetic?” I turned my back to Lisa while I got everything ready, and he prepared himself, but Lisa saw me. Somehow Lisa found the strength to give a few huge pushes and the fetal head advanced (Cue).

**Outcome**

Four and half hours after entering 2nd stage Lisa gave birth to her baby with an intact perineum. The obstetrician sat and watched.

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12. Links intuition to cues and reasoning

Overall: CLINICAL REASONING = GOOD

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The midwife demonstrated GOOD MIDWIFERY PRACTICE

NA = Not applicable, NK = Not known, MG = Midwifery guardian, MD = Midwifery domination, MA = Midwifery abdication
Appendix 14

Background to Sarah’s Story (5.1.4)
Sarah is a nurse and midwife with one year of post-graduate midwifery experience. She currently works shift-work in a consultant-led public and private hospital in a major city. Sarah’s story occurred in the public delivery suite when she arrived to commence a night shift. Sarah first met Kylie (a primigravida) and Tom when entering their birthing room to provide one-to-one care.

Sarah’s Story and Analysis
Prior to 2nd stage Kylie said (hesitates) her membrane were still intact (Cue) as if that was a problem [which meant] she couldn’t have the baby. So we discussed this and the possibilities of maybe and maybe not rupturing them (MBP: honest and complete information sharing use power integratively to empower Kylie to make an informed decision).

Kylie was starting to say that she felt she needed to push (Cue), so my sense was that she was fully dilated (Intuition). There was a very clear change from what I would guess to be transition to when she is fully [dilated] (Intuition – then looked for evidence). Kylie became very internalised (Cue), less aware of what’s going around her (Cue) and very focused (Cue) on the job of having her baby (DMP: Collected cues, interpreted them in order to rule in a hypothesis 1). I think whenever I see a woman become like that [internalised] I err on the side of saying as little as possible so as not to distract the mother (MBP: Understanding of optimising psychophysiology, trusting Kylie and her body to birth and uses power integratively to empower Kylie to birth).

I was starting to question if Kylie was fully dilated (DMP: Hypothesis 1 clarification) as it was a relatively slow 2nd stage for a third time mother (MBP: Reflexive practice) (Cue). Often babies come out in eight minutes or so (DMP: Knowledge and experience used to support hypothesis 1). Kylie’s 2nd stage [at this point] was about 37 minutes (DMP: Evidence for ruling in hypothesis). My sense (hesitates) was that the membranes were quite bulgy and not close to the baby’s head (Cue) (Intuition: Hypothesis formation 2 based on intuition) and maybe if it [the membrane] was close [to the baby’s head] the baby would have slipped down a bit faster (DMP: Using knowledge to explain hypothesis 2). Because the baby’s head was progressing reasonably slowly (Cue) I wondered whether other midwives would consider rupturing the membranes just to speed things up (DMP: Evaluating treatment options). (MBP: Reflexive practice- taking in to consideration what other midwives might or should do?). I was asking myself “well do we need to hurry this up for any reason?” (DMP: Evaluating treatment options)(MBP: Reflexive practice). I (slight hesitation) couldn’t really think of any convincing reasons to do rupture the membranes at that point (DMP:}

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Ruling in hypothesis and evaluating treatment options using sound knowledge base. (MBP: Accountability for own professional behaviour & assumes responsibility for women/baby’s well-being in labour). I was checking the baby’s heart rate after every contraction and it was perfectly good (Cue) (MBP: Assumes responsibility for fetal well-being in labour) I could see fetal descent [membranes bulging at perineum (Cue) and obviously Kylie was now fully dilated because the baby”s head was coming (Cue) (DMP: Diagnosis).

Outcome

Kylie gave birth to her baby „in the caul“ and Sandra gentle broke the membranes.

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**The midwife demonstrated GOOD MIDWIFERY PRACTICE**

MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication

NA= Not applicable, NK=Not known,
Appendix 15

Background to Daisy’s Story (5.1.5)

Daisy is a direct entry midwife and has been a midwife for four and half years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives in this practice also provide a home birth service for selected women.

Daisy was the primary midwife for Ella, a multigravida woman. Ella’s first birth was by emergency caesarean. This pregnancy, Ella wanted a vaginal birth and continuity of care so chose the group midwifery practice. At 25 weeks Ella contacted Daisy to say she had not felt the baby move for a day. Fetal death was diagnosed. Ella was admitted the next morning; under the care of an obstetrician to the local hospital delivery suite to have her labour induced using misoprostal. The hospital agreed to support Daisy, as this was her first fetal death, so she could continue to care for Ella. Ella had had 4 misoprostal tablets and her membranes were still intact.

Daisy’s Story and Analysis

I spent many hours with Ella before she went in to hospital talking about what she wanted (Cue), her options for things such as how she wanted to deal with the labour pains she would experience (Cue) and what would happen throughout the whole process (Cue) (MBP: Shared known common goal – uses power integratively to empower Ella to make informed decisions via open and honest information sharing) (CF: Continuity of care).

Early evening Ella’s behaviour changed (Cue) and there wasn’t another midwife in the room to ask (Cue) (DMP: Uncertainty of cue interpretation and/or hypothesis) (MBP: Lack of skills in negotiating seeking advice from senior midwifery colleagues). The pain Ella was experiencing was increasing (Cue). I asked if she wanted any pain relief as previously discussed but she declined (MBP: Known shared goal - midwife/woman partnership relationship) (DMP: Cue acquisition, interpretation and evaluating treatment options). Then Ella started to make some sort of different noises (Cue), which I thought were similar to the grunting women do when they’re in 2nd stage or getting ready to push and to birth (Intuition: Uses intuition and previous knowledge and experience to support hypothesis). Ella’s agitation level was different (Cue). She was quite emotional (Cue), which she could be in any stage, but her agitation level accelerated a little (Cue). I had never been in this situation [where there is fetal death] before and I wasn’t sure what to expect (Cue) My instinct was telling me something was
happening but I wasn’t sure what. The signs Ella was showing made me think maybe she question if she was in transition or 2nd stage (MBP: Reflexive practice) (Intuition: Uses intuition and previous knowledge and experience to support hypothesis).

Ella said she wanted to use the bathroom. I thought maybe Ella wanted the privacy the bathroom could offer her (Intuition: Uses intuition to evaluate hypothesis options) but then again maybe she just wanted to use the toilet. But Ella was definitely showing signs of being in 2nd stage (DMP: Uncertainty of cue interpretation and/or hypothesis). Then I started to think, this baby when its born is going to be small so the cervix won’t need to be fully dilated for her to birth (DMP: Accurate knowledge base – used to rule in a hypothesis 2). I thought, if Ella needs to open her bowels, it is possible it would not take too much to push the baby out whilst using the toilet (DMP: Accurate knowledge base to support hypothesis 2). This would be terrible for Ella, to not only suffer the death of her child but also to birth it down the toilet.

Something told me, with all the signs Ella was showing and the size of her baby, that I should take some action (DMP: Accurate knowledge base to support hypothesis 2). I decided the right thing to do was to ask Ella if she would mind if I put a bedpan over the toilet (Intuition: Uses intuition to evaluate treatment options, make a decision and implement planned care). I didn’t tell Ella why I suggested this or my thinking as she was emotional enough without me adding extra stress (MBP: caring nurturing and protective). Ella agreed.

Outcome

As Ella opened her bowels her membranes broken and she birthed her baby in to the bedpan rather than the baby being born into the toilet. It was the right thing to do; I made the right decision.

### QUESTIONS DERIVED FROM ANALYSIS

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Re: MIDWIFERY PRACTICE

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NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 16

Background to Adelaide’s Story (5.2.1)

Adelaide has worked for 33 years as a midwife. She is currently working in a birth centre attached to a consultant-led public hospital located in a major city. When the birth unit is quiet, Adelaide is required to work on the hospital's delivery unit where this story occurred.

Adelaide arrived at 7 am and began caring for Rosalie, a primigravida. Rosalie had laboured all through the night and had been diagnosed, two hours previously, as being in 2nd stage labour. Rosalie had an epidural, a CTG and had been actively pushing following verbal cues from the midwives since full dilation. The whole family were aware that the doctors were planning to conduct an assisted birth shortly.

Adelaide’s Story and Analysis

When I entered Rosalie’s birthing room I spent a few minutes getting to know Rosalie, Mike and Joan (MBP: Trying to establish a rapport with Rosalie and support people) (CF: Not a continuity of care model). I tried to engage them in conversation and basically get a feel of how Rosalie was feeling about the way her labour and birth was progressing (MBP: Trying to establish a shared common goal with the Rosalie). I looked at Rosalie’s position on the bed (Cue), her colour (Cue), whether she was perspiring (Cue), whether she was exhausted (Cue) or was she happy or sad (Cue)? In essence I assessed at her general well-being and her mental state (DMP: Cue interpretation, ruling in a hypothesis 1). I looked at the support people (Cue) and asked myself: Are they in a chair snoring (Cue)? Are they exhausted from supporting Rosalie all night (Cue)? (DMP: Cue acquisition ruling in hypothesis 2) I also assessed the room for clutter or whether it was disorganised (CF: Is the birthing environment a sanctuary or a surveillance room?) (DMP: Cue acquisition ruling in hypothesis 3).

