From worry to hope:
An ethnography of midwife – woman interactions
in the antenatal appointment

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material either in full or in part, for a degree at this or any other institution.

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## Abbreviations

### Data item abbreviations

Each antenatal appointment, interview and focus group was labelled with a use of letters and numbers to de-identify them to maintain privacy and confidentiality. For example:

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A-MGP7</td>
<td>An antenatal appointment from Hospital A that was provided by a midwifery group practice midwife and was the seventh observation done in the study.</td>
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<tr>
<td>PNI-A-MGP7</td>
<td>A postnatal interview with the woman who participated in antenatal appointment A-MGP7.</td>
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<tr>
<td>FG-B-Managers</td>
<td>A focus group that involved managers from Hospital B</td>
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<tr>
<td>FG-B-MGP</td>
<td>A focus group that involved the MGP midwives from Hospital B.</td>
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### AHMAC

Australian Health Ministers Advisory Council for the Commonwealth and state jurisdictions of Australia.

### Antenatal care

The care a woman receives from a healthcare professional during their pregnancy, which includes a series of appointments with a midwife or doctor who specialises in pregnancy and birth. It is synonymous with American term of prenatal care.
**Bulk billing**  
An Australian government funding arrangement within the Medicare system where the healthcare professional only charges the Medicare benefit for the service they have provided. This means the healthcare recipient does not incur any out of pocket expenses.

**BU**  
Abbreviation for birth unit in the data tables.

**CHC**  
Abbreviation for community health centre in the data tables.

**CMC**  
Clinical midwifery consultant: a high-functioning role for midwives in the state of NSW. The position description domains include clinical service and consultancy, clinical leadership, research, education and clinical services planning and management. It straddles clinical and managerial activities.

**CTG**  
Cardiotocograph – fetal heart recording technology

**LHD**  
Local health districts manage the governance of a number of healthcare facilities in a geographical area of the state of NSW. They are responsible to NSW Health.

**GBS**  
Group B streptococcus – a bacteria that pregnant women are routinely screened for in Australia.

**GP**  
General practitioner – a doctor working in a private medical practice in the community.

**MAWI**  
Midwives and Women’s Interaction study – the study that this doctoral study was based on.
Maternity care records
Include the hospital file and the general practitioner's (family doctor) share care card. The share care card/yellow card is a small trifold card that is used by the GP and midwives in New South Wales to record the woman's medical, family and obstetric history and antenatal appointment assessments.

MGP
A Midwifery Group Practice brings together a number of midwives, each with an individual caseload of women for whom she coordinates care as the primary midwife. Thus this model is sometimes referred to as caseload practice within a MGP.

NICE
National Institute of Health and Clinical Excellence in the United Kingdom

OPD
Outpatient department, which is now commonly called ambulatory care, and where many antenatal clinics take place.

PICF
Participant Information Sheet and Consent Form provides potential study participants with information about the research and those who agree to participate a place to sign.

SMC
Standard maternity care

Team midwifery
A group or team of midwives who share providing continuity of care to all the women booked with their team – as opposed to women having a named or primary midwife providing most of her care.

USS
Ultrasound
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<td>Western Sydney University. Although the University of Western Sydney has changed its name to Western Sydney University, I have retained the use of this acronym.</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Abstract

Better outcomes for mother and baby observed in 'midwifery continuity of carer' programmes are attributed to positive midwife-woman relationships formed within these models, but this effect is not fully understood. Like midwife-led care, continuity of midwifery carer in Australia continues not to be seen as mainstream.

To advocate for and better understand this continuity of carer model, this study used video ethnography framed by feminism and a critical approach. Midwife-woman interactions in a number of late pregnancy antenatal appointments were observed and filmed. These were at two Sydney hospitals with either the midwifery continuity of carer programme or in standard maternity care. Focus groups and interviews were undertaken. Thematic and content analysis techniques were used.

Worry was a common feature of the antenatal appointment. It reflects the worry pregnant women report: worry about pregnancy, their baby, uncertainty about birth and transition to motherhood. 'Dysfunctional' or 'iatrogenic' worry occurred with system-focused midwives invested in standardised/medicalised tasks, whereas 'functional' worry occurred with woman-centred midwives invested in the woman.

Hope creation was also seen, although less frequently. It occurred when worry was moderated and linked with adaptation of standardised and medicalised appointment factors, including environment, time, and midwife investment (how she interacted with the woman). Regardless of where they worked, some midwives were 'adaptive experts', but in most instances the midwives in continuity had greater opportunity to adapt. This adaptation resulted in midwife-woman interactions being bidirectional and shared, with discussing and storytelling taking place, rather than one-way midwife telling. These shared interactions created connection, or reflected the connection created by continuity of carer.

This study showed the benefit of the midwifery continuity of carer programme. It provided opportunity for midwives to adapt, worry was moderated, and women appeared more hopeful. Being more hopeful may enable women to better manage their labours and parenting, creating these improved outcomes.
Publications

Reports:

Presentations:
Published:

Unpublished:
Chapter 1 – Introduction

The first chapter of this thesis introduces the background and genesis for this study, which was a video ethnography undertaken in two hospitals in New South Wales (NSW) Australia. The aim of this study was to use a feminist lens and a critical approach (Hesse-Biber & Leavy, 2007; O’Reilly, 2012) to gain a better understanding of how midwifery group practice (MGP), a midwifery continuity of carer model, might influence midwife-woman interactions in the antenatal appointment.

There is now substantial high-level evidence of the benefits of midwifery-led continuity of care and midwifery continuity of carer (MCOC) for mothers and babies (Sandall, Soltani, Gates, Shennan, & Devane, 2016), but we still do not fully understand the micro components of what makes relationship-based care so successful. Furthermore, MCOC models, or models of maternity care where the midwife is the lead care provider, struggle to gain recognition and are still not embedded in the Australian contemporary healthcare system as a mainstream option for all women. In order to advocate for this model in a landscape where a fragmented medical model of maternity care is the norm and considered easier to provide, we need to better understand the influence of continuity of midwifery carer.

1.1 Background

In Australia, standard maternity care (SMC) remains mostly unchanged since it was established in the nineteenth and twentieth centuries. It is founded on a fragmented, industrialised system of care. Prior to the mid-twentieth century, general practitioners (GPs), nurses and midwives worked in local community settings where they were part of the community, recognised as the local doctor, nurse or midwife, and able to form ongoing healthcare relationships with the local people they cared for (Ackerknecht & Haushofer, 2016; Borsay & Hunter, 2012; Hunter & Leap, 2013). During the twentieth century, healthcare and particularly maternity care became industrialised, medicalised and taken out of the family and
community context and situated in the acute-care hospital setting (Davis-Floyd, 2001; Oakley, 1984; Wagner, 1994).

The Australian Institute of Health and Welfare’s most recent statistics, for the year 2015, show the majority of Australian women (74%) gave birth in public hospitals with a mixture of midwifery, obstetric and GP models of care. Around 26% of women gave birth in private hospitals with a known private obstetrician (Australian Institute of Health and Welfare, 2017). However, in these private settings, while a known obstetrician provides all the antenatal care and attends the birth, the labour and postnatal care are provided by midwives who the woman has never met. A very small number of women were cared for by a known private midwife at home or in hospital and these women experience the highest continuity of any of the models of care available. For the majority of women (74%) who gave birth in the public system they received standard fragmented maternity care. A small number had access to continuity of care models that included shared care with a GP or in a midwives' clinic (which in most cases provides continuity in the antenatal period only), or 'caseload' and 'midwifery group practice' (MGP) (which provides continuity across the childbearing experience) (Bureau of Health Information, 2017).

Caseload and MGP are terms used in Australia to describe midwifery continuity of carer (MCOC) models, which are mainly only available in large city hospitals in Australia. Due to demand, these models of care are typically booked out early. Despite government recommendations (Commonwealth of Australia, 2011; NSW Health, 2010) around 8% of Australian women are thought to have access to a MGP (Dawson, McLachlan, Newton, & Forster, 2016). Despite a tool having been developed to collect this data on different models of maternity care there, is to

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1 In most Australian public hospitals women are admitted as either a public patient or private patient. As a public patient they are cared for by the hospital staff, doctors, midwives and nurses. As a private patient they are cared for by a private obstetrician and the hospital staff.

2 GP shared care is where the general practitioner/family doctor, many of whom have obstetric qualifications, offer pregnant women care that is shared with the services of a local hospital. Women have some of their antenatal care with the GP and some with the midwives and doctors in the hospital.

3 Midwives clinics are antenatal clinics led by midwives rather than doctors and are part of the public healthcare system. They are situated in hospital outpatient departments and community healthcare centres.
date, a lack of political will to make it a requirement to collect data on outcomes for MCOC models (Bureau of Health Information, 2017; Donnolley, Butler-Henderrson, Chapman, & Sullivan, 2016; NSW Ministry of Health, 2018).

Regardless of whether the birth facilities are in private or public hospitals, they are divided into units, wards, or clinics where midwifery staff members tend to work mainly in one area and not across the full scope of midwifery practice (International Confederation of Midwives, 2017). For example, these units include the 'antenatal clinic', 'antenatal ward', 'labour and delivery ward', 'postnatal ward' and 'postnatal home care'. The consequence of this fragmented approach is that a woman's childbirth experience is divided into 'pregnancy', 'labour and birth', and 'postnatal' with different midwives who staff these separate areas providing her care (Newman, 2009). It is only when women access MCOC models that they have some sense of consistency, familiarity and advocacy over what is in reality a very fragmented and disparate maternity care system.

1.2 Midwifery continuity of carer (MCOC) models

In Australia, a MGP brings together a number of midwives, each working with an individual caseload of women. In these MGPs, the midwives organise themselves into partnerships or small groups. The MGP midwives care for women in a variety of settings, including the community, the woman's home or the hospital wards/units. A woman is allocated a midwife in early pregnancy who is responsible for the coordination of her midwifery care, referring to medical and other practitioners if needed. This involves providing all her antenatal care, being on-call or available for her labour and birth care, and providing out of hospital postnatal care until the baby is a minimum of two weeks old (some models extend this to 4-6 weeks) (Homer, Brodie, & Leap, 2008; Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008). These MGP midwives create their own backup agreements and working arrangements that take into account planned and unplanned leave (NSW Government, 2012), enabling a woman to have her midwifery care provided by a known midwife (Australian College of Midwives, 2017b). There is no standard
number of midwives in a group practice, although small numbers make it easier for a woman to know her backup midwife/midwives. Regardless of the approach taken, the underpinning principle is to maximise continuity of midwife carer.

Midwifery continuity of care is a modern-day approach to maternity care developed on the assumption that women do better and are more confident when supported by someone they know and with whom they have formed a relationship built on trust and rapport (Brodie, 1997). Changes to publicly-funded midwifery care to incorporate this way of working in developed countries, such as the United Kingdom (UK), Canada, New Zealand and Australia, have been part of a controlled 'renaissance of midwifery' (Shroff, 1997) that began in the 1980s.

Midwifery continuity of care involves a paradigm shift from the fragmented hospital-based maternity services formed during the twentieth century (Homer et al., 2008; Sandall, 1995) towards the philosophical belief that midwifery is 'woman-centred' and based on equal 'partnership' between the woman and midwife (Berg, Olafsdottir, & Lundgren, 2012; Guilliland & Pairman, 1994; Walsh, 1999). Like all forms of healthcare that situate the individual at the centre of their care and where they have a known healthcare provider, midwifery continuity of care remains vulnerable to the constant drive for centralised and fragmented healthcare systems (Freeman & Hughes, 2010; Homer, 2006; Homer, Leap, Edwards, & Sandall, 2017).

In Australia the establishment of midwifery continuity of care models evolved as a result of the Commonwealth Alternative Birthing Services Programme (Waldenström & Lawson, 1998). This provided funding for the development of the metropolitan-based birth centres in the early 1980s, where active physiological birth was promoted. These Commonwealth Government funds enabled teams of rostered midwives to develop skills to support women in low intervention environments. Since that time, midwife-led antenatal clinics and team midwifery models across the childbirth continuum have developed in pockets of innovation across Australia (Zadoroznyj, 2000).

A pattern of limited implementation and support for MCOC programmes in NSW, where this study was undertaken, is a reflection of similar patterns of limited
growth of midwifery-led care and MCOC programmes seen in other Australian states and territories during the past two decades. In NSW, MCOC models were initially implemented in large metropolitan hospitals where birth centres, midwife-led clinics and team models had already been founded; the development of such models then migrated to some regional hospitals and now there are a small number of MCOC programmes and projects trialling this model of continuity of midwifery carer in rural and remote settings (Australian College of Midwives NSW Branch, 2011; Lack, Smith, Arundell, & Homer, 2016; NSW Government, 2012). In spite of these developments, improvements to midwifery care in order to facilitate women having access to continuity of care from a known midwife, continue to be constrained in NSW (NSW Health, 2010).

1.3 Standard Maternity Care (SMC)

The Australian standard maternity care (SMC) system is fragmented and governed by the dominant medical model of care where midwives are required to be subordinate to the technocratic system often dominated by obstetricians (Lane, 2012) and heightened levels of government regulation. In public maternity care services this can involve a woman seeing a different care provider for most of her antenatal care and experiencing several care providers she may never have met before during her labour and birth. The majority of Australian midwives are employees of the acute-care hospital setting where they work in mainstream hospital structures (Australian Institute of Health and Welfare, 2017). In Australia in 2015, 5% of midwives reported attending a birth in a birth centre and just over 2.2% attended a birth at the woman’s home as the primary midwife (Australian Institute of Health and Welfare, 2017). Data on the numbers of midwives who work in continuity of care models is not available as place of birth or employment status (i.e. self-employed) appears to be the only data collected.

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4 Davis-Floyd describes three paradigms of healthcare that influence contemporary childbirth: technocratic, humanistic and holistic. These terms differ fundamentally in their definitions of the body and its relationship to the mind, and thus the healthcare approaches they foster. The technocratic model stresses mind-body separation and sees the body as a machine; the humanistic model emphasises mind-body connection and defines the body as an organism; and the holistic models insists on the oneness of the body, mind and spirit and defines the body as an energy field in constant interaction with other energy fields. (Davis-Floyd, 1994)
Fahy (2012) describes the model of SMC as 'de-centred', where 'no one is at the centre of care, and no one really cares for the woman who is the client' (p. 149). There is a contradiction between the professional ideal of being 'with woman' and the reality of employment and obligations to be 'with institution' (Brodie, 1997). As Mander (2001) comments: 'midwives and the midwifery profession have and continue to perform a kind of mutually confusing dance against the backdrop of increasing medical power and control' (Mander, 2001, p. vii).

1.4 Environment and organisation of maternity care in Australia

There is increasing concern about the rising rates of intervention in birth in Australia. This is described as the 'cascade of intervention' that ultimately leads to higher rates of caesarean section (Dahlen et al., 2012; NSW Department of Health, 2010; Tracy & Tracy, 2003). The spontaneous labour rate decreased from 57% in 2005 to 50% in 2015 (Australian Institute of Health and Welfare, 2017). The caesarean section rate in Australia has shown an upward trend over the last 15 years, increasing from 25.4% nationally in 2001 to 32.6% in 2010. The caesarean section rate of 43.1% for women in private hospitals much higher than the rate in public hospitals (28.4%) (Australian Institute of Health and Welfare, Li, Zeki, Hilder, & Sullivan, 2012). In 2015, the caesarean section rate again increased and was 33% (Australian Institute of Health and Welfare, 2017), which is higher than the Organisation for Economic Co-operation and Development (OECD) average rate of 27.9% and our nearest comparable neighbour New Zealand which has a rate of 26.3% (OECD, 2017).

In contrast to these spiralling caesarean section rates, the majority of women continue to seek to have a normal labour and birth (Fenwick, Hauck, Downie, & Butt, 2005; Safe Motherhood for All, 2017). When women have a sense of control (Green & Baston, 2003), have a choice to decide what is best for them (Sjöblom, Nordström, & Edberg, 2006), and have a strong sense of coherence (the capacity to use the resources available), they have a greater ability to avoid intervention and
have positive experiences of childbirth. Ferguson, Browne, Taylor, and Davis (2016); (Sjöblom et al., 2006) identified that women with a high sense of coherence in pregnancy had half the likelihood of caesarean section compared to women with a low sense of coherence. They also found that a woman's sense of coherence is raised and lowered by their degree of satisfaction with their births and lowered by some labour interventions. A woman's dissatisfaction with her care also relates to her being pressured to choose interventions and surgical options (Jenkinson, Kruske, & Kildea, 2017). It continues to be argued that these experiences and expectations for women are best met with improved midwifery continuity of care models where women and midwives can develop supportive and trusting relationships (Allen, Kildea, Hartz, Tracy, & Tracy, 2017; Fereday, Collins, Turnbull, Pincombe, & Oster, 2009; Forster et al., 2016; Walsh & Devane, 2012).

In Australia the government appears to be aware of the negative effects of the current organisation of maternity care on the quality of maternity (Commonwealth of Australia, 2009; NSW Health, 2010). For example, Table 1 shows the factors reported to influence women's satisfaction with maternity services in the document.

### Table 1: Factors that influence women's satisfaction with Australian maternity services

<table>
<thead>
<tr>
<th>Factors which improve satisfaction</th>
<th>Factors shown to reduce satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisation:</strong></td>
<td></td>
</tr>
<tr>
<td>• Short waiting times</td>
<td>• Fragmentation of care</td>
</tr>
<tr>
<td>• Flexible appointments</td>
<td>• Conflicting advice</td>
</tr>
<tr>
<td>• Sufficient time with carers</td>
<td>• Lack of rest</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td>• Reducing length of stay</td>
</tr>
<tr>
<td><strong>Nature:</strong></td>
<td>• Busy, rushed staff</td>
</tr>
<tr>
<td>• Involving women in decision-making</td>
<td>• Inadequate time to ask questions</td>
</tr>
<tr>
<td>• Consistency of information</td>
<td>• Inappropriate or non-individualised advice with too much information provided in a short period</td>
</tr>
<tr>
<td>• Good communication</td>
<td></td>
</tr>
<tr>
<td>• Having caregivers who listen</td>
<td></td>
</tr>
<tr>
<td>• Friendliness and support</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: Primary Maternity Services in Australia; A Framework for Implementation (Australian Health Minister's Advisory Council, 2008, p. 12)
1.4.1 Key Criticisms of Standard Maternity Care

Key criticisms from women about their experiences of SMC include experiences of fragmented care, multiple caregivers, long waiting times, a lack of control about health decisions, poor and inconsistent information, and the perception of rushed and unhelpful health professionals (Brown & Lumley, 1993; Homer, Davis, Cooke, & Barclay, 2002; Moos, 2006; Raine, Cartwright, Richens, Mahamed, & Smith, 2010; Safe Motherhood for All, 2017; Waldenström, Borg, Olsson, Sköld, & Wall, 1996; Waldenstrom & Turnbull, 1998). These criticisms are longstanding and repeatedly reported in Australian policy documents (Commonwealth of Australia, 1999, 2011; National Health and Medical Research Council, 1996, 1998; NSW Department of Health, 2000; NSW Health Department, 1989). Despite this, attempts to introduce new midwifery continuity of care programmes have been limited.

Moving to a system that provides less fragmentation and more midwifery continuity of care presents many challenges. Powerful medical lobby groups continue to promote midwifery as risky and in need of supervision without any evidence to support these claims (Wernham, Gurney, Stanley, Ellison-Loschmann, & Sarfati, 2016). Despite the evidence demonstrating that midwifery continuity of care is safe and beneficial, and the continual call from consumer-led groups and government reports advocating for an increase in the choices made available to childbearing women, lack of innovation in maternity care continues (Commonwealth of Australia, 1999, 2009, 2011; National Health and Medical Research Council, 1996, 1998). The profession of midwifery remains silenced and potentially invisible to childbearing women, particularly those who are pregnant for the first time and who have little idea about the services midwives can provide (Boxall & Flitcroft, 2007; Brodie, 2002, 2003; Byrom & Downe, 2015; Zadoroznyj, 2000).
1.5 Genesis of this study

This doctoral study evolved from the Midwives’ and Women’s Interaction Study (MAWI), a collaborative research project that included representatives from Western Sydney University (UWS5), one local health district (LHD) and two hospitals situated in Sydney, NSW. The team received a grant from NSW Health to support current, or to develop and implement new, women’s health initiatives in NSW LHDs. This was part of the NSW Women’s Health Plan 2009-2011 that aimed to improve equity in health in NSW (NSW Government, 2010). The primary intent of the MAWI project was to review and report on the new MGP that had been implemented at one of the two hospitals in this study, identified as Hospital A. This review was then expanded to include Hospital B and at that stage it became my doctoral study.

My rationale to take this evaluation project to a more critical level of examination of these two MGP programmes and the MCOC model related to a desire to make a difference and to explain how the provision of continuity of care by a midwife might affect midwife-woman interactions in the antenatal period. My decision was also informed by the continuing trend of evidence that the outcomes for women and their babies improve with midwifery-led continuity of care programmes (Sandall et al., 2016) but that little is known about how MCOC influences these (Green, Renfrew, & Curtis, 2000; Grigg, 2015; Thorogood, 2015). I am also aware that there continues to be a lack of political and professional support for widespread provision of MCOC programmes in the Australian healthcare system.

1.6 Positioning the research and the researcher

My initial role in the MAWI project was as a clinical midwifery consultant (CMC). During the grant application process, I was employed by the NSW Maternity Support Network, a NSW Government-funded body. This role straddled state government, the LHD, where the study took place, and adjacent health districts. My

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5 At the time of this study Western Sydney University was called the University of Western Sydney (UWS) and I have maintained the use of the acronym UWS throughout this thesis to aid clarity.
responsibilities included clinical leadership, policy development and research for maternity services at 22 hospitals. However, during the time between submission of the grant application in May 2011 and being awarded the funding in February 2012, I resigned from the CMC position and moved interstate. This provided me with the opportunity to undertake this study as a doctoral student.

The focus of this study on healthcare relationships was not a new area of enquiry for me but was actually the culmination of reflection throughout a midwifery career that spanned a variety of experiences. When I was a newly graduated midwife I worked within the fragmented maternity care system, where I learnt to place value on individual moments of care with women and to prioritise the relationships with other health professionals rather than with the women. It was during this early career period that I first understood that the woman’s maternity care experience was fragmented between place and person (McCourt, 2009). As the years went by I worked in a number of midwifery-led continuity of care and MCOC programmes. I experienced, firsthand, the difference between relationship-based care and fragmented care. As a result, I became aware not only of the ubiquity of fragmented care (Safe Motherhood for All, 2017) but also the resistance of those who favour it over the establishment of midwifery care where the focus is on the woman and on the relationship between the woman and the midwife (Brodie, 2003; Jenkinson et al., 2017).

Through thinking and reflecting on the experiences I had in my midwifery career and, in particular, my experiences of engaging in new models of midwifery, I realised I had always been challenging the status quo as an activist engaging with others to change systems and where actions spoke louder than words (Homer, 2006). My engagement with this doctoral study, however, has changed this personal ethos and now I am challenging the status quo with new knowledge as a midwifery researcher as well as being a 'grass roots' activist (Byrom & Downe, 2015; Craven, 2010).

Such personal reflections and the experiences described by others illustrate that midwifery care has the potential to be philosophically and fundamentally 'woman-
centred' and not simply part of the dominant medical-patient discourse (Berg et al., 2012; Leap, 2010; Yuil, 2012). In reality, however, midwifery and midwifery care has become politicised, scrutinised and marginalised by the dominant medicalised and risk-averse culture. (Dahlen, Jackson, & Stevens, 2011; Davis-Floyd, 2001; Wernham et al., 2016). This has led to midwives and childbearing women in Australia being invisible, undervalued and misrepresented (Brodie, 2002, 2003; Dawson et al., 2016). In my doctoral research I was taking on a researcher 'apprenticeship' role (Holloway & Galvin, 2017; Hunter, 2011) to gain a better understanding of what might inform the midwife-woman relationship and quality midwifery care. I was learning about how society and culture shape our knowledge of human interaction, healthcare relationships and healthcare environments (Heath & Hindmarsh, 2002; O’Reilly, 2012).

1.7 Study aim and objectives

The aim of this study was to gain a better understanding of how the MGP might influence midwife-woman interactions, in an attempt to understand why MCOC models improve outcomes for women and their newborns. The specific objectives of this study were:

1. To examine the actions/practices and language used by midwives and women when interacting in the antenatal appointment.
2. To explore the potential impact of the MGP model and SMC model on midwife-woman interactions in the antenatal appointment.
3. To identify factors that might influence the midwife-woman interactions in the antenatal appointment.
4. To examine the experience of the antenatal appointment from the perspectives of the midwives, women and managers.
1.8 Thesis structure

Chapter Two presents the evidence relating to MCOC, particularly in Australia, and the principles of woman-centred care and the midwife-woman relationship that frame the study and constitute its rationale. In this chapter the particular focus of this study on midwife-woman interactions in the antenatal appointments in the context of the SMC system and MGP is introduced. The political nature of the study, as an agent of change, is also introduced.

The study methodology and methods used are presented in Chapter Three. This chapter explains the use of video ethnography, framed by a feminist lens and critical approach, to examine midwife-woman interactions and the antenatal appointment experiences of these women. It also includes details on the ethics, recruitment, study setting, data collection and analysis.

The next three chapters (Chapter 4, 5 & 6) are then dedicated to particular aspects of the findings. Like many ethnographic studies, this study generated a remarkable amount of data (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; Pink, 2013) that needed categorising and in some ways segmenting in order to explain the whole picture that was going on in the antenatal appointments (Bazeley & Jackson, 2013). Chapter Four is an examination of the concept 'worry', which was identified as a central feature of every antenatal appointment. Chapter Five presents the three main factors found to influence the generation and moderation of this 'worry' in the antenatal appointment: 'environment', 'time' and midwife 'investment'. Chapter Six presents the three communication styles observed in the midwife-woman interactions, which are linked to the generation and moderation of 'worry', and these are 'telling', 'discussing' and 'storytelling'. To conclude this chapter, I also introduce the concept of 'hope', which was identified as a positive outcome when worry was successfully moderated.

Chapter Seven presents the discussion of the findings alongside relevant literature. This chapter also presents the limitations, future recommendations and conclusion to the thesis.
An Appendix concludes this thesis and contains additional data examples as well as data collection forms and ethics approval.

1.9 Conclusion

This chapter has introduced the issues with the SMC system and midwifery continuity of care and MCOC models in Australia, the genesis for this study, my position as the researcher and the study aims and objectives.
Chapter 2 – Literature Review

This chapter is a review of the literature related to the midwifery-led continuity of care and midwifery continuity of carer (MCOC) models and programmes, with a particular focus on the Australian context. This chapter also includes an examination of the principles of woman-centred care and the midwife-woman relationship that are fundamental to midwifery-led continuity of care and MCOC models. As Flint (1987) so fittingly identified with the emergence of midwifery continuity of care in the UK, the relationship and the getting to know each other during the woman's childbirth experience seem to be fundamental to midwifery care:

Mothers and midwives are intertwined, whatever affects women affects midwives and vice versa – we are interrelated and interwoven … To be a midwife is to be with women – sharing their travail and their suffering, their joys and their delights (Flint, 1987, p. viii).

In an attempt to remain focused on the data emerging from the observations, focus groups and interviews in this study and not become influenced too much by the existing knowledge, an in-depth systematic review of the literature was not undertaken early in the study. In the Discussion Chapter of this thesis, Chapter Seven, however, a large body of literature has been accessed and reviewed and critiqued alongside the findings of this study.

2.1 What is known about the effectiveness of midwifery continuity of care

In this first section, an overview of the high-level evidence relating to midwifery continuity of care is presented. This includes a specific focus on recent Australian studies, as it is the country where this study was undertaken. As this body of work is extensive, and for the reasons outlined above, not every study undertaken in this area will be reviewed.
2.1.1 Maternal and newborn outcomes from the Cochrane Systematic Review

A recent Cochrane systematic review (CSR) and meta-analyses of 15 randomised controlled trials (RCT) (N = 17,674) from around the world demonstrated many benefits and no harms associated with midwifery-led continuity of care compared to standard models of maternity care. This review included studies where women had been at low risk of complications as well as studies where women had risk factors. In this CSR seven of the 15 RCT were undertaken in Australia. All the trials included had involved professionally qualified midwives and none of the trials included homebirth. This CSR confirmed there are improved clinical outcomes for mother and baby and enhanced levels of satisfaction for women when midwives provide continuity of care (Sandall et al., 2016).

Table 2 provides an overview of the outcomes from midwifery-led continuity of care as reported by Sandall et al CSR (2016).

**Table 2: Outcomes of midwife-led midwifery continuity of care models reported by Sandall et al. in a Cochrane Systematic Review (2016)**

<table>
<thead>
<tr>
<th>Less likely to have an</th>
<th>Midwife-led vs Study population</th>
<th>Risk ratio (RR) (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>epidural (14 studies)</td>
<td>229/1000 vs 270/1000</td>
<td>0.85 (0.78 – 0.92)</td>
</tr>
<tr>
<td>episiotomy (14 studies)</td>
<td></td>
<td>0.84 (0.77 – 0.92)</td>
</tr>
<tr>
<td>amniotomy (4 studies)</td>
<td></td>
<td>0.80 (0.66 – 0.98)</td>
</tr>
<tr>
<td>an instrumental birth (13 studies)</td>
<td>129/1000 vs 143/1000</td>
<td>0.90 (0.83 – 0.97)</td>
</tr>
<tr>
<td>a baby born preterm (8 studies)</td>
<td>48/1000 vs 63/1000</td>
<td>0.76 (0.64 – 0.91)</td>
</tr>
<tr>
<td>a baby died (13 studies)</td>
<td>29/1000 vs 34/1000</td>
<td>0.84 (0.71 – 0.99)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More likely to have</th>
</tr>
</thead>
<tbody>
<tr>
<td>spontaneous vaginal birth (12 studies)</td>
</tr>
<tr>
<td>no analgesia/anaesthesia during labour (7 studies)</td>
</tr>
</tbody>
</table>
The CSR reported no adverse effects from midwifery-led continuity of care and that women who had midwifery-led continuity of care were more likely to be cared for by a midwife they knew. The majority of studies included in the CSR also reported higher satisfaction for women in the midwifery continuity of care models and a trend towards cost saving (Sandall et al., 2016).

The next section focuses on Australian studies that examined the effect of MCOC.

### 2.1.2 Recent Australian studies looking at MCOC models

In Australia there have been a number of studies demonstrating benefits of midwifery continuity of care; as stated above, seven of the studies included in the CSR discussed were Australian RCTs. Some of these Australian studies focused on MCOC in a caseload model and show benefits with populations of women with both a low risk (McLachlan et al., 2012) and a mixed risk (Tracy et al., 2013) of complications. Two recent Australian studies that are not RCTs but provide interesting findings on MCOC (Lewis et al., 2016; Turnbull et al., 2009) are also discussed.

**The COSMOS trial (Victoria) – women with low risks of complications**

The Comparing Standard Maternity Care with One-to-One Midwifery Support (COSMOS) RCT (N = 2314) was located in a Victorian metropolitan tertiary referral hospital and compared women at low risk of obstetric complications cared for by MGP (one-to-one midwife care) (n=1156) midwives to those experiencing SMC (n=1158). This study is also included in the recent CSR discussed above and is the largest RCT to date in Australia (McLachlan et al., 2012). As a standalone study it demonstrated additional benefits. Compared to the CSR the women in the COSMOS trial who had MGP care were also less likely to have a caesarean section and their babies were less likely to be admitted to the Neonatal Intensive Care (NICU) or Special Care Nursery (SCN). Rates of amniotomy, induction of labour or instrumental birth were not significantly different. Please refer to Table 3 (next page).
Table 3: Overview of outcomes associated with continuity of care by a primary midwife (caseload midwifery) reported by McLachlan et al (2016)

<table>
<thead>
<tr>
<th>Less likely to have an</th>
<th>MGP vs SMC</th>
<th>Risk ratio (RR) (95%CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>caesarean section</td>
<td>19.4% vs 24.9%</td>
<td>0.78 (0.67 – 0.91)</td>
<td>p = 0.001</td>
</tr>
<tr>
<td>epidural</td>
<td>30.5% vs 34.6%</td>
<td>0.88 (0.79 – 0.99)</td>
<td>p = 0.04</td>
</tr>
<tr>
<td>episiotomy</td>
<td>23.1% vs 29.4%</td>
<td>0.79 (0.67 – 0.92)</td>
<td>p = 0.003</td>
</tr>
<tr>
<td>a baby admitted to the NICU or SCN</td>
<td>4% vs 6.4%</td>
<td>0.63 (0.44 – 0.90)</td>
<td>p = 0.01</td>
</tr>
<tr>
<td>More likely to have</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vaginal birth</td>
<td>63% vs 55.7%</td>
<td>1.13 (1.06 – 1.21)</td>
<td>p = 0.001</td>
</tr>
</tbody>
</table>

The M@NGO trial (NSW & Queensland) – women with mixed risks of complications

The Midwives at New Group Practice Option (M@NGO) RCT (N = 1748) also located in a metropolitan tertiary referral hospital, but at two different sites in two states, NSW and Queensland, compared the outcomes between women receiving caseload midwifery care in MGPs (n=871) and SMC (N=877) for women including those whose pregnancies were associated with any risk factors. Women were excluded if they were under 18 years of age, over 24 weeks pregnant or already planning an elective caesarean section at recruitment, had a multiple pregnancy, or were planning to book with another care provider (eg, a general practitioner, caseload midwife, or private obstetrician).

No difference was found in neonatal outcomes, rate of unplanned caesarean sections, instrumental births, unassisted vaginal births and epidural use. However, in the SMC care group the proportion of planned or elective caesarean sections prior to the onset of labour differed and were significantly higher compared to the MGP group; SMC 11% vs MGP 8%, Odds Ratio 0.72, 95%CI (0.52 – 0.99, p= 0.05) (Tracy et al., 2013). Other outcomes from this trial will be discussed further on.
2.1.3 Other recent non-randomised Australian studies

Two other non-randomised Australian studies comparing MCOC to SMC also showed marked improvements.

A South Australian comparison of clinical outcomes

In a South Australian study, also situated in a metropolitan tertiary referral hospital, Turnbull et al (2009) (N = 4166) examined the differences between women who had received MGP to those who had SMC. In this study the differences according to obstetric risk categories of low, moderate and high were also compared between MGP and SMC. This study demonstrated significant differences favouring the MGP model in the low (n= MGP – 218, SMC – 773) and moderate risk categories (n= MGP – 354, SMC – 2211), but due to the small number of women in the high risk category (n= MGP – 46, SMC – 564), there was not enough statistical power to show if there was a beneficial effect of MGP in this group of women. Women in the MGP group were more likely to have a vaginal birth and less likely to have an instrumental birth, caesarean section, induction of labour and epidural analgesia. No differences in rates of perineal trauma, post-partum haemorrhage, antenatal hospital admissions, or admission to the NICU or the SCN were seen between the two groups. Please refer to Table 4 (next page).
Table 4: Overview of outcomes from MCOC in MGP reported by Turnbull et al (2009)

<table>
<thead>
<tr>
<th>Less likely to have an</th>
<th>MGP vs SMC</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>caesarean section</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>10.6% vs 13.4%</td>
<td>p = 0.002</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>17.8% vs 30.2%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>High Risk</td>
<td>24% vs 33.6%</td>
<td>p = 0.03</td>
</tr>
<tr>
<td>epidural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>22.5% vs 49%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>20.3% vs 38.4%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>High Risk</td>
<td>17.4% vs 32.6%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>instrumental birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>10.6% vs 19.8%</td>
<td>p &lt; 0.002</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>10% vs 15.7%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>High Risk</td>
<td>8.8% vs 10.3%</td>
<td>p = 0.03</td>
</tr>
</tbody>
</table>

| More likely to have   |            |         |
| spontaneous vaginal   |            |         |
| birth                 |            |         |
| Low risk              | 78.9% vs 66.9% | p = 0.002 |
| Moderate risk         | 72.3% vs 53.9% | p < 0.001 |
| High Risk             | 67.4% vs 46.1% | p = 0.03 |

A Western Australian mixed methods study

A recent Western Australian study also undertaken in a tertiary metropolitan hospital setting used a mixed methods approach to review the outcomes and experiences women had with a MGP with a 'no-exit’ programme between July 2013 and June 2014 (n = 232) Lewis et al. (2016). This compared the outcomes of this MGP programme to the outcomes of the Western Australian population giving birth at the time of the study. Women who had MGP care were more likely to have a vaginal birth and an intact perineum and less likely to have an epidural/spinal analgesia in labour or caesarean section. Please refer to Table 5, (next page).

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6 A ‘no exit’ programme accepts women into the MGP programme who have an initial low risk status for obstetric complications at the beginning of their pregnancy care. Then regardless of change in risk status or complications these women remain being cared for by the MGP midwife. The midwife then collaborates with obstetricians and other medical specialists to ensure the woman gets appropriate care.
Table 5: Overview of outcomes from MCOC in MGP reported by Lewis et al (2016)

<table>
<thead>
<tr>
<th>Less likely to have</th>
<th>MGP vs WA population</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>caesarean Section</td>
<td>13% vs 35%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Epidural</td>
<td>34% vs 59%</td>
<td>p &lt; 0.001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More likely to have</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>vaginal birth</td>
<td>87% vs 65%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Intact perineum</td>
<td>49% vs 36</td>
<td>p &lt; 0.001</td>
</tr>
</tbody>
</table>

2.1.4 Other Australian studies that have examined midwifery continuity of care

Other major studies in Australia have examined midwifery-led continuity of care models and have also been included in the CSR, but these have not been MCOC programmes but rather team midwifery. In these studies women continued to have better outcomes compared to the SMC system. For example, an RCT undertaken by Homer, Davis, et al. (2001) (N=1089) in a metropolitan hospital in Sydney, NSW, found a significant difference in the caesarean section rate between the community-based group who had continuity of care with a group of midwives and doctors and the women who had SMC, 13.3% (73/550) in the community-based group and 17.8% in the SMC group (96/539). In a secondary analysis Homer, Davis, et al., (2002) also found that women from the community-based group, who had a midwife during labour who they felt they knew, had a significantly higher sense of 'control' and a more positive birth experience compared with women who reported having care from an unknown midwife.

Another RCT (N=814) undertaken by Rowley, Hensley, Brinsmead, and Wlodarczyk (1995) at a tertiary referral hospital in NSW, which compared women who received team midwifery care to routine care or SMC, also identified significant differences in outcomes. Compared to the women in SMC the women under team midwifery care were more likely to attend antenatal classes (OR, 1.73; 95% CI, 1.23-2.42), to labour and give birth without intervention (OR, 1.73; 95% CI, 1.28-2.34) and less
likely to use pethidine during labour (OR, 0.32; 95% CI, 0.22-0.46). The babies born to the women in the team midwifery program also had less neonatal resuscitation (OR, 0.59; 95% CI, 0.41-0.86), although there was no difference in Apgar scores at five minutes (OR, 0.86; 95% CI, 0.29-2.57). Women under team care also had higher levels of satisfaction compared to the women who had the routine care.

2.1.5 Postnatal and longer-term outcomes for women and babies following birth

The immediate postpartum and longer-term benefits of continuity of midwifery are starting to become evident. Higher breastfeeding initiation rates are reported for women who received midwife-led continuity of care and MCOC, attributed to consistency of advice and prolonged postnatal support (Allen et al., 2017; De Koninck, Blais, Joubert, & Gagnon, 2001; McCourt, Page, Hewison, & Vail, 1998; Rowley et al., 1995; Sandall, Davies, & Warwick, 2001).

The potential added benefit of MCOC is the provision of care by a known midwife in the postnatal period for upwards of six weeks. This enables the woman to debrief about her pregnancy and labour and birth experiences. A meta-ethnography of 10 qualitative studies which reported on women’s perceptions and experiences of traumatic birth concluded that: ‘models of midwifery-led care can potentially increase the continuity of care and facilitate women’s active participation in their birth experiences’ (Elmir, Schmied, Wilkes, & Jackson, 2010, p. 1252). The opportunity to debrief with a known midwife is likely to be a major factor in this. A recent review of the literature on post-traumatic stress disorder also showed women who had midwifery-led continuity of care might be less likely to develop this disorder (Simpson, Schmied, Dickson, & Dahlen, 2018)

There is now emerging evidence of longer-term benefits of MCOC for women and babies. A number of participants in the M@NGO study (previously discussed) participated in a longitudinal cohort study examining the effects of the Queensland floods in 2011, a large natural disaster that flooded vast areas in and around the city of Brisbane. This flood occurred during the M@NGO study recruitment period
in 2011 (Kildea et al., 2018). The study, known as the Flood Study, included women enrolled in MGP (caseload midwifery) (n=55) and SMC (n=71) and asked the women to complete a number of stress scale questionnaires, both objective and subjective, and the Edinburgh Depression Scale, at recruitment then at six weeks and six months. Data from the six-week questionnaires showed that MGP mitigated the effects of the high-level stress created by the floods. Women in the SMC group had increased depression and anxiety scores compared to the women who had MGP. The authors attributed this difference in mood to the number of postnatal home visits that women in the MGP group received, 5.93 (n=43, SD = 2.24, range = 2-12), compared to the women in SMC in this study cohort, 1.90 (n=49, SD = 1.29, range =0-6). The benefit of MCOC and the development of a supportive and caring midwife-woman relationship was also considered an important influencer of the women’s ability to manage the stress of such large natural disaster.

2.1.6. Economic evaluation

Several studies have demonstrated cost savings associated with midwifery-led continuity of care programmes (Homer, Matha, Jordan, Wills, & Davis, 2001; Rowley et al., 1995; Tracy & Tracy, 2003). A recent systematic review examined the literature associated with economic evaluations and cost analysis of birth setting for women at low risk of complications from Australia, Canada, the Netherlands, Norway, the USA, and the UK. Although not conclusive the findings from this review found that eight of the 11 studies showed a trend towards cost savings for models of care that were the alternative to the standard model and were midwife-led (Scarf, Catling, Viney, & Homer, 2016). These were attributed mostly to location of care. Compared to the obstetric unit, homebirths showed the greatest financial cost saving. Freestanding birth centres were next to show a cost benefit and then alongside birth centres. These cost savings were associated with women having less interventions and procedures and a shorter length of stay or accommodation

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7 Freestanding birth centres are licensed healthcare facilities not physically or administratively attached to a hospital

8 Alongside birth centres are located next to a hospital and in most circumstances have close administration ties with the hospital
costs. However, lack of consistency with how costs were identified in the studies included in this systematic review, led the authors to be hesitant about comparability or generalisability of the economic benefits. Additionally, it was not made clear in this systematic review of literature how midwifery-led continuity of care might have influenced these cost savings.

The cost of MGP care in the M@NGO study in NSW was found to save on average AUS $566.74 more per woman than SMC (Tracy et al., 2013). Another examination of the data from the M@NGO study found that when they compared the birth outcomes and costs between caseload midwifery to SMC and to private obstetric care for first time mothers in a public teaching hospital that there were cost savings (Tracy et al., 2014). From the public hospital perspective, over one financial year the average cost of care for the typical primipara in MGP was $3903.78 per woman. This was $1375.45 less per woman than those receiving private obstetric care and $1590.91 less than standard hospital care per woman (p < 0.001). Similar differences in cost were found in favour of MGP for all women in the study who received caseload care. Another study undertaken at a South Australian metropolitan tertiary hospital examined the outcomes and costs associated for women who accessed the public system and who were classified with a 'moderate' obstetric risk pregnancy and cared for by the MGP (n=3,385) and SMC service (n=10,077) between 2004 and 2010. This study also found that as a result of the decreased interventions in the MGP cohort there were a number of associated financial savings (Donnellan-Fernandez, 2013).

Decreased rates of antenatal hospital admission and rates of pre-term birth have also been identified in a number of studies in the developed world that compared midwife-led care to standard care and this would also contribute to significant financial savings as well as ongoing morbidity for children (Biro, Waldenstrom, & Pannifex, 2000; Fereday et al., 2009; Flint, Poulengeris, & Grant, 1989; Harvey, Jarrell, Brant, Stainton, & Rash, 1996; Page, Beake, Vail, McCourt, & Hewison, 2001; Sandall et al., 2001; Turnbull et al., 2009; Turnbull et al., 1996). Limitations of all these studies include the fact that to date there have been no long-term studies.
looking at the cumulative cost savings that might occur due to impact on future births and the future health of women and children.

2.1.7 Satisfaction with midwifery continuity of care

There is mounting evidence that women are more satisfied when they receive midwifery-led continuity of care. The CSR discussed above stated that while there was a lack of consistency in measuring women's satisfaction the majority of included studies reported a higher rate of maternal satisfaction in midwife-led continuity models of care (Sandall et al., 2016). A recent NSW government evaluation of women’s experiences of maternity care in NSW found the two hospitals where women can only access midwifery continuity of care with the MGP had the highest satisfaction with care of any hospital in the state (Bureau of Health Information, 2017).

A questionnaire undertaken as part of the South Australian MGP study (Fereday et al., 2009) with 120 of the women who had MGP care and a 70% response rate, showed women were satisfied with their care, reported less anxiety and responded positively about their care. The women reported that 'accessibility' and the 'personal and professional attributes' of the MGP midwives were important factors associated a positive experience of childbirth. Likewise, a six-week postnatal questionnaire asking the women about their experiences with the MGP in the Western Australian study by Lewis et al. (2016) also had a high response rate of 97%, with 98% of the women stating they would recommend the MGP service to friends and family. An interview with 62 of these women, which was analysed thematically, showed an overarching theme of 'Continuity with Midwives' informed by six sub-themes that reflected the women's experiences with the MGP as positive and one of connection and support: "only a phone call away"; "home away from home"; "knowing me"; "a shared view"; "there for me" and "letting it happen".