I saw when Rosalie was pushing there was a tiniest little bit (emphasis) of fetal head on view (Cue), but Rosalie was so exhausted after labouring all night (Cue) that her pushing was not effective at progressing delivery of her baby (DMP: Using focused cue information to rule in hypothesis 4 and make a diagnosis). I knew the doctors, [once the shift changed in approximately 30 minutes], would come and do an assisted birth (Cue).

As Rosalie was pushing with each contraction (Cue) I sensed Rosalie did not want to throw the towel in and have an assisted birth (Intuition: Adelaide uses her intuition to make diagnosis) (MBP: Does not establish if this is what Rosalie wants –Lack of
rapport with her). I thought, in this instance, I had to do something; we (emphasis) somehow had to push this baby out unassisted (DMP: Cues clustered to rule in the diagnosis that a quick normal birth is possible). I knew that if I got the lithotomy poles adjusted to suit Rosalie’s anatomy (Cue) and she could just let her knees flop whilst supporting behind the back of her legs she would be able to get much more “push” into her bottom and get this baby round the bend of the pelvis (DMP: Uses accurate knowledge base to strengthen ruling in the decision) (MBP: Understanding of optimising psychophysiology). My decision was based on looking at the whole picture of Rosalie (Cue) and my knowledge of the body (Cue). I’ve observed placing the woman in the lithotomy position work in quite a few times in my experience (Cue) and from observing other midwives (Cue) (DMP: Uses knowledge and experience to strengthen ruling in the decision). Once I’d made my decision I explained to her what I wanted to do.

**Outcome**

Within twenty minutes of Rosalie agreeing to use the lithotomy poles she birthed her child unassisted.

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<th>QUESTIONS DERIVED FROM ANALYSIS</th>
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9. Prescribes and/or implements planned care | X
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11. Uses intuition to aid decision-making | X
12. Links intuition to cues and reasoning | X
**Overall: CLINICAL REASONING = GOOD | X**

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**The midwife demonstrated GOOD MIDWIFERY PRACTICE | X | MD**

NA = Not applicable, NK = Not known, MG = Midwifery guardian, MD = Midwifery domination, MA = Midwifery abdication
Appendix 17

Background to Nicoli’s Story (5.2.2)

Nicoli has been a midwife for 10 years. He works in a consultant-led public hospital in a major city.

Madj, a RN who was a senior student midwife, and Nicoli were caring for Jane, a multigravida woman, throughout the morning shift. During that time he had established a rapport with Jane who was now in late 1st stage labour with a CTG in-situ. Nicoli left Madja and Jane in the birthing room to give handover to the midwives who had arrived to start the late shift. When he returned to the room he found a doctor preparing to take a fetal blood sample. Apparently Madja had consulted the doctor because the CTG printout was showing decelerations suggesting the baby was experiencing some distress. This doctor was not covering birth suite but happened to be passing when Madja was looking for some support. Once the fetal blood sampling had been completed, Nicoli left the room a second time to complete the clinical handover. When he returned to the birthing room the medical practitioner was still present.

Nicoli’s story and Analysis

I finished the handover and went straight back to the birthing room [for the second time]. The doctor wanted to do a vacuum extraction (DMP: Doctor made a decision). A second doctor, who was on for birth suite, came into the birthing room seeking clarification of what was happening. The second doctor was junior to the first doctor, so once the situation had been explained the junior doctor deferred to the senior doctor’s decision. When I heard the first doctor repeat that he was going to do a vacuum extraction I asked him if Jane’s cervix was fully dilated” (DMP: Cue information) He said, “Yes” (cue).

Jane had only been in 2nd stage for no more than 15 minutes at this point (Cue) I was thinking several things: the CTG that I looked at before I left the birthing room wasn’t that bad there had been early decelerations from the baseline of around 140bpm to 115bpm lasting around 15-30 seconds; (DMP: Nicoli cue clustering - ruling in hypothesis CTG not normal but not very worrying either) the fetal blood sampling test had showed the baby was coping as the ph was within normal limits (result was 7.35) (DMP: Cue clustering- used to assist in ruling in hypothesis -Blood analysis normal limits); the fetal head was low (Cue); Jane’s [cervix] was fully dilated (Cue), she did not have an epidural (Cue) and had birth vaginally before (Cue) so I could see no reason why she
could not push the baby out vaginally (DMP: Cues clustered to rule in the diagnosis that a quick normal birth is possible).

I made the decision Jane did not need a vacuum extraction and that she could have a vaginal birth (DMP: Decision). I physically pushed the senior doctor out the way, turned to Jane ignoring the junior doctor, and said “We need to push this baby out now before these doctors pull it out.” (MBP: Is assertive with Jane and the doctors, uses power dis-integratively)

The two doctors just looked at me but kept silent. I was forceful in encouraging Jane to push as she had to push out this baby with the threat of these two doctors wanting to do a vacuum extraction hanging over her. Also the two doctors stayed in Jane’s birthing room to watch (CF: Not a peaceful, quiet birthing environment).

Outcome
Fetal decelerations persisted, although they had changed to late decelerations, throughout the time it took Jane to push her baby out vaginally. The baby was fine at birth with good Apgars. The doctors left once the birth was over.

Nicoli’s Reflection
This normal birth was being taken away from Jane and I thought that wasn’t fair. I (hesitation) felt bad in that if I had stayed in the room I might have been able to avoid the doctors being made aware of anything. But the doctors were trying to take the delivery away from me (emphasis) and Madja. I had to take back control of the birth (MBP: Power and ownership issues, not woman-centred).

<table>
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<td>1. The birthing environment warm, quiet and peaceful?</td>
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<td>2. The standard model of care was midwifery caseload?</td>
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<td>4. The woman’s goals for labour/birth were respected by doctors or senior midwives</td>
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<td>5. Policies appeared to be evidence-based?</td>
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<td>1. Accurate knowledge base in line with best evidence</td>
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appears to be comprehensive

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Re: MIDWIFERY PRACTICE

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The midwife demonstrated GOOD MIDWIFERY PRACTICE X MD

NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 18

Background to Maggie’s Story (5.3.1)

Maggie has been a midwife for 28 years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from this practice also provide a home birth service for selected women. Maggie was the primary midwife for Carla, (a multigravida) who is a personal friend and a midwife. Carla doubted her body’s ability to give birth throughout labour. Alison, a midwife and a friend of Carla and Maggie’s accompanied her. Maggie mentored Carla and Alison through their midwifery training.

Maggie’s Story and Analysis

I just knew Carla had gone through that transition stage (Intuition: uses intuition to form a hypothesis 1 then looks for cues) because she’d been really distressed (Cue) and very unsure of herself (Cue), and I could hear she was occasionally grunting at the height of her contractions (Cue). Carla became agitated thinking she wasn’t in 2nd stage or ready to birth (Cue) and asked if I should [vaginally] examine her to see where she was.

My first thought was: I normally trust a woman’s judgement and when the woman says to me “I’m concerned I don’t think it’s time”, I normally trust them and often they are right (MBP: Trusts a woman and her knowledge of her own body). But in my experience, particularly with midwives in labour, they often second-guess themselves and often misread their body signs (DMP: Knowledge and experience used to strengthen potential treatment options). I wasn’t looking closely at Carla so I don’t know whether there were any other physical signs of 2nd stage to be seen such as: fetal descent (Cue) or perineal bulging and anal pouting (Cue). To me it was very obvious Carla was in 2nd stage (Intuition: Using intuition to support hypothesis 1). Carla was saying that she was getting a lot of perineal pressure (Cue) DMP: Focused cue acquisition and interpretation to support intuitive hypothesis). I expected her to birth well because she birthed well twice before (Cue) (DMP: Using knowledge and experience to support hypothesis 2).

My dilemma was: should I examine Carla to check if she was in 2nd stage or not? I was aware that Carla would have performed a vaginal examination on a woman to establish 2nd stage (Cue) so I was questioning myself whether I needed to act as she would have done (MBP: Reflexive practice -taking in to consideration what other midwife/midwives (in this case the Carla) would do) (DMP: Evaluating treatment options). I was the senior midwife in the room so I felt there was more pressure to get it [the diagnosis] right (emphasis) (Cue) I suppose I didn’t want to make a mistake so, I guess I was questioning my thinking carefully and looking at what decisions I was making (MBP: Accountability for own professional behaviour –reflexive practice –
but worried about being judged negatively by Jane and Carla). I started to ask myself, is the baby in a mal-presentation? (Cue) Is the cervix not fully dilated? (Cue) Do I need to diagnose that there is something holding birth of the baby up? (Cue) Can I wait a little while longer as Carla has only [potentially] been in 2nd stage 15-20 minutes? (Cue). I knew there was no reason to suspect these as I had done a palpation at the beginning of labour: I had seen the [emotional] signs of 2nd stage (DMP: Ruling in and ruling out hypothesis to support final decision). Maybe if I could get Carla to relax enough the [fetal] head would come down deep enough, the baby would rotate and the cervix would fully dilate around the head naturally and birth would happen, especially in a woman who has had two children before (MBP: Awareness of optimising psychophysiology – reflexive practice). (DMP: Evaluating assessment options using knowledge and experience). I knew I didn’t need to examine her (DMP: Decision); I felt (emphasis) she was ready to birth (Intuition: Using intuition to form a hypothesis). I told Carla I didn’t need to and would not examine her (DMP: Implemented planned care).

I knew Carla very well I just held her close to me, telling her to trust her body, let go of negative thoughts, feel the baby coming down and just let it [the birth] happen (MBP: Understanding of optimising psychophysiology, uses her power integratively to empower Carla to trust her body to birth her baby).

Outcome

Carla gained the strength and belief that she could birth her baby, which she did very shortly. Carla said that having me talk to her in such a calm and knowing way empowered her to believe in herself again and that she could trust her body to let the baby be born just like her body had for previous babies.

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<td>1. The birthing environment warm, quiet and peaceful?</td>
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<td>2. The standard model of care was midwifery caseload?</td>
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<td>3. There are enough midwives to provide 1-to-1 care in labour?</td>
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<td>4. The woman’s goals for labour/birth were respected by doctors or senior midwives</td>
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<tr>
<td>1. Accurate knowledge base in line with best evidence</td>
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<td>2. Cue acquisition –</td>
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appear to be comprehensive | them but omits them
---|---
3. Cue clustering – appears to be comprehensive | X
4. Cue Interpretation – Generating multiple hypotheses – if relevant | X
5. Focused cue acquisition – if needed and relevant to hypothesis | X
6. Ruling in and Ruling out hypotheses – if relevant | X
7. Making a diagnosis | X Makes poor decision
8. Evaluate treatment options relevant to the diagnosis – if relevant | X
9. Prescribes and/or implements planned care | X
10. Evaluates outcomes | X
11. Uses intuition to aid decision-making | NK
12. Links intuition to cues and reasoning | NK

**Overall: CLINICAL REASONING =GOOD** | X

**Re: MIDWIFERY PRACTICE**

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<td>2. Shares a common, known goal with the woman</td>
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<tr>
<td>3. Trust the woman and her body</td>
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<tr>
<td>4. Maintains rapport with the woman appropriately</td>
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<td>5. Maintains rapport with the support people appropriately</td>
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<td>12. To what extent does the midwife show reflexive practice</td>
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<td>13. When the woman and midwife disagree about care the midwife takes appropriate action (documentation and consultation)</td>
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NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA=Midwifery abdication
Appendix 19

Background to Rene’s Story (5.3.2)

Rene is a direct entry midwife and has been qualified for two years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from this practice also provide a home birth service for selected women. Rene was primary midwife for Dimity, a primigravida. Throughout Dimity’s pregnancy they discussed her history of sexual abuse and the request that vaginal examinations not be performed by male doctors. The consultant male obstetrician, Mohammed, was notified antenatally.

Rene’s Story and Analysis

At this point in the story, Dimity was labouring in a quiet, calm and semi dark environment with Keith massaging her back (CF: Birth territory represents a sanctuary). I sensed by the way Dimity’s behaviour was changing she was either in transition or in 2nd stage (Intuition: Uses intuition to form a hypothesis then looks for cues/evidence). Dimity was restless (Cue) and her vocalisations were changing (Cue) and occasionally she was grunting (Cue) (DMP: Collected cues, interpreted them in order to support intuitive hypothesis). I listened to the fetal heart rate using a Pinnard and it was fine (Cue) (MBP: Assumed responsibility for fetal well-being).

Suddenly Mohammed [obstetrician] opened the birthing room door flooding the room with bright light (Cue) (CF: Mohammed showed no awareness of optimising Dimity’s birthing territory). Mohammed told Dimity she was taking a long time to birth so he wanted to examine her to see what was happening (DMP: Mohammed requires measurable evidence in order to form a hypothesis) (MBP: Mohammed uses power dis-integratively- inappropriate assertion acting paternalistically - does not trust Dimity’s body to birth). Dimity had only been in labour approximately eight to nine hours. Dimity looked frightened but said “no”. Mohammed repeated his need to do an examination but this time turned his back on Dimity and prepared to put on some gloves (MBP: Inappropriate rapport and assertion with Dimity). Dimity looked at me and started to become upset. Keith looked at me too (MBP: Seeking to re-establish known shared goal with Rene – No vaginal examinations by males). I felt they were looking for me to advocate for them, to stop something happening they did not want (Intuition: Uses intuition to reach conclusion that Dimity is expecting her to embrace her professional responsibility to act as an advocate for her and Keith).

I told Mohammed I did not think Dimity needed to be examined as the fetal heart rate was fine (Cue), the liquor draining was clear (Cue) and I thought she was in 2nd stage (DMP: Collected cues, interprets them in order to support intuitive hypothesis and make a decision to challenge Mohammed). Mohammed said that he could confirm if
Dimity was fully dilated or not by doing the examination (DMP: Evaluating treatment options-wishing to gather empirical evidence to rule in or rule out hypothesis) (MBP: Mohammed uses disintegrative power to dis-empower Rene). For the third time I said it the vaginal examination was not necessary (MBP: Is accountable and working within her professional scope of practice, but is not very skilful in finding alternative methods of negotiating with Mohammed rather than in front of Dimity and Keith) but Mohammed ignored me and walked towards Dimity asking her to move from the floor mat on to the bed (MBP: Disintegrative power towards both Dimity and Rene, not having open and honest information sharing which is dis-empowering Dimity from making an informed decision). By this time both Dimity and Keith were visibly distressed and anxious (Cue). So I knelt on the floor mat with Dimity and Keith (CF: Awareness, understanding and respect for their „birthing space” on the mat) and said, “Dimity it basically comes down to your choice, you can say no if you don’t want to be examined” (MBP: Uses power integratively, using honest and open communication which empowers Dimity, to take back the power and her birth-professional responsibility).

**Outcome**

Dimity turned to Mohammed and said „NO (emphasis) I don’t want to be examined”. Mohammed threw his gloves off and stormed out of the room. Approximately 45 minutes after Mohammed left Dimity birthed her baby on the floor mat.

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**Re: MIDWIFERY PRACTICE**

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**The midwife demonstrated GOOD MIDWIFERY PRACTICE**

NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 20

Background to Rose’s Story (5.4.1)

Rose has been a midwife for 10 years. She is currently working in a group midwifery practice as part of an attached birth centre in a major city. The midwives from the practice also provide a home birth service for selected women.

Rose’s story occurred when, as primary carer for Tia, (a primigravida), an epidural was requested. Tia was given information what having an epidural would involve, the positive and potential negative implications. As per birth centre policy, Tia was to be transferred to the hospital delivery suite. The transfer took approximately 30 minutes to arrange. Rose continued to care for Tia once she was transferred to the delivery suite. At this point in the story, as per protocol prior to an epidural, the CTG had been commenced and Rose had performed a vaginal examination (VE). The VE showed Tia’s cervix was fully dilated and that the fetal head was really low in the pelvis.

Rose’s Story and Analysis

I explained the [VE] finding to Tia and Rod and the different options she had (CF: Awareness of organisational policy governance) (MBP: Using power integratively via information sharing to empower Tia to make an informed decision) (DMP: Accurate knowledge base). Tia decided that she would forego the epidural now that she was fully [dilated] (MBP: Using power integratively via information sharing to empower Tia to make an informed decision). I decided I needed to let the labour staff and the anaesthetist know my findings and Tia’s decision so I left the delivery suite room (MBP: Informs medical staff and senior midwifery staff – collaboration –skills in negotiating). Also I decided that I needed to ask another midwife from my team to and take over from me as I had now reached 12 hours of practice (Cue) (DMP: Uses previous cues to rule in hypothesis). Hospital policy states we must be relieved after 12 e hours (CF: Awareness of organisational policy governance). I knew the baby would be born soon (DMP: Hypothesis formation) but I was absolutely shattered and felt I needed some help (MBP: Awareness of her professional accountability and responsibility). To make the phone calls and let the labour staff know took me around 15 minutes.

When I came back in to the room, Tia was involuntary pushing with the contractions (Cue) and there was about 20cents worth of fetal head on view (Cue) (DMP: Focused cue acquisition). I looked at the CTG and it was showing fetal brachycardia of around 70 beats per minute [bpm] and it was not returning to its previous baseline of around 110 bpm (Cue) (DMP: Focused cue acquisition, ruling in a hypothesis). The bradycardia was about two –two and half minutes long (Cue). I pulled the emergency buzzer
requesting urgent help (DMP: Evaluated treatment options and implemented plan care) (MBP: Assumes responsibility for fetal wellbeing).

As I was opening the pack to get the episiotomy scissors, a junior labour staff midwife came in. She helped me prepare the episiotomy equipment as I was trying to explain to Tia that the baby was not coping very well with the pushing and needed to be born now and that I was going to cut an episiotomy (MBP: Appropriate assertion/rapport with Tia – sharing information) (DMP: Evaluated treatment options, decision and implemented plan care). I infiltrated and cut the episiotomy (DMP: Implement planned care). The baby slipped out with the next contraction (begins to become upset).

**Outcome**

The baby was born very "flat" Apgars around 1-2. I initiated resuscitation, whilst the junior midwife watched asking what should she do? I asked her to get a neonatologist. Approximately two minutes later a neonatologist arrived and the baby was intubated and transferred to the Special Care Nursery. The cord blood showed the baby was acidotic (ph <7.2). The baby suffered two fits the next day and remained in the Special Care Nursery for six days (becomes quite upset).

**Rose’s Reflection**

I should have not left the room to speak to the labour ward staff or phone to ask for someone from my team to take over from me. If I had stayed in the room I would have seen the bradycardia sooner and could have acted straight away. I could have called for help sooner and the neonatologist could have been there at the birth. It was a lapse in judgement, maybe because I was so shattered. I regret my decision especially as I knew the baby was going to be born soon (starts to become tearful).