Reports of women’s dissatisfaction with their birth experiences are often linked to complicated, negative or traumatic birth experiences (Dahlen, 2010; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004). A recent survey of 1,735 Australian
women by 'Safe Motherhood for All' (Safe Motherhood for All, 2017), as part of a campaign for Respectful Maternity Care, found 26% of the women felt the birth was negative and this was more likely if they had intervention during the labour and birth, particularly an instrumental birth or caesarean section. Women who gave birth at home were overwhelmingly more satisfied with the birth with 96% feeling in control and 97% feeling the birth experience was positive. This is highly likely to do with the fact that intervention in birth is lower when a planned homebirth and in Australia the continuity of care with a known midwife is higher in all homebirth models than any other model of care.

Dissatisfaction with birth can have long term effects on women as well. Waldenstrom et al (2004) interviewed 2541 Swedish women during pregnancy, two months postnatal and after the first year and found that 6.8% of women still reported high levels of dissatisfaction a year after they had given birth. A prospective, longitudinal Australian study that conducted telephone interviews of 499 women in the postnatal period found a much higher rate of dissatisfaction, with up to a third of women continuing to experience trauma symptoms at 4-6 weeks after a traumatic birth (Creedy, Sochet, & Horsfall, 2000). Similarly, in the United States of America, (USA) a study suggested that up to a third of 103 women interviewed reported the birth as traumatic (Soet, Brack, & Dilorio, 2003).

In Australia a number of qualitative studies that have examined women and men's experiences of the maternity care system indicate what Dahlen et al. (2011) state as 'the broken maternity system is failing women and midwives' (p49) leaving them 'unsupported and at risk' of physical, social and emotional harm. A South Australian study of women (38) and men (24) from different metropolitan areas who had received maternity care in the previous six years, found their birth experiences were mostly medicalised and at odds with their expectations. Over half the women had a negative experience and half of these described their experience as "horrific", "traumatising" and "shocking" (Newman, 2009). They associated these negative experiences with unwanted or painful medical interventions, uncaring staff and treatment from "strangers". Both men and women reported having long-term
negative effects with attachment to their baby, physical and emotional health and relationship issues.

2.2 What are the effective components of midwifery-led continuity of care and MCOC

The next section of this review will look at some of the philosophical concepts that underpin midwifery and the models of midwifery-led continuity of care and MCOC. These include woman centre care, the midwife-woman relationship and partnership. These concepts will only be introduced as they are dealt with in much greater depth in the Discussion Chapter.

2.2.1 Woman-centred care

It has been well argued that what is central to the positive outcomes seen under midwifery-led continuity of care and MCOC models is the philosophy of woman-centred care and the power of the midwife woman relationship.

The midwifery philosophy of care that underpins the practices and behaviours that midwives espouse and demonstrate in their daily practice is conceptualised by the ability of the midwife 'to be with' woman (Guilliland & Pairman, 1994; Kirkham, 2010; Leap & Pairman, 2010). The term 'midwife' is derived from an Old English term meaning 'with woman' and is a fundamental principal of midwifery being an enabling profession and is associated with the concepts of 'producing', 'bringing forth', or 'bringing about' (Lundgren, 2002; Merriam-Webster, 2003; Pairman, Tracy, Thorogood, & Pincombe, 2011).

As noted in the Introduction chapter a feminist theoretical perspective has guided this study. A feminist perspective privileges the social aspects of a healthcare relationship emphasising the sharing of power and information between provider and recipient, enabling them to both share information as equals or peers rather than expert and naïve recipient (Morgan, 2015). Woman-centred care relies on attributes of a social relationship or a partnership, for example choice, control, and a relationship where individual needs are valued and respected. Taking this
approach, the woman (and her partner/family) are the focus of care (Pope, Graham, & Patel, 2001).

Andrist (1997) articulated a feminist model for women’s health care taking a grounded theory approach (Andrist, 1997). This study included participant observations of 94 interactions between woman surgeons, who were observed to create an atmosphere where women with breast cancer could participate in decision-making. Interviews with seven women were undertaken and four women were followed for their entire treatment experience. The model was founded on creating social transformation or change and had four themes. These included 'symmetry of provider-patient relationships', 'access to information', 'shared decision making' and 'social change'. Much of this is illustrated in midwifery-led continuity of care and MCOC models, with women centred care being the central concept.

The concept of 'woman-centred' care is fundamental to the midwifery profession, underpins the philosophy of midwifery professional organisations and is used as a framework for a range of policies and standards related to midwifery and maternity services provision, particular in Australia and the UK (Leap, 2009). Guilliland and Pairman (1994) developed a theoretical model of 'midwife-woman partnership' and raised the need for women to be at the centre of their care. 'Woman-centred' care is defined as midwifery practice that:
Woman-centred care is midwifery that:

- Focuses on the woman’s individual needs, aspirations and expectations, rather than the needs of the institution or professionals
- Recognizes the need for women to have choice, control and continuity from a known caregiver or caregivers
- Encompasses the needs of the baby, the woman’s family and other people important to the woman, as defined and negotiated by the woman herself
- Follows the woman across the interface of community and acute settings
- Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations
- Recognizes the woman’s expertise in decision making (Leap, 2009, p. 737)

'Woman-centred' care relates to a midwife's ability or skill 'to be with', to provide support and compassion, to share in a common experience with the women when providing care and being part of a reciprocal relationship. More recently it has been described as 'working alongside' or 'walking alongside' a woman (Australian College of Midwives, 2017a).

Berg et al. (2012) developed a midwifery model of woman-centred care from a synthesis of 12 qualitative studies about women’s and midwives' experiences of childbirth. The authors then had this model assessed by 30 practising midwives from their respective countries of Iceland and Sweden. The model includes five themes – three were central and intertwined. These were: 'reciprocal relationship', a 'birthing atmosphere' which radiates feelings of calm, trust and safety and 'grounded knowledge' where the midwife's knowledge is embodied, and she has the resources and skill to use this knowledge differently to each woman's individual needs. The other two themes influenced the care; 'cultural context' and norms that hinder or promote optimal care based on midwifery philosophy of care and a 'balancing act'. They concluded that midwifery care in contemporary medicalised society entails a balancing act to enhance the culture of care based on midwifery philosophies where the woman is central.

Recently a review of the midwifery theoretical literature pertaining to being 'with woman' reconceptualised this philosophy of woman-centred care (Bradfield,
Duggan, Hauck, & Kelly, 2018). It identified being 'with woman' is a fundamental construct of midwifery practice as well as continuing to be philosophically important to the profession. As a philosophy being 'with woman' continues to anchor, guide, inform and characterise midwifery practice (Leap, 2009).

### 2.2.2 The midwife-woman relationship and partnership

Central to the success of MCOC is the quality of the midwife-woman relationship. Guilliland and Pairman (1994) viewed qualities of the midwife-woman relationship to include partnership and a relationship formed on sharing of trust, control and responsibility. Lundgren and Berg (2007) found that a midwife-woman relationship included the paired concepts of how a woman perceived her care and how the midwife responded to her: surrender–availability, trust–mediation of trust, participation–mutuality, loneliness–confirmation, differences–support uniqueness and creation of meaning–support meaningfulness, and shared meaning through mutual understanding. Hunter (2006) sees reciprocity as an important midwife quality and Leap (2010) states a midwife needs to be able to be with a woman enabling her to sit with the uncertainty of the transitions she is embarking on and going through. Walsh and Devane (2012) also understood that advocacy and empathy were fundamental to a midwife-woman relationship. Providing continuity of care where a midwife-woman relationship grows across the duration of the woman's childbirth experience is seen as a relationship that develops a bond between the midwife and woman. It is recognised as a 'professional friendship' (Walsh, 1999) characterised by equality and inclusiveness (Jepsen, Mark, Foureur, Nøhr, & Sørensen, 2017), and is 'the glue that holds it all together' (Leap, Dahlen, Brodie, Tracy, & Thorpe, 2011).

Women have described the care they received in a midwife-led model of care as: empathic and caring; they had a greater sense of control and involvement with decision making, but also could rely on the midwife to support them during the transition phase of labour and 'give up' that control as they felt supported and protected (Walsh & Devane, 2012). A six-week postnatal survey with women who
had participated (N = 1748) in the M@NGO RCT comparing MGP to SMC had a 52% (n = 901) response rate. The women from both groups of participants in this study characterised the midwives as ‘informative, competent and kind’, while the women in the MGP group additionally characterised their midwives as ‘empowering and ‘endorphic’ (Allen et al., 2017).

In this next section the concepts of agency and structure are explored in relation to maternity care and their influence on MCOC models.

2.2.3 Agency / structure

The relationship between the midwife and the woman in midwifery-led and midwifery continuity of care models have been described as enabling, positive and empowering for both midwife and woman (Leap, 2010). However, it remains unclear as to how this personal and emotional connection is embedded in this professional relationship; and how the agency, individual skill and knowledge, of both woman and midwife is enhanced in this healthcare relationship.

Agency is understood in the sociological sense as incorporating the perception of autonomy and identity and an expression in decision-making and action (empowerment) in the individual (Giddens & Sutton, 2013). Structure, in a sociological sense, refers to patterns of action over time which are often customary and taken for granted leading to and causing people to act and relate in certain routines and habits (Lane, 2012; Scott, 2017). For example, in health or medicine the sociological structures created to distribute healthcare are the institutions, laws and policies (Giddens & Sutton, 2013; Smith, 2006).

In their efforts to clarify why low-risk women experience fewer birth interventions and improved outcomes Walsh and Devane (2012) undertook a metasynthesis of eight studies from the UK, USA, Sweden and Australia that had examined effect of birth centre care located outside of the SMC system. The methodologies used by these studies ranged from ethnography, grounded theory and phenomenology to broader descriptive research. Results suggest that the reduction of interventions and improved clinical outcomes in midwifery-led care might be explained by social
theory concepts of agency and structure. Higher levels of agency were reported by women and midwives in midwifery-led care and attributed to the mutually beneficial relationship they had developed. They were also attributed to the influence of structure or culture of the environment developed in the small midwifery-led units located away from the hospital and the SMC system (Walsh & Devane, 2012). Also, the positive effect of the MCOC programmes in Australia on women’s satisfaction (Fereday et al., 2009; Lewis et al., 2016) and in some instances agency (Allen et al., 2017) were not linked to location of the care but rather there was an association with how the MCOC programme influenced the midwife’s practices and the way she interacted with the women.

In another study led by Walsh (2006), women described hospital labour wards as "baby factories" and described "feeling like you were on a conveyer belt and that the midwives were robotic toward you” (p. 1332). In contrast, women receiving care through midwifery-led models reported their midwifery care as supportive, reassuring and sensitive to their individual needs, promoting their confidence with labour and birth and early parenting (Walsh, 2006b). Likewise, other studies in the UK, Australia and Sweden report this contrast in women’s experiences with midwifery care they received from the SMC and the midwife-led or midwifery continuity of care programmes (Fereday et al., 2009; Homer, Davis, et al., 2002; Waldenström, 1999; Walsh, 1999). Walsh & Devane (2012) and Allen et al. (2017) report that midwives working in these models of midwife-led or MCOC care are more effective in facilitating agency and a sense of empowerment for the women as they have an increased sense of autonomy and agency as a result of the midwife-woman relationship.

Healthcare system setup, patterns of work, provider behaviours and policies are said to be directed by these cultural norms, which prioritise the performance of tasks and allegiance with the institution in preference to the midwife-woman relationship (Hughes, Deery, & Lovatt, 2002; Kirkham, 1999; Olsson & Jansson, 2001; Pazandeh, Potrata, Huss, Hirst, & House, 2017; Stapleton, Kirkham, Thomas, & Curtis, 2002). Issues of time pressure and the focus of the organisation’s culture
on routines, procedures and fragmented maternity services were observed by Dykes (2005b) to impact negatively on the way the midwives interacted with breastfeeding women. Like, Scamell and Stewart (2014) they found time pressures when caring for women in labour undermined the midwives sense of autonomy and an overall midwifery endeavour to provide individualised care. This resulted in a midwifery service more focused on the needs of the institution than the woman (Choucri, 2012; Dykes, 2005b).

Appropriate support, facilitation or management of midwifery continuity of care programmes are also reported to provide benefits for midwives working in these models, creating personal growth and empowerment and leading to increased job satisfaction (Dawson, Forster, McLachlan, & Newton, 2017; Leap et al., 2011). Like the women in the studies they examined, Walsh and Devane (2012) link this positive influence of the midwife-led model of care on the midwives to the structure of the model being different to the SMC system. It is, however, less clear as to what is different in the structure (culture and environment) of this model of care that enables a positive and clinically effective midwife-woman relationship.

In this next section the concepts of power relationships in maternity care and their influence on MCOC models are explored.

### 2.2.4 Power relationships in maternity / healthcare

Power is recognised as a central element in all social interactions (Bourdieu, 1991; Foucault & Sheridan, 1979) and this can also be related to the midwife-woman relationship. In order to act appropriately in different care situations, it is important to understand the meaning of power (Nimmon & Stenfors-Hayes, 2016). It is also acknowledged that power is evident between individuals and within structures such as healthcare systems; this can be seen between professionals, such as the relationships between obstetricians and midwives and between healthcare providers and recipients (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017; Matthews & Scott, 2008; Newnham, 2016). It is important to acknowledge that power over patients (Foucault, 2008; Rafael, 1996), and particularly women in
childbirth, is widely used and often concealed and multi-dimensional (Fahy & Parratt, 2006; Prosen & Tavcar Krajnc, 2013; Rafael, 1996; Walsh, 2005).

Realising that power is enacted on a continuum between empowerment and oppression and has fluidity, which relates to situations, environment and the individuals concerned (Callaghan, 2002; Freire, 2014; Matthews & Scott, 2008), enables a clearer understanding of the power dynamics within a midwife-woman relationship (Davis, 2006). Using the concept of power to understand and critically interpret healthcare relationships has been reported in the literature using a variety of theories and research processes, one recent Australian example was Dove and Muir-Cochrane (2014) who found midwives had to assume a risk negotiator role to mediate relationships between women and the hospital staff.

Hoskanson Hawks (1991) defined positive or affirming power as:

... the actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve those goals are mutually established and worked toward (p. 758).

Such attributes may relate to the power within a midwife-woman relationship built up over the childbirth experience. The concept mapping undertaken by Hoskanson Hawks (1991) illustrate that the antecedents of power are:

... the presence of two or more people; the acquisition of power skills such as trust, communication skills, knowledge, concern, caring, respect and courtesy; possession of at least one of the four power sources informational, referent, expert or legitimate; an orientation of power as good and self-confidence (p. 758).

In the context of a positive and successful midwife-woman relationship these antecedents are purported in the literature as important building blocks (Homer et al., 2008; Miller & Wilkes, 2015).

The location and environment of where care is provided, or the place (Hammond, Foureur, Homer, & Davis, 2013), is shaped by social and institutional beliefs and priorities of its time (Choucri, 2012). Browne and Chandra (2009) note that the capacity of the midwife-mother relationship to be potentially healing or beneficial requires the time and environment that affects engagement and connection. More
specifically, within the context of the antenatal appointment, researchers have identified a number of attributes of midwifery care integral to generating a positive and effective midwife-woman relationship. Apart from continuity of care these include a midwife who is focused on: the woman; wellness instead of pathology; informed choice; shared decision making and consent and midwifery care that includes: negotiation; reciprocity; equality; shared responsibility and empowerment (Browne, O'Brien, Taylor, Bowman, & Davis, 2014; Hunter, 2006; Sword et al., 2012).

Mondy, Fenwick, Leap, and Foureur (2016) highlight that the space of childbirth is by its nature a private or domestic affair and one where the woman needs to be seen from a holistic perspective including the physical, the spiritual, the psychological and the social. However, few studies have focused their examination specifically on the interactions between the midwife and woman in the antenatal appointment under different models of care.

The next section looks briefly at the literature on human interactions and how this may relate to MCOC. As the study undertaken is an ethnography the interactions observed and recorded between the women and midwives are critical to the research.

2.3 Human Interactions

Human interactions, particularly in healthcare, are complex and multi-layered events that come with multiple viewpoints (Davis-Floyd, 2001; Lane, 2012). It is recognised that they are formed from a variety of social and cultural factors: the perspectives of the individuals involved, the purpose of the event; the environment and the relationship between the individuals (Andrews, Squire, & Tamboukou, 2013; Rose, 2016; Roter & Larson, 2002). The midwife-woman interaction in the antenatal appointment, representing a human interaction, is a facet of midwifery work that has not been studied in any great depth. The quality of the interaction has been overlooked in preference to highlighting the importance of the routine elements of the antenatal appointment that are assessment, screening and
education (Villar, Carroli, Khan-Neelofur, Piaggio, & Gulmezoglu, 2007). This focus on task has been attributed to the dominance of the biomedical model and the knowledge and power of bureaucracy and organisational efficiency believed to be efficient, which has resulted in the fragmentation of care and the use of multiple care providers for the childbearing woman (Wagner, 1994). Maternity care is now, more than ever, focused on tasks instead of the individual woman (Newnham, 2016).

Recent Australian research points toward the midwife-woman relationship in antenatal care being beneficial but does not identify what happens in the antenatal appointment to create this benefit. Newton, McLachlan, Forster, and Willis (2016), for example, surveyed and interviewed midwives working in caseload about their views and experiences of working in caseload at the commencement of the new caseload model in two Victorian hospitals and then two years after. The midwives in this study described working in caseload was "different" and allowed them to work in a way that they perceived as "real midwifery". 'Different' because their work was linked to being on-call for their women that resulted in it being activity based instead of the traditional shift patterns and they had to manage a work private life balance. It was seen as 'Real midwifery' because caseload offered midwives opportunities to develop relationships with the women, a degree of autonomy and a high level of satisfaction.

Conversation analysis was used by McKenzie (2010) to examine a series of antenatal appointments to find out what shaped the midwife-woman relationship. The researcher found that midwives and women used small talk in antenatal appointments about everyday topics to frame and build up their relationship and relied on conversations from previous clinic visits to frame new topics of conversations and plan for the future. As Fenwick, Barclay, and Schmied (2001) found in the postnatal period and in the neonatal units the relaxed social interaction of 'chatting' is significant in how women experience and/or receive their care.
From a sociological point of view, societal institutions and the relationships or social structures that arise between individuals, groups and institutions inevitably influence all human activity leading to and influencing all healthcare activities and policies (Giddens & Sutton, 2013; Kingdon, 2014). This is as at odds with Western scientific medicine which institutes itself as being objective and value-free where doctors base their care in medical science and objectivity and see their patients as subject matter (Abbott & Wallace, 1997). Centralisation and fragmentation of public healthcare has destroyed many of the previous championed notions of quality care being individualized, relationship-based and provided by a known healthcare provider (Safe Motherhood for All, 2017).

As discussed earlier in this chapter, the majority of research examining midwifery-led and MCOC programmes have either focused on the clinical outcomes, satisfaction levels or on interactions between midwife and woman during the labour and birth. Leaving less understanding about how the midwife-woman relationship is formed during the preceding antenatal period and how it potentiates the labour, birth or postnatal event. Like Davis Harte, Leap, Fenwick, Homer, and Foureur (2014) and Lomax (2011) who were curious about what influenced midwife-woman interactions in the birth room, the focus of this study is on the midwife-woman interaction in the antenatal appointment to gain greater understanding about this facet of midwifery care and the effect of a midwife-woman relationship on it. Human interactions and the micro components of this interaction during the antenatal appointment are of central interest in this study as they might reveal insights into what it is that really makes the MCOC different and effective.

2.4 Informing change

It is recognised that more needs to be done to improve the quality and processes of maternity care so that it meets the needs of each woman, her individual situation or family needs and her use of midwifery services that are focused on more than the identification and treatment of disease (Dawson et al., 2017; Dawson et al.,
Midwifery education and midwifery scientific research are important to the development of strategies to promote physiological birth, enhance woman-centred care and lower rates of intervention (Homer et al., 2014; Sandall et al., 2016; Thompson, Nieuwenhuijze, Low, & de Vries, 2016). It is argued that an impetus for change can be influenced by a greater understanding of how a positive midwife-woman relationship enhances the care provided. Such knowledge might potentially support maternity service reform at a service planning and development level, which appears to be where the motivation for change is at its slowest (Reiger, 2006). State and Commonwealth governments in Australia for example already recommend a commitment to MCOC with the Towards Normal Birth Policy (NSW Health, 2010) and the National Maternity Services Plan (Commonwealth of Australia, 2011). For example,

Continuity of care has been identified as an important feature of maternity care, particularly emphasized in New Zealand and the UK where a wellness paradigm for pregnancy and childbirth is promoted. New Zealand and the UK have also identified woman-centred care, access to range of models of maternity care, and a capacity for women to make informed choices about their care as underlying principles to guide reform (Commonwealth of Australia, 2011, p. 19).

Furthermore, it is acknowledged that to influence the individual's desire to change there needs to be either a first-hand experience of the changed action or to see it demonstrated and articulated at a practice-based level (Fenwick, Toohill, Slavin, Creedy, & Gamble, 2018; Olafsdottir & Kirkham, 2009; Swanson-Fisher, 2004). The powerful effects of the first-hand experiences of an enabling midwife-woman relationship have been described to have equipped change agents with much needed energy and passion required to promote optimal midwifery models of care (Crowther et al., 2016; Lindberg, Christensson, & Ohrling, 2005; Swanson-Fisher, 2004). For both midwives and women, potentially this motivation will be as result of experiencing an empowering midwife-woman relationship or bearing witness to exemplary midwifery care that is endorsed and supported by the governing hospital or organisation (Gutteridge, 2014; Hunter, 2005; Teate, Leap, & Homer, 2012).
In order to translate MCOC into new environments it is important to understand how these models impact on the midwife-woman interactions. Such knowledge will potentially elicit the benefits of ongoing supportive care that enables women to have improved outcomes and improved support from a known midwife. It is not simply continuity of care and carer that improves outcomes, as medical practitioners also offer continuity of care and carer to women during pregnancy (Freeman & Hughes, 2010), rather there is something in the way the midwife practises, her underlying philosophy of care and how she acts and interacts with women that appears to be facilitating more positive outcomes. It is therefore beneficial to understand how midwives affect this model of care and, in turn, how this model of continuity affects them and the women.

2.5 Conclusion

In this chapter a review of the literature related to midwifery-led continuity of care and the MCOC model has been presented, with a particular focus on the Australian context as this is the context that the study is undertaken in. Concepts such as woman-centred care and partnership that are central to midwifery models of care have also been explored along with power relationships and human interactions. The next chapter will present the methodology for the study.
Chapter 3 – Examining midwife-woman interactions

This chapter presents the research design, methodology and methods for this study. As identified in the literature review in Chapter Two, the positive outcomes that midwifery models of care deliver for women and their newborns are not embedded in the contemporary healthcare system. This relates in part to the oppression of midwifery within the medically-dominated Australian maternity care system but there are also gaps in the evidence and knowledge about how and why MCOC facilitates positive outcomes for women and their newborns.

The aim of this study was to gain a better understanding of how the MGP might influence midwife-woman interactions in an attempt to understand why MCOC models improve outcomes for women and their newborns. To do this I needed to understand the facilitators and barriers that affect the sociocultural reality (Thomas, 1993) of the antenatal appointment and the midwife-woman interaction.

As Miller states, an enthusiast and promoter of growth-fostering relationships,

> What goes on within a relationship to produce the 'good things'? To get at that, we have to look at the flow of forces within the interactions between people (Miller, 1986, p. 3).

I decided an ethnographic study framed by feminist and critical perspectives was the appropriate method. I conducted focus groups with midwives and managers and interviews with women and midwives and video-recorded midwife-woman interactions in a number of antenatal appointments at two metropolitan hospitals in Sydney, Australia.

The first section in this chapter presents the research design and theoretical framework and the second section presents the research methods used.

3.1 Research design

To inform practice and improve childbirth outcomes and experiences, research into contemporary midwifery and maternity care research is needed to develop a body of knowledge that is reliable and consistent (Chalmers, Enkin, & Keirse, 1989; Cluett & Bluff, 2006). The current and prevailing 'scientific' or 'biomedical' approach
(Chalmers et al., 1989; Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998) is underpinned by a positivist epistemological worldview (Creswell, 2003; Grbich, 2007). Researchers coming from a positivist perspective argue that reality and truth can be observed, measured and accessed through processes of reason and logic (Grbich, 2007). Research processes that are suited to this worldview are quantitative and include hypothesis testing, identification and measurement of variables within a controlled experimental research design. Based on this approach, predictions can be made about certain phenomena enabling evaluation using mathematical logic or statistical methods (Cluett & Bluff, 2006) and are dependent on 'things being sorted out in simple terms' (Byrne, 1998, p. 1). These methods, however, produce minimal information to develop our understanding of the healthcare action or the participant's experience.

I decided that, with the focus of my study on human interactions, it was too complex to rely on this traditional quantitative scientific approach (Berger & Luckmann, 1966; Grbich, 2007). This decision does not dismiss the value of a positivist approach. As I reported in the previous chapters, a number of high quality RCTs have identified a number of beneficial outcomes and effects of midwife-led and MCOC models. But what this positivist research does not explain is how these outcomes are achieved. Qualitative interpretative research plays an important role in quality improvement strategies for healthcare (Iedema, Mesman, & Carroll, 2013), and for understanding 'what we do' in healthcare (Bourgeault, Dingwall, & De Vries, 2010).

I have used a qualitative approach to facilitate a detailed exploration of the social interaction between the midwife and woman (Creswell, 2009; Murphy et al., 1998). I have also positioned the research within a social constructionist worldview with a feminist theoretical lens informed by a critical ethnographic methodology. I chose a feminist lens to explore the experiences of the women (midwives and pregnant women) and also to give voice to their lived experiences (Dykes, 2009a; Hammersley & Atkinson, 2007). Likewise, I decided to use ethnography with a critical focus because it allows for a political approach to the overall inquiry of the
sociocultural context (Thomas, 1993). Critical ethnography has the potential to expose issues of power and control within individual practice and within the organisations (Grbich, 2007).

This philosophical and methodological stance was fundamental to the research design. I was interested in knowledge generation and also creating a political and emancipatory voice for midwifery to improve women’s access to woman-centred midwifery care.

### 3.1.1 Qualitative methodology

Within a qualitative methodology the researcher is required to take a broader view to understand the meaning of our actions and interactions and why we act the way do. As Giddens & Sutton point out:

... much of what we regard as natural, inevitable, good and true may not be so, and [that] things we take for granted are actually shaped by historical events and social processes (2013, p. 4).

Using a qualitative approach has enabled me to explore the meanings people attach to their experiences and the social structures and processes that shape these (Popay, 1992). It provides 'an account of social action that helps us unravel the implicit rules and conventions that make social behaviour meaningful' (Avis, 2005, p. 4) and helps us to understand our social lives better and to view it in new ways.

A key strength of qualitative methodologies is the capacity to study social interactions and processes rather than simply identifying a causal relationship between variables (Murphy et al., 1998). It enables us to understand ‘the relationship between our own experiences and the social structures we inhabit’ (Abbott & Wallace, 1997, p. 5). In this study, for example, I aimed to acquire a better understanding of the antenatal appointment and the midwife-woman interactions by gathering multiple perspectives from women, midwives and their managers (Kralik, 2005; Murphy et al., 1998). I anticipated that these multiple perspectives would inform my interpretations and analysis (Field & Morse, 1985).
3.1.2 Social constructionism

The social interaction under investigation in this study was between the midwife and woman in a late pregnancy antenatal appointment. Framing this study in social constructionism meant taking a particular view of the world and of social reality (Crotty, 1998), and using this to explore how midwives, women and managers made sense of the antenatal appointment and of midwifery practice/care. We may take something for granted, such as the way that we interact in an antenatal appointment, so fail to see that the appointment itself is constructed through multiple and diverse social interactions. People construct meaning of their world and life as they engage in interactions with others and with the world they live in (Dykes, 2004). In the context of the antenatal appointment, for example, its function or how it is undertaken/enacted differs, as it is dependent on where, how and what is constructed as important, habitual or instituted (Berger & Luckmann, 1966). A social constructionist worldview acknowledges that our individual realities are a perception based on our experiences of society and our everyday lives (Berger & Luckmann, 1966).

In this study, one important structural or contextual concept is that of gender. Given both the past and contemporary patriarchal constructions of women’s reproductive health, maternity care and the role of midwives (Davis & Walker, 2010; Menke, Fenwick, Gamble, Brittain, & Creedy, 2014), this is a valid focus. As explained in the previous chapter, women and midwives have continued to experience oppression in patriarchal models of maternity care (Davis-Floyd, 2001; Wagner, 1994). Typically, the experience of the antenatal appointment is that there is less opportunity for health promotion and even less attention paid to the woman, her experience, her needs and her concerns or fears (Teate, 2010; Villar, Garcia, & Walker, 1993). My focus on gender in this study is sympathetic to the midwifery philosophical view that prioritises the midwife-woman relationship and considers the social interactions in the antenatal appointment are just as important as the medical functions of assessment and screening (Davis-Floyd, 2001; Hunter et al., 2008; Leap, 2010; Leap et al., 2011).
A social constructionist perspective focuses the investigation on everyday instances of social interaction to discover the sources and nature of the apparent orderliness of the social world (Dennis, Philburn, & Smith, 2013). As Silverman describes this is finding the ‘remarkable in the mundane’ (2013). I have examined the social interactions, routines and opportunities afforded to differing models of care, the organisation of this care and the environment within seemingly everyday antenatal appointment conversations and interactions. This, along with the knowledge gained from the women, midwives and managers, has enabled me to interpret and report the meanings of these interactions from multiple perspectives.

3.1.3 Feminist theory

Feminism is a philosophy and a practice (Jackson et al., 2003) and, depending on context and time, means different things to different people (Yuill, 2012). In broad terms it is a historical and social movement that developed to challenge the oppression of women (Kaufmann, 2004). Further to this generalisation, is the analysis that most people have been conditioned into gender roles through sexist ideology and ways of thinking, which customarily give males more power (institutional, social, and economic) and more opportunity to access resources (Given, 2008). A key assumption within feminism is that sexism and the power of patriarchy (that leads to sexism) are the problem, not men per se (Abbott & Wallace, 1997).

Feminist theory is concerned with what constitutes knowledge about women’s lives and how knowledge is constructed for women. Many feminist theories are founded in the everyday lives and experiences of women as well as the influence that social structures and power relations play in shaping knowledge production and shaping individual women’s lives (Hesse-Biber & Leavy, 2007; Kralik, 2005).

At the foundation of all feminist theory is the role of gender in determining how knowledge is constructed, by both the individual knowers and by social and cultural groups of women and men (Given, 2008). Gender is also the central category of analysis for all the varying theories (Ackerly & True, 2010). Central to feminist
theory is the influence of power on the issue of gender, whether that be power determined by race, culture, social class, or other social categories, and how it shapes what counts as knowledge (Ackerly & True, 2010; Given, 2008).

The multitude of feminist theoretical perspectives—such as second wave, liberal, radical, Marxist, poststructuralist, post-colonial, standpoint, black and Latino—makes it difficult to use just one feminist theory (Ackerly & True, 2010; Hesse-Biber & Leavy, 2007). Even within midwifery, a variety of different feminist approaches have been used and each individually endorsed as the most appropriate to inform midwifery practice and research (Stewart, 2004). Regardless of their differences and due to their central focus of gender, feminist theories span a continuum (Polit & Beck, 2010). At one end of the continuum the focus is on understanding both oppression and agency from the subjective perspective of individual women, such as with second wave and liberal feminism. At the other end of the continuum the focus is on social movements—how social structures, policies and power relations shape knowledge production and individual women’s lives and afford women a particular role and place in society—for example radical, Marxist, standpoint, or cultural feminism (Jackson & Jones, 1998). In all of these perspectives, women and their lives are valued and there is a focus on exposing women’s oppression and a concern for transforming their lives (Ackerly & True, 2010; Webb, 1993). Also, within feminist research it is recognised that women’s voices have been silenced by male-dominated research paradigms.

A feminist theoretical approach asks how women’s lives are affected, whether they are enabled in their decision-making, or put at risk by the actions of others (Jenkinson et al., 2017). In this study, I used a feminist lens to examine how both the pregnant woman and the midwife are affected by midwifery practice that is situated within the institutional patriarchal health system. Previous work has shown that certain midwifery and many maternity practices are influenced by the dominant biomedical model in contemporary healthcare (Davis-Floyd, 1994; Neiterman, 2013; Oakley, 1984; Parry, 2008). Likewise, feminist theory has been used to examine the impact of midwifery practice, particularly in models of care.
that promote continuity of care (Bourgeault, Sutherns, MacDonald, & Luce, 2012; Davis & Walker, 2011).

The focus of this study was to reveal what influences midwife-woman interactions. It also aimed at giving both pregnant woman and the midwife (all women in this study), the opportunity to voice their experiences (Ackerly & True, 2010; Jackson et al., 2003). In realising that the multiple perspectives of feminist research can be interpreted as part of a continuum I chose to apply an inclusive or eclectic approach to my research. This eclectic stance is recognised when researchers, such as myself, are wishing to choose research methods that are most appropriate to the topic under consideration, rather than claiming a privileged status for any particular method or methods (Ackerly & True, 2010; Jackson & Jones, 1998; Webb, 1993). This is similar to recent maternity and midwifery research projects where a feminist lens of analysis was used to explore and understand the lived experiences of women both at work and in the receipt of midwifery care (Edwards, 2001; Jenkinson et al., 2017; Keating & Fleming, 2009; Stewart, 2004).

I see feminist theory as a powerful resource to understand what types or models of midwifery practice/care work best for the childbearing woman and the midwife and enable them to have more control and power with their decision making. It offers a lens through which we can see and construct our understanding of the forces and feelings that shape women's lives (Kaufmann, 2004). The stance that I chose for this study included placing the woman at the centre of the analysis. In part I relied on standpoint feminism to focus on the views and perspective (standpoints) of the women, the midwives and the managers. As standpoint feminism is informed by Marxism (Harding, 2004), this enabled me to examine the structural influences – the macro as well as the micro – on midwife-woman interactions. I aimed to examine the influence of midwifery practice as well as the influence of the governing structures of the midwifery profession, the institution and organisation of maternity care.
3.1.4 Standpoint theory

The focus on subjective experience within many feminist theories can be explained by standpoint theory (Hesse-Biber & Leavy, 2007). It is founded on the work of Sandra Harding, which had in turn been informed by feminist theorists such as Dorothy Smith, Donna Haraway, Patricia Hill Collins, Nancy Harstock and Hilary Rose (Appelrouth & Edles, 2011). Smith describes the notion of feminist standpoint (or her preference to call it women’s standpoint) is underpinned by 'what one knows is affected by where one stands (one’s subject position) in society' (Appelrouth & Edles, 2011, p. 319). That is, each individual brings her own individual view to a social situation or to the analysis of a particular social world.

Smith explains that no two people will have the same standpoint as everyone has their own lived experiences that influences how they see the world. This experience can include multiple standpoints across a diversity of classes and cultures and be formulated on their personal and their public lived experiences.

Standpoint theory enriches the diverse group of feminist theories as it makes a diverse array of subjective points of view relevant. By its nature, it has the capacity to explain the diversity of feminist theories that have come to play, because these theories are derived from the standpoint of the women activists or researchers who established them. As the researcher for this study, I bring multiple standpoints, including midwife and researcher with a passion for woman-centred care, lesbian, white, middle-class and financially independent. Likewise, each study participant (midwife, manager or childbearing woman) brings their own standpoint gained from previous life experiences.

Smith’s use of standpoint theory goes beyond the empirical claim of an all-purpose analytical tool or a one-size-fits-all approach to the establishment of women’s knowledge (Smith, 1997). She emphasises that women’s knowledge is always rooted in a particular position and that women who are members of an oppressed group must be supported and enabled. Applying an analytical perspective such as this, which focuses on the experiences and perspectives of the women and the midwives, who appear not to see the oppression that they experience, provides me
with a valuable interpretative lens.

### 3.1.5 Woman-centred approach

Feminist theory recognises the centrality of women’s experiences and women's concerns as valid sources of knowledge, while feminism is concerned with valuing women’s ways of being, thinking and doing (Jackson et al., 2003). The ultimate aim of feminist theory is to transform the experiences of women through understanding and articulating their experiences and challenging the dominant structures and social order (Ackerly & True, 2010; Speedy, 1991; Webb, 1993). In the application of feminist theory, a woman-centred approach is recognised as fundamental, as it illuminates 'the life context and experiences of women, grounded by their frame of reference, experiences and language' (Kralik, 2005, p. 253). Being focused on the lives of women from a feminist perspective involves reflection upon experiences, values and ideologies and keeps the feminist goal of transformation in mind. Such critical reflection or awareness leads to consciousness-raising and action as women (and men) are enabled to view their world through a critical lens. The ultimate outcome of possible action is finding alternatives to gender-based oppression (Abbott & Wallace, 1997; Ackerly & True, 2010; Giddens & Sutton, 2013).

My decision to choose a feminist and woman-centred approach to frame this study sits well with its focus on midwifery continuity of care and models of midwifery care where the midwife is the lead provider rather than the doctor. The conceptual identity of midwifery in these models of care reflects the fundamentally feminist way of being and respecting a woman's decisions, her own knowledge and her skills (Berg et al., 2012; Leap, 2009). This is in contrast to medicine, which in essence is patriarchal and where the expert doctor is the one in control and the one who makes the decisions (Donovan, 2006; Frankenberg, 2009). As Leap (2009) states, feminist principles underpin woman-centred care where control is shifted away from the institution and health professionals to the woman herself. Midwifery is a practice that enables the woman to be placed at the centre of her care and be
involved in decisions. It is non-authoritarian, collaborative and respectful (Morgan, 2015).

There is an ongoing issue of invisibility and oppression experienced by midwives and the midwifery profession. The experiences of childbearing women can also be undervalued and misrepresented in their choices and exercise of control during their pregnancy, childbirth and parenting experiences (Bourgeault et al., 2012; Davis & Walker, 2011; Green & Baston, 2003; Keating & Fleming, 2009; Yuil, 2012). I see the application of a feminist lens on such issues, whether they are practice-based or philosophical, as ideal when looking to challenge the oppression of women or to uphold the beliefs and actions of those undertaking healthcare activities underpinned by feminist thinking.

3.1.6 Appreciating gender and language

Although the notion that sex or gender affects language and language use is contested (Wodak, 1997), in this study the feminist approach used aligns with the belief that gender does affect language and discourse, as defended by the disciplines of communication theory and feminist linguistics. Gilligan (1982) and (Tannen, 1993), for example, consider that women tend to think and speak in different ways to men. This perspective has enabled me to appreciate that how women relate to each other is often gendered and includes concepts of caring, connection and relationship (Wodak, 1997). These concepts are championed within midwifery-led and midwifery continuity of care models (Guilliland & Pairman, 1994; Kirkham, 2010) and it is essential to explore them within the midwife-woman interaction.

Gilligan (1982) generalises that women tend to define themselves by the 'relationship' they have with others and to view themselves as linked to others, whereas men define themselves as being separate to others and position themselves as autonomous. This understanding that women interact differently to men also crosses into psychological interpretations of biology where females, both animal and human, are believed to come together in times of stress; for example,
women adopt 'tend and befriend' behaviours (Taylor, 2012) rather than a male activity of fight or flight. Foureur (2008) argues that labouring women desire a space that embodies 'calmness and connection'. Many feminist theorists criticise bipartite interpretations that are based on the sex of individuals, for being simplistic and reductionist (Cameron, 1997). Despite this, I included this approach in my analysis because I was exploring a female activity where the context was women's childbearing and a profession (midwifery) predominantly founded in women's ways of relating. I consider it essential to explore female ways of relating. In addition, the philosophical stance of MCOC models aligns with this gendered stance and the ideals of connection, reciprocity, woman-centredness and female ways of relating such as caring and empathy (Hunter et al., 2008; Kirkham, 2010; Yuil, 2012). This is in contrast to the patriarchal and masculine way that many healthcare activities are undertaken and structured – indeed, the usual context of the antenatal appointment is a biomedical model, where women are perceived as needing medical advice and supervision (Cahill, 2001) rather than partnership and connection.

My consideration of the value of this analytical approach to exploring the effect of gender in the midwife-woman interaction has increased my awareness about the need to consider other social divisions that women bring to any social interaction, such as class, ethnicity and cultural identity. It has encouraged me to try to understand the influence of power relations and habitual activities on the social interactions and linguistic behaviours of those involved. Multidimensional analysis such as this also relates to institutional ethnography, which is where an individual's standpoint and the collective concept of ruling relations are brought together (Smith, 2006).

3.1.7 Ethnography

Ethnography is a study of human society and culture that provides rich and meaningful data (Newnham, Pincombe, & McKellar, 2013) by observing patterns of language, communication and behaviour and by focusing on the lived context of
the participants (Atkinson et al., 2001). Ethnography combines interpretive, phenomenological and hermeneutic traditions and is more than a set of methods that guide data collection (O’Reilly, 2009). Rather, it is a methodological approach to experiencing, interpreting and representing experience, culture, society and material and sensory environments that informs and is informed by sets of different disciplinary agendas and theoretical principles (Crotty, 1998; Pink, 2013). Ethnography has developed from its original classical origins in descriptive and naturalistic approaches to engage with other theoretical perspectives ranging from interpretivist, criticalist, feminism and postmodernism (Atkinson et al., 2001; Mantzoukas, 2012).

I chose ethnography as the basis of my inquiry into the antenatal appointment as it enabled me to gain insight into the subjective experience of the midwives and women and their actions within the appointment and to compare them between the two models of care (Tham, 2003). Ethnographers strive to acquire many perspectives of a culture (Angrosino, 2007). They seek to learn from, rather than study, members of a cultural group or society. As a methodology in healthcare research it provides access to health beliefs and health practices (Polit & Beck, 2010).

Ethnography enabled me to gain both 'emic' and 'etic' perspectives. I observed the midwife-woman interactions and asked people about their experiences or perspectives (Sharkey & Larsen, 2005). An 'emic' perspective is the insider's perspective and how members of the culture being examined regard their world. It includes the local language, means of expression or concepts that these members use to name and characterise their experiences (Atkinson et al., 2001). In contrast, the 'etic' perspective is the outsider's interpretation of the experiences of that culture – the words and concepts they use to refer to phenomena.

Ethnography also strives to find the tacit or 'taken for granted knowledge' about the culture – that which is often so deeply embedded in the cultural experiences that members do not talk about it or may not even be conscious of it. Ethnographers commonly seek three types of information: cultural behaviour (what
members of the culture do); cultural artefacts (what members of the culture make use of); and cultural speech (what people say) (Pink, 2013). It enables the researcher to observe and explore the everyday lives of the participants (Cluett & Bluff, 2006; Creswell, 2009) and to watch, listen and ask questions (Hammersley & Atkinson, 2007). This is often achieved through participant observation, where the ethnographer observes the culture under study while participating in the activities (Hammersley & Atkinson, 2007).

From a sociological perspective, ethnography is based on the premise that all humans have sufficient characteristics in common to begin to develop social relationships (Donovan, 2006), which also aligns with the anthropological perspective of culture:

Culture refers to the way a group of people live – the patterns of human activity and the symbolic structures (e.g., the values and norms) that give such activity significance. (Polit & Beck, 2010, p. 265).

Moreover, culture is the emotions, art, law, institutions of society, including childbearing and rearing practices, as well as physical artefacts produced by members of the group. Spradley and McCurdy (1972), for example report that the buildings, offices or the technological apparatus that people use reflect a culture. Culture is also knowledge learned, shared and understood by each member of the group so that their interactions and behaviours can be interpreted and understood by its members (Tham, 2003).

In this ethnographic study, underpinned by a feminist perspective, I sought to find and establish the meaning of the 'midwife-woman relationship' from the view or standpoint of participants (Hammersley & Atkinson, 2007), who are by way of their situation predominantly female subjects (midwife\(^9\) and pregnant woman) interacting within a woman's sociocultural domain which is pregnancy and birth. Donovan (2006) states that ethnography can expose the hidden cultural context of childbirth and motherhood and the life of women to the world at large.

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\(^9\) Midwives are predominantly women in first world countries like Australia, New Zealand, USA and UK.
3.1.8 Critical ethnographic approach

This study focused on the antenatal appointment and the interactions between midwives and women, which lends itself to conventional or classical ethnography. It also had a more critical intent as it aimed to better understand how the MCOC model might influence these midwife-woman interactions. I was engaged in unpacking, interpreting and giving voice to or raising awareness about this healthcare encounter, and exposing the facilitators and barriers that impact or shape this model of midwifery care. This endeavour was better situated within a critical ethnographic methodology, as I had the political purpose to actively raise the awareness of this midwifery model of care.

Critical ethnography asks 'what could be' instead of describing 'what is as is' experienced with classical Ethnography (Mantzoukas, 2012). Thomas (1993) describes critical ethnography as:

... a type of reflection that examines culture, knowledge, and action. It expands our horizons for choice and widens our experiential capacity to see, hear, and feel. It deepens and sharpens ethical commitments by forcing us to develop and act upon value commitments in the context of political agendas. Critical ethnographers describe, analyse, and open to scrutiny otherwise hidden agendas, power centres, and assumptions that inhibit, repress, and constrain. Critical scholarship requires that common sense assumptions be questioned. (Thomas, 1993, pp. 2-3).

Similar to the feminist approach of this study, this critical ethnographic approach delves into relationships of power in the production of culture, particularly in the everyday 'taken-for-granted' events, by exploring complex interactions between people and by revealing patterns of language, communication and behaviours that produce and reproduce such power relationships (Dove & Muir-Cochrane, 2014; O’Reilly, 2009). Critical ethnography relies on a reflective process of choosing between conceptual alternatives to challenge research, policy and other forms of human activity (Thomas, 1993). Critical ethnographers use their work to aid emancipation goals or to negate the repressive influences that lead to unnecessary social domination by some groups.