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<td>2. The standard model of care was midwifery caseload?</td>
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<td>3. There are enough midwives to provide 1-to-1 care in labour?</td>
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<td>4. The woman’s goals for labour/birth were respected by doctors or senior midwives</td>
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230 of 278
1. Accurate knowledge base in line with best evidence X
2. Cue acquisition – appears to be comprehensive X
3. Cue clustering – appears to be comprehensive X
4. Cue Interpretation – Generating multiple hypotheses – if relevant X
5. Focused cue acquisition – if needed and relevant to hypothesis NK
6. Ruling in and Ruling out hypotheses – if relevant X
7. Making a diagnosis X
8. Evaluate treatment options relevant to the diagnosis – if relevant X
9. Prescribes and/or implements planned care X
10. Evaluates outcomes X
11. Uses intuition to aid decision-making NK
12. Links intuition to cues and reasoning NK

Overall: CLINICAL REASONING =GOOD X

Re: MIDWIFERY PRACTICE

1. Stays in the room with the woman in labour X
2. Shares a common, known goal with the woman X
3. Trust the woman and her body X
4. Maintains rapport with the woman appropriately X
5. Maintains rapport with the support people appropriately X
6. Appropriate assertion with the woman and support people X
7. Honest and complete information sharing with woman/partner X
8. Uses power integratively to promote the woman’s empowerment X
9. Accountability for own professional behaviour in accordance with professional frameworks X X She left the room at a crucial time
10. Skills in negotiating with medical staff or senior midwifery staff NK
11. Assumes appropriate responsibility for woman/baby’s well-being in labour X X Left room
12 To what extent does the midwife show reflexive practice NK
13. When the woman and midwife disagree about care the midwife takes appropriate action (documentation and consultation) NK
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<th>14. The woman is the final decision-maker</th>
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<tr>
<td>The midwife demonstrated GOOD MIDWIFERY PRACTICE</td>
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<tr>
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Appendix 21

Background to Maggie’s Story (5.4.2)

Maggie has been a midwife for 28 years. She is currently working within a group midwifery practice as part of an attached birth centre in a major city. The group midwives also provide a home birth service for selected women. Maggie was the primary midwife for an Afghani woman Raja a primigravida. Raja and Mohammed, her partner speaks quite good English. Raja and Mohammed deferred to Zita: Raja’s, non-English speaking, Mother-in-law who accompanied them to the birth centre.

Maggie’s Story and Analysis

I had discussed labouring and birthing positions with Raja ante-natally (CF: Continuity of care) (MBP: Shares known goal with Raja and offers birthing stool). In the Afghan culture women believe a birthing stool is quite a good place to labour (Cue). Raja used the birthing stool in first stage and 2nd stage (DMP: Evaluated treatment options and implemented) (MBP: Shares known goal with Raja and offers birthing stool). She found it a very comfortable position to be in and cope with labour [pains] and pushing (Cue) (DMP: Evaluation of outcomes). Raja was pushing for quite a long time (Cue).

I felt unhappy with Raja being on the birthing stool for so long [approximately a total of 4-6 hours] because research has shown that in 2nd stage you really shouldn’t sit on birth stool for a very long time because of the risk of perineal oedema (DMP: Accurate knowledge base in line with best practice) and that’s what I’ve found in practice (DMP: Using experience to confirm empirical knowledge). I could see in the mirror under the birthing stool that Raja’s perineum was becoming quite oedematous (Cue) (DMP: Ruling in hypothesis and making a diagnosis of perineal oedema). I tried to encourage Raja to come off the birthing stool and go forward and kneel (DMP: Evaluating treatment options and trying to implement the planned care) (MBP: Assuming responsibility for Raja’s well being during labour, but does not have open honest discussion as to why she wants Raja to move – uses power disintegratively), but she didn’t want to move (CF: Raja has found a birthing position she feels comfortable with). There was much discussion between Raja, Mohammed and Zita. Mohammed told me his Mother said “Raja needs to stay on there [on the birthing stool] because the baby needs to come out” (Cue). Zita was continuously touching Raja encouraging her to stay on the birthing stool. (Cue) (MBP: Zita is using her power disintegratively with Raja and midwife).
It was very difficult for me, I felt challenged and questioned in my practice and knowledge and decision-making (Cue) (MBP: Feeling disempowered) but I didn’t want to be disrespectful towards Zita because the dynamics in the room were: Zita was very much managing the labour and where Raja should be in labour: the birthing stool (Cue) (MBP: Is not accepting her professional accountability as a midwife -relinquishing her role –poor negotiating skills). To me culture is very important especially as Raja only has Mohammed’s family in Australia and Raja has to go home with that family (MBP: Cultural safety). For me to cause Zita to lose face in front of her family was not something I was prepared to do (DMP: Ruling in hypothesis, evaluating treatment options and makes a decision). So I left Raja on the birthing stool (DMP: Decision).

Outcome

Raj birthed on the birthing stool and experienced severe perineal trauma which required medical suturing in theatre.

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NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 22

Background to Hannah’s Story (5.4.3)

Hannah has been a midwife for four years. She has two jobs: one as an independent midwife, and the other as a midwife in a consultant-led private hospital in a major city.

Hannah was the independent midwife for Karma who lived in a temporary structure three quarters an hour inland from the nearest town. Karma had free birthed her four children with her partner Jed. The last birth had been difficult so Karma and Jed wanted a midwife to assess, antenatally, that the baby was in a good position for birth. Hannah agreed. Hannah met Karma, Jed and the four children a couple of times in the antenatal period. At the antenatal appointments Jed always listened to the fetal heart rate using his ear. Hannah respected this and did not listen to the fetal heart rate. Hannah would only attend this birth if Karma and Jed felt it was necessary. At four in the morning Jed phoned asking Hannah to come as Karma had been in labour and pushing for an hour or two. Jed could see some fetal head at Karma’s perineum which had become swollen. They thought the baby was somehow stuck and they were worried Karma was going to suffer a prolapse.

Hannah’s Story and Analysis

When Jed phoned and I was on my way to their home, I was actually having palpitations (Cue). I hadn’t thought ahead that something awful could happen (Cue) as I was supposed to just be a kind of back up person. The baby must have sitting on Karma’s perineum at least for one-two hours plus the three quarters of an hour it took me to arrive, if not longer (Cue).

As Karma had free birthed all her other children I wanted to be careful not take any control away from her or Jed because I felt that control was a big issue for this family and they were worried what a midwife might do (MBP: Hannah is sharing a common goal with Karma and Jed but appears more concerned not to cause conflict than discussing openly and honestly her professional responsibility/accountability). Karma and Jed were obviously not going to be interested in going to hospital anyway (laughs) (Cue) (Intuition; Based upon previous history of free-birthing).

When I got to the location where they lived Karma and Jed were both naked and I felt like the whole labour and birth was intimate experience between them, their relationship and their family (Intuition: Awareness of Jed and Karma’s relationship) (CF: Karma and Jed have created a birthing environment that they feel safe and peaceful within). So obviously they felt a person coming into the room, as friendly as I could try
to be (Cue), and staying in the background as often as I could be (Cue), was still an intruder (Intuition: Hannah uses intuition to reach a the conclusion that she was being perceived as an outsider yet there are no explicit signs upon which to base her feelings) (MBP: Lack of midwife/woman partnership relationship). I sensed the tension in the air which made me feel like I wasn’t welcome in their space (Intuition: Power issues- using intuition) but in a way having known Karma and Jed all the way through their pregnancy I understood a bit about what they wanted and where they were coming from (MBP: Continuity of care, shares a common know goal with Karma). What I do was sit at the other side of the structure for that whole birth wondering how I could be less intrusive (DMP: Evaluation of treatment options) (MBP: Reflexive in practice –but limited). (Intuition: Hannah uses intuition to reach a the conclusion that she was being perceived as an outsider yet there are no explicit signs upon which to base her feelings) (MBP: Lack of midwife/woman partnership relationship).

Jed said he had just listened to the fetal heart rate, using his ear, and it was fine (Cue). I took that to mean „don’t listen to the fetal heart” (Cue) so I didn’t (MBP: Does not assume responsibility for baby’s well- being & does not show accountability for own professional behaviour nor maintains appropriate assertion or communication with Jed or Karma). Part of my decision not to listen to the fetal heart was that I could see the baby sitting on Karma’s swollen perineum (Cue) (Using a cue to ruling in hypothesis and makes a decision) (MBP: Does not assume responsibility for baby’s well- being & does not show accountability for own professional behaviour). I felt like the baby was going to come out any second (Cue) (Intuition: Using experience/guess work to form a hypothesis 1) but I sensed there was some kind of fear stopping the baby from birthing (Intuition: Uses feelings to form hypothesis 2). I sat on the floor at the other side of the structure and gently said to Karma “Your baby is about to be born. Don’t be scared. You can push don’t worry. You don’t need to worry about a prolapse” (MBP: Optimising psychophysiology-uses power integratively to empower Karma to trust her body to birth) (CF: Trying to creating a safe environment for Karma).

I gave Karma the emotional reassurance she needed to let go and birth her baby. I actually never put my hand on the mother or a hand on the baby at all (MBP: Abrogation of professional accountability/responsibilities) (DMP: Evaluated outcomes).

**Outcome**

Karma free birthed her baby in to Jed’s hands whilst Hannah sat against the opposite side of the structure.

**Hannah’s reflection**

I work within the Australian College of Midwives consultation and referral guidelines knowing that the woman can choose another path, it’s her choice (MBP: Trying to be convergent with what woman wants at expense of professional responsibility- Lack of awareness that she has relinquished the role of midwife and is working outside a
safe scope of practice: Lack of understanding what the referral guidelines are or what collaboration means). Jed and Karma wanted a midwife not to intervene (Cue) or interfere (Cue) but for me to sit on my hands (Cue) and do nothing (Cue) which all great midwives need to learn to do (*laughs confidently*) (MBP: Trying to be convergent with what woman wants at expense of professional accountability/responsibility). (DMP: Collected cues in order to make a diagnosis which resulted in poor decision-making). I thought this is what a midwife is suppose to do (*laughs confidently*) just to be a security blanket in a way and the woman to feel that she did give birth herself. I felt I did a good job (MBP: Reflexive practice).

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<td>1. The birthing environment warm, quiet and peaceful?</td>
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<td>5. Policies appeared to be evidence-based?</td>
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<td><strong>Overall: This context represents a BIRTH SANCTUM</strong></td>
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| 1. Accurate knowledge base in line with best evidence | NK |
| 2. Cue acquisition – appears to be comprehensive | X |
| 3. Cue clustering – appears to be comprehensive | X |
| 4. Cue Interpretation – Generating multiple hypotheses – if relevant | X |
| 5. Focused cue acquisition – if needed and relevant to hypothesis | NK |
| 6. Ruling in and Ruling out hypotheses – if relevant | NK |
| 7. Making a diagnosis | X |
| 8. Evaluate treatment options relevant to the diagnosis – if relevant | X |
| 9. Prescribes and/or implements planned care | X |
| 10. Evaluates outcomes | X |
| 11. Uses intuition to aid decision-making | X |
| 12. Links intuition to cues and reasoning | X |
| <strong>Overall: CLINICAL REASONING =GOOD</strong> | X |</p>
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NA = Not applicable, NK = Not known, MG = Midwifery guardian, MD = Midwifery domination, MA = Midwifery abdication
Appendix 23

Background to Helen’s Story

Helen has been a midwife for 24 years. She currently works in a consultant-led public hospital in a regional city. Helen’s story occurred when she arrived on a morning shift. Jacqui (multigravidia) had been labouring all night, and was draining meconium stained liquor. The night staff had minimal contact with Jacqui. Jacqui wanted a vaginal birth and intermittent fetal auscultation. Helen first met Jacqui, (whose first birth was by emergency caesarean section) during 2nd stage labour.

Helen’s story and Analysis

I introduced myself to Jacqui and she made it clear that she was annoyed she had been left alone most of the night and now there was another new person involved in her care (MBP: Lack of midwife/woman partnership with Jacqui). I felt there was animosity towards me (Intuition; Helen uses intuition to reach the conclusion there is animosity towards her). I certainly didn’t want to do anything that was in contravention to her birth plan (MBP: Shares common goal with Jacqui, but appears to be more concerned with not to cause conflict than discussing openly and honestly with Jacqui about her goals), so I retreated into my little cupboard (MBP: Helen does not accept accountability for her professional responsibility – Does not maintain appropriate rapport/negotiation with Jacqui) where I made sure I had everything ready in case something didn’t go quite right (DMP: Uses knowledge base to prepare for possible eventualities). While I was hiding in the cupboard trying to work out how I was going to find some common ground with this girl (MBP: Reflexive practice, trying find a means to establish appropriate rapport - Helen’s use of the term ’girl’ is patronising and appears integrative power issues). Jacqui went and sat in the dark on the toilet (CF Jacqui demonstrates her own goal for her birthing territory, warm, quiet and peaceful). I entered the toilet space and stood in the dark (MBP: I Helen enters Jacqui’s birthing territory and is seeking to connect or find rapport with Jacqui). I asked Jacqui if I could assess her progress by performing a vaginal examination and listen to the fetal heart rate as I was new on the scene and really needed to know what was happening (DMP: Needing to collect cues to form a hypothesis and treatment options) (MBP: Helen does not demonstrate trust in Jacqui and her body). Jacqui returned to the bed. The fetal heart rate was normal (Cue), but I had concerns as I could not determine on VE whether she was fully dilated or not (DMP: Uncertainty of cue interpretation), so I left the birthing room to report my findings to my colleagues and the registrar (MBP: Acknowledges her deficit in skills and seeks consultation/collaboration with fellow midwives and medical colleague). As I walked out the birthing room I noticed that the bath was full (Cue). At our hospital, the policy states if you are a „Vaginal Birth After Caesarean” section you are not allowed to have a water birth (CF: Policies normally govern practice).
I came back in to the room, a few minutes later, and Jacqui was in the bath with the lights turned off (CF: Jacqui has taken control of her birthing territory where she feels warm peaceful and safe). Jacqui had a contraction (Cue), she wasn’t expulsive (Cue), but her breathing had changed (Cue) and I thought we’re going to have a baby (DMP: Focused cue acquisition, ruling in hypothesis). She had another contraction (Cue); it was a little bit more expulsive (Cue) (DMP: Evidence for ruling in hypothesis). When the contraction was over, I put my hand on Jacqui’s shoulder and asked, “Would you like to get out the bath?” (MBP: Helen seems to not know how to negotiate/communicate decision-making with Jacqui). (CF: lack of knowing the woman, lack of continuity of carer in labour all contribute to the lack of MBP) Jacqui answered, “No, I’m quite comfortable here thank-you”. There was nothing else I could say (DMP: Reaches decision –leave Jacqui in the bath) (MBP: Helen chooses not to engage in honest and complete information sharing, failing to discuss the potential risks of having a water birth with the added risk factors Jacqui has – VBAC and meconium stained liquor: She appears afraid of conflict with Jacqui and relinquishes her midwifery role] but I was squirming inside as I am not water birth accredited (MBP: Helen chooses to withholds/gate keep this information using her power in a disintegrative way and in effect dis-empowering Jacqui from making an informed decision - Helen is aware that she is now entering territory that is outside her scope of professional practice).

I knew I had a mother who had a previous caesarean section (Cue), there was meconium-stained liquor (Cue), which requires continuous fetal monitoring as per policy (Cue) (CF: Hospital policy governing practice) and she was in the bath (Cue) I was thinking there had been no deviations in the fetal heart rates; Jacqui had no analgesic on board (Cue, Jacqui was not under the influence of narcotics). I decided I was just going to go with it let Jacqui have a water birth if that’s what she wanted. (DMP: focused cue acquisition, ruling in, ruling out resulting in making a decision) (MBP: Helen does not accept her accountability for her professional behaviour or that she is now working outside her professional scope of practice - Helen chooses to remain silent, using her power dis-integratively). I just thought if the birth goes well all well and good, if the birth goes pear-shaped I have to wear it. I could even lose my registration over this. I honestly thought about it in those seconds: I had to make a decision (MBP: Reflexive practice) (DMP: Evaluation of treatment options and outcomes). My decision was made in that I was doing something that was against hospital policy (CF: Helen knows she is working outside the organisational policy governance) I know I did the wrong thing (MBP: Aware that professionally she is working outside her scope of practice) but I very much did the right thing as I wanted the best thing for Jacqui (MBP: Midwife centred not woman centred: Acknowledges her own motivation/value to give Jacqui what she wanted -a water birth- influenced her decision-making).
Outcome

Helen did not call a second midwife as per hospital policy knowing she was working outside her scope of practice and did not want another midwife to be part of this. Jacqui gave birth in the water several contractions later.

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| Re: CLINICAL REASONING?         | -3          |
| 1. Accurate knowledge base in line with best evidence | -2          |
| 2. Cue acquisition – appears to be comprehensive | -1          |
| 3. Cue clustering – appears to be comprehensive | 0           |
| 4. Cue Interpretation – Generating multiple hypotheses – if relevant | +1          |
| 5. Focused cue acquisition – if needed and relevant to hypothesis | +2          |
| 6. Ruling in and Ruling out hypotheses – if relevant | +3          |
| 7. Making a diagnosis | Comment     |
| 8. Evaluate treatment options relevant to the diagnosis – if relevant | X           |
| 9. Prescribes and/or implements planned care | X           |
| 10. Evaluates outcomes | X           |
| 11. Uses intuition to aid decision-making | X           |
| 12. Links intuition to cues and reasoning | X           |
| Overall: CLINICAL REASONING =GOOD | X           |

<p>| Re: MIDWIFERY PRACTICE          | -3          |
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| 2. [\text{Comment}] | -1          |
| 3. [\text{Comment}] | 0           |
| 4. [\text{Comment}] | +1          |
| 5. [\text{Comment}] | +2          |
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NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 24

Background to Grace’s Story (5.4.5)

Grace has been a midwife for 30 years. She is currently working in Group Midwifery practice as part of an attached birth centre in a major city. Grace’s story begins when a colleague within the team called her into take over the care of Siobhan, a 17 year old primigravida. Siobhan had been in the 2nd stage labour and actively pushing for approximately 30 minutes. As the other midwife [Jade] was leaving, she said she had heard the fetal heart rate drop from around 120 beats per minute (bpm) to 80bpm using a Sonicaid and that it took approximately a minute-minute and a half to return to the baseline. As per policy, she had thought of transferring Siobhan to the hospital delivery suite but had not.