A critical ethnography is ethnography with a political purpose, providing insights
about fundamental questions of social existence often ignored by other approaches (Thomas, 1993) and is in line with a feminist perspective.

Combining a critical approach with the feminist lens enables this study to inquire and reflect on social injustice by focusing on gender to transform and to not simply explain social order. Carspecken, a theorist and advocate of critical ethnography, describes those who use it as looking to challenge the status quo and the dominant powers in society (1996). Other midwifery studies, which have applied either a critical or feminist lens or incorporated both, have been successful in looking beneath the mundane of the everyday world of midwifery care and the interactions with women to question and give voice to the participants in this social world. Burns (2011), for example, identified that the language and practices midwives used when providing women with breastfeeding support prioritised the product and action of breastfeeding rather than the developing relationship between mother and infant. Likewise, Dove and Muir-Cochrane (2014), in their examination of one MCOC programme in South Australia, found that the common obstetric risk-focused practices can be mitigated when the midwife and woman have a trusting relationship.

3.1.9 Micro and macro perspectives

Lupton (2012), in her critique of illness, disease and the body in western societies, emphasises the importance of combining macro and micro perspectives. Her definition of the macro perspective stems from a political economy approach, which emphasises structure over agency when focusing upon the influence of medicine in people's lives. The micro perspective, on the other hand, emphasises the construction of meaning and enactment of individual agency within medical settings. This balance between structure and agency is crucial to this study. I have endeavoured to synthesise the macro-political perspective with a micro-perspective of the women's experiences of antenatal care and midwifery care to identify the complexity between the interplay of women's individual experiences of midwifery care and their participation in the maternity system.
This conceptual link between the 'macro' and 'micro' in this study is the 'connect' between the small-scale antenatal appointment interactions and the large-scale influences of society and its institutions. It is driven by a desire to examine if our interactions at the micro-level impact on the larger world of social institutions, and the extent to which the latter influences our everyday lives. The two-way interchange is at the heart of many social processes and it is the view of Giddens and Sutton (2013) that a comprehensive sociological analysis requires situations and events to be understood at both the micro and the macro levels.

Like other healthcare interactions, the midwife-woman interaction within the antenatal appointment is influenced by social and cultural norms in which it is situated. In the healthcare situation these norms include the organisational culture of the healthcare setting, the collective and philosophical approach of the model/s of care, and the standpoints of different professional bodies and the individual clinicians (Callaghan, 2007; Strong & Dingwall, 2001). Once again, these social, political and cultural norms are best examined from the all-encompassing focus of ethnography (Deegan, 2001) to enable exploration of both the macro and micro level of the culture in question (Dykes, 2009a).

3.1.10 Ethnography in maternity care and midwifery

Ethnographic research has had a long history of application and interpretation within healthcare settings and organisations (Murphy & Dingwall, 2007). Classic examples are Goffman's research on mental hospitals (Goffman, 1961), Glaser and Strauss' work on death and dying (Glaser & Strauss, 1965) and Strong's on paediatric clinics (Strong & Dingwall, 2001). Ethnography has also been used within midwifery research and has provided rich data on contextual issues for the individual and the institution. Examples include the founding work undertaken by Kirkham (1987) who observed labour and birth care to develop a greater understanding of the factors that enhance or inhibit supportive labour care. She compared consultant units, where doctors were in charge and midwives, who had little autonomy, processed the patients (women); GP units where midwives had the
authority; and home births, where the women and their partners had the authority. She found the role, actions and language of the participants reflected the power structure of the setting where the labour and birth took place. Another example is a study by Hunt and Symonds (1995) which provided insight into the similarities between English labour wards and the industrial and factory-like nature of the hospital system, which meant women had the least power and midwives' lacked autonomy.

An ethnographic study by Walsh (2006b) of English free-standing birth centres observed that the intimate nature of small maternity units meant factory-like processes found in larger units could be avoided. He found that women in the free-standing birth centre were prioritised above the system, relationships were valued over tasks, and structural and temporal freedoms of the home-like environment benefitted women and midwives. Other midwifery studies have also used an ethnographic design to explore midwife-led care in birth centres to highlight the facilitative or inhibitory factors pertaining to the contexts of environment and relationship-based care within maternity care (Annandale, 1988; Coyle, 1999; Esposito, 1999).

Other studies of midwifery that have used ethnography include Kirkham's study of the culture of midwifery in the National Health Service Kirkham (1999) that found issues of autonomy, social support, control and relationship building were determining factors for midwives' sense of power and control or powerlessness. More recent ethnographic studies have described and explored the tensions experienced by midwives whose workplaces require them to practice in a manner that contrasts with their ideal framework of woman-centred midwifery practice and philosophy of care (Burns, 2011; Dove & Muir-Cochrane, 2014; Dykes, 2004). This study revealed a maternity care work practice governed by medical risk, institutional time constraints and fragmentation of midwives' professional role and relationships with women, resulting in negative experiences for both midwives and women (Newnham, 2016; Newnham, McKellar, & Pincombe, 2015).

In the next section I explain my research processes. Like other ethnographic studies
of midwifery, I aimed to examine the sociocultural reality (Dove & Muir-Cochrane, 2014; Newnham, 2016). The culture I examined was the antenatal appointment, the midwife-woman interactions within this, and the experiences and perspectives of the women, midwives and managers.

### 3.2 Methods

Multiple methods were used to collect data for this study. I observed and video-recorded midwife-woman interactions in 18 appointments; eight with MGP and 10 with the SMC system. I also undertook six focus groups, two interviews with staff, and 11 interviews with women. I examined and analysed the data using critical and feminist theoretical perspectives to understand the facilitators and barriers that affect the antenatal appointment and the midwife-woman interactions.

#### 3.2.1 Study Aims

The aim of this study was to gain a better understanding of how the MGP might influence midwife-woman interactions, in an attempt to understand why MCOC models improve outcomes for women and their newborns. The specific objectives of this study were:

1. To examine the actions/practices and language used by midwives and women when interacting in the antenatal appointment.
2. To explore the potential impact of the MGP model and SMC model on midwife-woman interactions in the antenatal appointment.
3. To identify factors that might influence the midwife-woman interactions in the antenatal appointment.
4. To examine the experience of the antenatal appointment from the perspectives of the midwives, women and managers.

#### 3.2.2 Setting

This study was situated at two public metropolitan hospitals in Sydney, Australia, which have been named as Hospital A and Hospital B to maintain confidentiality.
and privacy. Although, the opportunity to undertake this study at these two, somewhat similar, sites may not have increased the generalisability of the findings (Creswell, 2009), the in-depth examination of the sociocultural experience of the antenatal appointments has the potential to provide greater meaning (Bazeley, 2009) and be applicable and transferable (Cluett & Bluff, 2006) to other contexts sharing this same experience. As Newnham (2016) found, the medicalised model and an individual’s understandings, particularly with the medicalisation of childbirth, spans hospitals and countries. Making assumptions like these still do not evidence the quality of the findings and their applicability to other situations and contexts but providing an 'audit trail' in this chapter and the Discussion Chapter will identify the links I have made enabling the reader to pass judgement (Sandelowski, 1986).

Although in different local government areas the hospitals are located in the same LHD and have similar demographic features (ABS, 2016). These include having a younger population with a high number of people from culturally and linguistically diverse backgrounds and a majority who completed their education with a high school certificate. The predominant type of work was professional, clerical and administrative. The principal group of unpaid work in both areas was individuals caring for dependents, children under 15 and other family members. Table 6 reports on a discrete pool of statistical data (ABS, 2016).

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>A (%)</th>
<th>B (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born overseas</td>
<td>40.4</td>
<td>49.5</td>
</tr>
<tr>
<td>Family households of more than three people</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>Aged 0–35 years</td>
<td>53</td>
<td>61</td>
</tr>
<tr>
<td>Aged 0–14 years</td>
<td>23</td>
<td>18.5</td>
</tr>
<tr>
<td>Highest level of education – year 12 high school</td>
<td>49.8</td>
<td>47.6</td>
</tr>
<tr>
<td>Highest level of education – bachelor’s degree</td>
<td>12.7</td>
<td>17.4</td>
</tr>
</tbody>
</table>

The maternity services of these two hospitals are medium to large services in the Australian context (Hilder, Zhichao, Parker, Jahan, & Chambers, 2014). In 2016 Hospital A had approximately 3200 women gave birth and Hospital B had
approximately 5600 women gave birth (NSW Ministry of Health, 2018). Both hospitals provide a range of models of midwifery care in conjunction with an obstetric service and are endeavouring to implement services that meet the needs of the local women, their families and their cultures.

The context of antenatal care differs slightly between the two sites. This is due to geographical location of this care, the degree to which midwifery-led models of care are established, and role delineation (service capability) of the hospital. Hospital A’s maternity service is role delineated as a Level 5 and Hospital B is Level 6 (NSW Department of Health, 2002). Level 5 maternity services provide midwifery and obstetric care to women with low, medium and selected high-risk obstetric complexities. They are large regional or suburban hospitals and focus their services on the nearby community. A Level 6 facility is the specialised referral site for all maternity facilities in its jurisdiction and has emergency obstetrics, anaesthetic and neonatal intensive cover 24 hours a day, seven days a week.

3.2.3 Models of care

3.2.3.1 Standard maternity care

The SMC model at both participating hospitals was representative of the majority of the maternity care services provided by the Australian public hospital system. For example, antenatal appointments take place in the outpatient departments (OPD) and are performed by midwives and doctors. In the community health centres midwives undertake the antenatal appointments. The antenatal clinics rely on rostered teams of midwives and doctors. Some of the antenatal clinics, however, are midwifery-led, which are known as the ‘midwives’ clinic’ and are where women see one midwife for all their planned antenatal appointments. These appointments, however, are often only offered at dedicated clinic times or venues and have no flexibility with appointment scheduling for the woman or the midwife.

Hospital A provided much of its antenatal care in community healthcare centres with midwives’ clinics and a smaller percentage of antenatal appointments in the OPD. In the OPD the antenatal clinics were mostly for women with complex health
issues such as diabetes, medical issues or obstetric issues, which were provided by doctors or obstetricians, with midwives providing a support role for the doctors. Few midwife-led antenatal appointments happened in this OPD. The hospital strategy was to decrease the antenatal care burden on the OPD, as the OPD was limited by space, time and staff and also catered for other specialities such as gynaecology and orthopaedics.

Hospital B has an antenatal clinic that functioned mostly in the OPD with only a small percentage of midwives' clinics in the community healthcare centres. Due to role delineation within Hospital B, many of the antenatal clinics were dedicated to medical or obstetric issues. These included clinics for women with gestational diabetes, high body mass index (BMI), post-dates, or those planning for a vaginal birth after caesarean section (VBAC). Alongside these ‘high’ risk doctor-led clinics were midwife-led clinics for women who were seen as 'low' risk.

3.2.3.2 Midwifery group practice

The MGP in Hospitals A and B were newly established at the time of the study and founded on the caseload midwifery continuity of carer (MCOC) model. Although both MGPs provided labour and birth care for women in the hospital's birth unit (neither hospital had a separate midwife-led birth centre) they operated in slightly different ways when it came to backup arrangements and location of antenatal appointments.

3.2.3.2.1 Hospital A-MGP

At the time of the study, in 2012, the MGP at Hospital A had six midwives. By 2015 it had eight midwives. Their office, a small clinical room, was situated in the birthing unit and was where they organised their day-to-day work, completed hospital documentation and on occasion used it for antenatal appointments. The midwives did most of the antenatal and postnatal care in the woman's home. On occasion antenatal appointments also took place in the OPD, for example when woman required a vaccination, anti-D injections or a consultation by another health professional. Midwives had weekly meetings. They met with their manager in the
birthing unit fortnightly and had a peer-led meeting in the community on the alternate week. Their manager was the birthing unit manager, whose primary management responsibilities were the day-to-day management of the birthing unit.

The way this MGP operated resulted in the midwives having more opportunity to care for the women in their own personal caseload compared to a MGP with a structured roster and on-call system. The MGP had a different backup system for the weekdays and the weekend. During the week all the midwives were on-call (available) for their caseload women from 7pm Sunday to 7pm Friday. During the week they also shared a backup roster to support each other when they had worked their allocated working day hours (12 hours in a 24-hour period) or were busy. One midwife was on-call for the MGP from 7am to 7pm and another from 7pm to 7am. Over the weekend the midwives shared an on-call roster for the whole MGP, with three midwives being on-call for the whole MGP and the others off-call. One midwife was on-call from 7am to 7pm and one midwife on-call from 7pm to 7am for women who were labouring. A third midwife also did postnatal home visits and supported the day on-call midwife if they had more than one woman in labour. During the week the midwives also had a flexible system and diverted their phones to each other for a short period of time if they had planned activities, such as a sports game, appointment or social event. This flexibility also carried to the weekend in situations if a midwife who was off-call wanted to care for one of her caseload women.

3.2.3.2.2 Hospital B-MGP

At the time of the study the MGP at Hospital B had eight midwives and by 2015 it had 10 midwives. These midwives worked in two distinct group practices; one group with six midwives and one group with four midwives. The midwives provided antenatal and postnatal care in a variety of venues including in their own clinic rooms situated near the postnatal ward in the hospital, the woman’s home and the OPD. They shared a manager, a clerical support officer and an office with the ‘midwifery at home’ team who provided postnatal care to women in their homes who received SMC. In their shared office they organised their day-to-day work and
completed hospital documentation. They met with the manager, midwifery educator and their CMC every two weeks at a group meeting. Outside of this meeting the midwives and their manager maintained regular ad hoc contact for day-to-day work issues.

The backup system for the group of six midwives was a seven-day roster that included scheduled days off for each midwife and a shared on-call system for all the women they cared for. This resulted in a midwife being rostered on-call for a number of days as 'backup' for this MGP while the other midwives had rostered days off or rostered off-call days. On the rostered off-call day, the midwives worked office hours and were off-call for any unplanned work after office hours. This resulted in these six midwives having regular rostered days off and rostered off-call days per week, but for their on-call days they were on-call for a greater number of women, as they shared this on-call for the other five midwives in their MGP. As a consequence, these midwives had a greater chance of being contacted by women not in their own personal caseload on their on-call days, but alternatively had a set number of days rostered off.

The backup system for the group of four midwives was an on-call (available) service for the women in their own caseload. They negotiated day-to-day who would be the backup midwife when one of the other midwives was busy, had worked the maximum hours for a working day (12 hours in 24-hour period) or had a planned rostered day off. Although, this resulted in these midwives having fewer planned and rostered days they also had to do fewer backup days compared to the six midwives in the other MGP. As a consequence, they were on-call more, but often this was only for the women in their own caseload and they fewer call outs to care for women not in their own caseload.

3.2.4 Ethical Considerations

3.2.4.1 Ethics Approval

In accordance with Australian National Ethical Guidance Statement for Human Research (National Health & Medical Research Council, 2007) ethics approval was
obtained from the Human Research Ethics Committee (HREC) and UWS in November 2012. As part of this ethics approval a Site-Specific Approval (SSA) with the LHD was also obtained.

Application/Reference Numbers:

NEAF: HREC/12/WMEAD/240
Site Specific: SAC2012/7/4 (3555)
UWS Research Office: H10103 13/002430

There was a three-month delay in obtaining ethics approval. This was a similar experience to what Newnham et al. (2013) and Davis Harte, Homer, Sheehan, Leap, and Foureur (2015) reported with the ethics committee assessing the ethnographic methodology with a quantitative framework used for intervention or drug protocol studies.

Additional written information was sent to the HREC reassuring them no drug treatment or intervention was being used and stating this was an ethnographic study using a 'naturalistic' approach. I emphasised there was no manipulation or control and the natural state of the social world was to be observed, respected and interpreted from the standpoint of the participant and the researcher (Hammersley & Atkinson, 2007). A copy of this letter is included in Appendix A.

3.2.4.2 Confidentiality and Privacy

To maintain participant’s privacy and confidentiality all data was handled in accordance with Australian National Ethics guidance statement (National Health & Medical Research Council, 2007). All audio and video files were de-identified and stored on the UWS network and protected with password access. Each data file was labelled with letters and numbers (see glossary) and pseudonyms replaced the participants’ names. In addition, in accordance with data management guidelines, all data will be deleted seven years after it was obtained. Also, I told the participants during recruitment and consent that the data files would only be viewed/listened to by me and my supervisors.
3.2.4.3 Participant vulnerability

At the outset of this study a number of participant vulnerabilities were identified and some of these emerged during recruitment. As has been reported in other studies, some midwives felt vulnerable about having their practice observed (Iedema & Carroll, 2011; Lomax & Casey, 1998). These vulnerabilities relating to ‘camera consciousness’ are reported on later in the chapter on page 110-112. Other vulnerabilities that were considered possible did not eventuate. It was anticipated, for example, that women were at risk of disclosing confidential, personal or sensitive information during the recording of the appointment and that the recording of this may cause distress.

During the study I undertook a number of processes to maintain participant confidentiality and privacy to ensure I did not place them in any situation that may increase their vulnerability. The first was a steering group\textsuperscript{10} that provided governance and support for the study. Next, after ethics clearance and with support from Professor Dahlen and members from this steering group, I commenced an early information process at both hospitals in November 2012. I met with the CMCs and managers to finalise researcher access into the hospitals. Professor Dahlen and I then attended staff meetings at both hospitals to introduce the study idea; two with the MGP midwives and two with OPD staff.

At these meetings we discussed and provided written information on the study. A copy of this is included in Appendix A. We emphasised that participation was voluntary and described our processes to maintain their confidentiality and privacy. We then described to them what their participation would involve. This included being observed and video recorded at an antenatal appointment, being part of a focus group and potentially being interviewed. We also told the midwives that the women’s participation would involve being observed and video recorded during a late pregnancy appointment and interviewed when their baby was about six to eight weeks of age. At these sessions, and again at a later stage, the managers and

\textsuperscript{10} A steering group was set up for the MAWI study and also provided governance and support for this doctoral study. Membership included representatives from both hospitals, the LHD and UWS.
CMCs were individually invited to participate in focus groups.

The sharing of information was an attempt to reassure the staff that the research intent was to not cause any undue distress and that my presence would result in minimal interference with the observations, as the research intent was to gain a window into the everyday experience of the antenatal appointment (Hammersley & Atkinson, 2007; Pink, 2013). I explained I would place the video camera in the background of the appointment. I also talked about the use of an audio recorder and recording field notes in the observations and with other data collection activities. At these meetings and again during recruitment I emphasised that in the unlikely event that the participants did become distressed during these data collection activities, these would be suspended or ceased. Also, they would be offered the right to withdraw their participation and provided with information and access to debriefing and support.

Other mechanisms to protect the participants included a hospital delegate, midwife or manager overseeing recruitment in the OPDs. This involved them reviewing the hospital files in the OPD on the days I was recruiting to ensure I wasn’t recruiting a woman judged as vulnerable. I also carried identification, which included my university photo identification, a nametag and a laminated letter from the research governance office identifying me by name and stating I was authorised to undertake this research. A de-identified copy of this letter is included in Appendix A.

Regardless of our endeavours to reassure we still felt there was a level of distrust and reluctance to participate at this information stage of the study. We raised this with the steering group, which resulted in the decision to ask the staff how best to recruit. This led to a second round of staff meetings and appointments. During these secondary meetings we reaffirmed that their confidentiality and privacy was paramount to the process and reiterated that my supervisors and I, unless they consented otherwise, would be the only people to see the recorded data. The recruitment plan was altered, in accordance with the fundamental goal of an ethnographic study, which is to get to know the people involved and to ensure their
comfort (Hammersley & Atkinson, 2007).

3.2.4.4 Information and Consent

After the initial Information phase and then at each stage of recruitment, whether that was in the OPD or with the MGP, I sought clearance from a manager or staff member before speaking with the women or midwives. When I did talk with the potential participants about the study and the level of participation involved I also handed them a Participant Information Sheet and Consent Form (PICF). This document described the study; that participation was voluntary; potential risks and benefits of participation; strategies to ensure confidentiality and privacy; and what would happen with the study results. It also included a section for their signed consent. As well as my contact details, those of the chief investigator were also included, as they were the point of contacts if the participants had complaints or concerns. Each hospital site and participant group had a specific PICF developed; the women, the midwives and the managers. An example of a de-identified PICF is included in Appendix A.

A supplementary consent process was also sought, approved and built into the study for the video data, because video recording presents some specific issues. The power differences between researcher and participant are more apparent when using visual data (Carroll, 2009) and recorded video data of research participants often makes them identifiable (Rose, 2016). Wiles, Clark, and Prosser (2011) suggest there are four ethical considerations when using visual research methods. These include anonymity, guidelines and consent, ethical laws and the researcher’s personal moral framework, and, in particular, copyright. The supplementary consent was completed when it was anticipated that data was going to be used for any purpose other than analysis. An example of this was when video footage or photo images were used for oral and poster presentations at professional conferences and when they were used in this thesis. Examples of the media release form from the LHD and letter requesting consent from the participants are situated in Appendix A. Where this secondary consent was not gained images were not used or were pixelated to de-identify the individuals. All
visual data in this thesis has been pixelated.

3.2.5 Inclusion criteria

All participants self-selected. Women were included in the study if they were between 32 and 38 weeks pregnant, able to speak and read English, and had no medical or obstetric comorbidities that would involve having a subsequent appointment with a doctor. The decision to recruit women between these weeks of pregnancy was based on providing the woman information about the study at one appointment and then observing and video recording the subsequent antenatal appointment. Depending on the woman’s parity, the hospital's schedule of appointments for late pregnancy involved a woman having an appointment between 32 and 34 weeks of pregnancy and then returning at 36 weeks.

This timeframe between recruitment, consent and participation was a positive. It enabled participants time to consider their role in the study and the option to withdraw consent. For the midwives, managers and CMCs they had to be working in the antenatal clinic or the MGP at either of the hospital sites at the time the study was being undertaken.

3.2.6 Recruitment

The first decision in the second round of meetings was that recruitment needed to have a set timeframe. A seven-week period for recruitment and filming of the appointment was agreed upon and started in mid-April 2013. This was because the midwives and managers stipulated an intensive period of recruitment to decrease the impact of ‘having another researcher or student hanging around in the waiting room’ (field note, Information meeting, Hospital B-SMC 11/2012). Although not widely reported on in healthcare research, the midwives and managers at these meetings were identifying with the concept of being 'over researched' or 'researched out' (Clark, 2008). This is attributed to the demand placed on many of the larger public funded hospitals that have close links with medical research institutions and universities.
The second decision was to have different recruitment plans for MGP and for the SMC system. To coordinate recruitment across both sites and both models of care I created a single recruitment calendar. This was shared with the MGP midwives, midwifery managers and CMCs involved with SMC.

At the end of the observed appointments the plan was to get consent from the midwives to attend a focus group that was scheduled to take place after all the appointment observations had been done. Also, at this time it was planned that the woman would be asked to consent to me telephoning her six to eight weeks after her estimated date of birth to discuss her involvement in a postnatal interview.

3.2.6.1 SMC recruitment plan

The initial recruitment and participation plan for the SMC system was complex and involved me attending the antenatal clinic in the OPD and recruiting a midwife and a woman separately and then coordinating so we could all attend the woman's next antenatal appointment. To recruit at the antenatal clinic, I had to meet and introduce myself to a local staff member delegated to oversee and support me. In turn I was then introduced to the midwives and given time to talk to them about the study, hand them a PICF and gain their consent. This recruitment plan relied on a midwife being willing and available to be observed on the predicted day of the observed appointment.

The staff delegate then had to review the antenatal files for the women attending the clinic that day to identify any who met the inclusion criteria for recruitment. This delegate would then approach these women in the waiting room, provide them the PICF for the study and ask if they were willing to talk to me about their participation. I would then approach the women who had indicated they were open to participation in the study, discuss the study with them, and ask for their consent. Following the woman's consent to participate and the completion of her antenatal appointment I would confirm a time with the woman for her next appointment and arrange for the consented midwife to participate in that appointment.
3.2.6.2 MGP recruitment plan

The recruitment plan for MGP differed to SMC. I recruited the midwives and they recruited the women by telephone or at antenatal appointments. There were several reasons why the midwives were the first to approach the women. The midwives and I realised that the only way I could access the women was by telephone, as most women had their appointments in their home. This we believed to be inappropriate, as the women had no way of confirming my legitimate status as a researcher with a telephone call (Field note, Information meeting MGP Hospital B, 11/2012). The midwives taking on the recruitment meant they could protect the privacy of multiple women, who would be spared receiving telephone calls from an unknown researcher (field note, Information meeting MGP Hospital A, 11/2012). This of course meant the midwives took on the decision-making about who would participate. Such influences over who participates are reported as a limitation to the transferability of study findings (O’Reilly, 2009). However, as this study has relied on self-selected participants, this limitation needs to be acknowledged, but not over-called.

Due to the unpredictability of their work the midwives thought it best for them to schedule the time of the antenatal appointment observation when it suited the women and themselves and when the chance of them being called to a birth was the lowest (Field notes, Information meeting Hospital A & B, 11/2012).

3.2.6.3 Actual recruitment

The recruitment process that transpired did not follow the plans set out above. In the case of the MGP, the difference was that although the midwives had recruited the women I needed to arrange consent with each woman at the antenatal appointment that was observed and video-recorded. This altered the natural course of the antenatal appointments. In fact, I only witnessed one midwife and woman greet each other at the commencement of the appointment without me being introduced and interrupting the flow of the appointment. This occurred with appointment B-MGP16 and is reported in the findings chapter.
Due to a poor success rate of recruiting and consenting in the OPD the recruitment and consent plan there was also altered. Although I had consenting midwives and women for three appointments in the first two weeks of the planned seven-week recruitment, I only observed one appointment. After discussion with staff from the hospitals I developed a more streamlined recruitment approach. This involved me attending the antenatal clinics as arranged with the initial plan, but with the intent to undertake the observation on the same day. The recruitment period was also extended. In the end I observed 19 appointments and had also commenced the focus groups and interviews before the completion of these observations.

The recruitment for the focus groups was also adjusted. Initially we had planned only to invite midwives who had been involved in the appointment observations. However, due to the higher than expected number of midwives declining to participate in the appointment observations, an invitation was opened up to all staff who worked in the antenatal clinics and the MGPs. I anticipated that gaining a number of different perspectives would enrich the focus group conversations.

Although there were restrictions to the time I could recruit for the appointment observations, midwife hesitation to be video recorded affected recruitment. During recruitment individual midwives from the MGP at Hospital B and the SMC system at both hospitals raised concerns about 'surveillance' through the research and potentially by the management. One midwife said to me when I was sitting in the clinic waiting room and waiting to recruit, 'I bet the managers will want to watch the film, so no way do I want to be filmed' (Field note SMC Hospital B, 5/2013). Some midwives also indicated a preference for audio recording, believing that filming was more intrusive than the audio recording. One midwife, for example, said to me, 'the camera makes me nervous, how about we just audio tape it' (Hospital A clinic recruitment field note 4/2013).

### 3.2.7 Participants

The initial plan was to observe and film 20 midwife-woman interactions in a late pregnancy antenatal appointment, undertake focus groups with these midwives
and separate focus groups with their managers and CMCs, and interview the women in the postnatal period. This number of participants was based on decisions about what would be a realistic workload.

### 3.2.7.1 Appointment observations and video recordings

In total, 19 appointments were observed, and video recorded, and 18 appointments were analysed. One midwife was observed in two of the appointments so a total of 18 pregnant women, 17 midwives and one student midwife (under supervision) participated in these observations. Due to a woman experiencing an unexpected fetal death in utero, two weeks after one of the appointment observations, her interview was not analysed, and the midwife and woman took no further part in the study.

Ten appointments were observed, and video recorded at Hospital A. Four of these were with midwives working in SMC in the OPD at the hospital and the fifth SMC appointment took place in a clinic room at a community health centre. This community health centre was at a local shopping centre, situated 12 kilometres from the hospital. All five MGP appointment observations took place in women’s homes. Nine appointments were observed, and video recorded at Hospital B. Five of these were with midwives working in SMC in the OPD at the hospital. Three of the four MGP appointment observations took place in women’s homes and the fourth in a MGP clinic room near the postnatal ward. Table 7 illustrates this.

#### Table 7: Antenatal appointment observations by site, model of care & participants

<table>
<thead>
<tr>
<th>Hospital &amp; model</th>
<th>Site</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPD</td>
<td>CHC</td>
</tr>
<tr>
<td>A SMC</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>A MGP</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>B SMC</td>
<td>5^^</td>
<td></td>
</tr>
<tr>
<td>B MGP</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

^ One midwife was observed twice. ^^ One observation included a midwife and a student midwife

*One observation was not included in analysis due to an unexpected fetal death in utero.
The women from the MGP appointment observations were 36–38 weeks pregnant and the midwife was their allocated midwife. The midwife at these appointments had seen the woman for most of her antenatal care and anticipated caring for her when she gave birth and in the early postnatal period, once she was discharged home. In contrast, all except one of the SMC appointments involved women receiving care from a midwife who they did not know. The one occasion where the midwife had cared for the woman previously was noted to be only for one previous appointment. Also, two of the SMC appointment observations involved women who were less than 36 weeks pregnant. These two appointments took place at Hospital B and became part of the study as a result of me not confirming the woman's expected date of birth with consent. I decided to include these observations, as it would have inconvenienced the participants, who had in good faith agreed to be observed and video recorded. These women were between 26 and 32 weeks pregnant. These observations still provided a rich amount of valuable data.

3.2.7.2 Midwives

At Hospital A nine midwives participated in the appointment observations, five with MGP and four from SMC. The midwives from MGP had been working in it for the two years and since it had started. The four SMC midwives had worked in the antenatal clinics held in the OPD and at varying community health centres across the LHD for many years. Three of these midwives had a midwife-led clinic on some of their workdays, while the fourth midwife worked purely in the OPD and worked in other clinics, such as the gynaecology clinic.

The SMC midwife who participated in two appointment observations volunteered to participate the second time. She felt she 'could do a better job with how she talked with the women than what she did' the first time (A-Midwife Interview field note). This capacity to self-select, common with qualitative research methods, has the potential to bring a participant's bias (Freeman, 2006). Pink (2013) and Lomax and Casey (1998), however, see this 'camera consciousness' or 'reflective performance of practice' as a positive aspect of ethnography, as it enables
participants to illustrate their world and what they see as the important factors.

At Hospital B nine midwives and one student midwife participated in the appointment observations – five midwives and one student midwife from SMC and four midwives with the MGP. As in Hospital A, the MGP midwives from Hospital B had been working in the model since it had started (nearly two years). One of the SMC midwives had a midwife-led clinic, one day a week at a community health centre as well as working in the antenatal clinic operating in the OPD. The other four midwives worked in the OPD in the antenatal clinic and other women's health clinics. The student who took part was supervised by a midwife.

At both hospitals the SMC midwives were older than the MGP midwives and had more years of experience. This data is included in Table 8. This age difference between the two models with younger less experienced midwives choosing to work in MGP may reflect the changes that appear to be taking place in Australia.

### Table 8: Antenatal appointment observation – midwife participant demographic data

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Model</th>
<th>Total</th>
<th>Age (median)</th>
<th>Number of years since qualified as a midwife (Range of years of experience)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>SMC</td>
<td>4</td>
<td>40–61 (52)</td>
<td>4 (20–35)</td>
</tr>
<tr>
<td></td>
<td>MGP</td>
<td>5</td>
<td>25–50 (39)</td>
<td>1 3 1 (20)</td>
</tr>
<tr>
<td>B</td>
<td>SMC</td>
<td>5</td>
<td>33–57 (39)</td>
<td>5 (10–33)</td>
</tr>
<tr>
<td></td>
<td>MGP</td>
<td>5</td>
<td>25–48 (26)</td>
<td>2 2 1</td>
</tr>
</tbody>
</table>

NB. To protect confidentiality the country of birth data has been removed. The student midwife was not included in this table

#### 3.2.7.3 Women

At Hospital A the 10 women who participated in the appointment observations were aged between 26 and 37 years. Their demographics reflected those of the women in the local government area. The only difference noted between the women who were with the MGP and those in the SMC system was country of birth. Four of the five women with MGP were Australian-born, whereas two of the five women from SMC were born in Australia. Age, marital status, employment and parity were similar. More details of this data is in included in Table 8 (page 74).
At Hospital B the nine women who participated in the appointment observations were aged between 19 – 39 years. Variances were noted between the women who were with the MGP and those in the SMC system. Education levels differed, with only one of the five women from SMC having post-high school education, whereas all four of the women from the MGP model had certificate qualifications. There were also more women in paid employment in the MGP group (Table 9).
<table>
<thead>
<tr>
<th>Hospital &amp; model</th>
<th>Age</th>
<th>Country of birth</th>
<th>Children at home</th>
<th>What is your highest qualification?</th>
<th>University degree</th>
<th>Working</th>
<th>Married/de facto</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 10</td>
<td>12</td>
<td>Trade</td>
<td>Certificate/Diploma</td>
</tr>
<tr>
<td>A-SMC</td>
<td>31</td>
<td>Taiwan</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Indonesia</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>Australia</td>
<td>1</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>Pakistan</td>
<td>2</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>Australia</td>
<td>3</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>A-MGP</td>
<td>27</td>
<td>Australia</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Australia</td>
<td>1</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Australia</td>
<td>1</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>Australia</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Croatia</td>
<td>1</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>B-SMC</td>
<td>29</td>
<td>Lebanon</td>
<td>2</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>NZ</td>
<td>2</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Afghanistan</td>
<td>3</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Australia</td>
<td>0</td>
<td>1</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>Australia</td>
<td>3</td>
<td>1</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>B-MGP</td>
<td>28</td>
<td>Australia</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>Australia</td>
<td>3</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Australia</td>
<td>1</td>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>NZ</td>
<td>0</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
3.2.7.4 Focus groups

A total of six staff focus groups took place and 40 individuals participated. Some participated in more than one group; for example, a manager and a CMC participated in a focus group for the SMC midwives working in the OPD as well as a focus group for the managers and CMCs.

Table 10 shows the participants in the focus groups. These focus group participants included 13 midwives from the appointment observations, 13 other midwives from the MGP and SMC, eight managers, three CMCs, one student midwife and two multi-cultural workers.

Table 10: Focus group participants

<table>
<thead>
<tr>
<th>Hospital &amp; focus group</th>
<th>Midwives</th>
<th>Managers</th>
<th>CMCs</th>
<th>Student midwives</th>
<th>Multi-cultural workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-SMC</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>A-MGP</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>A-Managers &amp; CMCs</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>B-SMC</td>
<td>12</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>B-MGP</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>B-Managers &amp; CMCs</td>
<td>4#</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>8</strong></td>
<td><strong>3</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>40</strong></td>
</tr>
</tbody>
</table>

# One manager did not have midwifery qualifications

Once again, the age range and midwifery work experience were skewed between the two models of care. The midwife participants in the SMC focus groups had more years of midwifery experience and were older than the midwives in the MGP focus groups. Table 11 (next page) provides a demographic description of the focus groups participants. To protect confidentiality the country of birth data has been removed.
Table 11: Description of staff with midwifery qualifications who participated in the focus groups

<table>
<thead>
<tr>
<th>Hospital &amp; Focus Group</th>
<th>Total number of midwifery qualified participants</th>
<th>Age (Median)</th>
<th>Number of years since qualified as a midwife</th>
<th>Range of years of experience if greater than 8 year (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;2</td>
<td>2-4</td>
</tr>
<tr>
<td>A-SMC</td>
<td>7</td>
<td>28–61 (51.5)</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>B-SMC</td>
<td>13</td>
<td>24–57 (34)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>A-MGP</td>
<td>3</td>
<td>25–59 (39)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B-MGP</td>
<td>6</td>
<td>25–48 (28)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>A-Managers &amp; CMCs</td>
<td>3</td>
<td>50–55 (52)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>B-Managers &amp; CMCs</td>
<td>4</td>
<td>40–57 (48.5)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.2.7.5 Interviews

I undertook interviews with 13 participants. Ten of the 11 interviews were with women in the postnatal period who had participated in the appointment observations. The 11th woman was opportunistically invited to participate and had used the SMC system for her first childbirth and the MGP for the second. She was 34 years of age; the first child was 3 years of age and the second 12 months. The remaining two interviews were with midwives who had participated in the appointment observations; one from the SMC system and one from MGP.

3.2.8 Data Collection

Data collection was undertaken between April and September 2013. Contemporary ethnographic studies rely on a variety of data collection methods and analysis methods (Hammersley & Atkinson, 2007; Walsh, 1999). A total of 569 minutes of video data of appointment observations was collected, with 540 minutes of this included in the analysis. A total of 363 minutes of audio data was collected from the focus groups and 255 minutes from the interviews. All the audio recording from the observations, interviews and focus groups were transcribed verbatim by a
professional transcription service. I reviewed each of these transcriptions for accuracy and amended errors or added information not available from the audio transcript alone. Both the video and audio data were uploaded into NVIVO for analysis.

I recorded my reflections in field notes that I recorded as part of the recruitment, the appointment observations, focus groups, interviews and during analysis. These field notes were beneficial, as they captured how I felt being the researcher and my experiences with using the video camera. They were also useful in circumstances when the participants continued to engage with each other after I had turned off both recording devices or proceeded to talk with me about their experiences of the research or the antenatal appointment or model of care.

3.2.8.1 Appointment observations and video recordings

I used a video camera (HV40 Canon) and an audio recorder (Phillips) device for observing and recording the 19 appointments. I situated the audio recording device as close to the midwife and woman as possible. In the OPD it was set up on the desk and in the woman's home it was often on the coffee table. I set the video camera on a tripod for the majority of the observations, to capture as much of the facial expressions and upper body language as possible. Different angles were used with varying success. I also took the camera and held it when filming the interactions and conversations with the abdominal palpation. Only on two occasions did I hand hold the camera for other parts of the appointment. During the appointment I would sit near the camera but attempt to be out of the midwife and woman's direct line of vision. Again, this was not always easily achieved, as the majority of the appointment spaces were small. As the appointment progressed I also completed the observation tool and recorded field notes. At the end of each appointment I would also write in my field notes of my impressions and reflections of what I had just observed.

Video recordings of the appointments created opportunities for me to repeatedly view the midwife-woman interactions and enabled me to examine minute details
such as facial expressions or body language. They also enabled me to see other environmental factors that I did not notice at the time of the observation (Fele, 2012; Gibbs, 2008; Kennedy & Teate, 2015; Pink, 2001). As Pink (2007) notes, use of video in ethnographic work enables us to explore the private space of social behaviours and the details of everyday experiences and practice (Pink, 2013).

Also, the video recordings enabled me to verify aspects of my analysis, creating a higher level of reliability and validity than I could have attained with field notes or an observation tool (Morse, Barrett, Mayan, Olson, & Spiers, 2002). I was able to show my supervisors the video records to evidence my descriptions and interpretations (Knoblauch & Schnettler, 2012). The use of video to record the observation is also described as a way in which to enhance researcher reflexivity (Knoblauch 2012, Pink 2001) and to construct meaning and significance of the interaction filmed with both researcher and participant (Carroll 2009).

3.2.8.2 Focus Groups

A total of six focus groups: one with MGP midwives, one with SMC midwives and one with managers from each of the hospitals, were undertaken. They took place in a variety of rooms within the hospitals; a labour and birth room, an OPD clinic room, the birth unit, in a staff education and meeting room and in the waiting area of the OPD.

The intent of the six focus groups was to explore the midwives' and managers' perspectives and experiences of the antenatal appointment, midwifery care and the midwife-woman relationship. The questions used at the focus groups were based on a standard set of questions and adapted prior to each focus group taking place to examine the different issues raised during the course of the study that were unique to the memberships of the focus group, their model of care and their professional membership. Included in Appendix B is the original list of questions for the manager and CMC focus groups submitted as part of the ethics application. I have also included in the Appendix examples of how the questions were adapted for midwife focus groups and a photo of an adapted list of questions for one of
these focus groups. Such a comparative and exploratory method of inquiry is representative of the ethnographic approach (Hammersley & Atkinson, 2007; O’Reilly, 2012).

Professor Dahlen and I facilitated five of these focus groups, with the sixth focus group facilitated solely by me. The benefit of using two facilitators was that one person could facilitate the conversation and the other could record field notes or support the other facilitator. Although we had a set of questions for each focus group our aim was to stimulate discussion and so often we supported the discussion to continue even when it veered away from the question that had been asked (Freeman, 2006).

3.2.8.3 Interviews

Ten interviews took place in the women’s homes and the women were between six and 13 weeks postnatal. The interview of the eleventh woman was opportunistic and took place at a university office. The midwife interviews took place in rooms in the birth unit and OPD.

An interview is a central feature of ethnographic research. It is useful in gaining insights and personal experiences and thoughts that would rarely be revealed under other circumstances (Atkinson et al., 2001; Whitehead, 2005). It is also recognised that ethnography employs a broad range of interview forms (Sharkey & Larsen, 2005). This study is a good example of this, as I undertook planned formal interviews and had many opportunities to have unplanned informal conversations with participants who some defined as key informants in ethnographic research (Burgess, 1988). These informal interviews were in the form of corridor or curbside conversations.

I recorded the corridor conversations and curbside conversations with participants in the form of field notes in my field diaries, which are recognised as a standard method of recording newly raised concepts or variances during observations or

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31 Verbal consent to add people’s comments to the field diary were gained at time of conversation. If they declined, then the conversations were not recorded.
whilst out in the field (Hammersley & Atkinson, 2007). The data I gained through these informal interviews was valuable and assisted with analysis. For example, a curbside conversation that I had with one of the midwives following an appointment observation in a woman's home directed my attention to the connection between the concepts of time and autonomy for the midwives. This led me to framing certain analyses with the concept of time.

The 10 postnatal interviews with women were semi-structured while the three other interviews, two with midwives and one with another woman were unstructured. The postnatal interviews included me showing the woman a 2–5 minute snapshot of the video recording of the appointment and asking specific questions raised during the initial viewing and analysis. To start each interview, I asked the woman general questions about her experience with her antenatal care and midwifery care to hear her story. I then based the questions I had prepared before the interview on her experiences. In Appendix B I have included an example of the original interview questions submitted, as part of the ethics application, and the actual questions asked at the postnatal interview with woman from appointment A-SMC1. This interview strategy to engage in the woman's own story is seen by Oakley (1981) as important as it show a level of respect for the individual woman. Each interview played out differently depending on the snap shot of video data, the woman's perspectives of this and her experiences with her antenatal and midwifery care. Such fluidity of interview usage in Ethnographic research is valuable as the information gathered from the insider's perspective adds to the holistic perspective of the Ethnographic process (Sharkey & Larsen, 2005). The interviews with the midwives were also planned in a semi-structured manner with the questions used in these interviews based on those created for the focus groups.

3.2.9 Data analysis – what, when, how and why

The feminist theoretical framework chosen for this study enabled me to frame, interpret and analyse the midwife-woman interactions from multiple perspectives (Appelrouth & Edles, 2011) but always by placing the woman at the centre and
examining the influence of the midwife-woman interaction on the woman (Stacey, 1988; Yuil, 2012). The critical ethnographic approach, on the other hand, provided me a framework of critique to examine what influenced the midwife-woman interactions and in particular how the MGP influenced these. I examined the midwife-woman interactions from the micro to the macro. This involved examining and often counting the individual actions and interactions of midwives and women in the appointments (micro) and then examining the influence that the governing structures of the institution, the organisation of maternity care (macro) had on these (Dove & Muir-Cochrane, 2014; Lupton, 2012; Newnham, 2016). This macro perspective was often gained from the participants and at times from supportive literature, making the analysis both sensitive to the experiences of the participants and to contemporary theory (Dykes & Flacking, 2016; Grbich, 2007)

To do this I drew on thematic and content analysis methods. Thematic analysis is a method qualitative research that has been used for many years to identify and analyse patterns and is now gaining 'brand' recognition (Clarke & Braun, 2013). It is a method of analysis employed in recent feminist research (Jenkinson et al., 2017) and critical Ethnography (Dykes, 2005a; Flacking & Dykes, 2013) of midwifery care and women's experiences of that care. I used content analysis for its ability to put numerical values on particular phenomena in the video and audio data by counting or calculating certain actions, interactions, words and phrases (Neuendorf, 2016). It enabled me to examine and compare the midwife-woman interactions, their conversations from the appointments and also compile a number of commonalities from the audio records of the other data.

The six phase approach of analysis set out by Braun and Clarke (2006); 1) Familiarisation with the data, 2) Coding, 3) Searching for themes, 4) Reviewing themes, 5) Defining themes and 6) Writing up guided my research. The analysis process commenced in the early stages of data collection and continued until the end of the writing up process. It was an inductive and iterative approach (O’Reilly, 2009). By the later stages I had refined my analysis, which had become more
critical. I was not only looking at what and when things were happening in the appointments, but I was also asking how and why. I gained clarity and understanding of analytical purpose through an ongoing process of comparing and contrasting individual aspects of the data to each other and to the data as a whole.

3.2.9.1 From description to interpretation

At the outset, I was overwhelmed by the large amounts of textual and video data and struggled to know where to start. To break down the task I started with the accepted classical Ethnographic process of exploring and describing the data (Silverman, 2001). This involved sorting and storing the data, as it became available, into NVivo (Bazeley & Jackson, 2013; QSR International, 2012), a software programme used to organise all types of qualitative data (QSR International, 2012). As such this was a straightforward explorative and descriptive analysis that broadly categorised the type of data and where it was set, the participant's perspectives and experiences, and the conversation and interactions that took place in the antenatal appointments. For example, at this stage I had categorised the appointment conversations and identified the amount of appointment conversation each person contributed and what questions they asked. I also examined the topics of conversation in all the data (appointments, focus groups, interviews and field notes) and identified three early codes that related to the 'system' of care, the 'clinical' aspects of the antenatal appointment and to 'personal' stories or issues. I had also started to see the use of common phrases such as 'making sure' and 'is it normal?' throughout the data and had started to code the conversations that preceded these or took place after.

It was a valuable process enabling me to find a place to start the more complex critical part of the analysis of looking for the influence of the individual, the model of care or the system (structure) (Dykes & Flacking, 2016).

3.2.9.2 Comparing patterns, themes, contradictions and similarities

As the analysis progressed I began an iterative process of reading, re-reading,
viewing and reviewing all of the data one appointment at a time. I then compared and contrasted each of these to each other, to the participant's comments in the focus groups and interviews, between model of care and other significant aspects such as location of appointment. I was looking for connections and differences between each of the appointments and within each of the midwife-woman interactions (Braun & Clarke, 2006). The watching and re-watching of each video record and re-reading of each transcript informed the next stage of analysis and as a whole provided feedback in a process of 'building up and confirming the holistic view of the 'culture' under examination' (Grbich, 2007, p. 41).

As the analysis progressed I began to connect the participants' experience with what I was seeing and reading in the video and audio recordings of the appointments. I began to see recurring patterns of what was happening in the antenatal appointments. For example, the concept of time was identified in the focus group and interview data leading me to the create a number of emerging codes and eventually themes; worry and investment being woman-centred or system-focused. Then I used these emerging themes to frame my analysis and returned again to looking for similarity or contradiction with each of the video recordings and conversations. Figure 1 (next page) is a visual illustration of this iterative process I used and shows, with the aid of the arrows, how time was identified as a central influencer (facilitator and barrier) of the midwife-woman interactions.
**Figure 1: The iterative and comparative analysis process that identified 'time' as a central factor**

<table>
<thead>
<tr>
<th>Data</th>
<th>Process of analysis</th>
<th>Codes created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment observation and video recording</td>
<td>To start with I looked at the length of time for each appointment then compared this to model of care and location.</td>
<td>SMC appointments in the OPD were shorter</td>
</tr>
<tr>
<td>Field note A-MGP9</td>
<td>One midwife told me time was significant. This reflected an issue between the system and woman-centred care: 'I'm a rebel, I get in trouble for spending so much time with the women when they need it'</td>
<td>Time System Woman-centred</td>
</tr>
<tr>
<td>Focus groups and Interviews</td>
<td>Other midwives and women at their focus groups and interviews commented on investing in the women during the antenatal appointment. I saw this as them investing appointment time in the woman: 'Making sure that my ladies – I give 100 per cent to my ladies and did what I could for them, if at that moment – whatever it may be – whether it is talking about their spouses, having a whinge or whatever is needed' (Midwife Interview A-SMC)</td>
<td>Investment Woman-centred</td>
</tr>
<tr>
<td>Video recording</td>
<td>With these perspectives I then returned to the video records of the appointments and started coding the time: with certain actions or interactions such as antenatal assessments, looking at the computer or looking at the woman. This showed that midwife worry/focus was split between the woman and the system.</td>
<td>Worry/Focus on the woman or the system</td>
</tr>
<tr>
<td>Audio transcripts</td>
<td>I coded their conversation during these coded interactions and actions. This provided data on what was happening at the time of these activities, what they were talking about and what the focus was. Again, raising the issue of midwife worry being split between system and woman.</td>
<td>Worry/Focus on the woman or the system</td>
</tr>
</tbody>
</table>

At this stage the connections were emerging between what was I was seeing in the midwife-woman interactions in the video records to how the systems and structures informed the antenatal appointment (Callaghan, 2002; Silverman, 2001). The image in figure 2 (next page) is a screenshot of the coding from one
appointment conversation in NVivo. On the right of the screen in the vertical aligned writing a number of the emerging codes and themes are seen, including conversation topics, conversation styles and worry.

**Figure 2: Screenshot of coding from NVivo**

3.2.9.3 Content analysis

Quantitative content analysis of the video recordings and audio transcripts of the appointments was also a significant part of the analysis. I used it to focus on the detail of how the midwife and woman interacted and communicated with each other, their body language and their interactions with the local environment where the appointment took place. It was a systematic process of describing and quantifying the midwife-woman phenomena (Elo & Kyngas, 2007; Graneheim & Lundman, 2004; Rose, 2016).

Although quantitative content analysis is at times criticised by traditionalists in quantitative and qualitative research paradigms for being too simple and linear it has become a favoured method in contemporary communication, journalism, sociology, psychology and nursing research (Elo & Kyngas, 2007). As a method of analysis, the process of detailing the components of the interactions and styles of communication enabled me to focus in on particular words, phrases or statements,
interactions or actions and code or attach them to a number of concepts and
developing themes (Bengtsson, 2016). Once these data were coded or categorised, I
could then compare the frequency, duration and intensity of each verbal and
nonverbal action across the appointment data. For example, I marked on the video
recordings when they looked at each other, when they smiled, laughed or frowned,
when the antenatal assessments were done or when the midwife looked at the
computer or the medical record. I then divided the length of the antenatal
appointment in minutes by the length of time of each of type of non-verbal
interactions, which created a percentage of appointment time for that non-verbal
interaction. The image in figure 3 below is an example from one video recording in
NVivo.

Figure 3: Screenshot from video recording in NVivo

Rose (2016) reports that the technique of quantitative content analysis with visual
images needs careful thought as it can be so reductive that the social meaning or
interpretation is lost. She reinforces that the images need to be reduced in such a
way that the labelling of the components has analytical significance. The codes
must depend on a theorised connection between the image and the broader
context in which its meaning is made. This is also true of content analysis with textual data where the level of interpretation relates to level of researcher contemplation (Bengtsson, 2016). With the opinions, experiences and perspectives gained from the focus groups and interviews and my feminist informed lens I was able to interpret and connect the micro details of how the midwives and women communicated to the macro details of the healthcare system and society’s expectation of midwifery and the antenatal appointment (Callaghan, 2002; Lomax & Casey, 1998). Midwife use of open or closed questions, for example, was one way of I saw her using her authority and healthcare professional status to control the appointment. In contrast the storytelling style of communication used by the midwives and women reflected the sharing and reciprocity of a woman-centred approach by a midwife. The examination of midwife-woman interactions and conversations at the micro level also informed the influence and interrelationship of the three macro features of the antenatal appointment; environment, time and investment.

The quantitative content analysis of 'worry' that I undertook, for example, inspired by a woman's comment after her appointment observation and affirmed by midwives in focus groups involved counting the words of the appointment conversations where worries, concerns or issues were introduced and at times resolved or addressed. These often occurred or were associated with the phrases of 'making sure' and 'is it normal' that I had identified in the early stages of familiarising myself with the data. This counting enabled me then to calculate a proportional value of worry conversation in the antenatal appointments by dividing the words coded as worry by the total number of words for the appointment conversation. Then with these parts of the conversations coded I recoded to identify who (midwife or woman) initiated the worry, who addressed the worry, how the introduced it and what influenced it. The tables (12 & 13) on the next page show examples of this use of content coding with the emerging themes linked to the final them of 'worry'.
The combination of thematic analysis and this technique of content analysis enabled me to examine the data from description, the 'what' and 'when', and then to a more interpretative approach of 'how' and 'why'.

**Table 12: Content coding examples**

<table>
<thead>
<tr>
<th>Conversation extracts from appointment B-MGP16</th>
<th>Coding examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Woman:</strong> But I'll probably forget that this hurts. No but it's true, and then afterwards I'll be like oh, I shouldn't have done that. I know that's what I'll probably do. I don't know. I'm getting these cramps at night. That's just normal, isn't it, just to get that tightening right down there? That's normal.</td>
<td>Physical demands of pregnancy</td>
</tr>
<tr>
<td><strong>Woman:</strong> But that's just at night. Sometimes during the day, not much. But that's just normal.</td>
<td>All of my problems</td>
</tr>
<tr>
<td><strong>Woman:</strong> I don't know if it's not posterior anymore but it doesn't feel as sore on my back.</td>
<td>Is it normal?</td>
</tr>
<tr>
<td><strong>Midwife:</strong> OK. You've been doing a lot, so sometimes babies just want to stay in that position.</td>
<td>Uncertainty with labour and birth</td>
</tr>
<tr>
<td><strong>Woman:</strong> I know, that's what I was thinking. I bet it's stuck there and it just wants to stay there. I don't know, I just hope. I read all the pamphlets [Group B Streptococcus]. Everything is good. That's OK to do. You said 72 hours afterwards?</td>
<td>Uncertainty</td>
</tr>
<tr>
<td><strong>Midwife:</strong> It's 48 to 72 hours, yeah.</td>
<td>Making sure</td>
</tr>
<tr>
<td><strong>Woman:</strong> Yeah, that's fine to do it. It's pretty rare but it's best to check it. So that's all good,'</td>
<td></td>
</tr>
</tbody>
</table>

**Table 13: Worry codes**

<table>
<thead>
<tr>
<th>Talker</th>
<th>Conversation extracts from appointment B-SMC10</th>
<th>Worry codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midwife:</strong></td>
<td>... OK, are you feeling your baby move?</td>
<td>Midwife introducing generic/standard worry: fetal wellbeing</td>
</tr>
<tr>
<td><strong>Woman:</strong></td>
<td>Oh, so much</td>
<td></td>
</tr>
<tr>
<td><strong>Midwife:</strong></td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td><strong>Woman:</strong></td>
<td>I think it's going crazy.</td>
<td>Woman introducing individual worry: fetal wellbeing</td>
</tr>
<tr>
<td><strong>Midwife:</strong></td>
<td>Yeah?</td>
<td></td>
</tr>
<tr>
<td><strong>Woman:</strong></td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td><strong>Midwife:</strong></td>
<td>More so than your others?</td>
<td></td>
</tr>
<tr>
<td><strong>Woman:</strong></td>
<td>Yeah, like it's painful as well.</td>
<td></td>
</tr>
</tbody>
</table>
3.2.9.4 Balancing bias and being trustworthy

The personal stories from the focus group and interview participants of their everyday experiences with midwifery care and the antenatal appointment played an important role in understanding what influenced these experiences. Also, the early research act to take early analytical thoughts back to the participants in the focus groups and interviews to seek clarification and understanding informed many of the findings. Likewise, my researcher bias was balanced by this process of prioritising the participants perspectives.

In the early analysis I also sought other perspectives to ensure my early interpretations were reliable and valid (Morse et al., 2002) or what Lincoln and Guba (1985) see as ensuring the qualitative research process is credible, transferable, dependable and confirmable and therefore trustworthy. As Knoblauch, Baer, Laurier, Petschke, and Schnettler (2008), Davis Harte et al. (2014) and Pink (2013) highlight a solo interpretation of a segment of video only reflects what that one viewer has seen.

To inform my early interpretations, at this early stage, and to provide a level of rigour to the video analysis Professor Dahlen and I watched and then discussed what was going on in four of the 18 of the video recordings. We talked about and reflected on what the individual midwife's approach was in these video recordings and how their actions in the antenatal appointment reflected a number of society's influences including obligation to the system, her profession and the woman. I recorded in my field diary a list of what we had seen and what to look for and this is shown in the Field diary extract situated in Appendix B.

This shared examination of the video recordings led my focus to be more on the meaning of the interaction, who were the midwives interacting with and who/what were they paying attention to. As others have done in critical analysis, I was looking to see who had the control, who shared it, was it reflective of a social interaction or more reflective of a standardised healthcare interaction (Clancy, 2012; Grant & Luxford, 2009).
Also, sharing the two-five minute snap shot of the video recordings with the women in their postnatal interview proved to be an important way to balance my solo perspective. It enabled me to focus back on the women in the analysis of the video recordings. This experience with the postnatal interviews showed me that the women were focused on themselves and their pregnancy in the film and gave less thought to the midwives' actions. To me, as the researcher, this was a surprise and contrasted my standpoint, as I was looking at interaction from my experience as a midwife and researcher. This subjective perspective reported by the women, however, became influential in framing my later analysis of the conversations from the appointments. It, for example, highlighted that the central focus of the antenatal appointment was informed by more than just the 'worry' of institution and the midwife but was also informed by the woman's 'worry'.

3.2.10 Reflexivity

Undertaking video-recording of midwife-woman interactions required reflexivity on my part (Burns, Fenwick, Schmied, & Sheehan, 2012; Finlay & Gough, 2003). I had the power and authority of a researcher observing a social interaction that is usually private and behind closed doors. I was known as a midwife with a passion for midwifery continuity of care by many of the participants and consequently recognised to bring a bias to the project. This status as midwife and previous colleague with some of the participants also resulted in my researcher role becoming more participatory than anticipated, especially in the interviews, focus groups, and when I talked with participants and many non-participants at both study sites (Atkinson et al., 2001). Similarly, As Jackson, Clare, and Mannix (2003) contend justification and positioning of the research and researcher is most useful when one is discussing their part in knowledge-making.

3.2.10.1 Using Field Notes

The field diaries that I kept throughout the study, from research design, to data collection, to analysis and the write up aided my reflexivity of my influence on the
study and the biases I brought to the study. Avis (2005) sees the role of the qualitative researcher also being that of a research instrument and that often there is an emergent plan of inquiry that develops in conjunction with this role. Reflexivity involves the researcher reflecting constantly and critically on their decisions throughout the study (Finlay & Gough, 2003) and on their position (Berger, 2015).

My field notes helped me to develop my critical and reflexive thinking early on with data collection through to the analytical interpretations I undertook to frame my thinking (Hammersley & Atkinson, 2007). A diary extract, which has been typed up and de-identified, is included in the Appendix B. Also embedded in this is a photo of a collection of the diaries I have used throughout the study.

As Reed and Procter (1995) state these lived realities of the healthcare researcher and practitioner are best recognised, valued and openly reported. The recorded thoughts and decisions enabled me to revisit research design and analytical decisions and to demonstrate a transparency or rationale (Ortlipp, 2008).

Qualitative researchers cannot rely on the reproducibility of their techniques to establish credibility of evidence instead they must rely on transparency (Avis, 2005) that reports or shows an audit trail for decisions throughout the study progress, access to sites and participants, field notes, ethical considerations and analytical approaches (Pyett, 2003).

3.2.10.2 Observing and video-recording social interactions

Observing others in social interactions, as part of an ethnographic study, can impact on the interaction or those involved. My initial plan was to not be involved in the midwife-woman interactions at all during the appointments and anticipated that when I was observing and video-recording the appointments I would simply be an observer. However, as the data collection phase progressed my researcher position became one of observer and participant (O’Reilly, 2009). On a number of occasions, I became part of the midwife-woman interactions in the appointments. This occurred when I moved the camera to a better vantage point, when I was asked questions by the participants, or simply because I was in their private space.
3.2.10.3 **Camera consciousness**

My decision to sit in the appointments to observe and video record the midwife-woman interactions was, compared to placing a hidden camera, an overt way of undertaking the research. On one hand this overtness provided appropriate opportunity for gaining informed consent, but also it affected the objectivity, and some believe the validity of the data collected. As Lomax and Casey (1998) discuss, participants who are being observed and filmed in action will be conscious of the researcher and the camera and are aware that the video recorded images are then able to be analysed and re-presented.

During the early stages of the research at the staff information meetings and again during recruitment, issues of personal and professional vulnerability, for example, were raised by some midwives in relation to being observed and having their practice video recorded. When I discussed the video recording at Hospital B-SMC meeting, for example, one midwife said she 'would feel self-conscious' (field note, 11/2012) and another stated 'I don't want my practice, or my care, filmed' (field note, 11/2012). Other midwives were anxious about me observing their practice, for example 'it's just that I know you so well and I was worried you will not think I am doing a good job' (field note, 11/2012). They were also anxious about seeing themselves on film, comments included 'oh my ... I will have to make sure I have my hair done and lippy on' and 'I've never watched myself before' (field note, 11/2012). At one of the OPDs and just prior to two appointments taking place two midwives who had initially agreed to participate declined. As a result, I did not observe or record the appointment but did offer them an option to participate by attending the focus group.

Additionally, I noticed that when I handheld the camera near my head and face and looked at the camera LCD screen the participants being video recorded noticed me and the camera more than when the camera was set up on the tripod and I did not interact with it. Analysis of the video records confirmed this. When I was looking at the LCD screen on the camera or handholding it the participant's attention was
often drawn to the camera. For example, the video record from appointment A-SMC13 and B-SMC10 showed these midwives looked more at the video camera when I hand held it than when it was on the tripod. In contrast when I had set the camera up and sat away from it or below it, then the participants were more able to 'forget the camera was on' (B-MGP focus group).

Midwives in the SMC focus group from Hospital A and those who were interviewed also reported that when I was out of their direct line of site they felt less worried by the video camera. One midwife stated she noticed the camera more when I handheld it (A-SMC Interview field note). This increased awareness of being video recorded and being conscious of the camera when I hand held it may relate to me, as the intrusive researcher, being more in their line of sight rather than the camera being the problem. As Pink found, the camera impacts differently in each situation, on the relationships the researcher develops and on the social roles that the participant plays (Pink, 2013).

This 'camera consciousness' that they describe has the potential to elicit a response whereby the participants who are being filmed perform or act out what they believe the researcher wants to see. Their actions for the camera, however, may represent a positive outcome of video ethnography rather than a negative one and is what Pink (2013) describes as 'reflective performance of practice 'in practice' ' (p. 106). A process where participants being filmed, have thought and reflected on their work or their role in the social interaction and are performing it in way that is worthwhile or important to them. To some extent the diversity of midwife-woman interactions recorded on film from this study demonstrates this positive effect of video ethnography. Although there was a potential for the participants to be affected by my presence and that of the camera the participants still constructed their performances on what they valued or believed reflected their role. Thereby providing video data that was their interpretation of their role, not mine, and as a consequence also reaffirms the belief that all social interactions are constructed.
3.2.10.4 **Balancing issues with being the insider and outsider researcher**

I situate myself both as an 'insider' and 'outsider' in this research and at times write in first person to demonstrate reflexivity; self-awareness and introspection that are recognised techniques employed in ethnography (Edmonds-Cady, 2012) and feminist research (Webb, 1992). The actions of many healthcare researchers is to understate their bias (Hunter, 2011), however in this study my bias and position have informed much of the study design. To aid transparency and trustworthiness to this study I see it is important to both reflect and examine these (Berger, 2015).

My 'insider' position relates to a level of influence I had with some of the study participants. I was an experienced midwife, teacher and passionate promoter of MCOC who was known to some of the midwife participants, particularly those who were managers and held leadership roles in the two hospitals. In contrast my 'outsider' position related to my novice status as a researcher and that I was unknown and a stranger to many of the women and midwives who participated.

I appreciated that a balance was needed between the ambiguity of these two positions, and I did this with a deep level of reflexivity, transparency and authenticity in my interactions with the participants and with the analysis (Burns et al., 2012). Both roles had the potential to bring bias to the study and to impact on the study process or outcomes (Coghlan, 2001). Issues for the 'insider' on one hand included conflicts of loyalty, creating respectful researcher – participant relationships, (particularly with the midwives) and being identified or recognised with a bias towards MCOC. Alternatively, the 'insider' also has advantages of having an intimate knowledge or 'pre-understanding' of the organisation and the way it works, its everyday life, taboos and preoccupations (Coghlan, 2001). Consequently, these issues of being an 'insider' can be framed as problems or opportunities depending on the context of the situation (Burns et al., 2012; Coghlan, 2001).

3.2.10.5 **Balancing researcher power and trust through reciprocity**

As the ‘outsider’, particularly with the women participants, potential issues of trust
and fear of examination were considered when I sat and observed the appointments and when I facilitated the postnatal interviews (Edmonds-Cady, 2012). In these situations, I needed to demonstrate a relatedness or capacity to find common ground with the participants who viewed me as the 'outsider'. I did this by telling them of my experiences as a midwife. In addition, at the postnatal interviews, I shared two to five-minute un-edited snap shots of the video recordings to show what I had found, to stimulate conversation and to discuss their perspective. This is a strategy believed to be one way to enhance the researcher – participant relationship (Carroll, 2009). However, my endeavour to be seen as trustworthy by the midwife participants was questionable. Although, I had success with this with the managers and CMCs, the lack of trust that some of the midwives' showed with the research and with me was most likely the main reason for them not participating in the observations and video recordings.

Oakley states that feminist research requires a level of intimacy and reciprocity (Oakley, 1981). These are skills that I believe I had developed through many years of working with pregnant women and student midwives but are still skills I am developing as a researcher. From a feminist perspective the positioning of the research within a public (outsider) or private (insider) context also raises the question of researcher power within the research and whose voice am I representing in the analysis. Wilkinson and Kitzinger (2013) argue that there a number of ways to manage this from minimising or maximising your position to utilising or incorporating yourself and your experiences. However, even with these strategies there are as many criticisms as there are positives. Again, Wilkinson and Kitzinger (2013) promote the need for feminist researchers to question how they use their positions of power within the research, whether that be as an insider or outsider and to always focus on being ethical and reflexive.

3.2.10.6 Gaining access

To a great extent the success of this doctoral study relied on the success of the overarching MAWI project with recruitment, collaboration, funding and entry into
the private space of the antenatal appointment. In the first instance, at the executive level, the hospitals, UWS and NSW Health had a mutual agreement to work together on projects seen to benefit and inform public healthcare provision. This enabled hospital access for the study. Hammersley and Atkinson (2007) identify that this type of networking and close connection with different key stakeholders is influential for successful participation and recruitment. O’Reilly (2009) also recognises that negotiation of access throughout the hierarchy of the organisation is essential in gaining access at all levels of the organization from management to fieldworker. Parallel to this executive support was that the MAWI project was an opportunity for the hospitals, as it fulfilled a governance requirement for evaluation of the MGPs. As one CMC said to me 'perfect timing [executive level manager] came to the meeting today, she was really positive about the study, that seemed to go down well' (11/2012).

Next, the MGP midwives and clinical managers for the most part welcomed Professor Dahlen and me during this study time. On reflection, I attributed this acceptance to our 'insider' status as we had prior or existing membership of the group being studied and had ease with access to the study setting and with building rapport (Burns et al., 2012).

However, in the situation of this study, it was necessary to be aware of the power between the researcher and the participant/s, particularly with in-depth qualitative research (Iphofen, 2005). This is because the simple presence of a researcher in your life has the ability to increase the vulnerability of the individual being observed (Murphy & Dingwall, 2007). With this in mind and with the ease that most of the MGP midwives accepted me I was always mindful of my researcher role and the powerful position I was in. As a consequence, I never pursued an individual who declined participation.

Although I have discussed that some midwives from the SMC system were initially hesitant in participating I also found that the MGP midwives acted like 'gatekeepers' and restricted my access to the women and as a result to observing their practice
(O’Reilly, 2009; Tham, 2003). During the creation of the recruitment plan I experienced, like Walsh (2004) had, that even though the midwives were supportive of the study they still controlled who I saw and who I spoke to.

3.3 Conclusion

Feminist theory and critical ethnography have informed this study. I have undertaken a novel method of combining thematic and quantitative content analysis that proved to be an effective way in which to bring all aspects of all the different data together. This enabled me to compare the data and to see the connections, patterns and contraindications within. The next three chapters present the findings from this analysis.
Chapter 4 – Worry, a key feature of the antenatal appointment

4.1 Overview of findings

In the next three chapters I present the findings from this study. These include analysis of video data and audio transcripts from the antenatal appointment observations, audio transcripts from the focus groups and individual interviews, and field notes. Figure 4 (next page) is a visual model of these.

In this first findings chapter, I present 'worry', which was the central feature of the antenatal appointment. It was seen in the midwife-woman interactions in the observed appointments, and the midwives, managers and women reported it in the focus groups, interviews, and field notes. Midwives and managers were worried about 'making sure', women worried about 'is it normal?' and all were worried about 'doing the right thing'.

In the second findings chapter, Chapter Five, I present the three factors of the antenatal appointment found to influence the generation and moderation of worry are presented. These are 'environment', 'time' and midwife 'investment'.

The third findings chapter, Chapter Six, is about the three communication styles I observed in the midwife-woman interactions, which are linked to the generation and moderation of worry. These are 'telling', 'discussing' and 'storytelling'. Also discussed here is what I identified as 'hope', which is the outcome of 'worry' being successfully moderated.

I found that both midwife and woman come to the appointment with worry. During the appointment this worry is influenced by the factors environment, time and investment, which are in turn influenced by the system, the model of care and the midwife's approach resulting in a standard healthcare interaction or more of a social interaction. The style of interaction and communication then influence the worry to be addressed or not and for hope at times to be created.
Any reference to an 'appointment' in these chapters is an antenatal appointment.

Figure 4: A visual model of the findings

4.2 Worry

Worry was the key feature of the antenatal appointments observed in this study. In this chapter I identify this worry and the aspects that were distinct to midwives and women, and aspects that were shared between them. I discuss what influenced the midwives to worry, what influenced women to worry, and the impact a midwife’s standpoint or approach to the appointment had on the generation of worry.

Midwives' worry in the appointment resulted from their actions 'to make sure' and to be 'doing the right thing'. However, what influenced their worry differed. A midwife was either worried about the system (system-focused) or worried about the woman (woman-centred). Where midwives had a system-focused approach their actions and interactions related to the expectations and power of the standardised medicalised system, which privileged the system's governance and
authority. This is in contrast to midwives who had a 'woman-centred' approach, who prioritised the woman over the needs of the system and focused on the relationship she had with the woman.

For women the worry was different. They were influenced by three things; a need to gain certainty and reassurance about their pregnancy, for example asking, 'is it normal?'; the sociocultural expectations of a pregnant woman to 'do the right thing'; and to be 'making sure' by attending antenatal appointments.

4.2.3 Recognising worry

The centrality of worry in this study first emerged at the end of a postnatal interview when a woman reflected on how she felt about her MGP midwife and the care she had received throughout her childbirth experience. I recorded the woman's statement, 'she's mine, she worried for me' (Field note PNI-A-MGP 9). The idea that the woman viewed the midwife to be worrying about her was intriguing and aroused my interest. It led me to take this concept of worry to a focus group with the midwives from MGP at Hospital B. Here the midwives also identified worry as a feature of the antenatal appointment and a feature of their work. For example:

Midwife 1: Well she was right – we do worry about them ...
Midwife 3: ... we do worry about them, and it's not just generic worry – you actually worry about them. (FG-B-MGP)

The midwives' perception of worry, however, was more than a straightforward worry for the women. It was complex and contradictory, as highlighted in the quotes above. They identified that their worry was jointly influenced by their investment in the woman, for example, '...we do worry about them', and the demands that the 'generic' standardised and medicalised system of maternity care had on their practice. Investment in the woman was a positive feature of the midwife's actions in the appointment and is examined in detail in Chapter Five, in

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12 Data item abbreviations are described in the Glossary. This is a field note from the postnatal interview with the woman from the ninth observed appointment, which was done with the MGP from Hospital A.
combination with other influencing factors, which were environment and time.

The comments by women and midwives led to an in-depth examination of worry in the data. During analysis worry was frequently observed in the video recordings and audio transcripts of the appointments, was discussed in the focus groups and interviews and reported in the field notes. Worry was reflected in the problems, concerns and issues raised by the midwives, women and managers, and observed in how they talked and interacted.

In essence, worry was not identified as good or bad. Rather, it had many dimensions and was in fact a central part of antenatal care. Both midwives and women reported that it informed their interactions as they attempted to manage the needs of the healthcare system and the uncertainy of the woman’s future childbearing events. A midwife, for example, commented in a focus group that her worry was informed by being 'switched on' and 'focused on their needs' and was attached to both a sense of responsibility and hope.

Yeah. You do feel kind of responsible. I don't think you kind of leave it – I always think that it's very similar to having a child-like the way you worry about your adult children. You don't kind of hold on to them, but there is part of your brain always switched on and focused on their needs. And you do hope for them. (FG-B-MGP)

Also, a link between worry and hope was observed and associated with concepts such as shared aspirations, possibilities and connection. In the above quote, for example, hope was introduced by this midwife in relation to how she viewed her work and appeared to be a positive consequence of the worry she attached to her work. This association between worry and hope flowed through some of the midwife-woman interactions in the appointments and was reported in their focus groups and interviews. It is discussed in more detail in Chapter Six.

As part of their appointment conversations and interactions, the midwives and women introduced a number of distinct worries and also shared some similar worries. Their distinct worries reflected a difference in how the midwives and women approached the appointment, or their standpoint, which was also informed
by what they believed the antenatal appointment was for. These standpoints were reflected in various midwife-woman interactions. For the midwives, their standpoints ranged along a spectrum from an objective 'system-focused' standpoint to a subjective 'woman-centred' standpoint. For the women, their worry and actions reflected a subjective standpoint where they needed to confirm that their individual experience of childbirth was normal: 'is it normal?'

The midwives' system-focused standpoint was a product of their status as health professionals and employees and their obligations and responsibilities. When this standpoint dominated the appointment, I observed the midwife was less likely to take the individual woman's needs into consideration. Her actions were products of the standardised and routine procedures and policies of the healthcare system and termed as a 'standard healthcare' interactions. On the other hand, the woman-centred standpoint, described by one midwife during a focus group as 'we do worry about them' (FG-B-MGP), was a product of their individual investment or model of care that enabled them to know and connect with each woman and understand her individual worries. It resulted in shared and mutual 'social' interactions.

The midwife's standpoint, her approach to how she interacted in the appointment, or what she worried about was often not fixed. I observed that some midwives tended to oscillate between being system-focused to being woman-centred. A midwife's standpoint and her worry showed in the different verbal and non-verbal interactions they had with the woman and their interaction with objects in the room. In one MGP appointment, for example, the midwife oscillated between a system-focused and woman-centred approach with her use of the phrase 'making sure'. Early in the appointment she initiated a routine healthcare discussion about labour and birth 'to make sure' by educating the woman. This reflected an approach that was system-focused and inclusive of standardised and medicalised actions:

Midwife: If your waters break, don't freak out straight away, just put on a pad and have a look at the colour of the water.
Woman: Yeah, that's what to look for if the baby's poohed itself.
Midwife: Yes, ah...
Woman: OK, I can't remember what that's called.
Midwife: Meconium.
Woman: Meconium, that's it.
Midwife: So it's either clear, pink or green colour, all right? So if it is green colour, don't freak out, that's OK because it's quite a high percentage of babies will have a bit of meconium.
Woman: Yeah, it just means I'll probably have to deliver a lot sooner than I realise.
Midwife: Yeah, so we induce you. If you're not having contractions already we'll induce you and we'll monitor the baby to make sure baby's OK.
Woman: So that's if it's green?
Midwife: Yes. (B-MGP19)

The midwife tries to reassure the woman by saying, 'that's OK, because it's quite a high percentage of babies will have a bit of meconium', but her earlier alert message about the colour of the amniotic fluid, 'So if it is green colour, don't freak out', inadvertently raises the woman's worry about this potential future event. This alert message is then reinforced with her use of the phrase 'to make sure' and is indicative of a standardised healthcare message impressing on the women that she needs to get to the hospital so that the hospital could 'make sure the baby [is] OK'. The midwife's next statement, 'Yeah so we induce you. If you're not having contractions already we'll induce you and we'll monitor the baby to make sure baby's OK' also upholds the hospital as the place 'to make sure'. Although, this second statement was also given as a form of reassurance, it presents a standardised healthcare message that promotes the system's interventions of induction and monitoring and does not explore or examine how this new worry may affect the woman or how the woman could manage it herself, or even give her a choice.

Later in the appointment the midwife's use of the phrase 'to make sure', however, involved a more woman-centred approach when she used the phrase in part of an interaction viewed as shared and with a social intent. Her use of this phase, 'to make sure they're OK', was noticed and seen as an action to describe or affirm to the woman that her work was about looking after the women and their babies in
her care:

**Woman:** Oh yeah. So do you have many more appointments now?  
**Midwife:** I do, actually, I've got a couple more back at the hospital and want to make sure my women who had babies on the weekend, make sure they're OK.  

(B-MPG19)

The next section focuses on components of worry and concepts in more detail. It examines midwife worry, woman worry and the worry concepts that are shared by both the midwife and woman.

### 4.2.4 Components of worry

I identified three themes of worry: 'doing the right thing', 'making sure', and 'is it normal?'. In appointments there were many examples of midwives and women introducing or generating worry and then making attempts to moderate it. Many of the midwife-woman interactions in the appointments were informed by worry and associated with the actions of 'making sure', 'is it normal?' and 'doing the right thing'. Many of the interactions also included a crossover and connection between the concepts and themes of worry.

The themes and their associated concepts are illustrated in the figure 5 (next page).
I conducted quantitative content analysis of the number or times worry was introduced, and any attempts made to address it or moderate it in conversation between women and midwives. Across the 18 appointments, 14–89% of the conversation was focused on worry. On average 44% of the appointment conversations were about worry. These findings are presented in figure 6.
As part of this quantitative content analysis I also examined who was the individual initiating the issue or worry. The trend was that in the MGP appointments women initiated more of the worry-focused conversation, while in the SMC appointments the midwives did. For example, in appointment A-MGP2 the woman initiated 65% of the worry-focused conversation and the midwife 13%, while in appointment B-SMC17 the midwife initiated 81% of the worry-focused conversation and the woman 5%. These findings are presented in Figure 7 (next page).

These findings from figure 6 are also reported in table C-1 included in Appendix C.
Figure 7: Who was responsible for initiating the worry-focused conversations in the appointments

4.3 Midwives – making sure

Midwife worry was most often associated with their making sure, which was influenced by two standpoints; an obligation and responsibility to the standardised and medicalised healthcare system (system-focused) or based on the worry or concern introduced by the individual woman (woman-centred). In this section I focus on the midwife’s use of the phrases ‘to make sure’ and ‘making sure’, firstly from a system-focused standpoint and secondly from a woman-centred standpoint.

The pressure to ‘make sure’ was reflected in the midwives' language and actions more than the language and actions of women or managers. The phrases ‘to make sure’ or ‘making sure’, for example, were used 60 times across all the data sets. Midwives used these phrases on 45 occasions, whereas as women used them 10 times and the managers five times. These finding are reported in Appendix C in table C-2.
4.3.1 A system-focused midwife – making sure

When the midwife’s worry was system-focused, three actions stood out in the antenatal appointments. She was ‘preparing the woman to fit the system’, ‘getting the information’ and ‘making sure there was nothing there’. These actions reflected her need to fulfil her obligations to and compliance with the system. Midwives who demonstrated system-focused worry were observed to interact more with the computer and maternity care records and less with the woman.

The dominance of the standardised and medicalised systems and structures of the healthcare system was obvious in the approach used by some midwives. At the beginning of appointment B-SMC10, for example, the midwife had a system-focused approach to her worry. Her first question to the woman was, ‘Come in. Come in. So other than your back problems, anything else in pregnancy?’ Like many midwives in the SMC appointments, she was focused on issues and problems.

During a focus group one midwife described the pressure of the system as a need to collect and document all the information about the woman, her health and her current antenatal care, ‘you really want to make sure that you’re getting the information’ (FG-B-SMC). At another interview a midwife described the authority or dominance of the system over her practice.

Previous SGA [small for gestational age] doesn’t mean this baby’s going to be SGA so we’re going to do growth scans and we’re going to make sure that everything else is looking fine just like we normally do as a midwife, identify any abnormalities. It makes the doctors feel better if we do two growth scans through that. (A-MGP Midwife Interview)

Two aspects of the midwife’s practice of making sure are reflected in the above statement. One is the essential midwifery role to identify abnormalities, ‘just like we normally do as a midwife, [we] identify any abnormalities.’ The other aspect is the system’s authority over her practice, as she describes needing to send the woman for ‘two growth scans’ to ‘make the doctors feel better’. The latter

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13 Maternity care records used by the midwives in the antenatal appointments included the hospital medical record and the NSW Health GP shared care card that was a small tri-folded card that the woman carried with her to all her antenatal appointments.
illustrates the medical hierarchy where doctor's needs are prioritised rather than explaining that the use of serial ultrasounds (USS) is accepted best practice. The midwife's reflections in this quote identify her concerns about both making sure and 'doing the right thing'.

In many of the appointments, the midwife's need to prioritise the tasks of the hospital system restricted her ability to be woman-centred. In one appointment, for example, a midwife working in SMC initially used the personal pronoun 'I' to offer reassurance in a woman-centred way,

**OK. Look, I probably wouldn't be too worried about any of this. I don't want you to go home and panic and go oh my God, this baby is huge. It's not at all.** (A-SMC13)

Her next statement, however, contradicted this woman-centred approach, 'But we do need to take steps and I have to send you for an ultrasound just to make sure everything is OK'.

Her use of the phrases, 'we do need to' and 'I have to' is a reflection of not only her authority over the woman as the health professional, but also her position as an employee who feels obligated to comply with the healthcare system that governs her practice. In addition, this midwife's lack of authority in the system and her need to defer to the doctor's opinion was seen in her statement, 'Then we'll get you to see the doctor after you've had the ultrasound, and then if they think it's all cool ...'.

The dominance of the system and the midwife's need to comply was particularly evident in the verbal and non-verbal interactions between some midwives and women in the video-recorded appointments. Midwives frequently led the conversation by asking questions based on standardised antenatal tasks and assessments set out by the computer and or the maternity care records. These questions were often relayed by the midwife in the form of a list or menu and did not signal a concern or worry for the individual woman. Neither did the midwife's actions or questions take into consideration the woman's individual situation or prioritise her needs. In one appointment, for example, a midwife working in the
SMC system asked a woman about fetal movements with a respectful open-ended question, 'Now, just talking about the baby. Tell me a little bit about him?' (A-SMC14). However, her placement of the question within the first 20 seconds of the appointment and just after the woman sat down established the priority of the clinical tasks rather than the woman's emotional or social needs. The midwife's prioritisation of the standardised and routine tasks was also noticed during this question as she was looking at (interacting with) the computer and maternity care records instead of the woman.

4.3.1.1 Getting the Information

The midwives' action of 'making sure' involved obligation to gather information or what some midwives called getting the information. The system-focused approach and standardised nature of the appointment was often observed in the way the midwives asked questions. In some appointments the midwife even asked routine clinical questions out of context to the topic of conversation. For example, in one MGP appointment when the midwife and woman were chatting about another midwife, the midwife unexpectedly closed this topic of conversation down with one word and then launched straight into a clinical question about dysuria.

Woman: It's a good spot for her. Yeah, she is so nice and I don't know how she does that over and over again. Just doing classes all the time. Is that what she does?
Midwife: No she does lots of other things
Woman: I don't know how she does it ...
Midwife: She does one lot at a time and then she has a break. Yeah, no burning or stinging when you pass urine?  (A-MGP2)

The standardised nature of appointments was seen when the midwives asked clinical questions, as the midwife did above with the question 'Do you have any burning or stinging?' In total this particular question was asked in 13 of the 18 appointments. Although it was a question that forms part of a midwife's inquiry about a urinary tract infection, it was also just one of a number of clinical

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14 A urinary tract infection is a commonly experienced infection in pregnancy, and these are some of the symptoms of this type of infection.
questions asked by the midwives as they completed the routine checklists from the computer database and the maternity care records. I recognised it as a standardised question and an action of ‘getting the information’ as it related to one of the questions set out by the Obstetrix maternity care database used by the majority of Local Health Districts in NSW (KPMG, 2013).

The observed frequency of this question about dysuria and other questions that focused on fetal wellbeing and fetal movements, rather than the woman and her needs, reinforce the midwives' system-focused approach to the appointment. In addition, the midwife’s actions whilst asking this question further revealed the standardised nature of the appointment. Analysis of the video records of the appointments showed that when the midwives asked these questions most were either looking at the computer and entering information or reading from the maternity care records and writing in them. An example is reported in table 14 below.

**Table 14: Segment of conversation illustrating standardised midwife interaction from appointment B-SMC17**

<table>
<thead>
<tr>
<th>Talker</th>
<th>Conversation</th>
<th>Non-verbal interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
<td>So, any problems passing your urine? Any burning any scalding? No! Excellent. And do you have any questions at all?</td>
<td>Midwife seated at desk reading maternity care records and looking at computer while asking questions</td>
</tr>
<tr>
<td>Woman</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>No? I'll have that [shirt sleeve] down. Excellent. The tourniquet is going to make your blood pressure higher. Which isn't good. Straighten the elbow for me. Thank you. So, you're all organised for baby?</td>
<td>Midwife is standing and taking the woman's blood pressure and asking questions. Statement about blood pressure creates worry.</td>
</tr>
<tr>
<td>Woman</td>
<td>Yes.</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Packed?</td>
<td></td>
</tr>
</tbody>
</table>

The question about urination was the first verbal interaction of the appointment and was asked while the midwife read from the maternity care records and computer. The midwife’s body language (non-verbal interactions) and the clinical focus of this question set the scene for the appointment to be a standardised
clinical process of making sure. When she asked this question, there were no verbal or non-verbal actions by the midwife that indicated a welcome for the woman to the appointment. She did not look at the woman as she asked this question or while she documented in the computer and medical record. Her next action of moving straight to the blood pressure measurement while continuing to ask the woman other questions reflected the midwife’s focus of gathering information. This action of her simultaneously talking, writing and undertaking clinical assessments continued throughout the appointment. This resulted in the woman having no opportunity to raise her questions or worries, as the midwife was busy until the end of the appointment ‘getting the information’.

An association between the midwife's actions and a level of discomfort for the woman in this video recording of appointment B-SMC17 was also seen. During the blood pressure measurement, for example, the midwife's actions conveyed impatience as she directed the woman to roll her shirtsleeve down and commented 'The tourniquet is going to make your blood pressure higher.' Later in the appointment the woman expressed discomfort when she looked straight at the camera and grimaced and raised her eyebrows. This direct engagement with the camera occurred after the midwife had been telling the woman information to prepare her for hospital procedures and she had to exit the room unexpectedly.

This action of midwives 'getting the information' was reported by a woman to hinder her ability to raise her own worries and ensure the appointment was focused on her needs rather than the system's. During her interview this woman said that in one of her appointments (not observed in this study) the midwife was totally focused on the assessments and screening tasks. She felt invisible and outside of the process:

I was just a carrier for a baby and what I wanted or what I thought wasn't really essential to the process. It was just, I had to carry this baby and stay healthy in order to maintain a healthy baby and birth. Not for my own benefit or wellbeing or sense of [being] a good thing to be a good mother.

(PNI-20)
This approach by midwives can largely be explained by the pressure some of them felt 'to make sure' the information was gathered. At one SMC focus group, for example, one midwife stated:

... you're obsessive about doing certain things at different times, always writing on the yellow card, or looking up the person [in the computer database] each time ... if you find a woman you've never met before, you officially start from the beginning looking at everything. Because you want to make sure that you haven't missed anything. (FG-B-SMC)

The midwives felt accountable to the hospital or healthcare system and for some they prioritised processes and procedures rather than the woman. Other comments by midwives in the focus group reflected this, too. One said, 'I have a responsibility to check' and another affirmed this statement by saying:

... to make sure that everything has been looked at ... documented, and that when she presents to birth unit, that they've got the information there present. (FG-B-SMC)

Gathering information also appeared to be a role that they took pride in and one that they perceived as vital for the functioning of the system. For example:

Because particularly, not so much with the midwives, because we're pretty good at it, but if they come from a doctor's clinic to the midwives' clinic, lots of things aren't done that we have to make sure that they are done. (FG-B-SMC)

The system-focused approach to getting the information and making sure, was more evident in the SMC system than MGP. This likely reflects the pressure created by the fragmented, standardised and medicalised system. SMC midwives reported that they wanted to make sure they gathered accurate and adequate information, so the care the woman received for the next stage in the woman's childbirth was appropriate:

I think you want to make sure, there's always the possibility of error. When you're doing the check yourself, you want to make sure like the EDD is correct, how it was arrived at, that it's not a cumulative error, so that when you're coming to do post-dates assessment, you're not inducing a woman too early or too late. You're getting someone to order Prostin. (FG-B-SMC)
4.3.1.2 Make sure there's nothing there

The midwife's obligation to the system in their action of 'getting the information' and making sure was closely linked to the action of vigilance and use of the phrase 'make sure there is nothing there'. This phrase was a consistent rationale used by the midwives in the appointments from both SMC and the MGP. 'To make sure' or 'making sure' accompanied the completion of a number of clinical assessment tasks in six appointments from SMC and in six appointments from MGP. For more detail see table C-2 in Appendix C.

'Making sure' is directly linked to clinical assessments. From a biomedical perspective, the clinical assessment is widely recognised to be the major aspect of antenatal care (Australian Health Minister's Advisory Council, 2014; Villar et al., 1993). In this study the theme making sure was reflected in the tasks and conversations associated with clinical assessments done in the appointments. This included tasks such as abdominal palpations, fetal heart auscultation, blood pressure measurements and discussion about pathology and radiology tests. The link between making sure and clinical assessments was seen when one midwife used the phrase to justify why she was questioning the woman's recent history of having a bloody vaginal loss, 'Good. I just wanted to make sure that it hadn't sort of err, continued or progressed into ... bright coloured' (A-SMC6).