Grace’s Story and Analysis

Once I re-introduced my-self to Siobhan and Shayne (CF: Continuity of care), I asked if I could listen to the fetal heart rate, which I did using a Sonicaid (DMP: Acquiring empirical knowledge via cue acquisition). I heard no decelerations so I was thinking, in 2nd stage sometimes you do get decelerations in fetal heart as the baby comes through the pelvis (Cue) or as the baby’s head is crashing down on to the perineum (Cue) and then the heart rate will recover and be fine (DMP: Using knowledge and experience to rule in a hypothesis). So I was thinking the deceleration heard by Jade [previous midwife] was probably more mechanical, it was probably just a one-off and this baby is fine (Intuition: Uses knowledge and experience to make an intuitive diagnosis). I was also reassured by the colour of the liquor draining, as it was clear (Cue). If the liquor had been meconium-stained, that probably would have concerned me more because then I would have had another sign of fetal distress (DMP: Focused cue acquisition to support hypothesis and diagnosis). I listened intensely (emphasis) to the fetal heart rate probably for about another half an hour (Cue) intermittently (Cue) but not continuously. There were no more decelerations that I heard, it sounded really fine (Cue) (DMP: Focused cue acquisition to strengthen ruling in hypothesis and diagnosis).

I trusted and believed Siobhan could push her baby out and that she could do it without any problems (MBP: Trusting Siobhan’s body to birth her baby). The labour was progressing well (Cue). I could see fetal descent (Cue) so I knew the baby was going to be born soon (Cue) (DMP: Focused cue acquisition to rule in hypothesis 2), perhaps another half an hour, which is an okay time for a primigravida (DMP: Knowledge and experience used to support hypothesis 2). I also didn’t to traumatisi Siobhan by moving her from the birth centre to the hospital delivery suite (Cue) because we would have had to move at a really crucial time in her labour (Cue) as that has all sorts of
implications such as: maybe stalling her ability to push the baby out (Cue) or emotionally distressing her (Cue) or incurring a whole lot of really aggressive medical intervention (Cue). I didn’t want to bring in all those extra people (Cue) all the bright lights (Cue), all the noise (Cue), all the instruments (Cue) and disturb her whole sort of psyche of being (MBP: Understands optimising psychophysiology and importance of birth environment, trusting in Siobhan’s body to birth her baby –But uses her power disintegratively as does not have an open and honest discussion with Siobhan and Shayne thus disempowering her from making and informed decision).

In my thoughts was also my own need to create a wonderful birth experience for all women and if we moved, it could be destroyed (Cue). I was thinking I could help Siobhan get her baby out (MBP: Uses power disintegratively and becomes midwife centred rather than woman-centred). I made the choice to ignore the other midwife’s concerns and her intuition that was telling her that the fetal deceleration was out of context (CF: Continuity of care). I thought „no“, Siobhan and her baby will be all right here in the birth centre” and I decided not to transfer Siobhan to the hospital delivery suite (becomes quiet).

Outcome

Siobhan’s baby was born approximately an hour and fifteen minutes from when Grace took over their care. At birth the baby was very sick (becomes upset) and the baby didn’t breath. The baby needed resuscitating. A neonatologist, the nursery staff and another midwife were called. The baby remained in intensive care for several days, but appears alright now.

Grace’s Reflection

The outcome has led me to really question what I did (MBP: Reflexive practice). It was my responsibility to listen to what the other midwife was telling me. She knew the deceleration was out of context and was questioning it. When I walked in on the situation I didn’t have that sort of feeling (CF: Lack of continuity of care). I was thinking and more focused on the fact that I could help this woman get this baby out (MBP: Uses power disintegratively).

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Overall: This context represents a BIRTH SANCTUM

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### Re: CLINICAL REASONING?

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1. Accurate knowledge base in line with best evidence

2. Cue acquisition – appears to be comprehensive

3. Cue clustering – appears to be comprehensive

4. Cue Interpretation – Generating multiple hypotheses – if relevant

5. Focused cue acquisition – if needed and relevant to hypothesis

6. Ruling in and Ruling out hypotheses – if relevant

7. Making a diagnosis

8. Evaluate treatment options relevant to the diagnosis – if relevant

9. Prescribes and/or implements planned care

10. Evaluates outcomes

11. Uses intuition to aid decision-making

12. Links intuition to cues and reasoning

Overall: CLINICAL REASONING = GOOD

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### Re: MIDWIFERY PRACTICE

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1. Stays in the room with the woman in labour

2. Shares a common, known goal with the woman

3. Trust the woman and her body

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5. Maintains rapport with the support people appropriately

6. Appropriate assertion with the woman and support people

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10. Skills in negotiating with medical staff or

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NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Appendix 25

Background to Orchid’s Story (5.4.6)

Orchid has been a midwife for 36 years. She works in a consultant-led public unit located in a regional city. The midwives see the women at various times throughout their birthing journey but on an ad hoc basis. Orchid had met Sharma once antenatally, Sharma revealed she had been raped and requested that no men were to be involved in her care. The medical staff were advised. Orchid arrived to take over care for Sharma, a grand-multigravida, who had been in labour for several hours. The obstetrician and registrar on call this day were males.

Orchid’s Story and Analysis

At this point in the story, Sharma was lying over a bean bag and appeared to be coping very well with labour. I listened to the fetal heart rate using a Sonicaid and it was fine. For approximately an hour I just observed Sharma because I did not want to disturb her as she appeared to be very much focused on her labour and preparing to birth. After another 10-15 minutes Sharma said she had a strong urge to push and started pushing. I didn’t want to perform a vaginal examination to confirm the second stage, as per our hospital policy, as this was Sharma’s sixth birth and her previous history noted that the other five were relatively quick with second stages of about 5-15 minutes. Also I was concerned for her emotional well-being; I didn’t want to do a vaginal examination on a rape victim unnecessarily. Plus to do a vaginal examination effectively, I would have had to relocate her from the beanbag to the bed and I was reluctant to do that. It was a conscious decision not to perform a vaginal examination.

After approximately half an hour of active pushing, the fetal head was not on view, but I also didn’t care if she was fully dilated thinking that she would push any remaining cervix away. I believed she would birth the baby soon and the fetal heart rate was fine. Another half hour of active
pushing passed (Cue) and there was still not sign of the fetal head (Cue), no evidence of any anal pouting (Cue) or perineal distension (Cue), so I changed the plan and decided to perform a vaginal examination (DMP: Focused Cue acquisition to rule in/rule out a hypothesis, evaluate treatment options and make a decision) (MBP: Unsure what information was exchanged to empower Sharma to give informed consent). The findings were: Sharma had a very thick oedematous anterior lip of cervix (Cue) and was in a great deal of discomfort (Cue). I told Sharma I now needed to involved the medical team and they were all males (MBP: Uses power disintegratively telling rather than information sharing, disempowering Sharma). Sharma verbalised she was quite anxious about a male doctor coming in and became very distressed (Cue).

**Outcome**

The male doctor arrived and was very respectful towards Sharma. He repeated the vaginal examination with her consent. Sharma had an assisted birth.

**Orchid’s Reflection**

I should have, kept the clinical assessment cap to the fore-front realising that it was Sharma’s sixth birth (Cue) and she had been pushing for an hour (Cue) and I was not seeing any descent (Cue): no visible signs of progress (Cue). There had to be a reason (DMP: Focused cue acquisition trying to rule in a hypothesis). I should have checked rather than leave Sharma for a full hour of active pushing (voice soft) (DMP: Evaluates outcome of inaction). Instead I was guided by the „emotional health cap” (Cue) (MBP: Relinquishes the professional midwifery role) and I showed a bit of a maternalistic attitude, which was disrespectful of Sharma's ability to actually make the decision that a vaginal examination after half an hour was needed (Cue). By acting maternalistically I actually made Sharma more vulnerable to something she verbalised she was quite anxious about: involving male members of the medical team (Cue) (MBP: Reflexive practice taking in to consideration what her actions, decisions were and what they should have been?).

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<td>3. There are enough midwives to provide 1-to-1 care in labour?</td>
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<td>4. The woman’s goals for labour/birth were respected by doctors or senior midwives</td>
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5. Policies appeared to be evidence-based?  

**Overall: This context represents a BIRTH SANCTUM**

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**Overall: CLINICAL REASONING =GOOD**

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The midwife demonstrated GOOD MIDWIFERY PRACTICE X MD

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Appendix 26

Background to Henri’s Story (5.4.7)

Henri has been a midwife for 16 years but works primarily in administration. Henri was primary carer for Lyn, a primigravida, but a colleague [Lillian] had cared for Lyn for approximately 12 hours. During this time, Lyn had been transferred to the local consultant-led delivery suite because she was draining meconium stained liquor. A vaginal examination (done by medical staff) had determined Lyn’s cervix was fully dilated. When Henri and Amy entered the birthing room, Lyn had continuous fetal monitoring (CTG) in-situ and was being actively coached to push on the bed by Lillian. Amy was a new doula and a personal friend of Henri’s.