The phrase 'to make sure' was frequently seen in the study and associated with the intent 'to make sure [there is nothing there]. An analysis of the phrase 'to make sure' or 'making sure' identified it was part of the conversation in 12 of the 18 observed appointments. In seven of these 12 appointments the midwife's use of this phrase was observed more than once. In one SMC appointment, for example, the phrase 'to make sure' was used five times by the midwife. In this appointment the midwife used this phrase three times to provide rationale for undertaking the clinical assessments and getting information, as she wanted or needed 'to make sure [there's nothing there]'. For example, during the blood pressure measurement she recommended doing a urinalysis:
Make sure it's all right. I would test your wee-wee as well, make sure there's nothing there. Because of the headache it's been you know ... we have to look into if it effects the pregnancy as well ... to make sure ... blood pressure problems. (A-SMC1)

4.3.1.3 Preparing the woman to fit into the system

The final concept in the making sure theme is 'preparing the woman to fit into the system' and reflects a midwife who had a system-focused approach or worry. An example that reflected this was observed in a MGP appointment when the midwife used the word 'pathway' in conjunction with the phrase 'to make sure' when she was recommending the woman have two USS's to assess fetal wellbeing:

OK we'll put you on that sort of pathway ... just to make sure and then when we get the result with the next one [ultrasound] then we can take it from there and then they'll decide because they're not going to just look at the baby's growth ... they're going to look at other things as well. (A-MGP7)

In this segment of conversation, the midwife also moves from using second person, 'when we get the result' to third person language, 'they're going to look at ...'. This change in her language appears to reflect an attempt to differentiate herself from the system, but even with that intention she still appears to be preparing the woman to fit into the system.

The action of a midwife preparing the woman to fit into the system however, was mostly seen in the SMC system. In one SMC appointment the midwife's approach of making sure and preparing the woman to fit the system were reflected in her recitation of a list of information:

So, umm, did you pack an extra packet of nappies in there? As we only give you a few nappies. So you will need a bag, packet of newborn nappies. And you will also need maternity pads, at least two packets of maternity pads, as you will go through them. You know that when you have your baby, you have a nice vaginal delivery, you just have two nights in hospital. Then you go home. If you have a caesarean then you need to stay three nights then go home. (B-SMC17)

This SMC appointment B-SMC17 was one of the shortest appointments and at no stage did the midwife’s actions or conversation enable the woman to explore her options or choices. Her question at the beginning of this above quote, '... did you
pack an extra packet of nappies ...?' for example, was not so much asking the woman rather it was the entry point in the conversation for her to tell the woman information.

Conversations such as this one manifested from a system-focused standpoint/approach. Worry was generated and governed by standardised and medicalised system of healthcare. There appeared to be pressure on the midwives in the appointments to make sure by getting the information, making sure there is nothing there and preparing the woman to fit the system. The influence of the standardised and medicalised structures of the healthcare systems and procedures generated midwives' worry regardless of hospital, models of care or where the appointment venue was (hospital or home). It was associated with the midwife undertaking routine procedures, getting information and finally telling and preparing the woman for the upcoming processes and procedures that operated in the hospitals.

4.3.2 A woman-centred midwife – making sure

In contrast to the system-focused midwife, the action of making sure was seen less frequently in the woman-centred midwife. In the latter, her focus was on the 'woman's wellbeing', 'helping the woman to navigate the system' and appreciating the 'uncertainty about labour and birth'. A midwife who demonstrated woman-centred worry prioritised the woman's worries or demonstrated concern for the woman. In the appointments a midwife who demonstrated woman-centred worry interacted more with the woman and less with the computer and maternity care records. Midwives with a woman-centred standpoint were more likely to be in the MGP model, or a midwife who demonstrated expert ability to adapt the antenatal appointment.

Often, the first question or opening conversation in appointments with the MGP midwives or those away from the OPD were not problem focused. More often it was the beginning of a social or personal conversation/interaction. In one MGP
appointment, for example, the midwife and woman started the appointment with chatting about a woman they both knew.

Midwife: She’s having it in April
Woman: Oh OK.
Woman: Oh she was talking about having another one and I went, God. (A-MGP7)

4.3.2.1 Woman's wellbeing

One midwife who reflected a woman-centred standpoint in an appointment conversation used the phrase 'to make sure' when she was focusing on the woman's wellbeing. The conversation where this occurred was when she was talking to the woman about her midwifery role during the woman's labour:

So it’s important that you know – it sounds you already know that – is that we are there to help support you through your labour, how you wish that be. The only time things will change, as you briefly mentioned before, is if you’re … concerned about your baby, we might ask you to do certain things just to make sure that you’re both OK. But other than that, the other thing to remember if you do happen to be in the shower [at this] time and you’re comfortable there and you started feeling that urge to push, you don’t have to move, you can stay in the shower. (A-MGP9)

In this segment of conversation, she identified herself, as a midwife who was 'there to help support you through your labour.' This showed her to be helpful and supportive. The statements, 'how you wish that to be', 'you're concerned' and 'we might ask you' emphasised she was directed by the woman and not the system of care. The statement 'do certain things ... to make sure you're both OK' indicated that she was focused on the woman and the baby and not just the baby. The midwife's combined use of the word 'comfortable' with the labour activity of pushing revealed a positive image of labour and not a worrying one., while her statement of 'you don't have to move' created an image of the woman having options, such as using the shower.

This woman-centred standpoint was demonstrated by another MGP midwife in a focus group where she used the phrase 'to make sure'. This was when she linked
her work satisfaction to the woman having a positive experience and feeling in control:

The payoff is the work satisfaction for me and the enjoyable birth experience for the women because — and every time I get comments from the women after the birth – they might say, oh no-one ever told me about that sting that I would feel. So then I would tell every woman that I look after about the sting. Making sure that I talk about things that I never would’ve thought about talking about. So it makes them feel like they’re in control. (FG-B-MGP)

This midwife's reflection shows that she approaches her conversations with the women in her care from their perspective and is focused on their wellbeing as she wants them to feel 'in control'. She uses other women’s stories to facilitate this transfer of information.

The prioritisation of the needs of the individual women, or being woman-centred and worried about the 'woman’s wellbeing', was also described in this same midwife focus group. This occurred when one midwife shared how she and her midwifery partner 'make sure' they meet the women in the other midwife's caseload if there is a potential that they may be caring for these women in labour.

Yeah that's right. I think for us the focus is still on continuity and we tend to be like – if I know that I'm going to be away and it's Kay's on call day – we will make sure that we see that woman together … So they know both of us. (FG-B-MGP)

4.3.2.2 Helping the women to navigate the system

'Navigating the system' was a worry shared by the women and while it is explored in detail later in the chapter, it is important to consider it briefly here. The woman-centred standpoint or worry in 'helping her to navigate the system', was a stark contrast to the system-focused standpoint of preparing the woman to fit the system.

Midwives in the MGP appointments and in appointments situated away from the OPD were more often focused on helping the women navigate the system of care than preparing them to fit into the system. In one MGP appointment the combination of the midwife making sure and worry for the woman was seen in a
conversation about the woman's discharge from hospital.

Midwife: ... Are you feeling OK ... going home after you have had the baby?
Woman: Yes, I'm happy to go – as long as everything's as long as it's all good again ...
Midwife: Yep and we'll check all that and make sure it's [ok] ... even the smallest things sometime keep you in. OK ... it's a shame, but hopefully.   (B-MGP4)

In this conversation the midwife focused on the woman's needs as she explained that her focus was to 'make sure' that she 'checks' all the 'smallest things' are done so that her hospital discharge is not delayed.

Other aspects of this conversation from appointment B-MGP4 that also reflected a woman-centred approach or worry was that the midwife was focused on or worried about issues that the woman worried about. The first was that she considered the woman's needs after the labour and birth, 'Are you feeling OK ... going home after you have had the baby?', which is a worry more often felt by women than midwives. The second was her use of empathy with the phrase 'it's a shame' and the third was her optimism about the future event with her use of the word 'hopefully'. Hope is discussed in more depth in Chapter Six.

In comparison, and as discussed earlier, the SMC midwives in the appointments showed less worry for the woman's individual needs, as they were focused on completing the appointment tasks rather than asking the woman what she wanted or was worried about. One example is that few midwives in SMC appointments, which were mostly late pregnancy, spent any time focusing on or looking past the woman's labour and birth hospitalisation. Their focus was on the tasks of the antenatal appointment and then the needs of the system and how the woman fitted into that.

There were some exceptions where a few midwives in the SMC appointments did reflect a woman-centred standpoint. Analysis of the phrase 'to make sure' in the SMC appointments did reveal two occasions where the midwife helped the woman navigate the system. One midwife, after being told by the woman she had no family
or friends attending her labour and birth, focused on making sure the woman had extra support during her labour:

OK so I think that’s what we put down on your last visit. So I actually put it on the front here as well to make sure that someone stays with you during your labour. So – because you don’t want to be in the room by yourself. You need someone there for support as well. (A-SMC14)

As part of this conversation the midwife’s approach helping the woman to navigate the system included her writing on the woman’s maternity care records a request that birth suite staff organise two midwives to care for her in labour. This indicated that the midwife’s use of the phrase ‘to make sure’ was focused on the individual needs of the woman and providing her certainty about access to labour and birth support. The second example in a SMC appointment when the midwife advised the woman how to access bulk billing for her pathology tests.

Always when any – in the future if you have any pathology done or anything, when you book somewhere just make sure – you ask if they bulkbill. Or they charge Medicare or they charge you extra, OK? (A-SMC1)

Analysis of SMC appointment A-SMC13, situated away from the OPD at the Community Health Centre, showed a midwife who was more woman-centred than system-focused. In one segment of conversation the midwife reflected an intent to help the woman navigate the system when she emphasised to the woman, who was thinking about having a vaginal birth after caesarean, that she had the option of talking with the hospital doctors at her next appointment:

Yeah, any issues that you might have with it. If you want to go and talk to the doctors again we can make that appointment. You go back to [Hospital A] and if you want to change your mind at all at any stage. (A-SMC13)

Included in this SMC appointment were messages of optimism by the midwife. One example was when they were talking with the woman about her pregnancy discomforts:

So it’s still a bit early so yeah, and those pains or those sensations that you’re getting is quite normal now anyway. It’s all the ligaments stretching so just keep that in the back of your mind that it’s all good. (A-SMC13)

Her inclusion of the statement ‘keep that in the back of your mind that it’s all good’
was also a message or reassurance that her ligamentous pains were indicative of pregnancy physiology rather than something pathological or wrong.

Unlike many other midwives, particularly from SMC, this midwife was concerned about the woman's pregnancy discomforts. In essence, women were the ones who worried about their pregnancy discomforts and generated a focus on them in the appointments. The next section discusses this and the other worries that women reflected in the appointments in more detail.

4.4 Women's worry – 'is it normal?'

The theme of worry associated with the women in this study was identified and associated with their preoccupation of is it normal? The women's use of this question was seen as an action to gain reassurance and a sense of certainty about their childbirth experiences. The concepts associated with their questions of is it normal? included worry about their pregnancy discomforts, expressing an uncertainty about the period after the labour and birth and navigating the system. What women in this study worried about was based on a 'subjective' and personal experience of their pregnancy and their concerns for what lay ahead with their labour, birth and postnatal period. It was different to the 'objective' worry reflected by the midwives.

All the concepts of worry introduced by the women highlighted a need to confirm their individual experience of the universal experience of childbirth was normal. An action that was influenced by their own perspective and not an action founded on a collective or objective experience of pregnancy. In the next segment of appointment conversation, the woman expresses her worry about how her older child will react to the newborn:

**Woman:** I'm just worried for her, she's more with me, because [my husband] working long hours and she's just going mummy, mummy, mummy. That's because I want to come home straightaway from hospital and that.

**Midwife:** They adjust.

**Woman:** She's going to be...
There is an adjustment period and all kids react differently but it's an adjustment period and then you won't even remember.

She won't even remember.

When she goes in her bed she wants me, that's because we've got a big house.

Sometimes when you get further along in your pregnancy they start – it's almost like they just know that things are about to change.

It is, especially the last couple of – last month, oh my God, she's so jealous. My sister-in-law has a daughter similar, just three days difference and if she came to me, I was looking after her baby and she just asked me something. She just asked for water or whatever and she came and said, no, no, no, this is my mum, my mum. Don't talk with her, don't look at her and don't do anything. She is very jealous but she's going to be all right with the baby.

She'll adjust, she'll be fine. (A-MGP9)

As seen here midwives often responded to a woman's worry in a standardised or objective way. Possibly this is as a result of regularly hearing similar worries from many different women and knowing that women's worry is most often not realised.

The midwife's response to this woman's story, for example, was matter of fact and showed minimal worry or concern for this woman's issue, as she made little effort to explore it with the woman. Such standardised responses highlighted the different approaches women and midwives often had in the appointment.

A woman's use of the question 'is it normal?' was also to gain reassurance and consensus that their experience of pregnancy was similar to other women, and as such a 'normal' experience. In another appointment conversation, for example, even though the woman did not ask 'is it normal?' she did indicate being worried about not having felt Braxton Hicks contractions. Her worry was founded on Braxton Hicks being a common or normal experience that women have when pregnant and her experience of not feeling them heightened her worry:

Yeah. That's like with Braxton hicks. I haven't felt any...

Yes, that's fine.

Oh that's good.
You're about the only other person who worries about that ...

[Laughter]

I haven't felt ... I don't know... if everything's never done it before so ... so it's ... [partner using humour to mimic his wife's worry about no knowing]  

(B-MGP4)

The women's use of the question 'is it normal?' also demonstrates the societal expectation of the antenatal appointment as the place for pregnant women to seek advice and reassurance from the midwife, who is the 'expert'. This was evident in one SMC appointment when the woman started her questions about her pregnancy discomforts, which included headaches and numbness in her legs, with the opening phrase 'is it normal?'. She also asked questions about her labour and birth and the upcoming admission to the hospital, such as whether her baby was a normal size to birth: 'is the baby too big for me ....?' (A-SMC1). At the end of this appointment the woman's expectation that it had been an opportunity for her to gain answers and reassurance was confirmed when she thanked the midwife for solving her problems, 'Yeah, all problems it's good. You solved all the problems.'

Further examples of the woman's use of the question 'is it normal' in the appointments as a question used to introduce the woman's individual worry and as an action that sought reassurance from the midwife are included in Appendix C in table C-3.

4.4.1 Pregnancy discomforts

One of the common worries introduced by the women in the appointments were issues related to their pregnancy discomforts, with pain being the most commonly raised concern. In one appointment, for example, the woman introduced her worry about the lower back pain she was experiencing: You know. These past probably about two or three days I would say it's like my, lower back is just really painful.' (A-SMC6)

In another segment of appointment conversation, the woman and midwife discussed supra pubic pain the woman was experiencing:
Woman: No, but just a lot of pain down here.
Midwife: Suprapubic pain, like...
Woman: Yeah.
Midwife: ... Right there?
Woman: Yeah.
Midwife: OK, when you cross your legs is it sore?
Woman: Wherever, however I sit. (B-SMC10)

Other pregnancy discomforts raised by women included heartburn, swollen legs, tiredness and vomiting. Examples of these are recorded in the table C-4 in Appendix C.

4.4.2 Uncertainty about the period after the birth

Another topic of worry in the appointment primarily introduced by the women was worry about events after the birth of the baby; the postnatal period. In one appointment the woman told the midwife that she wasn’t ready for the baby to be born, as she was worried about what lay ahead for her:

Woman: Sick of it.
Midwife: Sick of it?
Woman: Yeah to the point where, like, where I’m ready to like, I don’t want the baby to come out. [Laughs]
Midwife: Oh you want stay pregnant? [Laughs]
Woman: Yeah. I have this voice in my head is saying hurry up hurry up, come on where another voice is saying no, no, I know what is ahead of me stay in there for a little bit longer
Midwife: Yeah it's much easier to look after in ... (A-MGP7)

This worry or uncertainty about life after the birth of the baby was also heard when a woman discussed worry about her finances in the postnatal period:

Yeah, yeah, yeah, and I buy more toilet paper because I'm on full pay for the first three months and then I go down to half pay for five months and it's not because I've done a budget, but you probably know, so I'm a bit of a worrier. I worry that I'm not going to be able to pay for this, pay for that because Graeme's not a worrier. So I kind of do all the worrying and I've always been like that. My mum's even worse. So I thought while I've got full pay, I'm just going to stockpile up on a lot of those sorts of expensive things. Then just do every day groceries and on half pay. Like things like paying the land rates and all that, I've paid them for a year in advance so that I don't have to worry. (B-MGP19)
Although women raised their worry about the postnatal period in many of the appointments it was only the midwives working in the MGP who focused or worried jointly with the woman about this. In one MGP appointment, for example, the midwife asked the woman about returning to work:

**Midwife:** How long are you having off?
**Woman:** Ten months. I'm not going back until like the middle of April next year so it's just weird thinking about it, going. I'm not like retiring but I'm having all this time off.
**Midwife:** Well it's not really time off is it when you're looking after a baby.
**Woman:** No, that's what everyone says to me but it's still not – like I guess ...

(B-MGP8)

The fragmentation of the woman's care in the SMC system resulted in the midwife having little or no connection with the woman past the moment of care she was providing. This resulted in the midwife having little need to invest in the woman from one appointment to the next or for the woman's future labour and birth and postnatal events. This lack of investment meant the midwives prepared the woman to fit into the system rather than helping the woman to navigate the system.

The influence or dominance of the system was also a factor in the observed appointments. It was related to midwives' and women's actions and comments associated with them doing the right thing. This is discussed in the next section.

### 4.5 Similar and shared worry – doing the right thing

The examination of the midwife-woman interactions in the appointments and the reporting of their experience from focus groups and interviews identified a number of similar or shared worries between women and midwives. These were informed by their desire to be 'doing the right thing'. They all showed worry about the 'unborn baby', 'uncertainty about labour and birth' and 'navigating the system'. These shared worry concepts, however, were complex and at times contradictory. Uncertainty about labour and birth and navigating the system reflected a midwife who was woman-centred and doing the right thing to support the woman who was
also worried about these things. In contrast, a midwife who reflected a system-focused standpoint in relation to these concepts was doing the right thing in order to comply with the standard procedures and policies.

The influence or effect of doing the right thing introduced worry into the appointment conversation and interactions between the midwives and the women. It often led to their interactions being more focused on the system and the midwife than the woman. Doing the right thing was conceptually entwined with making sure.

In contrast to the midwives' frequent use of the phrases 'to make sure' or 'making sure' women's use of these phrases reflected a desire to be doing the right thing, or an action of navigating the system. One woman in a MGP appointment, for example asked the midwife, 'Oh so I can pack my wheat bag?' (B-MGP16). She was doing the right thing by confirming she was allowed to bring her wheat bag into the hospital. Her next statement, 'Oh and my yellow card [GP shared care card], I have to make sure I don't forget that' reflected a compliance with the system. She was indicating to the midwife she understood her role to not forget her yellow card, as she knew it was an important document for the system.

Likewise, doing the right thing reflected the influence of the system over the midwives. In one appointment the midwife told the woman, 'I'm getting a reputation now, so I'm a bit worried' (A-MGP9) in reference to her having missed two births in the recent weeks due to a long commute. Although this was a spontaneous comment, it described the worry she had about her professional image at the hospital and relationship with her peers in the birth unit and being seen to be doing the right thing.

A vulnerability or sense of surveillance, as reflected in the above quote, appeared throughout the appointments for the midwives and to a lesser extent for the women. Both felt pressured to do the right thing in the appointment or when they talked about a future interaction with the system. An example of this was seen in one appointment when the woman told the midwife about her worry of not being
allowed to labour and birth naturally if her baby was breech again.

Midwife: ... Why did you have a caesarean?
Woman: She was breech.
Midwife: OK. Have you spoken to anyone about what you want to do this time?
Woman: Me and my husband want to try and go natural.
Midwife: OK, cool.
Woman: But I'm a bit worried because now I'm starting to feel up the top that it's the same as before. So I don't know if I'm going to be able to or not. (A-SMC13)

Similarly, a midwife bought the concept of doing the right thing into an appointment conversation when she used the word 'allowed' in a description of an induction of labour hospital guidelines: ‘There'll only be a few days that you're allowed to be after the ninth so, hopefully, it's before the ninth’. (B-MGP4)

This action of the policy 'allowing' or 'not allowing' signified the system's authority over both the midwife and the woman. This need to do the right thing also informed the midwife-woman interactions regarding a shared worry for the unborn baby.

4.5.1 'Just to make sure baby's good'

Worry about the unborn baby was a part of every appointment observed. It involved the midwives asking and telling the woman about fetal movements and other aspects of fetal wellbeing. It also involved the midwife performing the clinical assessments of abdominal palpations and auscultation of the fetal heart. Midwife questions ranged from open-ended questions, for example, 'so you mentioned yesterday that you were happier with the movements? Still moving today?' (B-MGP16), to more closed questions, for example, 'So baby's been moving around fine?' (B-SMC18) and 'Baby's moving well?' (B-SMC11).

The midwife-woman interactions around the fetal wellbeing assessments involved not only the previously discussed actions of the midwife 'making' sure and the woman asking 'is it normal?' but also there was a shared action and focus of doing
the right thing. Their focus on the wellbeing of the unborn baby represented a coming together of worry by the woman and the midwife. It appeared to be the central focus of the antenatal appointment whether the midwife had a system-focused approach, or a woman-centred approach.

Table 15 (below) shows one example of the coding of a conversation that reflected this. In this conversation the midwife's question about fetal movements generates worry about fetal wellbeing for the woman. She then appears to be attempting to moderate this worry by reassuring the woman had about her baby's movements.

Table 15: Segment of conversation and coding examples from appointment B-SMC10

<table>
<thead>
<tr>
<th>Appointment conversation</th>
<th>Worry codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife: OK, are you feeling your baby move?</td>
<td>(Fetal wellbeing)</td>
</tr>
<tr>
<td>Woman: Oh, so much. … Yeah, like the way – I don't know – kicks, pushes. Yeah, it's a bit painful, a bit. It's unusual.</td>
<td>(Pregnancy discomfort), (Worry about unborn baby) &amp; (Is it normal)</td>
</tr>
<tr>
<td>Midwife: Sort of almost like bruising sort of feeling when it keeps moving?</td>
<td>(Assessing) &amp; (exploring)</td>
</tr>
<tr>
<td>Woman: Feels like scratches, flicks. I don't know, yeah. It's a weird feeling, like I think it's a jungle in there, I don't know.</td>
<td>Pregnancy discomfort), (Worry about unborn baby) &amp; (Is it normal)</td>
</tr>
<tr>
<td>Midwife: The movements are so reassuring to us.</td>
<td>(Reassuring) &amp; (moderating worry)</td>
</tr>
<tr>
<td>Woman: Yeah, it's a lot of movements, yeah. Some movements are really like painful. I don't know if that's normal.</td>
<td>(Worry about unborn baby), (Pregnancy discomforts) &amp; (Is it normal)</td>
</tr>
</tbody>
</table>

In the SMC appointment B-SMC12, the midwife's system-focused approach was revealed by her use of the phrase to make sure she showed worry about the wellbeing of the unborn baby, while the woman's part of this interaction was that of quiet compliance. She sat quietly throughout and at the end of the appointment she followed the advice provided by the midwife and went for a cardiotocograph (CTG) and USS. They both appeared to both be doing the right thing. For example, the next segment of appointment conversation shows the midwife worry:

OK, that's great. So baby's heart rate is really good. The baby's measurement is a little bit small, so I'll probably have to just mention it to
the doctor because they might want you to go to have an ultrasound just to check on the growth. But I'll just let you down [from the examination bed]... great. Just have a seat. So the baby doesn't seem to have grown since the last visit, but it could be just the position the baby's lying in. Sometimes we just want to make sure that the baby's growth is continuing to grow and that it's at the right size and the doctor may want you to have an ultrasound.  

(A-SMC12)

Just prior to this conversation segment the midwife had performed an abdominal palpation to assess the fetal growth 'to make sure that the baby's growth is continuing' and had found the measurement to be a 'little bit small'. Her comment, 'to just mention it to the doctor because they might want you to go to have an ultrasound just to check on the growth' highlighted that she was doing the right thing by the system. She was informing the doctor; the authority in the system and confirming her findings with the technology approved by the system; an USS. Her action of doing the right thing by the system was affirmed with her next comment, 'it could be just the position the baby's lying in'. The midwife had noted that the position of the fetus may be the reason for the change in the fundal height measurement rather than it being as a result of inadequate fetal growth. However, due to her lack of authority, she was checking just in case.

In contrast to the previous example the next example shows a midwife who is a little more woman-centred in her approach. In this appointment, A-MGP7, the woman was worried, and checking is it normal? and the midwife was doing the right thing by the woman and the system:

Midwife: So you're happy with your movements today?
Woman: Yeah. Yeah.
Midwife: You're sure?
Woman: Yeah, yeah, yeah, yeah. It's more just like – it's hard to know. It's hard to know is it just slowing down because you're getting towards the end, there's less room and it's just – do you know what I mean – or if it's something to worry – I think stress a lot.
Midwife: You need to be really really aware.
Woman: Yep, yep.
Midwife: Because we know baby is down here. You need to be really aware because that will be the first thing indicator that baby is starting to struggle. (A-MGP7)

In the above conversation the woman's and the midwife's worry about the unborn baby was a central focus, as it was for the entire appointment. The midwife's worry was first noticed when she asked the woman 'So you're happy with your movements today?', while the woman's worry was reflected in the uncertainty she had with the baby's movements and knowing if they were normal: 'It's hard to know is it just slowing down because you're getting towards the end, there's less room'. Also, their comments, 'or if it's something to worry', and, 'You need to be really really aware' reflected a mutual action or worry of doing the right thing.

Throughout appointment conversations that focused on the wellbeing of the unborn baby unequal power dynamics between the midwife and the woman were seen. In all the video recordings of the appointments, as with the previous example, there appeared to be a ritual where the woman waited for the midwife to ask questions or be directed to have the clinical assessments done. This symbolised the unequal power between that of a health professional and a healthcare recipient. In every appointment the midwife introduced and led the conversations and interactions focused on fetal wellbeing. The absence of any woman initiating an appointment conversation about their worry about their unborn baby reflected a sociocultural expectation that women are passive recipients in the appointment.

4.5.1.1 'Go and have a CTG'

In these shared actions of doing the right thing the midwives routinely recommended to the women to have a technological procedure to make sure about the unborn baby. Midwives from both models of care and both hospitals recommended or directed the woman to have technological procedures. In eight of the 18 appointments the midwife recommended the use of a (CTG) or USS. Four of these occurred in MGP appointments and four were in SMC appointments. The association of midwife worry about fetal wellbeing, their use of the phrase 'to make
sure' and the offer of technological monitoring reflected a standardised approach and a reliance on technology. It also reflected midwives' attempts to gain certainty. The review of the midwife actions and conversation from appointment B-SMC12 earlier in this section of the chapter shows this.

The midwives' reliance on technology that was associated with their system-focused worry and actions of doing the right thing also reflected their preference for the knowledge provided by technology rather than the woman's knowledge. This was seen in the audio transcript of appointment B-SMC18 when the midwife explained to the woman why she was ordering an USS:

So we'll just – that's what we do, we've had one today it must be in the weather. We seem to be ordering ultrasounds. So all we're doing – what we want to do is to establish that the baby is growing at the normal size, so it's not a fat thing we're looking at. We're looking at the head circumference, the length of the legs and things like that. So they are the things we're looking at to make sure that the baby's growing right. Now if we find that baby is not growing as baby should it just means that we continue on with normal visits but you go and have a CTG, you know the monitor that they put on. (B-SMC18)

In this conversation the midwife's reference to the weather that accompanied her explanation for the USS and the CTG signified they were standard, normal and routine. This explanation was also a message of reassurance, but one based from an authoritarian expert approach. The midwife's statements were telling the woman what the system was doing, rather than looking to gain the woman's consent: 'all we are doing', 'what we want to do' and 'things we're looking at to make sure'.

In the appointments the midwives' system-focused approach or worry about doing the right thing and their recommendations for the use of technology also reflected their compliance or obligation to the system. Midwives reported they undertook assessments and recommended further technology to make sure they were doing the right thing by the hospital policies and procedures. In one SMC midwife focus group a midwife stated her desire was 'to make sure' her actions in the appointment did not disrupt the system:
... I want to make sure that the pathology or the ultrasound and everything has been looked at are documented, and that when she presents to birth unit, ... they've got the information. (FG-B-SMC)

4.5.1.2 'Something you'd want to closely monitor'

Another aspect of midwife-woman interactions attached to their conversations of worry about fetal wellbeing was the midwife sanctioning the woman to be self-vigilant. Midwife conversations that promoted self-vigilance included comments and questions about the baby's movements and the appearance of the liquor after the woman's membranes have ruptured. This was seen in one appointment A-MGP9 conversation when the midwife's combined use of the phrases 'if you feel changes' and 'closely monitor' with her use of the phrase to 'make sure' instructing the woman to have a high level of vigilance.

So if you feel changes in that, if you think OK, this is normally when the baby's quite active but I'm not feeling that today, then that would be something you'd want to closely monitor and make sure the baby is moving. (A-MGP9)

However, in this midwife's conversation even though she was instilling a level of self-vigilance in the woman her approach included woman-centred aspects attached to this worry about the baby. For example, she sought permission, 'if you think [this is] OK' and personalised the worry for the woman with the statement 'but I'm not feeling that today'.

The influence of the system's authority over worry about the unborn baby was, perhaps unsurprisingly, more system-focused than woman-centred. In some of the appointments the midwives were only system-focused, with little or no regard for the woman. In many of the appointments, however, and particularly in the MGP appointments, the midwives oscillated between being system-focused and being woman-centred. In one appointment the midwife started with a system-focused approach when she was talking to the woman about induction of labour:

So the hospital policy is that at 41 weeks we go into the hospital ... and ... check in on your and baby, check how everything is going and make sure everything is all good with the pregnancy. The hospital's recommendation is that you're induced at 10 days overdue. (A-MGP9)
In this conversation the midwife's use of the phrase 'make sure' in combination with a worry about fetal wellbeing reaffirmed the routine procedures of the system as necessary, and that a post-dates pregnancy is a worry. In contrast, the midwife's comments in the next segment of conversation from the same appointment demonstrates aspects of a woman-centred approach where she reassured the woman and informed her that she had a choice:

OK? Having said that a normal pregnancy is up to 42 weeks, so you can choose to wait til 42 weeks, you have a discussion with the doctors about that and you might need to go in for some extra monitoring just to make sure baby's good but a normal pregnancy is up to 42 weeks. Leah was pretty close to being on time, wasn't she? (A-MGP9)

In this conversation the phrases such as 'you can choose' and 'a normal pregnancy is up to 42 weeks' reflects reassurance and choice. The midwife's inclusion of her knowledge about the woman's previous pregnancy also appeared to enhance her ability to reassure the woman.

4.5.2 Uncertainty about labour and birth

After worry about the unborn baby the midwife-woman conversations in appointments mostly focused on the upcoming labour and birth. In one appointment, for example, the midwife stated, 'OK, so the big time is coming' (A-SMC1). This was an expected finding as most of the appointments observed were close to the woman's expected date of birth. In many of these appointments, however, midwives and the women also voiced uncertainty about labour and birth. There were many attempts by midwives and women to create certainty about the labour and birth by doing the right thing for the labour.

Uncertainty about labour and birth accompanied many midwife-woman conversations that focused on the occipito posterior position\textsuperscript{15} of the fetus in utero. It was a worry that women mostly introduced. In appointment A-MGP8, however, the midwife and woman jointly discussed their worry about the position of the

\textsuperscript{15}Occipito Posterior position of the fetus in utero is thought to predispose many women to have a long and complicated labour.
unborn baby.

_Midwife:_ Are you getting back pain?
_Woman:_ No, not really. I know that sounds – that's posterior isn't it?
_Midwife:_ Yeah, I think bub does feel a little bit posterior, just because it's pretty hard to feel the back. If you're getting kicks on both sides at sort of like the same time that can mean bub's right around the back and you've got legs on either side. Sometimes when you've got the back all the way around here, then ... (A-MGP9)

Table 16 illustrates the other occasions that this worry was raised in the appointments.

**Table 16: Examples of worry about the baby being in an occipito posterior position**

<table>
<thead>
<tr>
<th>Appointment Conversations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A-MGP2</strong></td>
</tr>
<tr>
<td><strong>A-SMC1</strong></td>
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<tr>
<td><strong>B-MGP19</strong></td>
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<td></td>
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<tr>
<td><strong>A-MGP8</strong></td>
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Uncertainty about labour and birth was also associated with another fetal position; engagement of the fetal head. Again, it was a topic of conversation introduced by the women regularly during the appointments and often at the time of the abdominal palpation. For example 'When does the tummy, like, when does it drop? It's just when he's ready to ...?' (A-SMC6) and 'Yeah, and I hope he's behaved and he's moved right down.' (B-MGP3)

The midwives and women's approach to managing their _uncertainty of labour and birth_ was noticed to be different and associated with how they approached their worry of doing the right thing.

**4.5.2.1 'I just don't know what I am going to be like'**

A woman's worry about the upcoming labour and birth observed in many of the appointments included questions aimed at gaining certainty for herself. The
woman's worry about the upcoming event of giving birth reflected a subjective worry and a worry about not knowing what was going to happen. In one appointment a woman voiced a worry about managing the labour and an uncertainty about how she would react to the labour when she said, 'I don't know what I'm going to be like. Am I going to be like, don't touch me. But I don't know, ...' (B-MGP16). This uncertainty was common across several appointments. The women wanted to know how to do the right thing in labour. In appointment B-MGP19 the woman starts a discussion about her expectations of her labour with the midwife:

Woman: Yeah, nice and long, yeah. And Graeme was like very – because originally I was just going to try the gas and whatever happens, happens. Then knowing that there's the bath option, which we never knew, and yeah, we were like both really up for it and because I am a low risk, as you know, I don't have any issues so far, I'm hoping that that will continue through my labour.

Midwife: Hopefully.

Woman: Have you had that yourself? Like people that usually have easy pregnancies so ... (B-MGP9)

In this conversation the woman's uncertainty about the labour and birth was seen when she asked the midwife if her personal thoughts and expectations were similar to other women, 'Have you had that yourself? Like people that usually have easy pregnancies so ...' She was attempting to gain certainty that because she was 'low risk' and had an 'easy' pregnancy she would have an easy labour.

In another appointment the woman reflected worry associated with knowing what to expect or do during the transitions stage of labour when she said, 'Umm ... remind me again transition, is that like once you're fully dilated or that's like halfway abouts?' (B-MGP4). Similarly, in another appointment the woman's worry associated with doing the right thing and managing the pain of labour was noticed when she said, 'I just don't know how I'm going to be. I could be just like get me out of the water.' (A-MGP2).

The worry that women raised in the appointment associated with doing the right
thing and an uncertainty of labour and birth was not only observed with first time mothers. In one appointment, for example, the woman who had previously given birth, said:

I was actually start to panic when I came in the labour, I was start shaking and I was scared. The midwife say, just relax, because the baby's going to be nervous and maybe you're going to have some complications. Then I was OK, OK, I'm going to relax, I'm going to be cool. (A-MGP9)

Although, just after this comment she did acknowledge that this worry about what to expect with the labour and birth was stronger with her first pregnancy:

I think I'm going to be better, because it's second time. First time I didn't know. I didn't know what's going to happen, I didn't know what I'm going to do but now roughly I know, yeah, whatever – what's going to happen. (A-MGP9)

4.5.2.2 'Provided everything's good'

In contrast, the midwives' uncertainty with the women's upcoming labour and birth and the concept of doing the right thing was often associated with them having a medicalised standpoint about labour and birth. In this standpoint a labour and birth can never be regarded with certainty, and as such labour and birth are worrying for the midwife and are full of uncertainty. Along with the midwives' uncertainty about the labour and birth they also had an expectation that women would do the right thing. The dominance of this medicalised approach to labour and birth was seen in one appointment when the midwife told the woman about third stage of labour. It was associated with the midwife's use of the phrases 'usually we let the cord stop pulsating' and 'provided everything's good':

<table>
<thead>
<tr>
<th>Midwife:</th>
<th>Usually we let the cord stop pulsating maybe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
</tr>
<tr>
<td>Midwife:</td>
<td>So the baby gets all the blood you know all the blood that's coming from the placenta. So that can take a few minutes, so ...</td>
</tr>
<tr>
<td>Woman:</td>
<td>That's alight. Yeah.</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Provided everything's good. (A-MGP2)</td>
</tr>
</tbody>
</table>

The combination of these phrases in this conversation highlights the midwife's uncertainty about the third stage of labour and her reliance on the medicalised
active management style.\textsuperscript{16} The midwife she is explaining that for her to be doing the right thing she needs to be reassured and certain that the progress of third stage is good and the woman is not having a postpartum haemorrhage before she can allow the baby to get the benefit of extra placental blood flow.

In another appointment this medicalised approach used by one midwife was associated with the woman doing the right thing rather than her. This occurred when the midwife stated her worry about the woman having a quick or precipitate labour. The midwife in this conversation was reaffirming the 'right' thing for the woman to do was come in early:

\begin{quote}
Midwife: So baby number four and you had pretty quick labours didn’t you?
Woman: Yeah.
Midwife: Yeah, so are you all packed and ready in case something happens?
Woman: Yeah.
Midwife: That’s good. Probably you don’t want to wait too long at home because you’ve had the fast labours.
Woman: Yeah.
Midwife: Yeah and you know the signs of labour and when to call birth unit?  
\end{quote}

\textbf{4.5.2.3 Navigating the system together}

In the appointments and interviews the women voiced their worry about being prepared for or knowing what was needed to navigate the system of healthcare or the hospital processes when they were admitted. For one woman it was about not knowing the hospital car parking arrangements:

\begin{quote}
Oh, actually I just thought of something else … This is going to be a silly question but because I don’t go to the hospital, when we go to park, do we need the – is it $8?  
\end{quote}

The same woman’s comments from this appointment also reflected a worry of doing the right thing and navigating the system when she asked the midwife about

\textsuperscript{16} To prevent a postpartum haemorrhage the third stage of labour has traditionally been actively managed with an intramuscular injection of an oxytocin medication and the clamping and cutting of the baby’s cord immediately after the birth. Recent evidence is that delaying the clamping and cutting of the cord is beneficial for the baby, but practice has been slow to adopt this.
the hospital’s expectations of what she should bring to hospital for her labour and birth admission:

…. I’ve packed my bag. Any suggestions on what – I packed a change of clothes for myself, pyjamas just in case I have to stay overnight, pads, nappies, clothes and a blanket for the baby, camera, my swim costume. Nigel brought costume as well. I think that’s it. (B-MGP16)

Other women’s comments that reflected their attempts of navigating the system were not only linked with their uncertainty about the labour and birth but were also associated with making sure they had social support. Having and ensuring they had social support in the unfamiliar hospital environment was important for some of the women in this study, as it is for most women. In one appointment the woman reflected this worry, as she knew her husband could not be there to support her in labour:

Woman: No one was there only two midwives were there.
Midwife: That’s what I – yeah, because your husband stayed at home with the children.
Woman: Yeah, husband busy with children. (A-SMC14)

In the MGP appointments some women’s comments also reflected worry about who would be the midwife caring for them during their labour. For these women knowing the midwife was important in helping them to navigate the system. In one MGP appointment the woman asked the midwife, 'Say if I go into labour, who then – so your partner, is it Cheryl who's doing it now?' (B-MGP16). In this same appointment the woman's next question was seen as an attempt to also navigate the system and gain certainty regarding arrangements should her MGP midwife not be available: 'Oh OK. So one of them would answer. How do they know then my preferences? They've got my folder?' (B-MP16).

Subtle differences, with this worry about preparing the women or helping them to navigate the system, were noticed between the two models of midwifery care. Midwives in the MGP appointments were more focused on helping the women navigate the system of care than preparing them to fit the system. In contrast many of the midwives in SMC were focused on preparing the women to fit the system.
One midwife at a focus group (FG-A-MGP) reflected this was a consequence of SMC being a fragmented model of care, because when you work in SMC ‘you’re not going to be there for the labour and birth’ whereas when you work in MGP ‘you're going to see them again’.

4.5.3 Transferring worry

Worry was also transferred between the midwife and woman. This was seen at the end of appointment B-SMC18 when the woman left more worried than when she arrived. To start with, this appointment was relaxed and respectful. The student midwife and woman immediately struck a conversation, as they knew each other, because this woman was one of the student’s ‘continuity of care’ experiences.17

During this appointment conversations and interactions illustrate how the midwife’s worry was transferred to the woman. This was noticeable when the midwife and student midwife interacted, and the left the woman sitting and waiting. Their worry was different to the woman’s. They were focused on system requirements and making sure rather than moderating the woman’s worry about is it normal? For example, at one stage of the conversation they were focused on the fundal height assessment and the woman was focused on her pain after sexual intercourse:

Midwife: 31 centimetres.
Student: Yeah that's exactly what I got
Midwife: What was she last week?
Woman: Yeah so I got this really severe pain and it just stopped (B-SMC18)

The woman was worried about her pain, while the midwife and student were focused on confirming their fundal height measurements and organising an USS and CTG, rather than reassuring the woman about her pain. Instead of interacting with

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17 In Australia midwifery students are required to complete a number of 'follow throughs' or 'continuity of care' experiences with women during their midwifery degree/diploma. These experiences require them to be at all aspects of the woman's childbirth experience. Her antenatal appointments, her labour and birth and her postnatal care.
the woman they conferred between themselves, looked at the computer and read from the maternity care records, 'Yeah that's exactly what I got' and 'What was she last week?'

The student's next action was an attempt to reassure the woman about her pain, 'Try Panadol, take just a simple pain relief if needs be. But if you're worried you know that number on the front of the yellow card today?' However, the midwife's focus was still with the fundal height measurement:

   OK we need to look at this fundal height. The fundal height last week was 33. Fundal height today was 31. That's probably 'cause the head's engaged a lot more but we can't assume that, so an ultrasound would be the way to go there. (B-SMC18)

At this stage the woman was reassured by the student and indicated confidence in her own ability to assess if there was a problem or worry with her pregnancy:

   OK no worries that's fine ... Yeah I'm not worried that's why I thought, I thought 'cause it's my third I kind of roughly know what's happening, so ...

(B-SMC18)

Under the direction of the midwife, however, the conversation returned to a focus on the fundal height and fetal wellbeing when she said, 'Given that you're 36 weeks and you're measuring 31 weeks, that's quite a big difference'. At this stage the woman did not show any worry about the baby when she stated, 'Yeah. Me and Dad are tiny too, so ...' Still, the midwife prioritised her worry when she said, 'Or whether it's more because it's not growing'. She also introduced to the woman the need for an USS to monitor the fetal growth: 'an ultrasound will show if you’re having a small baby', and the need for her to self-monitor the fetal movements: 'But the most important thing that you can do is monitor your movements, that's the most important thing'.

Even with attempts from the student to reassure the woman, the woman finally succumbed to the midwife's worry and cries.

   Student: Is there anything else you want to ask, anything else you want to talk about?
   Woman: No, just the size thing, that's about it now [crying]. ...
Student: Get that done just for peace of mind as well. Just to keep everything alright on this. Alright you take that one … So if it doesn’t move just ring up
Woman: OK so 10 times every two hours.18 (B-SMC18)

The communication pattern of this appointment reflected a standard healthcare interaction with a midwife who had a system-focused approach. Although the student demonstrated attempts to discuss and listen to the woman it was the midwife's focus on fetal wellbeing, making sure and doing the right thing, that dominated. As a consequence, the woman left the appointment more worried than when she came.

In most of the appointments, however, the introduction of worry was accompanied with an attempt by the midwife, and on occasions the woman, to take away, address or moderate the worry. Moderation efforts have been reported on briefly in this chapter but further illustration of them is presented in the third findings chapter, as they often related closely to the concept of hope. In the appointments when the worry was successfully moderated it resulted in the woman having a sense of hope and optimism for her future childbirth events.

4.6 Conclusion

In this chapter the feature of worry and the underpinning themes and concepts have been explored. A number of accompanying conversations, actions and interactions of the midwives and women in the observed appointments have been presented. I have also drawn on the opinions and perspectives of the midwives and women to illustrate the pervasiveness of the system's worry on their actions and their understanding of what the antenatal appointment represents. Although worry was not always a dysfunctional behaviour, it informed a midwife’s standpoint and approach to the antenatal appointment. It also influenced what she focused on or prioritised and her interactions with the women.

18 Advice to women about self-monitoring in Australia does not include the '10 movements/day' ideal any more but focuses on women being aware of a change in the fetal movements that is not common or routine for them.
The next two findings chapters provide an in-depth exploration of other factors of the antenatal appointment found to affect the generation or moderation of worry, or how this worry is communicated.
Chapter 5 – The influence of environment, time & investment on midwife-woman interactions in the antenatal appointment

In Chapter Four I presented the principal finding of this study that worry was the central feature and focus of the antenatal appointment and of midwife-woman interactions. In this chapter I present other factors found to influence the antenatal appointment and the nature of the midwife-woman interactions and how worry was generated and moderated. These are environment, time, and midwife investment. Figure 8 (below) is a model of the study findings that highlights the relationship between the worry of the antenatal appointment and these other three factors. As the focus of this study is midwifery practice and the influence of midwifery models of care, this chapter reports mostly on the midwife's actions.

Figure 8: A model of the factors that influenced the antenatal appointment
This chapter starts with an overview of environment, time and briefly introduces midwife investment. The major section of this chapter is devoted to midwife investment. To examine the factor of midwife investment this section uses examples of findings from the detailed analysis of four different appointments and relates these to the broader findings of the whole analysis to show:

- the differences where a midwife’s investment was system-focused, and a midwife's investment was woman-centred.
- an appointment which shows the positive effect of the woman's home on the midwife-woman interactions
- the expert actions used by one midwife to adapt the environment and time of a SMC appointment to enhance her ability to be woman-centred.

My analysis of the video and audio recordings and participants' views reveals the complex interrelationship between the environment and time of the appointment and midwife investment. Although the term ‘investment’ is typically used as an economic term, for example ‘the outlay of money usually for income or profit’ (Merriam-Webster, 2017), in this thesis it related to the energy or effort a midwife applied to her work; her effort to build a relationship with the woman and her commitment to the woman. A midwife's investment related to how she approached her work, how she interacted with the woman, and what she worried about or focused on. This investment shifted along a continuum from the midwife being entirely system-focused to being fully woman-centred. In addition, a midwife's investment was influenced by the environment and time factors of the appointment.

Midwife-woman interactions, their conversations and the individual actions of some midwives, ranged from a standard healthcare (medicalised) interaction to a more social interaction. The differences between these interactions have been described here but are considered in more depth in Chapter Six, where the differing styles of communication and interactions seen in the appointments are described.

Ultimately, the opportunities provided by the MGP model of care were the strongest determinant of a midwife's investment being woman-centred rather than system-focused. Furthermore, the model of care, whether it was MGP or the SMC,
was the principal influencer on the appointment environment and time, although there were exceptions. Although not the primary focus in this study, I did find that women's expectations of their antenatal care also influenced the midwife-woman interactions.

The first section of this chapter is focused on presenting the environmental factors that affected the midwife-woman interaction; the latter part of this section reports on the influence of time in the antenatal appointments.

5.1 Environment

The environment of every appointment had a powerful effect on the nature of the midwife-woman interactions. Environmental factors included the location of the appointment, the layout and décor of the appointment space and the overarching healthcare system structures and processes that governed the antenatal appointment and the midwives' practice. I observed these at the time of the appointment observations and then during the analysis of the video recordings and audio transcripts. Additionally, participants discussed the influence of the environment on their experiences of the antenatal appointment in their focus groups and interviews.

As discussed in the methodology chapter, the appointments mostly located in the antenatal clinic in the OPD or the woman's homes. One appointment was observed in the community health centre, one in the birth unit and one in the MGP clinic room located away from the OPD.

5.1.1 The hospital OPD: 'It might come across as quite rushed. It will be impersonal'

In the OPD the verbal and non-verbal interactions between the midwives and women were often disjointed and unidirectional. The midwives, and in particular the women, had little control over what took place in the appointment. As a result, most of SMC appointments taking place in the OPD, and the midwives and women who participated in them were generally disadvantaged by this location. Typically, the layout and décor in
this context reflected a medicalised hospital environment governed by institutionalised systems and structures. A manager at one focus group described the appointments in the OPD as being impersonal and time pressured: ‘in the clinic, you are short of time and you have to cover a lot of ground in a very short time. It may come across as being quite rushed. It will be impersonal’. (FG-B-Managers)

The nature of the OPD environment in both hospitals in this study was clinical. They were busy, bustling and impersonal. In both hospitals the waiting room was the entrance to the OPD and was situated off a busy hospital corridor or foyer. The waiting rooms were large with many plastic chairs set up in rows. The walls were adorned with posters promoting healthcare messages and women reported the OPD waiting area as impersonal:

it's almost like ... the RTA [Roads and Traffic Authority – NSW Government] office where you've got your numbers flashing up. You're waiting for your number to be called. There's no interaction with anyone. You have no idea how long ... it's going to take or how long it's going to be.  (PNI-20)
See I would never go public if I didn't have that continuity. If in the beginning, if I didn't get on caseload, then I would have gone to a private doctor, because I just wouldn’t do the cattle thing. Not for me.
(PNI-WMGP3)

The administration desk dominated both waiting rooms. It had a raised front section, purpose built, to separate the staff from the 'patients'. The staff that worked behind this desk controlled who or when the 'patient’ could get to or access their appointment. For example, while waiting to recruit in the OPD waiting room of Hospital A, I observed and recorded in my field notes an interaction that took place between a midwife at the desk and a woman who had arrived late for her appointment: 'Woman ... reprimanded by midwife at the desk for being late and then advised that she could only see her for 10 minutes. the midwife was not flexible ...' (field note 13062013).

In both hospitals access to the clinic rooms in the OPD was beyond the desk or

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19 I have used the term 'patient' instead of pregnant woman because the medicalised and institutionalised environment appeared not to be set up for individuals who questioned or asserted their choice, but rather I sensed the expectation of the institution was that the people in the waiting room would abide by the institutions procedures and be patient as they waited to have an appointment with the expert health professional.
situated off other hospital corridors that were restricted to the public. To gain access staff needed a security swipe card. At Hospital A the walls of the corridors were painted in bright non-standard hospital colours, but many posters placed on the walls covered the colour. These posters diluted the benefit of the cheery bright colour and sent a clear message that this was a clinical space. They advertised hospital policies and reported on local research. At Hospital B there were no prints or bright paints to soften the environment. In the main the walls were painted an off-white colour.

The clinical and impersonal nature of the hospital was noticeable in single appointments observed in the birth unit, and to a lesser extent, in the MGP clinic room. The layout and décor of the community health centre resembled the OPD. The first time I entered the community health centre I was greeted by a large desk with Perspex security panels. This desk was where clients checked in, made appointments, and paid. The foyer space had many healthcare posters and was also the entrance to the waiting area, which had rows of plastic chairs. The clinic rooms mostly opened directly onto a central waiting area, but a number were also accessed by short corridors. Like the OPD, the walls in the waiting area and the clinic rooms were painted an off-white colour and adorned with healthcare posters.

In the OPD of both hospitals, the midwives were often busy managing the comings and goings of the clinic and undertaking clerical duties. For example, as I waited near the OPD desk at Hospital B to recruit I recorded the following field note:

> The area around the desk area of the clinic is busy – piles of maternity care records on the desk, signs and information posted on the walls, which include lists of hospital area phone numbers, 'how to' guides for tasks, etc. The midwives are busy they are doing more than the care of women. They are coordinating doctor’s clinics, talking to interpreters and ward clerks in between taking women into clinic rooms to do the antenatal appointment. (field note 10052013)

During the manager’s focus group from Hospital A the participants attributed these negative features of the OPD to the acute healthcare system misunderstanding the different needs of a maternity care service. One manager, for example, stated,
'maternity just doesn't fit into a hospital'. They reported that the authority of the acute healthcare system impacted negatively on their ability, as managers, to create a service where midwifery care was focused on women.

... they're trying to force us into it [acute care system]. They're trying to – I find it all the time. I get conflicting advice from the ... upper level of management ... that say things like, oh your midwives are so bloody precious. (FG-A-Managers)

Many similarities were seen in the OPD clinic rooms of both hospitals, especially in relation to the décor and the placement of equipment and furniture. At Hospital B, the typical OPD clinic room had walls painted an off-white colour, an examination couch and hand washing sink on one side of the room and a desk and chairs on the opposite side. The desk had a computer and keyboard, telephone, and space for the medical record. On the wall above the desk was a bookcase and attached next to it was a sphygmomanometer. Other items that adorned the walls around the desk and the examination couch included information posters, pamphlet holders, sharps container, examination light and an obstetric Doppler. Figure 9 shows the setup of the desk and computer in one of the clinic rooms at Hospital B.

**Figure 9: OPD appointment room – computer and desk setup**

At Hospital A, the standardised and clinical layout of the OPD space and the clinic rooms was less evident, owing to some of the décor being altered. In each clinic
room one wall was painted a different colour and was decorated with one or two prints of flowers or a nature setting – in one clinic room a wall was painted a turquoise colour and had a print of a water lily.

However, in both of the hospital OPDs, the desk, computer and chairs in the clinic rooms were arranged in a way that favoured a midwife-computer interaction rather than a midwife-woman interaction. This negatively affected many of the midwife-woman interactions as it resulted in midwives being focused more on the computer than the woman. My field note from my analysis of the video recording from appointment A-SMC6 read:

> The setup of the desk and seats resulted in the woman sitting in a chair at a lower level than the midwife and not facing her. This resulted in the woman needing to twist in her chair and to look up at the midwife, the computer or the maternity care records. The midwife's chair is setup in front of the computer making it easy for her to work and read from the computer and the medical record. To talk or look directly at the woman the midwife had to either slide her chair or twist her body. (field note 20012014)

### 5.1.2 The woman's home

#### 5.1.2.1 'I'm not doing a tick box ... things spontaneously come up'

In contrast, the woman's home was not clinical or impersonal and the environment positively affected the midwife-woman interactions. The women met the midwife at the front door and were the one who allowed the midwife to enter. The maternity care records did not govern the midwife-woman interactions and there were no computers. Instead the midwives and women sat mostly on a couch in the woman's lounge room or at the kitchen table. Women often offered the midwife a cup of tea and on one occasion something to eat.

Mostly, the midwives interacted more with the woman in the appointments located in the woman's home or located away from the hospital OPD (Community Health Centre and MGP clinic room). In these locations the midwife and woman turned or looked towards each other more and their verbal and non-verbal interactions were
more shared and reciprocated (what I later describe as 'mirrored'). I recorded the midwives and women talking for similar amounts of time when they met in the woman’s home or away from the hospital OPD, whereas in the OPD appointments the women often talked less than the midwife. Figure 10 illustrates this.

**Figure 10: Comparison of who talked in the appointment and appointment location**

Midwives from the MGP reflected that being away from the OPD changed the way they interacted with the women. During the MGP focus group from Hospital A one midwife described she did not follow the standard routine 'tick box' approach set out in the maternity care records when she was in the woman’s home. As result, she felt this made their conversations more spontaneous:

> I feel like I'm not doing a tick box, although we do have them in our records. You're not going by education, tick this one, yes, I've done that, tick this one, I've done that. It just flows more freely and I think things spontaneously come up more.  
> (FG-A-MGP)

The midwives attributed their decreased reliance on a 'tick box' or 'checklist' approach when they were in the woman's home was because the woman’s issues or worries were more evident. For example, '... you're not using your checklist or the back of the form any more, you're just going through all of these things because they're all in front of you.' (FG-B-MGP).
"When you walk into their home you're a guest"

The routine and clinical nature of the appointment interaction was also fundamentally altered when the appointments took place in the woman's home. Not only did women appear to have the authority and were more comfortable to raise or introduce their worries, the midwife's interaction with the woman changed. This effect on the nature of the midwife-woman interaction was attributed to the change in the power dynamics between the midwife and woman. One midwife described how in the hospital appointments she dominated the interaction, but in the woman's home the woman controlled the appointment and the midwife was the guest:

I think when we're in a hospital we own this space. We kind of dominate what goes on in the conversation and the rest of it and I think when you walk into their home you're a guest. You're very much on their terms. (FG-A-MGP)

The midwives also described that when they did an antenatal appointment in a woman's home their interactions were more social or personal and not just about standard healthcare and clinically-informed assessment. For one MGP midwife it altered how she felt about her midwifery role and she felt she was now 'part of a community'. She saw herself as the midwife who was more invested in the woman than the system, as she, the midwife, was not 'just a person that they come to see and it's this visit', but rather, 'It's more like, oh yes my midwife will come in and she will do a check-up.' (FG-B-MGP). In Chapter Six I report the effect of location on the appointment when it is away from the OPD and how this alters conversation and interactions to be more social than just a standard healthcare interaction, and the effects of this on how woman and midwife deal with worry.

'I had that trust already with her because she'd come into my house'

During the postnatal interview, the woman from appointment B-MGP16 commented positively about having the appointments in her home. Having these appointments located in her environment created trust because the midwife had got to know not only her but other family members:
She’d come to my house and I had that trust already with her because she’d come into my house, she knew my husband, she had met my son, she’d met my mother. I had a lot of trust in her. If she said something had to be done I would trust that was the case and I wouldn't be scared or have to question.  

(B-MGP16)

She attributed the trust she had in her midwife to them having more time together at the antenatal appointments. During her postnatal interview she compared the experience of the care she had with this MGP midwife to her previous pregnancy experience of antenatal care where there was little time given to her in the antenatal appointments. She said, 'I trusted her heaps more than – I didn't even really know my obstetrician [previous pregnancy carer] because my appointments were only five minutes long …' (PNI-B-MGP16).

### 5.2 Time

Antenatal appointment time was multi-dimensional and closely linked to environment. It related to midwife use of time and to the repeated times that midwives and women had in the MGP and the midwife-led clinics in the SMC. In both these midwifery models of care the same midwife and woman would meet throughout the woman's schedule of antenatal appointments. These repeated meetings enabled the midwife and woman to create a connection across the woman's pregnancy. In the MGP, however, these repeated meetings spanned the continuum of the woman's medicalised childbirth experience, including labour and birth and early postnatal period. As a consequence, the MGP model connected the midwife and woman across the fragmented system of maternity care.

The length of the appointments differed between locations. Appointments in the OPD at both hospitals were the shortest, and those in the woman’s home the longest. Furthermore, appointments not in the OPD, but still in the hospital, were longer than those in the OPD. The average (mean) length of the appointment in the OPD was 21 minutes and ranged between seven and 36 minutes, whereas in the woman’s home the appointments lasted on average for 40 minutes and ranged between 15 and 80 minutes. In the MGP clinic room the appointment lasted for 29
minutes, in the birth unit it lasted for 33 minutes, and in the community health centre it was 26 minutes long. See figure 11 (next page) and table D-1 in Appendix D that report the length of all the appointments.

**Figure 11: Length of appointment by location and model of care**

5.2.1 Use of time by midwives in the antenatal appointments

The length of each appointment was also linked to the midwife's use of time. The use of time reflected midwife investment, which varied along the continuum from being system-focused to woman-centred. This included allocation of time to tasks, to conversations and use of objects/artefacts of the system, such as the computer and maternity care records. Also, a difference was seen in the number or amount of time allocated to interactional features, including different body language, topics of conversation and communication styles across the 18 appointments. Overall, the focus of the midwives' actions during the appointments ranged from interacting predominantly with the computer and the medical record to predominantly interacting with the woman. To illustrate the differences in the midwife actions the percentage of time that the midwife and woman looked towards each other or not
in every appointment is presented in figure 12 (next page). This data is also reported in Appendix D in table D-2.

**Figure 12: Percentage of appointment time midwife, woman & support person look towards each other or not**

This examination of time in the video recordings showed that, on the whole, the midwives in the OPD appointments spent less time looking towards the woman than the midwives in the appointments that were not in the OPD. In figure 12, seven appointments stand out and show that the midwife and woman spent at least 80% of the appointment time looking towards each other. Out of these seven appointments only two were with a midwife working in SMC and in the OPD. The remaining five were with a midwife working in the MGP, of which four were located in the woman's home and the fifth in the MGP clinic room.

Although this simple calculation of body language shows there is more appointment
time where the midwife and woman look towards each other in MGP compared to SMC, it did not explain what else was happening in the appointments. Also, it does not explain how these interactions reflect the midwife’s investment as system-focused or woman-centred. The use of more qualitative analytical techniques, however, showed the influence the MGP model had on facilitating more ‘repeated time’ between midwife and woman. Examples of what were identified with the qualitative analysis are presented next.

5.2.2 MGP: repeated time across the childbirth continuum

5.2.2.1 ‘We talk about it so much over the pregnancy’

The repeated time the midwives and women had in the MGP and with the midwife-led clinic enabled them more opportunities to discuss worries or issues. In the OPD, the fragmented approach of the SMC resulted in the midwife and woman having less or no opportunity for repeated time. Repeated time enabled the midwife and woman to revisit worries from one appointment to another or to the labour and birth and the postnatal period. Plus, their repeated meetings enabled the midwife and woman to prioritise which of the woman’s worries they talked about and when they talked about them. In the MGP appointments the conversations were also less reliant and therefore less controlled by the system’s checklists that allocated certain tasks and conversations to certain appointments.

In one MGP appointment the benefit of repeated time was seen when the midwife and woman talked about toilet training the woman’s older child:

| Midwife: | How’s the toilet training going? Or did you abandon that again? [Laughs] |
| Woman: | It’s bad. |
| Midwife: | It’s hard in winter too, isn’t it? |
| Woman: | She’s sick now but – because I didn’t push her. Are you asking for Sarah? |
| Midwife: | Yeah, yeah. |
| Woman: | Because she was sick the last couple of days I didn’t push her. I felt a bit sorry for her. |
Midwife: It’s hard quite often. Many, many women are pregnant and think we need to toilet train our little one.

Woman: Yeah, before this baby came. I don’t want two babies in nappy. (A-MGP9)

The opening question, 'How’s the toilet training going? Or did you abandon that again?' showed they had previously talked about this issue. Also, in this segment of conversation the midwife's woman-centred approach or investment was seen. It included asking the woman about an issue that was important to the woman and showing a level of empathy when she said, 'It's hard quite often. Many, many women are pregnant and think we need to toilet train our little one'. The midwife's approach teamed with the influence of repeated time facilitated the woman to talk through her concern, creating an opportunity for the woman to moderate this worry herself.

The benefit of repeated time in the SMC appointments was only seen in the midwife-led clinic and where the midwife and woman had met at previous appointments. In the midwife-led clinic appointment A-SMC14, for example, the midwife and woman revisited an earlier discussion about the woman's worry of not having a support person with her for her labour. This prior knowledge enabled the midwife to address the woman's worry, 'OK so I think that's what we put down on your last visit. So, I actually put it on the front [maternity care records] here as well', and to reassure her by restating her solution 'to make sure that someone stays with you'.

During their focus group at Hospital B the MGP midwives confirmed the benefit of repeated time. This was explained by one midwife when she compared her experience of working in a SMC midwife-led clinic to working in the MGP. She commented that the benefit of repeated time with the women was not only linked to pregnancy, but that it was also linked to the connection created from meeting repeatedly throughout the childbirth continuum, including the labour and birth and postnatal period:
... I've had continuity of care in the clinic for three years before I started this [MGP]. It was the only continuity of care clinic at hospital [B], so I was trying to do a similar thing in the clinic, but I tell you that this is very different still. It's so different when you work from the beginning to the end ... it's not just seeing the same patients.  

(FG-B-MGP)

Also, at the same focus group another midwife explained that repeated time in MGP altered how she and the woman shared information. She compared her experience of working in the SMC system to the MGP and found that in the latter appointments became part of a joint and connected discussion that took place across the pregnancy and not just part of one isolated healthcare event:

Because you're providing them info – the information over all the clinic visits and it's not just a five-minute talk, right what are you going to do kind of thing. [Instead] It's a – we talk about it so much over the pregnancy.  

(FG-B-MGP)

Other midwives at this MGP focus reported that repeated time with the women enabled a relationship to be created and linked this to the development of trust:

You can't create the trust and the relationship – it's not just the information, it's the relationship. You can't create the same depth of it without having the time.  

(FG-B-MGP)

I think because you see it through [whole childbirth continuum] ... you actually know that most of the time it will be OK. You have much more trust in the birth process.  

(FG-B-MGP)

Another midwife at this focus group reported that the trust created by having repeated time with the same woman also increased her confidence in the birth process, her assessment and decision-making:

Because you know the woman, what she looks like when she's not in labour ... you can see her changes; you know her behaviour is different ... Your assessment is more accurate.  

(FG-B-MGP)

Another midwife at this focus group reported that because she knew the woman she was more confident in advocating for her:

... yeah, it's more – you have more of a judgement I feel on the woman and you can say, she's going to do it soon just leave her alone. And you're
probably more confident to say that. Possibly because you know her. (FG-B-MGP)

Correspondingly, because of the relationship with their MGP midwife, the women had confidence in their decision-making and advice. As one couple said in their postnatal interview:

... we knew her from the first appointment and all that and we had a relationship so ... whatever she said I knew that was right. (PNI-B-MGP4)

The woman from this interview described this as 'there's [being] a lot of trust there ...', while her partner commented that he gained confidence in the woman's labouring efforts because he knew the midwife and trusted her judgement:

... then I was like telling Andrea [the woman – his partner] just reinforcing whatever she [midwife] was saying pretty much and just staying strong because she was the one with pretty much a smile on her face. (PNI-B-MGP4)

Another woman reported that repeated time with her midwife, which she termed as 'she would check up on me all the time' was 'really important' for her:

because I was going to be on my own ... I need[ed] somebody to be with me the whole time. So that was really, really important to me as she would check up on me all the time. (PNI-B-MGP3)

In the next section I present the factor of investment, which was closely linked to environment and time in the antenatal appointment. I introduce the concept of midwife investment and present a number of findings from the detailed analysis of four appointments. These are used in conjunction with the broader analysis findings to show how the different environment and time factors of the antenatal appointment affect the midwife-woman interactions and a midwife's investment.
5.3 Investment

A midwife's 'investment' related to and was often dependent on the environment and time associated with the appointment and model of care. It was evident in the verbal and non-verbal actions of the midwives and in who, what or how they interacted within the appointment. It was also dependent on what influenced the midwife to worry or what her principal focus was and, as such, was central to her actions in dealing with or moderating worry. It shifted along a continuum from being system-focused to woman-centred, as figure 13 shows.

Figure 13: Midwife investment and associated factors
5.3.1 System-focused investment

Regardless of where the appointment took place, I observed the influence of the fragmented healthcare structures and the standardised and medicalised hospital systems in the actions of every midwife. Midwives' verbal and non-verbal interactions were often formulaic, standardised and routine and were typically based on the worries that the system prioritised. Their worry or appointment focus often related to prioritising the clinical assessments and was often more about the pregnancy and the fetus than the woman who was becoming a mother. In every appointment, for example, a midwife asked about fetal movement and in 17 of the 18 observed appointments blood pressure was measured and recorded. In contrast, not every appointment included a midwife asking what the woman was worried or concerned about.

The comments and actions by some midwives also showed that they took the standard or routine nature of the appointment for granted and accepted it as normal. One MGP midwife used the word 'normal' instead of standard when she referred to the clinical and medical assessment tasks of the antenatal appointment, '… we'll go through all our normal visit stuff that we do' (A-MGP9). This also occurred in a SMC appointment; '… we continue on with normal visits …' (A-SMC18), reaffirming that the standardisation of the antenatal appointment was normal and acceptable for her.

In contrast to the midwives in the MGP appointments, those in the SMC appointments, particularly in the OPD, were primarily focused on and invested in the completion of the system's tasks and processes rather than enquiring how the woman was. An example of this was the amount of time the midwife spent interacting with the computer and maternity care records instead of with the woman. At one end of the spectrum one MGP midwife spent no appointment time looking at either the computer or the maternity care records and one SMC midwife spent just 2% of her time looking at the maternity care record. In comparison at the other end of the spectrum one SMC midwife spent 22% of the appointment time
looking at the computer and 25% looking at the maternity care records and one MGP midwife spent 30% of the appointment looking at the maternity care records. It is important to note that the MGP midwives had no access to computers in appointments in the woman’s homes and relied on the maternity care records. This data is reported in figure 14 and in Appendix D in table D-3.

**Figure 14: Percentage of appointment time midwife looking at computer/medical record**

The midwife's reliance on the computer and maternity care records in the SMC appointments, compared to the MGP appointments, most likely reflects the fragmentation of the woman's care, which resulted in the midwife not knowing the woman. As a consequence, the midwives in the SMC appointments had to rely on the computer/maternity care records to identify any issues or worries particular to the woman. With the fragmented SMC appointments in the OPD there was no repeated time to get to know the woman, build a relationship or invest in her or her needs. During the MGP midwives' focus groups from Hospital A one midwife reflected on how standardised and task based she was when she worked in SMC system:
... when you were in the standard system did you think about preparing somebody, or was your investment of your care just about the day and that bit of care you were providing? (FG-A-MGP)

For some women in this study the standardised nature or system-focused approach of the midwives in the SMC appointments was a negative. During her interview, for example, one woman described her experience of antenatal care in the SMC as, 'I was weighed at the beginning, fundal measurements, heartbeats and occasionally there was some kind of other test or something' (PNI-20). She felt there was no focus on her individual worries or needs, 'there was never any discussion of my own sense of wellbeing, what my birth plan was, anything else.' (PNI-20). She described her experience of SMC as being measured and checked and part of conveyor belt system: 'it was very much checked, measured, yes, tick, tick, tick, you're done, off you go. Next person.' (PNI-20)

In the next section I present some of the findings of the detailed analysis of the video record data from appointment B-SMC11. It demonstrates the negative effects of the standardised maternity care system on midwife-woman interactions found in many of the SMC appointments.

5.3.1.1 'She was more concentrating on ... on my stomach'

In appointment B-SMC11, the midwife-woman interactions, the environment and time showed a midwife invested in the system, leaving the woman feeling powerless, uncomfortable and shy.

It was the shortest appointment observed in the study, lasting seven minutes and 20 seconds and noticeably shorter than the allocated 20 minutes for appointments at this hospital. The midwife was also focused on the computer/maternity care records rather than the woman. I commented on the brevity of this appointment in my field diary on the date of the observation, 'no midwife chit chat, focused on medical record and computer, not the woman, asked only clinical questions' (field note B-SMC11 10052013). The midwife talked for 76% of the time, while the woman talked for 24% of the time and the partner did not talk at all.
For most of the appointment they sat at the desk with the midwife asking questions, the woman providing answers and the midwife documenting these in the computer and medical record. The computer and maternity care records prompted midwife's questions. When seated at the desk the midwife sat in a chair that faced the computer and the woman and her partner sat in chairs next to the desk, resulting in them facing away from the desk. To talk the midwife and woman had to twist in their chairs to face each other across the corner of the desk. A still clip of the video-record from this appointment below in figure 15 shows the midwife's and woman's seated arrangement.

**Figure 15: Still clip from appointment B-SMC11**

All aspects of the interactions between the midwife and woman were associated with standard questions and clinical assessments. Only one comment from the midwife provided any reassurance to the woman. This occurred during the abdominal palpation and was when she remarked about the position of the unborn baby in the mother's abdomen and pelvis, 'Head's well down', and was followed by what was seen as an empathetic comment, 'no wonder you're feeling a lot of pressure'.

The midwife relied on questions to direct the appointment and their conversation.
There were 14 questions in total and all except one of these was closed ended. As a consequence, the woman was restricted to 'yes' (yeah), 'OK' or 'no' answers in all except one answer. These questions are reported in table 17 (next page).

**Table 17: Midwife’s questioning during B-SMC11**

<table>
<thead>
<tr>
<th>Midwife questions from B-SMC11</th>
<th>Coding of questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have your yellow card?</td>
<td>System – closed</td>
</tr>
<tr>
<td>Any problems since your last appointment? Any concerns?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>No? All good?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>A lot of pressure?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>Baby's moving well?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>Good. How often would you say baby's moving?</td>
<td>Clinical – open ended</td>
</tr>
<tr>
<td>A lot, good. Any burning or stinging when you go to the toilet?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>Excellent. Any swelling in your hands or your feet?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>Good. Alright, I'll check your blood pressure. You haven't had</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>any contractions yet?</td>
<td></td>
</tr>
<tr>
<td>You know when to call birth unit?</td>
<td>System – closed</td>
</tr>
<tr>
<td>Yeah, if your waters break, if you're contracting regularly,</td>
<td></td>
</tr>
<tr>
<td>baby's not moving or if you're bleeding give the birth</td>
<td>Clinical &amp; System – closed</td>
</tr>
<tr>
<td>unit a call, OK?</td>
<td></td>
</tr>
<tr>
<td>Do you have any questions at all?</td>
<td>Clinical – closed</td>
</tr>
<tr>
<td>Do you have purple appointment card?</td>
<td>System – closed</td>
</tr>
<tr>
<td>So, it'll be 24 May. Do you want the same time, 9.55?</td>
<td>System – closed</td>
</tr>
</tbody>
</table>

The majority of these questions were associated with the midwife completing the standardised clinical assessment, for example, '... Any swelling in your hands or your feet?'. A number also related to the institutionalised system of care, for example 'Do you have your yellow card?'. None of the questions generated any social or personal interaction and there was no attempt to connect with the woman as an individual or as an equal. In all, the conversation was dominated by clinical (71%) and or system related (34%)\(^{20}\) topics and included long silences. In total 64% (5 minutes) of the conversation was silent as the midwife wrote in the maternity care records, entered data in the computer or undertook clinical assessments.

Apart from sitting at the desk, the other two principal interactions in this appointment were clinical assessments. They included the midwife performing the

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\(^{20}\) Coding of conversation often overlapped, as more than one topic was found in a segment of sentence of conversation. As can be seen here where the total adds up to 105%.
abdominal palpation on the woman as she lay on the examination couch and the midwife standing to perform the blood pressure measurement on the woman while she sat next to the desk. The woman and her partner were bystanders to the midwife-computer or medical record interactions. For much of the appointment time the woman waited for the midwife to complete her tasks or her interactions with other objects. For example, the woman looked at the midwife as she wrote in the maternity care records for 17% of the appointment time and she looked at the midwife while she entered data into the computer for 8% of the time. Nearly half of the appointment (49%) involved the woman not looking towards the midwife; instead she looked elsewhere, for example in her bag or around the room. Throughout this time the woman's partner sat next to her and did not engage in any part of the appointment. He looked around the room and at his wife and kept his arms crossed.

The midwife's verbal exchanges with the woman in this appointment were short, intermittent and sandwiched between the longer interactions with the computer, the maternity care records and when she was conducting the clinical assessments. The times that the midwife looked to the woman were before and after entering data into the computer, writing in the maternity care records, undertaking a clinical assessment and asking questions. For example, the midwife took 1.57 minutes to perform the abdominal palpation and during this time she looked to the woman five times for a total of eight seconds and talked to her for 19 seconds. To illustrate this, I have included in table 18 (next page) the time stamps of the midwife-woman conversation and body language during the abdominal palpation.
Table 18: Appointment segment from B-SMC11 during the abdominal palpation

<table>
<thead>
<tr>
<th>Time stamp</th>
<th>Midwife-woman interactions</th>
<th>Speaker</th>
<th>Conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:30-2:39</td>
<td>Midwife &amp; woman walk from chairs at the desk to the examination couch.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:39-2:41</td>
<td>Woman lays on examination couch &amp; rearranges her scarf around her neck</td>
<td>Woman:</td>
<td>Just need to re-arrange this</td>
</tr>
<tr>
<td>2:41-2:42</td>
<td>Midwife looks to woman’s face</td>
<td>Midwife:</td>
<td>Joint laughter (tentative)</td>
</tr>
<tr>
<td>2:42-2:48</td>
<td>While the woman is looking at ceiling the midwife is looking at foot pedal of examination couch as she pushes it to raise it to a higher height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:48-2:50</td>
<td>Midwife reaches up to examination light, situated above the couch, and pulls the tape measure off to use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:50-2:51</td>
<td>Midwife looks at woman’s face &amp; woman looks to midwife’s face</td>
<td>Midwife:</td>
<td>Right show me your tummy</td>
</tr>
<tr>
<td>2:51-2:53</td>
<td>Woman raises her shirt to reveal her abdomen &amp; looks to ceiling. Midwife looks at woman’s abdomen &amp; starts to measure it</td>
<td>Midwife:</td>
<td>Sorry I’ve probably got cold hands</td>
</tr>
<tr>
<td>2:53-2:55</td>
<td>Woman looks at midwife</td>
<td>Woman:</td>
<td>You’re alright</td>
</tr>
<tr>
<td>2:55-3:06</td>
<td>Midwife measures the woman’s abdomen using tape measure. Woman looks at the ceiling &amp; midwife looks at woman’s abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:06-3:07</td>
<td>Midwife looks to woman’s face and woman continues to look at ceiling</td>
<td>Midwife:</td>
<td>Good</td>
</tr>
<tr>
<td>3:07-3:11</td>
<td>Midwife replaces tape measure on light</td>
<td>Midwife:</td>
<td>Baby is a good size</td>
</tr>
<tr>
<td>3:11-3:12</td>
<td>Midwife starts abdominal palpation – neither midwife or woman are looking at each other</td>
<td>Midwife:</td>
<td>Baby is a good size</td>
</tr>
<tr>
<td>3:12-3:26</td>
<td>While the midwife performs abdominal palpation &amp; looks at the woman’s abdomen the woman is looking at the ceiling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:27-3:30</td>
<td>The look at each other &amp; smile</td>
<td>Midwife:</td>
<td>The head is well down – no wonder you are feeling a lot of pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Joint laughter</td>
</tr>
<tr>
<td>3:30-3:31</td>
<td>Midwife reaches for obstetric Doppler and looks away from woman [unable to see woman’s face as obscured by midwife’s body]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:31-4:16</td>
<td>While the midwife listens to fetal heart &amp; looks at her watch the woman looks at ceiling</td>
<td></td>
<td>No talking</td>
</tr>
<tr>
<td>4:16-4:18</td>
<td>They look at each other &amp; smile</td>
<td>Midwife:</td>
<td>Good. Baby is very happy</td>
</tr>
<tr>
<td>4:18-4:22</td>
<td>Midwife looks at the woman’s abdomen, grabs tissues &amp; wipes Doppler gel off</td>
<td>Midwife:</td>
<td>Probably too happy to make him come out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Woman:</td>
<td>Woman laughs</td>
</tr>
<tr>
<td>4:22-4:27</td>
<td>Midwife continues to wipe woman’s abdomen with tissue</td>
<td></td>
<td>Silence</td>
</tr>
<tr>
<td>4:27-4:28</td>
<td>Midwife looking at bed as she lowers it</td>
<td>Midwife:</td>
<td>I’ll just bring the bed down</td>
</tr>
<tr>
<td>4:28-4:38</td>
<td>Midwife moving tissue box away from woman as she continues to lower the bed</td>
<td>Woman:</td>
<td>Yeah. Thank you</td>
</tr>
<tr>
<td>4:39-4:41</td>
<td>Woman rolls to get off bed, unassisted by midwife who walks to sink</td>
<td>Midwife:</td>
<td>That’s alright. There you go.</td>
</tr>
</tbody>
</table>
As table 17 shows, the midwife spent little time looking at or talking with the woman. Indeed, it was the woman who looked more towards the midwife, possibly in an attempt to engage her in a conversation. During the entire appointment, the midwife looked to the woman for 8% of the time, whereas the woman looked to the midwife for 25% of the time. In total, 85% of the appointment time involved the midwife not looking at the woman; instead she was looking at the computer (25%) and the medical record (21%) or focused on her other tasks (39%). There were minimal mirrored or reciprocated midwife-woman interactions. Only 10% of the appointment time involved them looking towards each other while they talked. In addition, the midwife never interacted with the woman's partner.

Only a small amount of appointment time involved the midwife and woman smiling or laughing together. The midwife smiled for 13.3 seconds and the woman for 18.4 seconds, with only 4 seconds of the smile time mirrored between them. Two episodes of shared laughter were noted. The first was during the abdominal palpation when the midwife commented about the baby's head being low in the pelvis and creating the woman's pelvic pressure discomfort. This episode of laughter for the woman appeared to be a relief, as she found out the reason why she was having so much pressure in her pelvic area. For this woman her pelvic pressure was a significant worry, as she raised it throughout the appointment. Likewise, the woman's action of smiling was seen as a sign of nervousness and also linked to this worry. Each time she introduced her worry about the pelvic pressure to the midwife in the appointment she smiled. The second act of shared smiling and laughter, which was short-lived, also related to a sense of relief and was observed after listening to the fetal heart rate.

The nature of the midwife-woman interactions in appointment B-SMC11 was matter of fact and task-oriented encounters for them both. Other appointments from this study included a number of facial expressions including frowns, grimaces,

\footnote{Coding of body language was often complicated by multiple interactions occurring at any one time. This resulted in the data times sometimes not adding exactly to 100%}
attentive looks at the other person and smiles and other expressive body language, such as use of hands and nodding and shaking of their heads. In this appointment, however, the midwife and woman's facial expressions were mostly neutral with hardly any other expressive body language.

This woman from appointment B-SMC11 reported she had received continuity of antenatal care for her first two pregnancies. She described her experience with the SMC antenatal care for this pregnancy as negative. She reported seeing a different midwife at every antenatal appointment. Her comparison of the midwife in this appointment to the midwives who had cared for her in her previous pregnancy gave an indication of why she found the SMC appointments a negative experience:

She was very different. She was more concentrating on ... my stomach ... whereas the other midwives, they were very – the liked to socialise as well as just – which was really good for me. I find that very comfortable, so they're not only concentrating on my stomach. I feel I'm a bit shy when ...

(PNI-B-SMC11)

She reflected on the midwife's actions in this appointment negatively, as she was 'more concentrating on my stomach', which made her feel uncomfortable and shy. Conversely, she reflected that with her other pregnancies her experiences of antenatal care were more positive and comfortable for her, because the midwives had socialised.

The next section is an overview of woman-centred midwife investment. At the end it includes some of the findings of the detailed analysis of the video record data from appointment B-MGP3. This is used to present the positive effects of the MGP model of care on midwife-woman interactions found in many of the MGP appointments.
5.3.2 Woman-centred investment

During their focus group the MGP midwives from Hospital A talked about their practice in the antenatal appointment and commented that their actions involved more than a completion of tasks and procedures for the system. They viewed their actions and interactions to be focused on and invested in the woman and her upcoming birth and parenting experiences. For example, 'like you're preparing these women that you've met antenatally for the birth and the parenting days' (FG-A-MGP).

Environment, as discussed previously, was linked to the amount of time a midwife devoted to appointment tasks or actions and conversations with the woman. A woman-centred approach was often more evident in appointments located away from the OPD and particularly with appointments that took place in the woman’s home.

Both midwives and women believed time was a key factor in a midwife being woman-centred or invested in the woman. Midwives in the MGP focus group from Hospital B linked their woman-centred investment to repeated time and the continuity of carer principle. They described how their experiences of working in the MGP and with the women across the childbirth continuum created a personal investment in the woman's childbirth experiences and outcome. They had a connection with women, and expectations of being involved in a woman's future care:

> I feel like – funnily enough obviously it's their pregnancy, their labour and their birth – but you feel like part of it is yours as well. ... You share that because you’ve talked about it so often, you’ve made plans. (FG-B-MGP)

The midwives from this MGP focus group identified that their connection with and their investment in the woman was created by the repeated time they had with her during her pregnancy, her labour and birth and her postnatal period:
you’ve talked about what her [the woman's] hopes might be, what her [the woman's] outcomes might be, what would happen if this happened, what if it doesn’t. So you talk about it in so much depth that you really do feel like you’re also going through it with them and that’s why. (FG-B-MGP)

Their investment in the woman and her future labour and birth resulted in some midwives taking a protective role, 'that's also why I think we protect them because we feel like it is our labour and birth, as well, that we want to protect.' (FG-B-MGP).

At her postnatal interview one woman commented that the midwife's positive attitude, which I interpreted as investment, encouraged her, reassured her and made her feel confident:

Yeah confident definitely. Yeah so ... she really encouraged me all the time, like all the way through my pregnancy saying you’re doing things right or whatever, so that was reassuring yeah. (PNI-B-MGP4)

In comparison to the midwives in the SMC appointments, the MGP midwives demonstrated greater levels of connection with the women and investment in the worries the women brought to the appointment. Woman-centred investment included more than just the 'here and now' of the present time and the completion of the antenatal appointment tasks. It also involved the midwife performing interactions that were more relational than many of the standardised healthcare interactions. It included the midwife talking with the woman and addressing issues of the past and present that may impact on future childbirth events. These efforts by midwives to address a woman's worries for the benefit of future events demonstrated their investment in the woman and in the woman's hopes and aspirations for her upcoming birth.

5.3.2.1 'I can talk and be more relaxed with you'

The analysis of the video recording and audio transcripts from the MGP appointment B-MGP3 showed a midwife with woman-centred investment and midwife-woman interactions that were shared and reciprocated. Also, the positive influence of the MGP model was seen to positively inform the environment and time factors.
Although this appointment took place in a hospital room, with similar lay out of furniture to the OPD clinic rooms, its location and the noticeable changes to its décor softened the clinical nature. This room was situated near the postnatal ward and away from the busy and impersonal environment of the OPD. The room décor alternations included one wall being painted a warm green colour and decorated with a number of framed baby photos and the examination couch covered with colourful and patterned sheet rather than a hospital sheet.

At their MGP focus group Hospital B, where this appointment took place, the midwives told me they had decorated this room themselves. They had identified the need for a dedicated MGP clinic room and had decided to redecorate, which was endorsed but not financially supported by hospital management. Their efforts to paint and alter this room in their own time reflected their level of investment in the model of care and in the women. It also created an environment where they and the women had more agency and control; 'we've got little rooms – we make them our own' (FG-B-MGP).

In appointment B-MGP3 a number of the midwife's action were adaptive. These included, for example, not using the computer during the appointment and not wearing a uniform. These are seen in the still clip of this appointment in figure 16 (next page).
I attributed the more relaxed and less clinical midwife-woman interactions in this appointment to be partly as a result of these adaptations made by this midwife. One of the midwives during the MGP focus group from the hospital where this appointment took place confirmed the positive benefit of a midwife not wearing a uniform when she remarked about a comment a woman had made to her:

Do you know how nice it is ... coming here [MGP clinic room]. You're just wearing that outfit and you're not in a uniform and I can talk and be more relaxed with you. (FG-B-MGP)

Also, by not using the computer the midwife from appointment B-MGP3 had created more time for her and the woman to talk, which I also saw as an illustration of midwife investment to prioritise her interactions with the woman rather than the computer. As she said at the completion of this appointment, 'I try not to use the computer during the appointment, it interrupts.' (Field note B-MGP3). In this 27-minute appointment, for example, the midwife looked to the woman 84% of the time, at the medical record 13% of the time and she had no interaction with the computer.

Both SMC and MGP midwives reported that the action of looking towards the woman and engaging with her instead of the computer was an important feature of woman-centred care. When reflecting at their focus group on what they do to
enhance their interactions with the women the SMC midwives from Hospital A said:

Face them, you don’t sit at a computer, you actually look at them ... give them your full attention, ... you’re not doing paperwork, ... you’re actually exploring what can we do for you. (FG-A-SMC)

Unless a midwife made an effort to disengage herself from the computer it dominated the appointment, as was reported earlier (page 161–167) with the analysis of appointment B-SMC11. In appointment B-MGP3, however, the midwife actively disengaged herself from the computer by turning away from it and facing the woman. This created more midwife-woman interactions than midwife-computer interactions.

In appointment B-MGP3 the midwife and woman shared more of the talking time compared to many of the other appointments. For example, the midwife talked for 57% of the appointment time, the woman for 37% and her support person for 6% of the time. Their conversation was also more focused on the woman and her needs and was more relational, social and personal. The midwife-woman's non-verbal interactions also reflected a level of sharing and mutuality. For example, in figure 16 their body language is mirrored with both of them looking towards each other with elbows bent and hands at their faces. Although some of the midwife's questions from appointment B-MGP3 were still clinical in nature most of them maintained a focus on the individual woman and her context and demonstrated knowledge of what the woman's concerns and issues were. For example, a crossover of conversation topics was noted with 62% of the conversation related to personal issues as well as clinical with only 23% related to system issues. The midwife's ability to maintain the appointment focus on the woman and her personal issues was also done through a use of stories. Through the sharing of stories, the midwife and woman created a connection, reduced the power dynamics typical of a healthcare appointment, and moderated the worry the woman introduced. More detailed analysis about the use of stories is provided in Chapter Six.

The connection and sharing in this appointment is presented in the next section that focuses on one segment of conversation presented in table 19 (next page). This
1.38 minute segment of conversation about the woman's past negative experience with her labour and births took place five minutes into the appointment. It shows a level of congruence and connection between the midwife and woman with a sharing of worry and their shared and mirrored body language.

Table 19: Appointment segment from B-MGP3

<table>
<thead>
<tr>
<th>Time Stamp</th>
<th>Midwife-woman interaction</th>
<th>Speaker</th>
<th>Conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:28-</td>
<td>Midwife has her back to the computer &amp; is leaning on desk with one elbow, the chair &amp; her body are turned to woman who is leaning back in her chair with one arm leaning on the desk. They are both looking at each other &amp; woman is nodding as midwife talks.</td>
<td>Midwife:</td>
<td>I guess you said to me the last couple of times you gave birth on the bed and that's not really what you want.</td>
</tr>
<tr>
<td>5:33-</td>
<td>Woman is using both arms to gesture &amp; shaking her head as she talks. Midwife is looking at woman, still leaning on the desk with her left elbow &amp; her chin is resting on her hand of the bent left arm that is resting on the desk.</td>
<td>Woman:</td>
<td>Yeah, when I say on the bed, I was told to lay back and that's it. Like, I said, I want to go to the toilet, they said no. They wouldn't let me get off the bed. I said, ...</td>
</tr>
<tr>
<td>5:33-</td>
<td>Woman is using both arms to gesture &amp; shaking her head as she talks. Midwife is looking at woman, still leaning on the desk with her left elbow &amp; her chin is resting on her hand of the bent left arm that is resting on the desk.</td>
<td>Woman:</td>
<td>... I need to go to the toilet. They're going, no you don't. I got really shitty, I said, I need to go to the toilet. Then they gave me a bedpan. They wouldn't even let me get off the bed.</td>
</tr>
<tr>
<td>5:43-</td>
<td>Midwife moves her body to a more upright position &amp; then settles back to her leaning position</td>
<td>Midwife:</td>
<td>OK ...</td>
</tr>
<tr>
<td>5:43-</td>
<td>They both smile at each other.</td>
<td>Woman:</td>
<td>Yeah, and then of course I couldn't go, so then they wanted to take it away but I wouldn't let them because it was kind of comfortable.</td>
</tr>
<tr>
<td>5:54-</td>
<td>Midwife nods as woman talks</td>
<td>Woman:</td>
<td>Just feels comfortable, yeah.</td>
</tr>
<tr>
<td>6:04-</td>
<td>Woman is using both head (nodding &amp; shaking) &amp; arm movements to reinforce her point. Raising eyebrows &amp; grimacing. Midwife continues to lean on the desk &amp; look towards woman &amp; is focused on looking towards the woman's face.</td>
<td>Midwife:</td>
<td>So yeah, that's – and I was just – it was just, you had to lay there and that was that. So, this time I'd rather be moving around and...</td>
</tr>
<tr>
<td>6:04-</td>
<td>They both smile &amp; laugh. Woman's whole body moves in her chair as she reinforces this point &amp; uses both hands to gesture her point.</td>
<td>Woman:</td>
<td>We will not have that problem. I'm pretty sure we will not have that problem.</td>
</tr>
<tr>
<td>6:12-</td>
<td>Woman laughs &amp; turns to her support person. Midwife is nodding &amp; smiling &amp; continues to lean on the desk.</td>
<td>Midwife:</td>
<td>We will not have that problem. I'm pretty sure we will not have that problem.</td>
</tr>
<tr>
<td>6:12-</td>
<td>Woman smiles &amp; uses both hands to</td>
<td>Woman:</td>
<td>Yeah, I don't want to be kind of stuck. I</td>
</tr>
</tbody>
</table>
6:21 gesture & turns back to midwife.
6:21-6:31 Woman leans back on desk & mirrors midwife's leaning position. 
So, she has her right arm resting on her elbow with her hand near her face & the midwife has her left elbow resting on the desk with her chin resting in her left hand. Both are nodding in unison.
6:31-6:36 They continue to nod, then laugh & smile at each other & then the woman shakes her head & smiles.
6:36-6:50 Both mirroring each other's leaning action on the desk & nodding & smiling.
6:49-7:06 Woman leans back & uses her hands to gesture her points: she grabs her little finger to signify a point & then waves her hands with each other point. Midwife is nodding & continues to lean on desk.

| 6:21 | don’t want to be stuck like that [Doula: bed will be out of the room] |
| 6:31 | I think most of the births that I've recently had were in the bathroom, and I think at least half of them would have been on the toilet. |
| 6:35 | That's fine. Well this last – they wouldn't let me do anything else. |
| 6:36 | So, we want to be doing – what we want to be doing, as far as all the other things that are available for pain relief, you've done very well without anything before, so I don't expect any demand for... |
| 6:50 | Yeah, what I've gone through the last times, & same philosophy this time, is if I really need it, I'll give something a go, but I haven't needed it in the past so I don't anticipate needing it now. What's happened the last – they've given me pethidine before – I don't think it did anything. |

This table reveals the high level of focus or investment that this midwife had in the woman and the woman's worries throughout the appointment. This midwife invested appointment time to discussing the woman’s worry. She did this by introducing the woman's worry into the conversation: 'I guess you said to me the last couple of times you gave birth on the bed and that's not really what you want.' Her next action provided a receptive space or environment for the woman to share her experience, as she chose a posture that reflected her interest in the woman. In this example it involved her leaning on the desk, on the medical record and having her back to the computer. I interpreted this action of having her back to the computer and her body covering the medical record reduced the influence of the system and showed her focus or interest in the woman.