Henri’s story and Analysis

We re-introduced ourselves to Lyn and Tom (her partner) (CF: Continuity of care) and Lillian left. The atmosphere in the birthing room was like a train wreck (Cue), because labour hadn’t been going as Lyn wanted (CF: Birthing environment not warm quiet and peaceful). Lyn and Tom were obviously fed up and it was almost like (hesitation) they had given up fighting for what they wanted (Cue) (Intuition: Henri uses intuition to form a hypothesis). Approximately an hour after we arrived Lyn felt the natural urge to push (Cue) and was pushing really well (Cue). There’s a hospital’s policy, which states that following an hour of active pushing, if there is no progress, medical assessment and possible intervention is required (CF: Organisational policy which governs practice).

I saw Lyn’s labia and vagina were becoming more oedematous as time as passing (Cue) and she had been fully dilated (Cue) and pushing for well over an hour and half (Cue) and there seemed to be little visible evidence of fetal decent (Cue). Lyn was really tired and had really low energy reserves (Cue). But she was having [intravenous] fluids (Cue) and was moving around and changing positions (Cue). Meconium stained liquor was still draining (Cue) but the CTG was good (Cue) (DMP: Cue acquisition and interpretation to rule in 2 hypotheses). Despite these things, I knew from when I saw her antenatally, that first and foremost, Lyn didn’t want any intervention or any drugs. I thought, we can really push the hospital policy time limits further to achieve this for Lyn (DMP: Evaluating treatment options -makes a decision). I was being sensitive around what Lyn wanted (MBP: Shares a common known goal with Lyn). There is also definite research around the benefits of intervention and drug-free births for the woman and the baby, long-term, short-term and postnatal depression (DMP: Using empirical knowledge to support hypothesis).
I decided to try and collaborate with the doctor and get them to agree to do what Lyn wanted: wait longer (MBP: Trying to collaborate with medical staff). My communication style with the doctor and midwifery staff was pushy (Cue). I was telling them what I wanted: to birth without any help or intervention (MBP: Lack of appropriate communication skills-Lack of respect for medical/midwifery staff - Lack of understanding what collaboration is). The [midwife/doctor] collaboration went downhill from that. The doctor said Lyn needed assessing and possible intervention (DMP: Doctor wants to collect empirical evidence of how Lyn is progressing in labour in order to evaluate treatment options). I made the decision to ignore the policy, the time limits, the doctor and the midwives and get Lyn to push the baby out in her own time (DMP: Makes a decision) (MBP: Is now working outside Organisational policy, medical advice –trusting Lyn’s body to birth her baby). The doctor and the labour midwifery staff were unhappy with my decision and I was [verbally] fighting everyone not to intervene because I knew Lyn wanted a drug and intervention free birth (silence) (MBP: Lack of appropriate communication skills- lack of respect for medical/midwifery staff -lack of understanding what collaboration is). I was also conscious that I felt pressure to make that decision because I had Amy with me. She was a new doula and very excited as it was our first birth together and it was all going to crap (laughs). I was thinking how come I’m not showing myself as a good midwife here at all? (laughs) (MBP: Fear of being perceived as a poor midwife seems more important than collaborating with medical team or protecting Lyn).

As I had stopped the doctor and midwifery staff coming in the birthing room by my [verbal] interaction, MBP: Uses power disintegratively) I went back in to the birthing room. By the time three hours had passed, post the diagnosis of full dilation (Cue), Lyn’s labia and vagina became more oedematous (Cue) than I’ve ever seen before or since. It was like all the intravenous fluid had just gone straight to her perineum (Cue). It was horrible. By this time Lyn had become bothered and very distressed (Cue), although the fetal heart rate remained normal (Cue).

Outcome

I talked with Lyn and we agreed that we needed medical help now as the baby just was not birthing (DMP: Ruling in hypothesis and making a decision) (MBP: Sharing information). I then had had to ask the same doctors who I had been fighting with for over three hours to help. Lyn had a drug free ventouse delivery

Henri’s Reflection

It was just a really awful situation that I couldn’t rescue and Lyn was really traumatised by her birth and how it ended (MBP: Unaware of how her role in this scenario affected the outcome and the potential short and long lasting psychological impact for Lyn).
### QUESTIONS DERIVED FROM ANALYSIS

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<th>Re: CLINICAL REASONING?</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accurate knowledge base in line with best evidence</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Cue acquisition – appears to be comprehensive</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collects them but omits them</td>
</tr>
<tr>
<td>3. Cue clustering – appears to be comprehensive</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>4. Cue Interpretation – Generating multiple hypotheses – if relevant</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>5. Focused cue acquisition – if needed and relevant to hypothesis</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>NK</td>
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<tr>
<td>6. Ruling in and Ruling out hypotheses – if relevant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>7. Making a diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>Makes poor decision</td>
</tr>
<tr>
<td>8. Evaluate treatment options relevant to the diagnosis – if relevant</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td>9. Prescribes and/or implements planned care</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
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<td>10. Evaluates outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11. Uses intuition to aid decision-making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NK</td>
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<tr>
<td>12. Links intuition to cues and reasoning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>NK</td>
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<tr>
<td>Overall: CLINICAL REASONING =GOOD</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
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<table>
<thead>
<tr>
<th>Re: MIDWIFERY PRACTICE</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stays in the room with the woman in labour</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2. Shares a common, known goal with the woman</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X Pre-labour but does</td>
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<td></td>
<td></td>
<td></td>
<td>not recheck during labour</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3. Trust the woman and her body</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>4. Maintains rapport with the woman appropriately</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Maintains rapport with the support people appropriately</td>
<td></td>
<td></td>
<td>NK</td>
<td></td>
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<tr>
<td>6. Appropriate assertion with the woman and support people</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>7. Honest and complete information sharing with woman/partner</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>8. Uses power integratively to promote the woman’s empowerment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>9. Accountability for own professional behaviour in accordance with professional frameworks</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. Skills in negotiating with medical staff or senior midwifery staff</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11. Assumes appropriate responsibility for woman/baby’s well-being in labour</td>
<td>X</td>
<td>X</td>
<td>Not the woman</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. To what extent does the midwife show reflexive practice</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13. When the woman and midwife disagree about care the midwife takes appropriate action (documentation and consultation)</td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14. The woman is the final decision-maker</td>
<td>X</td>
<td></td>
<td></td>
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</tbody>
</table>

**The midwife demonstrated GOOD MIDWIFERY PRACTICE**

X MD

NA= Not applicable, NK=Not known, MG=Midwifery guardian, MD=Midwifery domination, MA= Midwifery abdication
Decision-Making Theories and their usefulness to the midwifery profession both in terms of midwifery practice and the education of midwives

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Professor of Midwifery, Newcastle University, School of Nursing and Midwifery, Callaghan Campus, New South Wales, Australia

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Decision-Making Theories and their usefulness to the midwifery profession both in terms of midwifery practice and the education of midwives

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REVIEW

A review of the literature: Midwifery decision-making and birth

Elaine Jefford*, Kathleen Fahy, Deborah Sundin

Newcastle University, School of Nursing and Midwifery, Callaghan Campus, NSW 2308, Australia

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Routine vaginal examination to check for a nuchal cord

By Elaine Jefford, Kathleen Fahy and Deborah Sundin

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The Nuchal Cord at Birth: What Do Midwives Think and Do?

by Elaine Jefford, Kathleen Fahy and Deborah Sundin

Abstract:
Background: No good evidence exists to support the practice of routinely checking for the nuchal cord, yet it is a common medical intervention in birth. Some evidence shows damage to the baby because the practice more frequently leads to premature cord-cutting and the vaginal examination, required by such routine checking, may be physically and/or emotionally damaging to the women. Our objective was to learn what training midwives have received and what their current practice is in relation to a possible nuchal cord at birth? Method: Questions about nuchal cord at birth were posted to two on-line midwifery discussion forums and responses were invited. Twenty-six midwives from 10 countries responded to questions on nuchal cord practices. Results: The teaching and practice of routinely checking for the nuchal cord at birth is widespread, according to at least some participants from all 10 countries. Other midwives from the same countries argued that, although they were aware that the procedure is the dominant midwifery practice, many midwives neither teach it nor perform it routinely. Conclusion: In the absence of clear evidence, firmly entrenched positions are being argued for and against routine checking. The debate is infused with high emotion. Those arguing for routine checking cite safety for the baby as their main concern. Those arguing against checking cite the need to keep birth normal and the well-being of the baby as their primary concerns. There is a need to reconsider how the possibility of nuchal cord at birth should be conceptualised from a midwifery perspective to ensure woman-centred decision-making.

Introduction
Within many settings midwifery is an art practiced behind closed doors. To enter such an environment as second midwife is a privilege and provides a wonderful opportunity to witness colleagues engaged in the craft of midwifery. In one instance the first author observed a primary midwife assisting a woman to birth. After the baby’s head had birthed and before delivery of the shoulders the midwife pushed two fingers into the vagina of the woman. The woman’s hips briefly lifted off the bed and she said “Ouch, what are you doing?” The midwife calmly said, “Oh, I’m just feeling for the cord in case it’s around your baby’s neck.”

In our view that one action demonstrates how the philosophical foundations of the contemporary midwifery model of care can be at odds with what is probably a widespread practice.

Contemporary midwifery is defined as a partnership between a woman and a midwife where knowledge and power are shared. The midwifery partnership model of midwifery practice is based on mutual trust and respect between the midwife and woman. We argue that one of the most fundamental “risks” of checking for the nuchal cord is that it is contrary to midwifery’s espoused philosophy of supporting, nurturing and protecting normal birth. Midwives generally agree that they practice a holistic, woman-centred philosophy. In the midwifery model of care, only interventions that are really needed and are known to be beneficial are performed. Midwives have come to recognize that interfering with birth, which is a healthy physiological process, through rigid application of routine procedures, inhibits women’s behavior and their ability to birth naturally. It takes control away from the birthing woman, undermining midwifery and the art of being with women.