Her body language and conversation were also relaxed, open and focused solely on the woman. In the segment of conversation above she spent more time listening to
the woman than talking. Her comments were also compassionate and empathetic, 'Oh, that's very unfortunate.' and 'Just feels comfortable, yeah?'. These actions enabled the woman and the midwife to gain a greater understanding of the woman's worry and to develop a plan for the upcoming labour and birth that moderated the woman's worry. Shared aspirations and hope are also seen here and these are discussed in more detail in Chapter Six.

The repeated time influence of the MGP model on the nature of the midwife-woman conversations is also seen in this conversation. In the first statement, for example, the midwife shows she already knows about the woman's worry with two comments: 'I guess you said to me the last couple of times ...' and 'you gave birth on the bed'. Also, in this opening statement when she says 'what you want' she is showing she already knows understands the woman’s worry and her hope for her future labour and birth.

Later in the appointment this connection and woman centre investment between the woman and midwife, which I have linked to repeated time, was noticeable when the midwife said to the woman: 'You know give me a call' and 'So I actually like to know – if you start feeling something'. It was also evident when they talked about the management of the third stage of labour:

<table>
<thead>
<tr>
<th>Midwife:</th>
<th>As far as the synto?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman</td>
<td>See how we go. I'm happy for you to do it if you think it's necessary, but if we can get away with it, then I'm happy to get away with it.</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Fantastic, I think that's a great way of – the policy of the unit is that we stab everybody just in case, but I think you know what you're talking about and if that's what you want, I'm quite happy. (B-MBP3)</td>
</tr>
</tbody>
</table>

To start, the midwife used an open-ended question to explore the woman's preference for this stage of the labour: 'As far as the synto?' This unbiased question enables the woman to state her preference for the third stage of labour to not have active management: 'See how we go'. The woman's response shows she is aware of the midwife's authority and knowledge: 'I'm happy for you to do it if you think it's
necessary'. She is still able to state her preference: 'but if we can get away with it, then I'm happy to get away with it.'

The midwife's reply to the woman: 'Fantastic, I think that's a great way of – the policy of the unit is that we stab everybody just in case, ... ', not only aligns her with the woman and illustrates that she respects the woman's thoughts, but also establishes that her care is based on the individual needs of the woman and not completely governed by the system's procedures. Her next comment, 'I think you know what you're talking about and if that's what you want, I'm quite happy' also illustrates her respect, trust and connection with the woman.

The connection, trust and woman-centred investment in the midwife's actions and interactions in appointment B-MGP3 was also reported by the woman at her postnatal interview. She described the midwife in this appointment as 'client focused' in comparison to other midwives who she found were 'protocol' driven:

The other midwives ... just seem to be, or the typical type of scenario seems to be, this is what you do, this is the protocol, blah-blah, we follow one, two, three, four, five. That's it, and stiff shit about anything else really. But she doesn't seem to be like that at all. I mean I get that she follows protocol, of course she follows protocol, but she's client-focused. It's about your experience, and a couple of times I've said what do you think about this? She goes 'hey it's your baby, you're having the baby, it's not my birth, you do what you want'. (PNI-B-MGP3)

The findings from the analyses of these two appointments, B-SMC11 and B-MGP3, demonstrate the differences in the nature of the midwives' interactions seen in many of the appointments. Even though there were similarities in the demographics of the participants in these two appointments, the model of care, repeated time, midwife use of time and alterations to the local environment influenced how the midwife interacted with the woman in these appointments.

5.3.2.2 A difference in a woman's expectation

The women's expectations of their midwifery care in both of these appointments also influenced their investment in their midwifery care and their interactions with the midwife. Although both women in these two appointments shared some
similarities, both being pregnant with their third child and having a support person with them at the appointment, they had very different expectations of their midwifery care. The woman from appointment B-SMC11 had no expectations, or felt she was not provided any encouragement in this appointment to express them, whereas the woman from appointment B-MGP3 did have expectations and felt she was able to express them.

During her postnatal interview the woman from appointment B-SMC11 commented she had minimal expectations of her care and that she felt she had no say in how her care was provided. When I asked her 'Do you think that would help, having a midwife that saw you during your pregnancy and then was there for you when were in labour?' She stated, 'Yes, I reckon, but like what I said, I can't say for her to be there. It would be nice, but that [is] the way it works. You can't have those expectations.' (PNI-B-SMC11). As a result, her antenatal care was just a check-up, which she did not need to invest or actively engage in. Other women who participated in this study also conveyed they had minimal expectations of their antenatal care, for example; 'I think they took my blood pressure and if I have a problem I can ask them … ' (PNI-A-SMC14). One woman, for example said, 'I didn't really have any expectations or anything like that – it was all just very new, really. You kind of just roll with whatever's happening …' (PNI-A-MGP2).

In contrast, the woman from appointment B-MGP3 valued the concept of midwifery continuity of care and invested in it. For this pregnancy she had actively sought midwifery continuity of care as she didn't 'want to be telling my story a million times over and have a stranger walk into the room then have to tell my story again' (PNI-B-MGP3). For this woman, having the same midwife was integral to the support and care she wanted from her antenatal care and also her labour, birth and postnatal period. During her postnatal interview, for example, she said she 'was … on my[her] own … and need[ed] somebody to be with me [her] the whole time'. This need for support around her childbirth and investing in relationship-based care was also seen with her decision to have a doula. Having the same midwife was
important to her and she invested in getting this.

Observing and examining the other SMC appointments and the comments from the women's interviews also showed that, even when women have no expectations for their antenatal care, they did find that the efforts of some midwives to interact with them made a positive difference. During one postnatal interview, for example, one woman from SMC reflected positively about the midwife taking the time and making an effort to explain what she had written on the woman's shared care card, 'Yeah ... she explained me everything but the other midwives they write and give the card, the don't explain' (PNI-A-SMC14). Similarly, a woman from MGP during her postnatal interview commented that even though she had not sought out midwifery continuity of care she found knowing her midwife at her labour was beneficial: 'it was nice to have a friendly face and just someone who knows you' (PNI-A-MGP2).

The detailed analysis of the MGP appointment B-MGP16, which took place in the woman's home, showed a number of key beneficial characteristics of woman-centred care; respect, equality, trust and friendship. The next section presents one part of this analysis. In this appointment the typical power dynamics of a healthcare relationship between a midwife and woman were not observed. Instead it was the woman who led the appointment.

5.3.2.3 'I'm in their territory so ... they ... set the pace'

Antenatal appointments taking place in the woman's home appeared to be more 'equal' interactions compared to the appointments that took place in the OPD. The power and authority in the interaction was shared. The woman's authority from appointment B-MGP16 was first seen when I arrived early at her house to do the observation. As I waited in my car for the midwife to arrive the woman 'came out of the house to my car, introduced herself and invited me in' (field note B-MGP16). Once inside she took charge and directed me to setup the video recorder near the kitchen table, as this 'was the usual place for our appointment' (field note B-MGP16). When I observed other appointments in the women's homes the woman,
midwife and I, often jointly made the decision of where the camera should go. In contrast, in the OPD appointments it was the midwife who took control and who directed the woman and me.

During the MGP focus group at Hospital B, the midwives commented about the positive benefits for the women with having the appointments at their home. One said, 'because the women are in their own environment they feel a lot more comfortable'. They thought the women had more control: 'I'm in their territory so I guess they kind of ... set the pace. Yeah and they're a lot more vocal about what they want'. They also thought there were benefits for them because they were able to understand and appreciate the individual woman better, 'You know more about them when you see them at home.' Also, the midwives experienced time differently in the woman's home environment:

I feel like the clock's not ticking as well at home whereas in the hospital we're limited to three rooms – we might book an appointment and there might not be a room available. (FG-B-MGP)

Due to being early at this appointment, I was in the house, and observed the initial midwife-woman interaction without my researcher presence affecting it. The woman and midwife greeted each other with smiles and common social greetings asking how each other was. The woman then invited the midwife into the house and offered both of us a drink, a cup of tea, and an action that reflected her hostess status. Later, after the consent had been completed and before the appointment conversation started, the woman also offered food, which was another customary act of a host.

From this beginning stage of the appointment the woman was the person who mostly controlled it. This was first seen when she directed the midwife to take her blood pressure measurement. Initially, I thought she took charge at this stage because she and the midwife were nervous of my presence and that of the camera. However, once the task of the blood pressure was completed they appeared to regain their composure and the midwife then stepped into appointment mode with the question: 'how have the last few days been?'.

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The familiar environment of the woman's home facilitated more social midwife-woman interactions rather than the appointment being made up of standard medical and clinical healthcare interactions. In the first instance the kitchen table, around which the majority of the appointment took place, created a relaxed social atmosphere. They sat at this table and only left it to do the abdominal palpation on the woman's couch in the lounge room. There was no need for them to twist or strain to look at each other, as they sat facing each other across the corner of the table. The non-clinical nature of this appointment was enhanced by the domestic objects on the kitchen table situated between the midwife and woman and central to their interaction. These were water glasses, a carafe of water and a cake. The objects associated with a typical antenatal appointment and a standard healthcare interaction – maternity care records and the sphygmomanometer – were not central to their interactions. Instead they were used for short periods of time and then repacked in the midwife's bag or placed to the side of the table. The woman's GP shared care card, for example, was placed on the table between them, but then was not opened or used by the midwife until late into the appointment. Their postures while they sat at the table were relaxed and often mirrored each other. They moved from leaning on their elbows on the table to resting back in their chairs. This can be seen in figure 17, on the next page.
Another example that indicated the woman had the authority and was taking control of her care was her use of a notepad, which was placed on the table in front of her for most of the appointment. She referred to this notepad a number of times and often asked the midwife questions from it and wrote things in it. An action that reflected those of a health professional directing the appointment rather than those of someone receiving care. To demonstrate this inverted midwife-woman interaction I have included a list of questions in Table 20 (next page) which the woman asks the midwife after looking at her notepad.
### Table 20: Questions the woman asks the midwife after looking at her notepad from appointment B-MGP16

<table>
<thead>
<tr>
<th>Time stamp</th>
<th>Midwife-woman interaction</th>
<th>Speaker</th>
<th>Appointment Conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:37-10:48</td>
<td>Woman looks down at her notepad &amp; reads from it as she is talking to the midwife</td>
<td>Woman:</td>
<td><strong>But that’s ...Oh and like, oh that’s we’re on that today, but the mucous has been increasing from yesterday</strong></td>
</tr>
<tr>
<td>12:06-12:10</td>
<td>Woman looks at her notepad</td>
<td>Woman:</td>
<td><strong>... So, I was going to ask you. How do you know if my cervix is getting ready [laughs]? I don’t know ...</strong></td>
</tr>
<tr>
<td>14:10-14:15</td>
<td>Woman looks at notepad then at her stomach</td>
<td>Woman:</td>
<td><strong>I'm just getting these cramps at night. It's normal isn't it to get that tightening?</strong></td>
</tr>
<tr>
<td>14:50-14:56</td>
<td>Woman points to pathology bag with pathology request form &amp; swab. Midwife turns to look at what the woman is pointing at</td>
<td>Woman:</td>
<td><strong>I read all the pamphlets</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife:</td>
<td><strong>Yep</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Woman:</td>
<td><strong>Everything is good, That's OK to do?</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife:</td>
<td><strong>Yep</strong></td>
</tr>
<tr>
<td>20:08-20:23</td>
<td>Woman looks at her notepad</td>
<td>Woman:</td>
<td><strong>Oh ... actually I just thought of something else because I have written it down. This is going to be a silly question, but ... coz I don’t go to the hospital ... when we go to park we need the ... eight dollars</strong></td>
</tr>
<tr>
<td>21:10-21:17</td>
<td>Woman writes down information in her notepad</td>
<td>Woman:</td>
<td><strong>Only $1 and $2?</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife:</td>
<td><strong>Only $1 and $2.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Woman:</td>
<td><strong>Oh my gosh. All right. So too bad for the $0.50 I was saving. Only $1 ...</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife:</td>
<td><strong>So overnight it's quite easy to get parking ...</strong></td>
</tr>
<tr>
<td>21:47-22:00</td>
<td>Woman looks at her notepad &amp; writes in it</td>
<td>Woman:</td>
<td><strong>... and they take credit cards? I'm going to have to raid his moneybox because I only thought of that yesterday. I thought to myself, hang on a second, if we rock up and we have no money for the parking, where are we going to park?</strong></td>
</tr>
<tr>
<td>22:45-22:50</td>
<td>Woman looks at &amp; reads from her notepad</td>
<td>Woman:</td>
<td><strong>Oh OK, alright that's cool. I've packed my bags. Any suggestions ...</strong></td>
</tr>
<tr>
<td>24:06-24:25</td>
<td>Woman looks at her notepad and writes in it</td>
<td>Woman:</td>
<td><strong>Oh, so I can pack my wheat bag? Oh, OK because I find that really good, because at night ... Oh ok then pack my wheat bag ... Oh and my yellow card ... I have 'to make sure' I remember that</strong></td>
</tr>
<tr>
<td>24:45-25:10</td>
<td>Woman writes in her notepad again &amp; at this stage the midwife starts to write on the share care card.</td>
<td>Midwife:</td>
<td><strong>Yeah. Especially if you call one of us and you're progressing really quickly, at least the birth unit staff have some idea of what's happening...</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Woman:</td>
<td><strong>Oh OK, yeah, that's true.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife:</td>
<td><strong>...and can help you out until we get</strong></td>
</tr>
</tbody>
</table>
there. Because yeah, you live a little bit closer to the hospital than me. So yeah, very important you take that with you.

OK. I’ve written in a little – like I’ve put a post-it note on the bag but it should be – it’s always in my bag but then I might not be thinking straight and forget it.

Woman: OK.

I’ve written in a little – like I’ve put a post-it note on the bag but it should be – it’s always in my bag but then I might not be thinking straight and forget it.

Woman: I’ll just tell him this weekend [laughs] … baby seat … its capsule actually … it reverses back

25:32-25:43

Woman writes in her notepad.

Midwife continues to write on the share care card & acknowledge woman with glances up from her writing & saying yes

Woman: I’ll just tell him this weekend [laughs] … baby seat … its capsule actually … it reverses back

26:01-26:10

Woman reads from her notepad & writes in it

Woman: Oh, I am still taking ...

26:38-26:41

Woman reads from her notepad & writes in it

Woman: I don’t need to pack anything else do I?

26:59-27:05

Woman reads from notepad

Woman: That’s it I think ... so that is all my questions

This particular pattern of interaction where the woman used her notepad to lead the midwife-woman interaction contrasted with many of the midwife-woman interactions in the other appointments, particularly, those in the OPD. In this appointment, for example, the woman relied on her notepad for 7% of the appointment time. She also read and looked at her shared care card for 3.7% of the time, an action not seen in any of the other appointments. In the OPD the typical midwife-woman interaction involved the midwife looking at or reading from the computer/medical record then asking the woman questions or directing the woman to a clinical assessment task. When this woman relied on her notepad she led the interactions, ensuring her worries were raised and addressed.

During her postnatal interview the woman from this MGP appointment reflected positively about the midwife. At one stage she described her relationship with her midwife, as a 'friend relationship', which she related to the midwife asking her what she wanted instead of telling her what she had to do. She also said that her midwife never spoke down to her:
It was asking me, not telling me. It was different. She said when would you like to be induced if you don’t have her by the 10 day mark. It wasn’t if you haven’t had her on your due date you have to be induced or anything like that. ... So I think it was more like a friend relationship than – I didn’t ever feel like she spoke down to me. (PNI-B-MGP16)

5.3.2.4 ‘She was OK, she knew everything’

In appointment B-MGP16 the midwife’s interactions with the woman reflected a level of power sharing or equality and respect and the benefit of repeated time associated with the MGP model. This was observed in her verbal and non-verbal interactions with the woman and other object in the appointment space. For example, she looked towards the woman regularly and had minimal reliance on the maternity care records. She appeared to already know the woman’s history and concerns. In total the midwife and woman looked towards each other for nearly 90% of the appointment time and they talked for 92% of the time. The midwife only engaged and relied on the maternity care records to direct her conversation for short periods of time towards the end of the appointment. In total she interacted with the maternity care records and her diary for 7% of the appointment time.

The midwife did not refer to the maternity care records to ask the woman any questions or to check any information during the appointment. She relied on the maternity care records to direct the appointment between the 27 and the 28.30-minute point and asked her first two clinical questions, as she read and wrote in the medical record and GP share care card, ‘You mentioned yesterday you were happier with the [fetal] movements?’ and ‘No burning or stinging when you pass urine?’.

She then directed the woman to do the abdominal palpation with the statement, ‘Excellent, alright we might have a listen to the baby’s heartbeat and see how the measurements are going’. The remainder of the midwife’s interaction with the maternity care records and her diary then occurred at the end of the appointment.

At this time, she completed her appointment documentation and organised the next appointment with the woman.

I attributed this to the repeated time of the MGP model, whereas the woman
attributed this to her midwife caring about her and being passionate about her work:

Well I think she genuinely cared, she really cared. I think she really loved her job and I think you could tell that she was passionate about it ... she remembered everything. She'd even remember what we spoke about the last appointment, which is rare; usually people would have to look on their computer to see their notes of what they talked about. But she was OK, she knew everything. She was like oh yeah, I remember when this happened. (PNI-B-MGP16)

Other examples of equality between the midwife and woman in this appointment was that the woman was the dominant speaker. She talked for 65% of the conversation, and the midwife talked for 35% of the conversation. Only one other appointment included a woman speaking more than this. The midwife in this appointment responded to the woman's question and worry about what would happen if she was not at her birth by acting reassuringly. She opened the medical record and showed the woman where her birth plan options were written and named the other midwives who were her backup.

Early in this appointment I attributed their laughter to being nervous about being filmed. Later in the appointment it became apparent the amount of laughter and smiling seemed to reflect a relaxed, equal and respectful relationship. They smiled and laughed more together more than as an individual action; smiling together for 20% of the appointment time and laughing together for 12% of the time. They both smiled independently from each other for 7% of the time; the midwife laughed independently for 7% of the time and the woman for 3% of the time. As a result, the midwife became the principle listener. She was the one who smiled and laughed more. Often the woman from this appointment told stories and jokes about her personal situation or experiences with her pregnancy and her upcoming labour and birth and the midwife listened, explained, reassured and laughed with the woman about it. A segment of conversation that shows this is reported in Appendix D in table D-4.

The midwife and woman's non-verbal interactions, their body language, reflected
their trust, equality and respect. Often their body language and facial expressions mirrored each other. For example, they faced each other 89% of the time and their facial expressions mirrored each other for 82.5% of the time as they talked or listened. The midwife’s attentiveness, which reflected her woman-centred investment, was noticeable when she listened to the woman. She frequently looked directly at the woman as the woman talked and rarely did any other tasks or interactions with other objects in the appointment during this time.

The findings from these two MGP appointments, B-MGP3 and B-MGP16, show two midwives more woman-centred than system-focused. Midwives in the MGP appointments often showed a level of woman-centred midwife investment that was not seen in the SMC appointments. This I attributed mostly to the midwives in the SMC appointments not having the same opportunities that the midwives in the MGP model had. However, two SMC midwives acted differently to their SMC peers and appeared to adapt their work and interactions to be more woman-centred than system-focused.

**5.4 Adaptive Experts**

These midwives from SMC system adapted their practice, their clinical environment and use of time. They chose not to use or look at the computer when they were talking to the women, or they adapted how they used the maternity care records and included the woman in their interaction with the maternity care records. In SMC appointment A-SMC14, for example, as the midwife handed the woman her medical record at the end of the appointment she showed the woman what she had written and explained what it meant.

Similar to the MGP midwives, the midwives from SMC found that when they were away from the hospital OPD, for example at the community health centre, the women interacted more positively with them, and they felt this improved the appointment experience. One midwife, for example, told me that when she worked at the community health centre, or what she referred to as the 'outreach clinic', the
women asked more questions and were more open:

I do outreach as well so I get to know the women – they ask more questions and they open up to you. I like it. (field note B-SMC, 10052013).

Although this improved appointment experience appeared related to greater flexibility in these 'outreach' clinics it also appeared linked to the appointment environment. The midwife from the SMC appointment A-SMC13, which took place at the community health centre, talked about the different feel of the community health centre compared to the hospital OPD:

It's very clinical in the hospital, like it's almost – it's not – I couldn't even pinpoint it, I couldn't even tell you what it is exactly. I think being out at the [Community Health Clinic] … It's ... much more relaxed, because I think it might be next to the shopping centre. (A-SMC Midwife Interview)

The midwife from this interview was observed in two appointments (A-SMC 13 and 15) and showed a number of adaptive actions that reflected greater woman-centred investment. These enabled her to interact more with the woman and connect with and invest in the woman's individual needs or worries, rather than being solely focused on the tasks and routine practices of the antenatal appointment.

At first glance this midwife looked similar in appearance to her SMC colleagues and undertook the same clinical processes and asked some similar questions. The key difference was that she adapted her practice, for instance by modifying the scheduled times for appointments in the midwife-led clinic she ran at the community health centre. After a focus group she shared her frustrations with me about what was happening to her midwife-led clinic while she was backfilling someone else's work in the hospital. She had received complaints from a woman booked into her clinic about the midwife who had replaced her as she was making the women stick to their scheduled appointment times. This midwife said she had a flexible drop-in arrangement and the women could come to the clinic at any time on the day she was in the centre. (field note 02072013).

Another example of her adaptive practice was that she modified the local
environment of the appointment, in a similar fashion to the midwife in appointment B-MGP3. She only used the computer for 11 seconds during the appointment and relocated the maternity care records to corner of the desk, closest to the woman, and slid herself on her chair to this corner. As a result, they sat across from each other, shoulder-to-shoulder at times, with the open maternity care records in between them on the desk for 66% of the appointment time (see figure 18 below). This enabled them both to read it. Their physical closeness and the placement of the maternity care records appeared to affect their interactions. Their body language around the medical record was shared and mirrored between them. For example, the woman looked towards the midwife 65% of the appointment time and the midwife looked towards her for 66% of the time. The woman looked at the medical record 23% of the time and the midwife looked at the maternity care records for 21% of the time.

Figure 18: Still clip from appointment B-SMC13

These simple actions by the midwife to relocate the maternity care records and to not interact with the computer created more time with the woman and enabled more shared midwife-woman interactions. It also appeared to boost trust and
respect, as the woman was able to observe what the midwife read or wrote in the maternity care records. It adapted the negative time and environment features of the institutionalised clinic room setup.

The decision to not rely on the computer and to relocate the medical record closer to the woman in this appointment appeared to be a conscious choice by this midwife and some other midwives in the study. It was one adaptation that demonstrated a greater level of investment in the woman and decreased the typical standardised medical approach observed in many of the other appointments. Other SMC appointments where this adaptive action was seen were: A-SMC14, B-SMC10 and B-SMC12. However, the midwives in these appointments still used the computer for extended times during the appointments.

This midwife used this same pattern of interaction in the other appointment I observed (A-SMC15), even though it was located in a hospital OPD clinic room. In this appointment the midwife again adapted the local environment to enhance and increase her interactions with the woman. She moved her chair away from the desk and faced it towards the woman and her partner. This resulted in the computer being marginalised and all three participants being able to look directly towards each other without turning or twisting in their chairs.

Another adaptive action observed in these two appointments (A-SMC13 and A-SMC15) was that the midwife chatted with the women and shared personal information about herself. This sharing of personal information appeared to create connection with each woman, as it identified similarities or shared experiences and perspectives. During appointment A-SMC13, for example, when the midwife was gaining the woman's consent for the standard vaccinations for the baby, she quipped 'let's do that now because I'm very forgetful', thus sharing a personal failing. Her deliberate action may have been influenced by the physical closeness she had with the woman at this stage, as they were both leaning over and reading from the maternity care records. This personal declaration appeared to shift the power between her and the woman, as she was now an individual with human
failings and not the complete authority figure in their interaction.

This midwife was respectful when she shared and chatted with the woman. She did not share sensitive topics and was not overly familiar. For instance, she commented positively about the woman's nail polish, 'I love those nails', and acknowledged her personal preferences, 'Now green is my favourite colour'. This conversation encouraged a level of reciprocity and connection as the woman responded with, 'Thanks. I looked at yours when I walked in and I went OK.' Equally, the midwife's next comment, 'I'm not meant to have nails', also demonstrated a desire to connect with the woman. She was pointing out a similarity between herself and the woman distancing herself from the system and its standardised policies on staff uniforms and appearance. The woman accepted the offer of connection by responding, 'Aren't you? But if you know what you're doing with them ...'

This midwife's conversations with the woman in appointment A-SMC13 manifested differently to the majority of the other SMC appointments and were more like those in the MGP appointments. Their verbal interactions included topics of a more social or personal nature and were not solely clinical or system-focused. They demonstrated more equality and sharing of power with more discussions and sharing of stories, which also enabled the woman more time to discuss her worries, options and choices and in some situations appeared to moderate her worry. One example was when the woman raised her worry with the midwife about her baby being in a breech position:

**Woman:** But I'm a bit worried because now I'm starting to feel up the top that it's the same as before [breech]. So I don't know if I'm going to be able to or not.

**Midwife:** OK. How many weeks are you right now?

**Woman:** I'm all over the place that's all. I'm 26 weeks.

**Midwife:** So it's still a bit early so yeah, and those pains or those sensations that you're getting is quite normal now anyway. It's all the ligaments stretching so just keep that in the back of your mind that it's all good. Then I'll get to see you again and we can talk about any...

**Woman:** Changes.
Midwife: Yeah, any issues that you might have with it. If you want to go and talk to the doctors again we can make that appointment. You go back to [Hospital A] and if you want to change your mind at all at any stage.

Woman: No worries. (A-SMC13)

In every midwife action in this appointment the midwife was constantly focused on the woman. This created more time for them to talk, which enabled the woman to not only receive information from the midwife, but also for her worry to be raised and addressed. The midwife only looked away from the woman for 13% of the appointment time, when she was engaged in other activities, but even then she was doing something directly connected to the woman. She spoke on the telephone to find out the woman's pathology results, washed her hands before and after the abdominal palpation, and looked up information for the woman from information leaflets on the wall near the desk.

The action of the midwife to make a telephone call to follow up on the laboratory results, which is shown in a segment of conversation, demonstrates her focus was on the woman's individual needs and that she did not rely or wait for the standard system to complete these tasks. She chose to contact the laboratory, because the woman had asked even though she expected the standard system would not have the blood results ready:

Midwife: So you're 26 weeks now. Have you had the sugar test?
Woman: Yes I did it this morning.
Midwife: Fab. So we won't get the results until ...
Woman: Well I spoke to the lady and she said if you needed them today just to ring up and she'll have them. So that's up to you.
Midwife: So that's what we might do. We'll do that now. What time did you finish?
Woman: Twelve. I finished at 12 o'clock.
Midwife: OK. I'll see if it's ready. Just bear with me. I think we just follow up on it so you know what's going on.

[Phone call discussion]
Midwife: OK so she's going to fax me the results when they're ready. They haven't got it yet so the courier man is probably around at this time trying to get there. Then if it's high I'll ring you
tomorrow. So they'll fax it to where I live at Hospital [B]. All right?  (A-SMC13)

This midwife was being accommodating and respectful of the woman's requests. Her comment just before she called the laboratory, 'I think we just follow up on it so you know what's going on' affirms that her action to telephone the laboratory was for the benefit of the woman to enable her to know the process; the 'what's going on'. Furthermore, the midwife's joke about the failings of the system, 'the courier man is probably... at this time trying to get there', also connects the midwife with the woman instead of the system.

5.5 Investment – a reflection of a midwife's motivation and connection

As discussed, the midwife's adaptive actions in appointments A-SMC13 and A-SMC15 aligned more with the MGP midwives' actions than those in the SMC system and reflected woman-centred investment. Even though her role in the OPD and the community health centre restricted her ability to offer continuity of care, she made extra effort to ensure the women got the best midwifery care that they could. One example took place in appointment A-SMC15 when she told the woman how to contact her during her working hours if the woman was worried and needed reassurance:

Well, we'll see you in two. But if you think you need to talk to someone sooner, you know you can call me. I'm here. You know when I'm here, Tuesday, Thursdays, Fridays. I'm out at [community health centre] on Wednesday.  (A-SMC15)

During her interview this midwife, from A-SMC13 and 15, talked about her connection with the local community as her inspiration for making an extra effort to meet the needs of the women. She understands and empathised with them:

... because I grew up there, it's a different culture. I can understand that you can't have your shoes out the front porch overnight, because they won't be there. Or you can't hang your baby clothes outside, because it won't be there ... So if you were somebody that didn't live here and came
and worked here, you wouldn't know that stuff. (Midwife Interview A-SMC)

The connection this SMC midwife had to her community what motivated her to be woman-centred. At her interview she explained she adapted aspects of the standardised appointment to invest in the individual woman:

Making sure that my ladies – I give 100 per cent to my ladies and did what I could for them, if at that moment – whatever it may be – whether it is talking about their spouses, having a whinge or whatever is needed. (Midwife Interview A-SMC)

In contrast, it was the MGP model of care that motivated the MGP midwives to adapt and be more woman-centred than system-focused. They had pride in their model of care, were invested in it and connected to the women through it. This motivation to invest in the women encouraged them to adapt the environment and time of the appointment and the standardised system.

Analysis of the audio transcript revealed that the MGP midwives typically told the women to call them if they were worried. In appointment A-MGP7, when the midwife was attempting to reassure and moderate the woman about feeling decreased fetal movement, she said to the woman, '... ring me. If you worried, ring'. It was a simple message of reassurance and a way to support the woman to deal with her worry, and reflected the connection developed during the woman's antenatal appointments. It also reflected the midwife's expectations that she would be supporting and caring for the women during the labour and birth and her postnatal period.

This ongoing involvement in the woman's childbirth continuum, as seen in the midwife's comment above, created investment in the woman's future care, her labour and birth, and postnatal care. Similarly, this connection created by the continuity of carer principle of the MGP enabled the midwives more opportunity in the antenatal appointments to share and appreciate a woman's worry and to support a message of hope or optimism over time and into the future.

In contrast, the factors identified as barriers in the SMC appointments, which
typically related to the fragmented, standardised and routine practices of the hospital and the overarching institutionalised healthcare system, inhibited this connection between midwife and woman. The experience for most midwives working in SMC was that they were restricted by the standard and fragmented approach to maternity care. The structure of the standard system of maternity care resulted in midwives working in one area of the hospital and, in the case of this study, the antenatal clinic of the OPD. They had little capacity in these areas of the hospital system to alter and adapt the environment or time of the antenatal appointment to meet the needs of the woman, as the system dominated their work. This disconnect or inability to invest in the woman’s future was heard in many of the SMC appointments when they attempted to reassure the woman, for example, 'OK, call the birth unit if you have any problems ...' (B-SMC11). This fragmentation of the woman’s care resulted in the midwives not being readily able to invest in the woman or offer her ongoing care, hope or support for future care events.

5.6 Conclusion

Parts of this chapter have included detailed accounts of analysis of four appointments, which have been compared with the broader analysis findings. A complex interrelationship existed between the three factors of environment, time and investment. The factors of environment and time strongly affected all the appointments and featured in the participant's comments in the focus groups and interviews. These were signposts for the differences in the midwife's investment, her actions in the antenatal appointment, and her interactions with the woman. When environment and time were positive and facilitative the midwife was able to invest in the woman, be woman-centred, and engage in relationship-based care. When they were negative the midwife's ability to be invested in the woman was limited and her approach remained system-focused.

Facilitative environment and time factors of the antenatal appointment were also
linked to a connection and investment between the midwife and woman across the childbirth continuum. A positive and enabling relationship or connection between the factors of environment, time and investment was found mostly in the MGP appointments and when the appointments occurred away from the hospital OPD. When these factors were not enabling and positive the midwives needed external motivation to adapt or alter them to maintain or create a level of woman-centred investment. These motivators were the continuity of care principle associated with the MGP model of care and in the SMC system they were often associated with other aspects that created a connection between the midwife and woman, such as being a member of the local community or a desire to do the best for the women.
Chapter 6 – Telling, discussing and storytelling

In Chapter Four I presented worry as the central feature and focus of the antenatal appointment and of midwife-woman interactions. In Chapter Five I presented environment, time, and midwife investment, the factors found to influence the antenatal appointment and the nature of the midwife-woman interactions and how worry was generated and moderated. In this chapter I examine how the model of care influenced the communication styles adopted by midwives. In the first section I use examples of the findings to show the differences in the midwife-woman interactions between a standard healthcare interaction and a social interaction. In the next section I present the differences in the midwives’ communication styles between the telling, discussing and storytelling and the midwife’s focus or approach and the influence of the model of care. In conclusion, I present examples that connect these midwife-woman communication styles and interactions to the generation of worry, the moderation of worry and on occasion the creation of hope in the antenatal appointment.

Although I have presented the communication styles and interactions as separate categories in this chapter, I rarely witnessed them as dichotomised, single interactions. Only two of the 18 appointments exhibited just one style of communication or interaction. Most appointments included some aspects of a social interaction with the midwife and woman relying on the communication style of discussing as well as telling. In a smaller number of appointments, the inclusion of storytelling as well as telling and discussing was also seen.
From my observations and analysis of the video recordings and audio transcripts from the appointments, I found midwife-woman interactions and the way they talked with each other ranged along a continuum from a standard healthcare interaction to a social interaction. These interactions also varied, at times, during an appointment and often varied from one appointment to another. At one extreme of this continuum, a one-sided telling practice by the midwife reflected a standard healthcare interaction. These medicalised and system-focused interactions were more evident in the SMC system and when the appointment focus was just on health assessment and education. In contrast, the woman-centred appointments, which were most common in the MGP, involved less telling and more discussing and storytelling that reflected a more mutual and shared social interaction that appeared to moderate the woman's issues and worries. The visual model in figure 19 above illustrates the relationship between these communication styles, the type of midwife-woman interaction, model of care and midwife focus/approach.
Appointments that included discussing and storytelling as well as telling were more likely to take place in the woman's home and with the MGP. In contrast, when telling dominated the appointments they were more likely to be in the SMC system and OPD. Figure 20 below illustrates this relationship between communication style, model of care and location of the appointment.

**Figure 20: Communication styles, model of care and location**

Often, when and what the midwife asked the woman reflected how the midwife and woman interacted. When an appointment was dominated by standard healthcare interactions, such as assessment tasks and education, the midwife commonly asked the questions associated with standardised tasks. In the SMC appointment B-SMC11, for example, the midwife only asked the woman questions associated with the antenatal assessment or her knowledge of the hospital admission processes. One example was seen during the blood pressure measurement:
Midwife: Excellent. Any swelling in your hands or your feet?
Woman: No.
Midwife: Good. Alright, I'll check your blood pressure. You haven't had any contractions yet? (B-SMC11)

In contrast, an appointment that included social interactions involved the woman and midwife sharing questions that often related to personal issues or worries as well as clinical issues. In the SMC appointment A-SMC13, for example, during the blood pressure measurement the midwife asked about the woman about her older child:

Midwife: Let me check your blood pressure if that’s OK?
Woman: I’ve got to take this thing [jacket] off
Midwife: You can. You don't have to. Just pop that down. We’ll be right. So how are you finding your one-and-a-half year old? (A-SMC13)

6.1 A standard healthcare interaction

In this section I focus mostly on the analysis of the SMC appointment A-SMC6 and one segment of conversation where the midwife is telling a woman and her partner about antibiotic prophylaxis for Group B streptococcus (GBS). This is to show what I characterised as a standard healthcare interaction and how it reflects the negative influence of the medicalised and fragmented maternity care system. In this appointment the midwife focused on appointment tasks, antenatal assessments, and telling the woman what she needed to know about the next part of her maternity care; the labour and birth. Although many of the midwives did not specify that the fragmentation of the maternity care system had a negative influence, they did tell me how conscious they were of preparing and educating the women for the next part of the maternity care system. One SMC midwife during the focus group from Hospital B said:

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22 Antibiotic prophylaxis for GBS is a routinely offered and promoted intravenous treatment administered to women in labour with GBS to decrease the transfer to the baby (NSW Health, 2005)
I want to make sure that the pathology or the ultrasound and everything has been looked at are documented, and that when she presents to birth unit, that they've got the information. (FG-B-SMC)

Managers also were aware of the negative influence of the fragmented and medicalised aspects of the maternity care system on the midwives' practice. One manager during the focus group from Hospital B, for example, told me that the nature of the midwives' practice in the SMC appointments was often a consequence of the midwives not knowing the woman or expecting to see her again: 'Yeah, because probably a lot of the times they wouldn't know – they may not have met that woman.' (FG-B-Managers)

Appointment A-SMC6 took place in the busy environment of the birth unit in a clinic room with a similar layout and décor to the OPD clinic rooms. The midwife's verbal and non-verbal interactions were rushed and system-focused. She was time-pressured and focused more on completing the tasks, assessments and documentation requirements, than talking with the woman about her own needs or worries. The midwife looked towards the woman/partner 40% of the appointment time. The remainder of the appointment included many midwife-computer interactions (25%) and midwife-medical record interactions (14%). During a conversation we had at the end of the appointment the midwife confirmed she was busy, which I recorded as a field note, when she said:

Twenty minutes is a short time to get all your health information across, undertake an assessment and assist the woman to be confident in her ability. (field note-A-SMC6)

Although the midwife indicated she was focused on the woman, their conversation topics during the appointment related to clinical and system issues more than the woman's personal issues. Only 9% of their conversation related to personal issues with 65% related to clinical issues and 26% to system issues. Even though the midwife was chatty at times during the appointment she maintained a standardised healthcare focus. The couple shared more of the conversation than other SMC appointments (woman talked 29% of the conversation and the partner 11%), but the midwife still led most of conversation (60%) with a telling communication style.
Only 10% of the appointment involved storytelling. The remaining 30% was discussing.

During the analysis of the video and audio transcripts of the GBS antibiotic prophylaxis conversation the midwife was the one who introduced worry about this topic. Her worry about GBS appeared to be related to the hospital’s standardised approach to this issue. She was focused on moderating the system’s worry about GBS and relaying messages of confidence and trust in the system she worked in. Conversation and coding associated with this GBS conversation is shown in Table 21 below.

Table 21: Analysis examples from appointment A-SMC6 – GBS antibiotic prophylaxis

<table>
<thead>
<tr>
<th>Talker</th>
<th>Appointment conversation</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife:</td>
<td>Now, with regards to the GBS swab that you had done, that’s come back as being positive.</td>
<td>(Direct, succinct introduction to topic)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>So, do you understand about Group B strep?</td>
<td>(Checking-closed question)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah, I had, I read, so I know I have to have antibiotics.</td>
<td>(Confirmation that she has to have antibiotics – no option)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Yes. So, we are going to document all over your file and into the Obstet program with regards to you being GBS positive and ... the moment you come in labouring they give you antibiotics. They usually pop a cannula into the vein and it’s good old penicillin. ... it works quite quickly.</td>
<td>(Midwife not acknowledging woman’s limit of knowledge about GBS) (Description of procedure – very important and serious) (Sense of urgency) (play down, moderate worry – ease of procedure) (Trusted, well used, quick and very effective – moderate worry)</td>
</tr>
<tr>
<td>Partner:</td>
<td>Is this just to stop any chance of infection really, isn’t it?</td>
<td>(Partner checking, now worrying)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Passing onto the baby.</td>
<td>(Confirming – limited response)</td>
</tr>
<tr>
<td>Partner:</td>
<td>Yep</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>Yes. But we always have – you have plan A, plan B. We’ll continue to monitor baby ...</td>
<td>(Reducing worry, other plans)</td>
</tr>
<tr>
<td>Partner:</td>
<td>Yep</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... for 24 hours ...</td>
<td></td>
</tr>
<tr>
<td>Partner:</td>
<td>Yep</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... with a fourth hourly temperature ...</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>Uuhh</td>
<td></td>
</tr>
<tr>
<td>Partner:</td>
<td>Yep</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... and ah just monitoring the breathing rate ...</td>
<td></td>
</tr>
<tr>
<td>Partner:</td>
<td>Yep</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... as well. But ... it seems to work very, very well,</td>
<td>(Very effective – reducing worry)</td>
</tr>
</tbody>
</table>
Partner: getting the antibiotic on board ...
Woman: Is it as soon as the waters break? Come in straight away? (Highlighting urgency, worry reintroduced)
Midwife: If your waters break, call us ...
Woman: Yep (The generic us – system)
Midwife: ... OK and talk to us. They'll tell you over the phone with regards to coming in. You should come in. You need the ...
Woman: Yeah (The generic us and them)
Midwife: ... antibiotics started ...
Woman: I probably would
Midwife: ... because that little pouch has now got a hole in it and so we don't want that umm ...
Woman: Yeah (Urgency re-introduced)
Midwife: OK. Alrighty. Now, if these pains ...

During this GBS conversation, the midwife relied on the telling communication style. One example was the way she asked the couple, 'So do you understand about Group B Strep?' It was more of an opening statement to a standardised conversation telling the woman about the system's procedures with antibiotic prophylaxis than an enquiry about the woman's knowledge of this bacterium. Also, the midwife created no opportunity for a discussion, even though the woman's answer showed minimal knowledge and understanding about GBS prophylaxis. Her procedural description of the treatment did not provide the couple with information about the bacteria, the antibiotic, or the risks associated with either administering the antibiotic treatment or not administering it.

The midwife's use of high alert phrases during this segment of conversation, for example, 'document all over your file' and 'the moment you come in labouring they give you antibiotics', generated worries for the couple rather than moderating the worry or providing reassurance. The woman, for example showed a level of worry when she asked, 'Is this just to stop any chance of infection really, isn't it?' She also appeared worried about getting the antibiotic treatment on time when she said, 'Is it as soon as the waters break? Come in straight away?'
The midwife's attempt to moderate these worries reflected her system-focused and standardised approach. Even though it was the standardised approach of the system that had created the worry in the first place, the midwife still showed a level of trust in the healthcare system's ability to moderate the worry. This was seen in her use of pronouns, such as 'But we always have ... plan A, plan B' and 'We'll continue to monitor baby', which reflected her allegiance with the system. This was also seen when she offered the couple certainty through the 'plans' to 'monitor baby' and about the success of the antibiotic treatment, 'But ... it seems to work very, very well, getting the antibiotic on board ...'. Likewise, reassurance in the ability of the system to manage this worry was heard in the midwife's choice of words. For example, her use of the casual speech 'pop' when she said they would 'pop a cannula in', indicated the procedure was easy and spontaneous. The word 'good' in the comment 'good old penicillin' inferred the penicillin was 'good' while 'old' inferred penicillin was a trusted and reliable. The comment 'it works quite quickly' inferred that the treatment was quick, effective and provided certainty.

At the end of this conversation about GBS it appeared that the worry had not been moderated and was linked to the midwife's use of high alert instructions that overrode her messages of reassurance:

    If your waters break call us ...', 'You should come in, you need the ... antibiotics started ... because that little pouch has now got a hole in it and so we don't want that ... getting up there, so ... (A-SMC6)

Saying 'OK' and 'Alrighty' at the end of this conversation closed this topic down preventing the couple from asking questions or being able to discuss the information she had just given them.