The nuchal cord is defined as “...the coiling of an umbilical cord around the neck.” Checking for the cord requires performing a vaginal exam during second stage of labour. A tight nuchal cord at birth is rare. There is very limited reliable evidence of neonatal morbidity and/or mortality associated with a tight nuchal cord at birth. Consequently, several authors hypothesize that “nuchal cords ordinarily do no harm” (12, 16-18). Indeed, a nuchal cord is perceived by some as a common event within a normal vaginal birth (12, 18-22).

A search of Pubmed, CINAHL, Medline, Cochrane Collaboration and Joanne Briggs Institute showed that no randomised control trials (RCTs) had been conducted regarding the practice of feeling for a nuchal cord. No policy directive or documented procedure/guidelines in relation to the practice of feeling for the nuchal cord were located in Canada, Australia, New Zealand (NZ), Norway, Denmark, Ireland, parts of the US and UK (23). However, routinely checking for the nuchal cord may cause harm that is not being considered.

For some women, routine vaginal examinations have negative implications for their parenting abilities, their sex life or even whether they want more children. Vaginal examinations are particularly sensitive for women who have a history of sexual abuse. A vaginal examination may create the feeling of being invaded. The examination may stimulate memories of the original abuse or even be experienced as re-victimization.

If a nuchal cord is found on vaginal examination, practitioners historically have been advised to try to slip the
loop of cord over the head or back over the shoulders. If looping the cord over the head is found to be difficult or impossible, then practitioners are advised that the cord should be clamped and cut before the birth is completed.\(^{(27)}\) The negative effects of premature cord clamping for the infant include shock, hypotension, anemia and death\(^{(15, 28-38)}\). Cerebral palsy has been positively co-related with early cord clamping for nuchal cord, particularly if shoulder dystocia ensues\(^{(15, 28)}\).

In this paper our concern is not about managing an extant nuchal cord, which we think should involve the lowest level of intervention and trauma. Rather, our concern is the routine practice of midwives inserting their fingers into a woman’s vagina during the birth of the baby. The issue of consent was implied but not explicitly discussed. We were interested to investigate current international teaching and practice related to nuchal cord as a basis for designing a further study concerning decision-making processes and the nuchal cord at birth.

**Method**  
Two on-line discussion forums were used to post questions related to midwives’ clinical practice and teaching related to nuchal cord: One was an international midwifery forum and the other was a UK national midwifery and consumer forum.

**Question:** What do midwives say about their training and current practice to the possibility of a nuchal cord at birth?

**Participants.** Participants were 26 respondents who were practising midwives or midwifery teachers from Australia, UK, US, Norway, Denmark, New Zealand, Ireland, Mexico and Canada. Of the 26 participants, 17 were from the International Midwifery Forum. They came predominately from the field of midwifery and were located around the world. Their responses fell into two categories: education/training, and current practice. The other nine respondents were practicing midwives from the UK Midwives and Consumer Forum. Whilst the responses fell into the same groups as those in the International Midwifery Forum, only two mentioned education and training.

**Education/Training Regarding Nuchal Cord.** Teaching to feel for the nuchal cord within midwifery education appears to be widespread, according to those midwives who participated in the on-line forums. Fourteen respondents from the UK, New Zealand, US, Mexico and Australia were taught this within their midwifery training. Respondents from New Zealand and Northern Ireland said that they were aware that students were still being taught to feel for the nuchal cord in clinical environments. Opinions from two US respondents were diametrically opposed with one stating that all midwifery students within the US are encouraged to undertake the practice of feeling for the nuchal cord, while the other claimed that the vast majority were not.

Several respondents from the US, Australia, Ireland, New Zealand, UK and Northern Ireland stated that once a nuchal cord had been felt, they reverted to carrying out the intervention they had been taught during their training: clamping and cutting the cord. An Irish respondent provided her rationale for doing this:

“…there is something basic and instinctive about wanting to release a cord from the infant’s neck.”

Academic respondents, predominately from the US but also one from the UK, continue to teach midwifery students to feel for the nuchal cord. When asked what evidence informed their teaching, the responses included: American birth videos, literature from 1773 and 1842 \((38, 39)\) and *Varney’s Midwifery* (p. 26).\(^{(40)}\)

This latter reference was faxed to me along with the comment: “I can’t imagine a midwife who doesn’t check for a nuchal cord. We consider it an essential hand maneuver at birth” (a US respondent).

Although all the academic respondents were aware that the procedure is a dominant midwifery practice, two midwifery academics from New Zealand and Ireland said they discussed it with their students, but did not teach it.

**Current Practice.** From the 26 respondents who answered the question of whether their current
practice is to routinely feel for a nuchal cord, Danish and Norwegian respondents said that they did not. The Danish or Norwegian midwives had neither observed the practice nor read about it within their text books. The Norwegian respondent went on to say:

“I remember amazing my fellow students and later colleagues in Norway by reading them a passage from some English text in which it states unequivocally that whenever one found a nuchal cord, one proceeded to clamp and cut it before the shoulders where born.”

Several respondents from New Zealand, UK, US and Australia proclaimed that despite having been taught to feel for the nuchal cord in their training, they had now “unlearnt” the behavior. An Australian respondent said she stopped feeling for the nuchal cord because women reacted negatively to the procedure: “It was uncomfortable/hurt/was distressing to women.”

A UK respondent mentioned: “The amount of pain that has been inflicted upon women whilst feeling for the cord should not be forgotten…."

Another reason given by respondents for “unlearning” the practice of feeling for the nuchal cord related to the woman having a waterbirth. The philosophy behind waterbirths is concerned with promoting humanistic childbirth practices: “hands off,” no intervention, let nature take its course. Midwives” non-actions are specifically aimed at the support of birth as a physiologic, rather than pathologic process. It is also difficult for the midwife to check for a nuchal cord in water, however the mother may do so. The following responses capture these points:

“….I love to watch the baby unravel from its cord, sometimes gently assisted by us…. I have grown in confidence to practice hands-off birth, especially in water….” (a New Zealand respondent)

“It wasn’t until I watched a wonderful English waterbirth, where the midwife didn’t check for cord that I began to walk on the „dark side.”” (a US respondent)

In her response, the US respondent also referred to “somersaulting,” the maneuver expounded by Schorn and Blanco whereby the midwife carries out a series of steps, ultimately assisting the baby to unravel from its cord.(12) A potential problem with this maneuver is that it can place some stress on the cord and is not applicable to all births.

Another comment that demonstrates how the philosophy of waterbirth has affected her current practice of feeling for the nuchal cord is: “If in water we don”t investigate… I endeavor to do the same on dry land.”(a UK respondent)

A routine vaginal examination to check for the nuchal cord is practiced by four UK respondents; one Northern Ireland respondent; two US respondents; and one Mexican respondent.

The rationales provided by these respondents varied. Two comments that captured the main themes were:

“Feeling for the cord is just routine here and because epidurals are too, women are not really aware of it going on….” (a USA respondent)

“….there is no cost involved…associated with this practice and possibly no „risks” other than potentially and unnecessarily clamping the cord too early.” (a USA respondent)

**Conclusion**

A review of the relevant literature shows that the practice of routine vaginal examination for a nuchal cord has no strong evidence base and that routine checking can have negative physical and psychological effects for some woman and babies. We used two on-line midwifery discussion forums to gain some understanding of contemporary practice and education related to the nuchal cord at birth. Teaching students to feel for a nuchal cord continues in UK, US, New Zealand, Ireland, Mexico and Canada. Routine checking is said to be the dominant midwifery practice in these countries. In contrast, respondents from Norway and Denmark expressed amazement at a practice they had never witnessed. This makes the dominant Western practice of routinely checking seem to be more about tradition and standardization of practice, both of which are supported with some passion.

We acknowledge that these data were obtained using a convenient sample; consequently, it is not representative. Nevertheless we would argue that the results of this small study indicate that midwives” decision-making in feeling for the nuchal cord in the second stage of labour is a complex phenomenon. Woman-centred decision-making in this area does not always occur. We recommend that further research is needed to explore:

1). The processes midwives use when engaging in clinical decision-making during the birth;
2). The factors that influence midwives” decision-making in relation to management of the nuchal cord; 3). How midwives ensure that their decision-making in the second stage of labour is woman-centred;
and

4). The factors that contribute to how much information midwives provide women in order to obtain consent.

Elaine Jefford is a PhD student at Newcastle University, Australia. She is researching midwives’ clinical decision-making during birth. She emigrated from England in March 2005 to Canberra, Australia, and is currently working for Australian Capital Territory (ACT) Health.

Kathleen Fahy is Professor of Midwifery at Newcastle University, Australia, and supervisor of a number of Research Higher Degree (RHD) students. She is an editor and author of Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research. Kathleen is currently researching third stage labour care and group-based antenatal care using this theory.

Deborah Sundin is Honours Program Convenor for the School of Nursing and Midwifery at the University of Newcastle, Australia. She coordinates the final year of the undergraduate curriculum and supervises a number of RHD students. Deborah’s research interests focus on critical care, decision-making models and processes.

References

7. Schorn and Blanco.
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