### 6.2 A more social interaction

In contrast, the analysis of the MGP appointment A-MGP7 sat centrally on the continuum between system-focused and woman-centred interactions. The midwife-woman interactions and conversations reflected both standard healthcare and social interactions. Although this midwife's approach was governed by the system,
she offered the woman a less standardised approach to the worry they both had about the unborn baby. This ability to be less standardised enabled their worry to be moderated. This section focuses mostly on the analysis of their shared conversation about organising a CTG to assess fetal wellbeing.

This appointment was characteristic of many of the MGP appointments. It was in the woman's home and their conversations indicated they knew each other. Irrespective of these factors, many of the midwife's actions were standardised, for example, she spent nearly 60% of the appointment not looking towards the woman. Half of this time she interacted with the maternity care records and the rest of the time she conducted antenatal assessments, blood pressure measurement, and the abdominal palpation or searched through her bag for forms or equipment. As the appointment progressed it became apparent that she was worried about the wellbeing of the unborn baby.

Regardless of her standardised approach the midwife included the woman in many of these standard appointment activities and they did chat about personal topics. She placed the maternity care records on the couch between her and the woman for the majority of the appointment and included the woman in her interaction with the maternity care records. She told the woman what she had written and showed her the ultrasound (USS) report as she told her the findings. This enabled the woman to understand every interaction the midwife had with the maternity care records. This was in contrast to many appointments where women were often not able to see what the midwife was doing with the computer/maternity care records.

The midwife and woman shared the conversation. The woman talked for 55% of the appointment time and the midwife 45%. They spent 70% of the appointment discussing and 15% of the appointment storytelling. Storytelling was a positive experience for the woman. At her postnatal interview she said it helped them connect and made her feel comfortable:

She was very direct she didn’t fluff around, she did what she needed to do, but she ... told me a bit about her personal life, which was good ... It makes
you connect with them. She was very straightforward, to the point and you kind of need that when you don't know what's going on. You don't want someone to fluff around or anything and yeah, it's just I don't know if it was her professionalism, I don't know if it was the fact that she sort of gave you a bit of her personal life as well and her personal experience made you more comfortable. But yeah, I felt completely comfortable with her.

(PNI-A-MGP7)

Along with this woman's positive experience with how the midwife communicated, the opportunities provided by MGP model of care enabled the midwife to adapt her work and positively influence the woman's experience. During the segment of appointment presented below in table 22 (next page), the midwife offers the woman the opportunity to ring and come in for a CTG if she is worried. Although the plan for the CTG was a standardised healthcare action to provide greater certainty about the wellbeing of the unborn baby, the midwife's offer to be available to do a CTG for the woman came from her connection with the woman and her commitment to take into consideration the woman's needs. The midwife's ability to be flexible was facilitated by the flexible working arrangements of the MGP model.

This conversation illustrates the midwife's approach and focus was informed by her duty to the system and her individual worry for the woman. The midwife starts with a standardised message of high alert, 'So I've got the ultrasound report that's showing it's [unborn baby] between the tenth and the twenty-fifth percentile'. Then her use of the pronoun 'we' in her next statement; 'If it's below the tenth, we'd be worried but it's not' confirms her worry. At the same time, she is also trying to reassure. Her next question, 'What was Charles?', for example, is a more individualised message of reassurance. By asking about Charles, the woman's first child, the midwife was gathering information and providing context. This comparison to her first child's weight may indicate the decreased fetal growth on the USS may not be an indication of pathophysiology for this baby, but one of familial physiology. In addition, her statement, 'Yeah. So if this baby is growing like that, he's going to be bigger than Charles.' showed an effort to reassure and an offer of hope.
Table 22: Analysis examples from appointment A-MGP7 – worry about fetal wellbeing

<table>
<thead>
<tr>
<th>Talker</th>
<th>Appointment conversation</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
<td>So, I've got the ultrasound report, that's showing it's between the tenth and the twenty-fifth percentile. If it’s below the tenth, we'd be worried but it's not. An estimated fetal weight at the moment with still four weeks to go, is 2.5. What was Charles?</td>
<td>(High alert message) (Introducing worry)</td>
</tr>
<tr>
<td>Woman:</td>
<td>He was 2.6 at fully – at term.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>Yeah. So, if this baby is growing like that, he's going to be bigger than Charles.</td>
<td>(Reassuring based on woman's feedback) (Discussing not telling)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Cool.</td>
<td>(Hopeful)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>So, I'll just see how you measure today. It might be good to get another one done two weeks after this one, like we did last time, just to make sure...</td>
<td>(Less directive language)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah, because I know with Charles, it was – he did – the longer we went, the more it tailed off. So...</td>
<td>(Reassuring)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>But even still...</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>... it's only 100 grams, that was two weeks ago – well, nearly two weeks ago I think – no, it was a week ago.</td>
<td>(Hopeful)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>So that's good.</td>
<td>(Reassuring)</td>
</tr>
<tr>
<td>Woman:</td>
<td>It's a good sign.</td>
<td>(Woman and midwife reassuring each other)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>So, the movement's OK?</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah. Yesterday, I don’t know, it’s sort of slowing down but I don’t know if that’s just because baby is getting on. Last night I sort of went to bed...</td>
<td>(Storytelling) (Introducing her uncertainty – worry)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>The characteristics change, like instead of great big flying flings...</td>
<td>(Midwife encouraging and showing she is actively listening)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah...</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>It’s more like...</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>... it just seems a bit more sluggish...</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... pushing...</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... because there’s not enough room but you still have to have the same number.</td>
<td>(Contextualising the situation for the woman) (Reaffirming worry message) (Storytelling)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Well, it’s always been crazy active whereas last night I went to bed, I’m like it hasn’t really been crazy today. Then I sat up for a little bit and I just felt – it was wriggling and squirming and doing its thing but just not as crazy as normal. But I sort of think...</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>OK, so that was yesterday. What about today?</td>
<td>(Asking for more information)</td>
</tr>
</tbody>
</table>
Woman: Yeah, it's been fine today but it wasn't until yesterday afternoon and that's normally when baby's really crazy, is at night time after I have dinner and everything, you sit there and go oh stop it. But I didn't get that last night. The only thing I could remember was it having hiccups when I was in the shower I thought that that's alright. Then when I went to bed, I was like yeah, I haven't really felt it move much since then. But, yeah, as I said, when I sat up and I had a drink – I just had a cold drink – and then it woke up a bit and I was like oh it's all right, went to bed. But today it's a bit more active. (Storytelling)

Midwife: So, you're happy with your movements today? (Seeking the woman's opinion -not telling)
Woman: Yeah. Yeah. Midwife: You're sure? (Checking)
Woman: Yeah, yeah, yeah, yeah. It's more just like – it's hard to know. It's hard to know is it just slowing down because you're getting towards the end, there's less room and it's just – do you know what I mean – or if it's something to worry – I think stress a lot. (Storytelling) (Confirming her worry and stress)

Midwife: You need to be really really aware. (High alert message)
Woman: Yep, yep. Midwife: Because we know baby is down here. You need to be really aware because that will be the first thing indicator that baby is starting to struggle. (Asking for confirmation) (Introducing her stress and worry)
Woman: Yeah and I think that's what I'm stressed about. (Introducing the option to call her to provide reassurance)

Midwife: I would rather you ring me and say baby, I'm not sure, I'm not really sure... Woman: Better not let you. Midwife: Come in, have a trace done, absolutely perfectly beautiful healthy trace, go home, everyone's happy. (Straightforward procedure) (Midwife acknowledging the woman's worry is also her worry) (Bringing hope back into the scenario)

Woman: Yep. Midwife: OK? Woman: Yep. Midwife: So, you need to ring me. If you're worried, ring. (Reaffirming the option to call her-an individual response not a system response)
Woman: I will.
Although the midwife had a heightened level of vigilance and worry throughout this conversation she made many efforts to reassure the woman. For example, she led an episode of discussing about the worry rather than just telling the woman. This appeared to moderate the worry they both had about the unborn baby and the negative effect of the system’s vigilance. In these shared discussions the midwife led with comments and questions enabling the woman to discuss her worry and tell an intimate story of her worry:

Yeah, it's been fine today but it wasn't until yesterday afternoon and that's normally when baby's really crazy, is at night time after I have dinner and everything, you sit there and go oh stop it. But I didn't get that last night. The only thing I could remember was it having hiccups when I was in the shower I thought that that's alright. Then when I went to bed, I was like yeah I haven’t really felt it move much since then. But, yeah, as I said, when I sat up and I had a drink – I just had a cold drink – and then it woke up a bit and I was like oh it's all right, went to bed. (A-MGP7)

In the next part of the conversation the midwife's checking and questioning of the woman reflects her direct and professional manner, her vigilance and her worry when she asks the woman, 'So you're happy with your movements today?' and then checks again by asking, 'You're sure?' She then indicates a level of reassurance by offering to be available for the woman:

I would rather you ring me and say [my] baby, I'm not sure, I'm not really sure ... Come in, have a trace done, absolutely perfectly beautiful healthy trace, go home, everyone's happy. ... So you need to ring me. If you're worried, ring. (A-MGP7)

Although, this midwife's language often system-focused and standardised, it also reflects her worry about the unborn baby was also informed by the woman's worry.

The analysis of these two appointments, A-SMC6 and A-MGP7, demonstrates the influence of the midwife's approach and model of care on the communication styles and the manifestation and moderation of worry. Even though a situation of acute worry attached to the wellbeing of the unborn baby was identified in appointment A-MGP7 the midwife's approach created a sense of reassurance.
6.3 Communication styles

6.3.1 Telling

The telling style of communication existed, to varying degrees, in all appointments. At its most extreme it reflected a one-way interaction with the expert midwife dominating the conversation and telling the woman information, or 'educating' her, about hospital and childbirth processes and often asking closed questions. The woman's actions were those of a passive recipient of expert care and information and often she was silent as she listened and received this information. The one-sided style of communication inhibited the woman's participation and the information provided was not individualised. In her action of telling it was more common to see the midwife introduce system-focused issues or worries rather than enabling the woman to introduce her worries. Additionally, when the telling communication style dominated there was no exploration or discussion, often leaving the worry un-moderated.

Environment and time factors, presented in the previous chapter, influenced the practice of telling, and reflected a midwife more invested in the system than the woman. The appointments where telling dominated occurred in the SMC system in the OPD and a focus on the computer/maternity care records dictated many of the midwife-woman interactions. Typically, these appointments were shorter, as the telling style was time-efficient. It enabled the midwives to complete the appointments in the allocated amount of time, which for the two OPDs in this study was 20 minutes.

Telling was formulaic, systematic and included many closed questions that resulted in women providing short phrases or singular word answers. It avoided generating complicated time-consuming conversations. During the repeated viewings of the video recordings it, at times, felt like a 'rapid machine gun' approach of 'firing' questions at the woman. With this approach, completion of the system's tasks was paramount. The midwife's telling actions were governed by the standardised,
routine and medicalised function of the antenatal appointment as a place of surveillance: as one midwife said to the woman, 'that is what we do here ... we like to keep an eye on you' (A-SMC13).

6.3.1.1 'It's like being protected or something'

Frequently, the use of the telling communication style was used to prepare and educate the woman for the hospital and her labour and birth. In appointment B-SMC17, for example, the midwife only used closed-ended questions and telling statements to educate the woman about the system and the labour and birth processes in the hospital. At one stage of this appointment the midwife questioned the woman about her knowledge of when to come into hospital with two questions, 'So you know when to call the hospital?' and 'When?' She then, went on to educate the woman about this issue or worry, which she had introduced:

... and when they're painful. If you're getting them five minutes apart and they don't hurt and you think 'Oh this is a breeze and I can talk through this'. They're not bad enough. But if you find that you cannot have a conversation when you're actually getting the contraction that's the time you ring up the birth unit. (B-SMC17)

A midwife's action of telling also represented the perceived sociocultural function of the antenatal appointment, as the place where women expected to be educated and prepared for their admission to the hospital and for their labour and birth. At the MGP focus group at Hospital A, one midwife described the central function of the antenatal appointment as 'I think definitely education on labour and birth, getting them prepared for that'. At her postnatal interview one woman indicated the midwives' telling and educating actions were protective:

Oh, I feel quite good. It's like being protected or something. Yeah, because they tell me you should doing some exercise, and they gave me books, booklet, flyers, ... And told me that you should have these to read ... oh wow they gave me so much information ... (PNI-A SMC1)

In the SMC system, I considered the midwives' reliance on the telling communication style related to them not having an ongoing connection with the women. For many of the midwives in the antenatal clinic their role was limited to
the OPD. They did not work in the birth unit or the postnatal ward. This resulted in them having minimal capacity to connect with the women and minimal opportunity to reflect, monitor or evaluate how their actions in the appointment affected a woman in other parts of her childbirth care. This was discussed in Chapter Five and related to the concept of 'repeated time'. Similar practices were also observed in the midwife-led antenatal clinic where the midwives provided continuity of care across the antenatal period. Their role of working only in the OPD resulted in them having minimal contact with a woman other than during her pregnancy. At the MGP focus group from Hospital A, a midwife reflected on her previous experience of working in the OPD describing her inability to know if the women had acted on the information she had provided:

I guess when you're working in the clinic you're not going to be there for the labour and birth. It doesn't make you care less but it's hard to give them a lot of education and know whether they're going to take that on.

(FG-A-MGP)

This comment from the MGP midwife above also confirmed it was not simply their ability to be at the woman's birth that mattered; 'doing it this way [MGP] and giving them education'. It also related to a MGP midwife having less pressure than the SMC system midwives, because 'you know you're going to see them again'. In contrast, the SMC midwives felt they had to tell the woman as much as possible as they had no expectations that they would see a woman from one appointment to another.

The midwife's comment above also reflected the typical authority that a health professional often assumes over a health recipient, as she expected or felt the need to educate the women in her care. Regardless of model of care midwives often took on the role of educator. Equally, the authority of the system over a midwife's practice is also illustrated in this statement.
6.3.1.2 'You know the signs of labour and when to call the birth unit?'

Appointment B-SMC12 was characteristic of a SMC appointment in the fragmented and busy OPD. Prior to and during the observation I noticed the midwife from this appointment was time pressured. She had other responsibilities including supervising and managing the staff of the OPD.

The midwife’s action of telling also revealed a reliance upon and obligation to the system. Her approach was ‘tick box’ and governed by the computer checklist, prompts and maternity care records. She split her time equally between looking at the computer/maternity care records (48%) and looking towards the woman (47%). Her commonest recorded body language was her sitting at the desk with the maternity care records in front of her and her facing the computer. From this position she turned her head to look towards the woman to ask questions or to tell her information, but always returned to the computer/maternity care records to read or to enter information.

The midwife’s reliance on the computer/maternity care records, which I saw as artefacts of the system, was attributed to her working in the fragmented SMC system and her not knowing the woman. At the stage of the appointment when the midwife was telling the woman when to come in or to contact the hospital rather than asking the woman information she accessed it from the computer:

Midwife: ... and that you will ring birth unit if the baby's movements are reduced?
Woman: Yeah.
Midwife: Fantastic... I'll just have a quick look at what the midwife wrote for your last visit. .... Alright, so we talked about calling birth unit (B-SMC12)

In this appointment the midwife used a 'telling' communication style for 90% of the conversation and just 10% was coded as discussing. No storytelling was coded. She rarely acknowledged the woman as an experienced mother. The communication style was formulaic, with the midwife checking, testing and telling the woman with 58% of this conversation related to clinical assessment topics; 49% related to
healthcare system issues and no conversation related to personal or social topics. The purpose of the midwife's telling actions in this appointment was based on the standardised tasks of this late pregnancy appointment. These included the routine antenatal assessments, teaching this woman about pre-labour, alerting her about when to come to hospital and alerting her about fetal wellbeing.

The midwife's approach in this appointment reflected a level of authority and expertise. She asked many closed questions and was the dominant talker. She talked for 80% of the conversation. I initially attributed the woman's quietness and passivity in this appointment to English not being her first language. However, later in the appointment the midwife said; 'OK, so Healthy Eating for Pregnancy, I'll mark that page for you and you can have a read. Can you read English?' and the woman responded 'Yes, of course.' (B-SMC12) Although the woman did not see language as a barrier to her interactions with the midwife, I reflected that the differences in ethnicity between her and the midwife may have influenced the midwife to be more direct in how she communicated. I also considered that this language and cultural barrier may have caused the woman to be passive, as it may have been culturally inappropriate for her to engage in a discussion with the expert midwife.

The midwife's system-focused approach and authority, however, was tempered by kindness. At a late stage of the appointment I recorded in my field diary that she was 'tough, but not unkind' and 'leaning in and looking at woman'. She was attentive to the woman when not interacting with the computer or medical file. When she was looking towards the woman or directly interacted with her she used a complex mixture of nods and smiles when talking and used frowns or had inquisitive looks on her face when she asked questions.

Regardless of her kindness in this appointment, the midwife's actions and words introduced worry to the woman and she did not moderate this for the woman. The next segment of the appointment, presented in table 23 (next page), shows the negative effect of the directive and formulaic nature of a standard healthcare interaction, where telling dominates.
Table 23: Analysis examples from appointment – B-SMC12 – when to call the hospital

<table>
<thead>
<tr>
<th>Talker</th>
<th>Appointment conversation</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife:</td>
<td>Yeah and you know the signs of labour and when to call the birth unit?</td>
<td>(Checking)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td>(Responding to closed question)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Did the midwife talk to you about that last time?</td>
<td>(Checking)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td>(Responding to closed question)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Yeah, so can you tell me what they are?</td>
<td>(Testing)</td>
</tr>
<tr>
<td>Woman:</td>
<td>The numbers?</td>
<td>(Responding to open question-unsures)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>When you would ring birth unit?</td>
<td>(Testing)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Oh, she didn’t talk [unclear]</td>
<td>(Unsure)</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Oh OK, so if you have the regular contractions ...</td>
<td>(Reminding)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Oh OK.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... That are increasing and getting close – increasing in strength and lasting longer and getting closer together.</td>
<td>(Formulaic information - reminding)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>So around five minutes apart I think with you. If you think it’s coming sooner then you ring earlier ...</td>
<td>(Individualising standard information)</td>
</tr>
<tr>
<td>Woman:</td>
<td>OK.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... Yeah, because you would know with – you made it to the hospital for all your previous pregnancies?</td>
<td>(Reassuring woman reminding woman of her expertise)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>You haven’t got too far to come?</td>
<td>(Checking)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... [suburb]?</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>OK, so that’s the contractions. We’ve talked about fetal movements, if they’re reduced you always ring birth unit and come in.</td>
<td>(Reminding, formulaic telling, directing)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Oh OK.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>If your waters break you need to come in, so that can happen before labour starts but we always want you to come in and get checked out because of the risk of infection if your waters break.</td>
<td>(Formulaic, telling, directing)</td>
</tr>
<tr>
<td>Woman:</td>
<td>OK.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>Don’t stay at home, so you always must ring first, put a pad on because they’ll want to see what the colour of the fluid is.</td>
<td>(Directing to institutional requirements)</td>
</tr>
<tr>
<td>Woman:</td>
<td>OK.</td>
<td></td>
</tr>
</tbody>
</table>
In this segment of conversation, the midwife's worry associated with her 'making sure' dominated. She was making sure the woman knew the standard admission processes for the birth unit and her getting to the hospital in time. Worry was seen with the midwife's repeated use of high alert commands, for example, 'ring earlier', 'always ring ... come in', 'you need to come in', 'we always want' and 'Don't stay at home ... you must'.

Similarly, the midwife's question, 'Did the midwife talk to you about that last time?', showed the negative influence of the standardised and fragmented system. Not only was she 'making sure' by teaching the woman about when to come into hospital for her labour and birth but she also appeared to test the woman's knowledge and comprehension with her question, 'Yeah, so can you tell me what they are?'. Her next action, not waiting for the woman's answer, reinforced her authority. Regardless of the woman's parity, she appeared unsure of the woman's knowledge and was reciting generic information, saying, 'Oh OK, so if you have the regular contractions ... that are increasing and getting close – increasing in strength and lasting longer and getting closer together.'

The midwife's use of formulaic and routine language also reflected the dominance of the standardised, medicalised and fragmented system of care. Two examples were:

If your waters break you need to come in, so that can happen before labour starts but we always want you to come in and get checked out because of the risk of infection if your waters break. (B-SMC12)

Don't stay at home, so you always must ring first, put a pad on because they'll want to see what the colour of the fluid is. (B-SMC12)

The midwife's use of formulaic and alarming language in association with the spontaneous and physiological event of 'waters break[ing]' escalated it to an incident of worry. Her comments in these two examples 'we always want you to come in and get checked' and 'they'll want to see' signalled the breaking of waters to be dramatic and worrying. Her comments; 'to get checked', to 'check ... the risk
of infection' and 'to see ... the colour' also signalled the system to be safe and the
best place to assess and manage these risks for the woman. The midwife's action to
combine these phrases with the pronouns 'we' and 'they'll' created an image of the
system being the higher authority and the midwife, as a representative and
employee of the system, and as a higher authority who the woman was expected to
derer to and place her trust in.

In addition, in this segment of conversation, the midwife was 'doing the right thing'
just in case others did not. At the end of this appointment observation this midwife
told me that her focus in the appointments was to teach and educate the woman.
This was because her experience in the OPD was that the women did not always get
the right information from other midwives or doctors:

... she was running late as she had to spend more time with woman in the
previous appointment who had questions about her thalassemia trait that
no one had explained to her and she needed to spend extra time
explaining the condition to her. She blamed this on the woman not having
any continuity of care with her antenatal care in the OPD. (field note
10052013)

The midwife's actions in this segment of conversation showed little focus for the
woman or her worries. She did not seek to clarify or confirm with the woman about
the information she has introduced. She did not focus on or identify what concerns
the woman had about her upcoming labour and birth. The midwife made only two
attempts during this segment of conversation to individualise the situation or
moderate the worry she had introduced. This was seen when she said, '... Yeah,
because you would know with – you made it to the hospital for all your previous
pregnancies' and when she said 'So around five minutes apart I think with you. If
you think it's coming sooner, then you ring earlier ...' Regardless, the midwife
continued to introduce worry about getting to the hospital in time with alert
messages.

The field note I wrote in my diary after observing this appointment and after the
midwife had directed the woman to have a CTG and had booked her into see the
doctor for her next appointment captured a series of standardised and medicalised
actions: 'woman is directed onto the conveyor belt of the system' (field note B-SMC12 10052013). In this appointment the midwife's worry was based on 'making sure' and 'doing the right thing'. Rather than reassuring the woman about her individual worries she was preparing the woman for the next fragmented phase of her maternity care.

6.3.2 Discussing

The communication style of discussing occurred in most appointments and occurred more when the factors of environment, time and investment operated in a positive way. It occurred more in the MGP appointments and those situated in the woman's homes. In contrast to telling, discussing reflected a more equal and reciprocal interaction where the midwife and woman shared information and learnt from each other. It enabled the women to contribute to the conversation and at times direct it, which enabled them to introduce their worry into the appointment and prioritise it over the standard healthcare requirements.

When the midwife-woman interactions included discussing, and storytelling, there were more shared verbal and non-verbal interactions, instead of the midwife principally interacting with the computer/maternity care records. Discussing involved the midwife and the woman talking, asking questions and providing answers. Typically, discussing conversation segments started with an open-ended question, which appeared to be an invitation for the woman to talk about her situation and prioritise her issues or worries. Table 24 (next page) lists a number of questions that preceded a segment of conversation identified as discussing.
Table 24: Examples of appointment questions that preceded an episode of discussing

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Who asked</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-SMC1</td>
<td>Midwife:</td>
<td>OK. Tell me, how are you going?</td>
</tr>
<tr>
<td>A-SMC14</td>
<td>Midwife:</td>
<td>Now, just talking about the baby. Tell me a little bit about him</td>
</tr>
<tr>
<td>A-MGP8</td>
<td>Midwife:</td>
<td>... So, you're just going to finish up this week then? What are you going to do?</td>
</tr>
<tr>
<td>B-MGP16</td>
<td>Midwife:</td>
<td>Anything else that you've done differently since this has been happening?</td>
</tr>
<tr>
<td>B-MGP16</td>
<td>Woman:</td>
<td>... What can I do in labour so it [hip] doesn't hurt as much? Because I think if I squat it's going to really hurt. I tried to squat and I was like oh, it just really hurts right in there</td>
</tr>
<tr>
<td>B-MGP19</td>
<td>Woman:</td>
<td>Have you had that yourself? Like people that usually have easy pregnancies so...</td>
</tr>
</tbody>
</table>

Discussing was the connexion between telling and storytelling and negated some of the power dynamics between the midwife and woman. Despite this, many of the discussing interactions still showed a level of power and authority reflective of a healthcare provider-recipient interaction. Compared to storytelling, discussing was informed by the clinical purpose of the appointment rather than a social purpose. In appointment A-MGP8, for example, the midwife and woman discussed the woman's expected date of birth.

  Midwife: Let's have a look exactly how far along, so not long to go. Sixth of June?
  Woman: No, it's not. It's going so quick.
  Midwife: Yeah, it feels like it's gone really quick since our first visit. So today, what are we, seventh of May
  Woman: One, two, three, four, so 35 weeks and four days.
  Midwife: Four days is it?
  Woman: Something like that. I don't know, I just personally ...
  Midwife: I've got 35 weeks and five days, does that sound about right?
  Woman: Yeah, that'll do. (A-MGP8)

By talking about their feelings associated with the pregnancy passing by quickly, rather than it being just about the facts of the pregnancy, they were sharing and empathising with each other. However, the midwife continued to look through her diary to find what she thought the exact date was while the woman talked. This
reflected the midwife's authority. She directed their conversation to this topic and she closed the conversation down when she confirmed what the expected date was.

6.3.2.1 'So it sounds like you're going to let us know'

In appointment A-MGP9, discussing style made up 65% of the conversation storytelling 30% and midwife telling 5%. It was a typical MGP appointment. It took place in the woman’s home and their conversations indicated they knew each other. The midwife spoke for 60% and the woman for 40%. Much of their conversation was about the upcoming labour and birth and postnatal period, with only short periods dedicated to assessments and tasks. Their discussing enabled them to share the expectations they had for the upcoming labour, birth and postnatal events, creating a shared understanding:

Midwife: Massage too. How did you feel about being touched in labour, do you remember?
Woman: No, actually I can't remember.
Midwife: Some women when they're having contractions or they're in labour it's, don't touch me, don't touch me and then other women don't mind, actually like massage on their back.
Woman: I was – there was actually massage was helping maybe still in the home, because I didn't have big and strong pain but when we came in hospital I didn't want nobody to touch me, because I was in big pain and I didn't want anything then.
Midwife: So it sounds like you're going to let us know.
Woman: That's it, yes.
Midwife: Because that's the only other thing I want to say is if for some reason I started massaging you or doing something like that and you didn't like it, then this is your labour. Whatever makes you feel comfortable
Woman: That's it, yeah.
Midwife: ... is what we're there to do. So if you don't like it you just say, stop, I don't like it.
Woman: Yeah and I don't know how it's going to be, maybe I'm going to be, yeah, I wanted something or maybe I'm going to be saying, look, just leave me alone. You never know.
Midwife: You'll let us know?
Woman: Well ... [Joint laughter] (A-MGP9)
The midwife starts this conversation about massage by asking the woman her opinion and her experience; 'Massage too. How did you feel about being touched in labour, do you remember?' This invites the woman to share her knowledge. Then the midwife's next comment after the woman replied, 'No, actually I can't remember' introduces the idea that massage is optional and personal choice. The woman's response to this statement tells the midwife her experience of massage did not help her when she was in established labour. Then their shared conversation, which had episodes of storytelling as well, enabled the woman to reject the midwife's idea of massage. The midwife's next comment, which showed she accepted the woman's ideas, knowledge and experience, 'So it sounds like you're going to let us know', reflected equality, reciprocity and trust.

6.3.2.2 'Whatever makes you feel comfortable'

Midwife investment in the woman, which I termed woman-centred investment in Chapter Five, was another positive characteristic associated with the communication styles of discussing and storytelling. In the above segment of conversation from appointment A-MGP9 about massage, the midwife's investment was apparent when she said, 'Whatever makes you feel comfortable', indicating she respected the woman's wishes and would not want to massage her inappropriately. Midwife investment was also seen when she explained to the woman that her role was to abide by the woman's choices and decisions, 'So if you don't like it you just say, stop, I don't like it.'

6.3.2.3 'Oh good. OK, that's good then. All right. What else is different last few days. Anything different?'

Woman-centred investment and the associated shared communication styles of discussing and storytelling occurred more often in MGP appointments than SMC appointments. Although some midwives in the SMC appointments encouraged and used the discussing style these periods of shared conversation were mostly associated with the antenatal tasks and assessments and were not linked to future events. Unlike the MGP midwife, the connection that these SMC midwives created
with the women rarely appeared to go any further than the here and now of the appointment. An example of this was seen in an episode of discussing in appointment A-SMC1, when the midwife returned to the worry the woman had raised early in the appointment about having headaches. In this segment of discussing, shown below, the midwife assessed the woman's headache with a number of open-ended questions, enabling the woman to talk about her headache and raise other worries. It did not reflect the typical disjointed yes-no question answer format observed in other SMC appointments, but it also did not reflect connection:

Midwife: ... OK. You said you've been having some headaches yesterday, as well?
Woman: Yeah, that's right.
Midwife: Only just yesterday morning?
Woman: And today, this morning
Midwife: And today. It's when you get up?
Woman: That's right, when I get up. But I try and eat breakfast ... I feel better.
Midwife: You feel better?
Woman: Yeah but...
Midwife: After some food?
Woman: Yeah, after I had some food.
Midwife: OK. So you're eating well throughout the day?
Woman: No – actually when I had – after I ate some food this morning I back to bed for a few minutes, I still have a little bit headache as well. Around here. But probably after one or two hours it's gone ...
Midwife: it's gone?
Woman: Yeah ...
Midwife: ... Drinking plenty of water?
Woman: Yeah, that's right.
Midwife: Yes. What's plenty for you? How many glasses a day?
Woman: Like I have a bottle like this. Sometimes I will have three pints for the morning
Midwife: OK, so you drink plenty.
Woman: Yeah.
Midwife: Oh good. OK, that's good then. All right. What else is different last few days. Anything different?
Woman: Last few days, oh maybe it's two things. ... Well sometimes I feel like [this] goes a bit tight. ... Just for this one. We feel the baby's movement, we're just wondering maybe because I feel
the movement is not as many as used to be, probably we do some research and we found out probably because he's going to deliver soon

Midwife: So you don't have as many movements, that's what you're trying to say?
Woman: Yeah, that's right. ...
Midwife: OK. Let's just stop – one thing at a time because you went from the [your] head to the movement... and we are going spend more than 15 minutes. Let’s start with your blood pressure. (A-SMC1)

6.3.2.4 'I'm a rebel, I get in trouble for spending so much time with the women when they need it'

In appointment A-MGP9 the midwife also oscillated between being woman-centred and system-focused. At the end of the observation of this appointment I spoke to the midwife prior to us getting into our cars. I recorded some field notes, which included the midwife saying: 'I'm a rebel, I get in trouble for spending so much time with the women when they need it'. This comment was in response to me remarking that the appointment had lasted a long time (80 minutes). Although I saw her rebel status as a reflection of her woman-centred investment, some of the midwife-woman interactions in this appointment were standardised and system-focused. In total 63% of their conversation was coded as social and about personal topics, 22% of it was jointly coded for personal and clinical topics and 15% included joint coding of personal and system related topics.

In this appointment the midwife and woman shared the conversation. Discussions and stories led by the woman were about her previous pregnancy and labour experience and the midwife led discussions and shared stories of other women's experiences of labour and the system. The midwife talked for 60% of the appointment and the woman talked for 40%. The midwife was less directive, less definite or certain and more suggestive than other appointments.

In this appointment the influence of the MGP and its MCOC principle positively influenced many of the midwife-woman interactions. The midwife had minimal interactions with the maternity care records (15% of the appointment time), which I
related to her knowing and being familiar with the woman's individual situation. For example, these midwife-medical record interactions occurred after a conversation or after an assessment, not before, and were related to her documenting information.

Their conversations were free flowing and showed a level of familiarity. The midwife introduced personalised and individualised options to manage or deal with the worry or issues raised in the appointment. An example was when they discussed the older child’s toilet training:

Midwife: How's the toilet training going? Or did you abandon that again? [Laughs]
Woman: It's bad [Laughs]
Midwife: It's hard in winter too, isn't it?
Woman: She's sick now, not because I didn't push her ... I felt a bit sorry for her
Midwife: It's hard quite often. Many, many women are pregnant and think we need to toilet train. ...
Woman: Yeah, before this baby come. I don't want two babies in nappy. (A-MGP9)

Although the woman used a story to explain and emphasise her worry and negative experience of toilet training, the midwife's actions were more associated with the discussing style. She listened, affirmed and then shared the experiences of other women to reassure and empathise with the woman. More information about storytelling is included in the next section of this chapter.

This shared conversation also reflected more of a social interaction than a standard healthcare interaction. The worry central to this conversation was not that of a standard antenatal appointment but it was important to the women and this was recognised by the midwife. It reflected peer or friendship interaction, not a healthcare provider-recipient interaction.

Body language in this appointment was relaxed and exhibited familiarity. This appointment took place in the woman's lounge room, and apart from the abdominal palpation and blood pressure measurement, they sat together on the woman's couch. No computer interrupted their interactions and the maternity care
records were placed between them or nearby on either the couch or coffee table. The midwife looked towards the woman 83% of the time and the woman looked towards the midwife 87% of the appointment time. They frequently turned towards each other while they sat on the couch, mirrored each other's body language, smiling, frowning, nodding, shaking their heads and leaning in and out, and had many episodes of shared laughter.

6.3.2.5 ‘I really think it's important to spend time when the women need’

The feature of repeated time associated with the MGP appointments, discussed in Chapter Five, was a positive influence on the midwife-woman interactions, as more discussing, and at times storytelling, appeared to take place because of it. It enabled them to get to know each other and for the midwife to be familiar with the woman's individual worries and issues. The repeated meetings associated with the MGP appointments enabled the midwife and woman to revisit worries, creating more opportunity for them to be moderated. After the observation of appointment A-MGP9, for example, the midwife said to me:

I really think it's important to spend time when the women need, as it decreases their anxiety and also often the length of time for the next appointment.  (field note 07052013)

For this midwife 'spending time' with the woman was based on the needs of the woman rather than system. In this way the midwife adapted or worked around the standardised system and this enabled both her and the woman to moderate the woman's worry. From the midwife's perspective this had benefits because 'it decreases their anxiety' and 'the length of time for the next appointment'.

6.3.2.6 'So maybe I'm better to ask, what you want for your labour, instead of me throwing all these different things at you?'

The midwife's actions in appointment A-MGP9 demonstrated an ability to adapt the standardised practices of the appointment, creating more social interactions and the ability to focus on the woman as she completed the task and assessments. For example, she adapted her use of the hospital's birth plan document. Initially when
the midwife used the birth plan she used it as a checklist, which standardised the conversation resulting in a question-answer format and telling the woman information, for example, 'But do you know about the morphine and epidural and how they work and things like that?' Then, later in this conversation, when the birth plan was being used, the midwife altered how she used it and their conversation flowed more; 'it gives us ... an idea of what you want ...'. This comment altered the conversation from being directed by the birth plan to the birth plan being used more as a tool to encourage a discussion about the woman's preferences. Then later the midwife completely disassociated herself from the birth plan;

so some of these questions – this is a really ... old birth plan ... so some of these questions are a bit funny ... so maybe I'm better to ask, what you want for your labour, instead of me throwing all these different things at you?  (A-MGP9)

Her use of the birth plan was a standard procedure for Hospital A at the 36-week appointment and reflected the hospital's governance over her practice. A manager confirmed this directive, which I recorded as a field note, when I stated that I had observed all the midwives at Hospital A using the birth plan:

We now use birth plans at the 36-week visit, as a standard, to ensure they [midwives] provide women with all the appropriate information. I personally don't like it, but we've found that some women came into hospital in labour had received no information from the midwives in the antenatal clinic. (field note A-Manager 27062013)

The midwife's efforts to adapt how she used the birth plan reflected her being woman-centred. In a later part of the birth plan conversation, for example, she stated to the woman, 'Some things we can't plan for, we don't know what's going to happen ...' Initially this was seen as a negative statement implying a level of uncertainty for the upcoming labour and birth, regardless of the level of planning done in this appointment. However, during a later stage of analysis, this comment was seen to reflect a level of authenticity, familiarity and understanding of the anxiety and worry that this woman had about her upcoming labour and birth.
6.3.2.7 'So, contingency plan in case things happen quickly'

In contrast to appointment B-SMC12, the segment of conversation in appointment A-MGP9, about the woman 'getting to hospital in time', included more discussing of this worry than the midwife telling the woman what to worry about. Their sharing and discussing enabled the woman to be involved and to create solutions or moderate this worry herself. During this conversation the midwife supported the woman to focus more on what was important to her rather than being directed by the worry of the standardised system of care (see table 25).

Table 25: Analysis examples from appointment A-MGP9 – contingency plan

<table>
<thead>
<tr>
<th>Talker</th>
<th>Appointment conversation</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
<td>That's right. Now, you had a fairly quick labour for a first baby with your first. So generally – a lot of the time next babies can be a bit quicker. So contingency plan in case things happen quickly and you need to get to the hospital. So, if you need to get to the hospital quickly, because things are starting to happen very quickly probably it's a good idea to call whoever’s going to look after Laura [her other child], take her in the car with you to the hospital and get them to meet you at the hospital and pick her up from there.</td>
<td>(Acknowledging) (Less certain) (Less certain and using an example or story from her experience) (Other options) (Less certain) (Woman’s need – individual) (Softer, less directive and more suggestive – offering a solution) (Knows the woman's needs)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah, that’s actually a good idea. But they are able to reach – they’re just two minutes away.</td>
<td>(Discussing – declining midwife solution with her own solution) (Positive)</td>
</tr>
<tr>
<td>Midwife</td>
<td>That’s good, that’s fine.</td>
<td>(Acknowledging and confirming) (Positive)</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah, they’re close; his brother and his mum and dad, when the baby is here.</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>That’s good. So, you’ve got a few different options there.</td>
<td>(Choice, flexibility)</td>
</tr>
</tbody>
</table>

The midwife’s discussing style of communication was less definitive than with a telling style and also reflected the influence of the system and a focus on the woman. Also, this pattern of discussing invited and enabled the woman to be part of the conversation.

There was a mixture of messages from the midwife; for example, the midwife
acknowledged and individualised the woman's situation, 'Now, you had a fairly quick labour ... with your first', which identified that her worry was based on the woman's individual situation. Her next statement, 'So generally – a lot of the time next babies can be a bit quicker', then showed that her worry was informed by the standardised system of care and her previous experiences as a midwife. The mixed messaging was also associated with the midwife's use of both high alert word and words that moderated and reassured. High alert word included; 'happen quickly' and 'very quickly', which emphasised this as an issue or worry, while words used to moderate and reassure included; 'fairly' and 'generally'. Regardless, the midwife's language around this issue of worry upheld a positive message of reassurance that not every labour and birth experience is the same and that there are different ways to experience them and or manage them, for example, 'So, contingency plan in case things happen quickly and you need to get to the hospital.' Her use of the word 'contingency', was also less directive and introduced the idea that there were other options. This was then reaffirmed with the next part of the midwife's conversation, 'So, you've got a few different options.'

The midwife-woman interactions and conversations in this segment of conversation also reflected a sharing of power, respect and reciprocity. The woman acknowledged the midwife's idea of how to look after the older child if the labour was quick; 'that's actually a good idea'. More importantly she was able to decline midwife's solution to the worry and propose her own solution; 'But they are able to reach – they're just two minutes away'. Likewise, the midwife's positive response to the woman declining her solutions reaffirmed the woman's authority. As did her acknowledgement that the woman was able to manage this herself, 'So you've got a few different options there'.

### 6.4 Storytelling

Storytelling occurred more often in the MGP appointments and those located in the women's homes and included the midwives and women sharing stories about their
past experiences and future expectations. They were co-created, included a story requester/listener and a storyteller, and unfolded in two ways. The first was when one person requested the story and then listened while the other person told their story. The second way was when one person started with a personal story and the other then requested more of the story or reciprocated by adding her own personal story.

Storytelling aligned more with a social interaction than a standard healthcare interaction. It encouraged interaction and connection through reciprocity and mutuality and altered the power dynamics of the midwife-woman interaction to be more shared and equal. Importantly, it aided the woman to have greater understanding of the topic at hand, enabling her greater capacity to consent to or decline care. In some situations, storytelling moderated the worry created by the standardised assessment and screening practices of the antenatal appointment. Through their sharing of stories, the midwives and women also solved problems and created connections, which again created opportunities for their worry to be moderated and for hope and optimism to be fostered.

6.4.1 'Do you do that?'

During appointment A-SMC13 an episode of storytelling occurred when the midwife shared her personal experience of managing her weight. It was an attempt by the midwife to moderate the woman's worry, while at the same time creating connection and equality. In this example, the woman's worry about her weight had been triggered earlier in the appointment when the midwife, as part of her standardised antenatal assessment, asked the woman to weigh herself.

Midwife: All right? Now let me help you up [from the examination couch]. I want you to put one hand there. There we go. Now, I like to weigh.

Woman: Of course you do. Because I'm overweight?

Midwife: No. We just like to keep a track and see how things are going. So I'll get you to weigh yourself and you keep your shoes on. Just wait until it goes to zero. That's it. 66.3, really good. OK. (A-SMC13)
Then later in the appointment the woman returned to her worry about her weight when she asked the midwife 'with the whole weight thing, was it 10 to 15 kilograms that they say?' The midwife's first response to this question reflected a standardised offer of reassurance, by telling, or giving information.

Look that's in a textbook. Some ladies in their first pregnancy they'll put on like 20 kilograms, some will put on five kilograms. As long as your belly is growing it doesn't really, yeah. Your body mass index wasn't big to start with so I'm not too concerned at all with your weight gain. So you're doing really, really well. I just want to keep you right on track. (A-SMC13)

However, this response did not reassure the woman, as she responded indifferently with 'Yep, that's what I want.' At this stage of the conversation the midwife's style of communication changed. She moved from a standardised response to sharing a story about her personal issues with managing her weight:

Or you end up like me and then it's really hard to get – it's so hard. After 40 it's bad and you don't want to end up like that. See I used to eat maybe an apple, really bad. When you're younger, cigarettes, apple, coffee, that's it. You know but then when ...

(A-SMC13)

The midwife's action of sharing her story about her issues with weight gain appeared to transform the woman's worry about her weight gain. It also created a positive change in their interactions and appeared to reduce or change the position of power held by the midwife, which had been established by the midwife's standardised practises and actions seen earlier in the appointment. At this point the woman responded positively and with some empathy to the midwife's story; 'But when you get older you can't'. This invited the midwife to continue sharing her story; 'Then what I do is if someone doesn't eat their leftover – like if they're not eating dinner, I can't throw it out so I'll just eat it.'

A change in their power dynamics in the next part of this conversation was seen when the midwife asked the woman 'Do you do that?' This question aligned the midwife with the woman, as it revealed a personal vulnerability and sought the woman's approval. It also created an opportunity for the woman to connect as she was asking the woman for her experience, which then occurred when the woman...
responded by sharing some personal information about herself; 'No because my husband eats every bit of food there is.'

This action of storytelling by the midwife also enhanced the appointment. The midwife's story was personal, indicated a level of empathy and equalised their power. It created reassurance and connection with the woman and also fulfilled the standard healthcare action of providing a message about maintaining a healthy weight through healthy eating.

6.4.2 'Yeah .... that makes sense'

Another example of a midwife using storytelling to reassure or moderate a woman's worry was seen in appointment B-MGP4 and involved the midwife providing the woman information as part of a story to help her answer the woman's questions about transition of labour. This example is presented table 26 (next page).
Table 26: Analysis examples from appointment – B-MGP4 – yeah that makes sense

<table>
<thead>
<tr>
<th>Talker</th>
<th>Appointment conversation</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman:</td>
<td>Generally, how long does it go for [transition], just two to three ...</td>
<td>Worry, open-ended question</td>
</tr>
<tr>
<td>Midwife:</td>
<td>Oh, it depends. It really depends. If you’re in the bath, normally it’s quicker ... because you have got that warm water around you relaxing you.</td>
<td>Discussing</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah ...</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>It sort of ... helps relax the ... you and the process. But it’s an important process altogether because I had – what I can remember from when I worked birth unit is I never saw a lot of transition because women would use other sort of drugs ...</td>
<td>Discussing, Storytelling</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah ...</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>And it’s so abnormal. You need transition. You need to get that anger and frustration in you and ...</td>
<td>Discussing</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah ... Ready for the next stage.</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>... the hormones, all those endorphins that keep you relaxed and calm and</td>
<td>Discussing</td>
</tr>
<tr>
<td>Woman:</td>
<td>Yeah</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td>.... able to keep going. You need [that all] to push.</td>
<td></td>
</tr>
<tr>
<td>Woman:</td>
<td>yeah .... that makes sense ...</td>
<td></td>
</tr>
</tbody>
</table>

Although this midwife’s story was not about her personal life it was a story about the personal feelings evoked by her work, which were informed by her recent experiences of water birth. This story demonstrated her change in view about the transition stage of labour being a positive experience for women rather than a negative one.

Other episodes of discussing and storytelling by the midwife and woman in appointment B-MGP4 were also seen. These also created connection and influenced the woman to look more positively and confidently toward her upcoming birth. She had a better understanding, less worry and more hope attached to it. The next segment of conversation illustrates this woman’s hope and a positive outlook:
Midwife: It's just ... Then when you actually get into the rhythm of pushing it's – you're working with your contractions, so you're not worrying about the contractions anymore, you're worried about pushing ...
Woman: Yeah really happy to push through?
Midwife: Which is good. Are you getting excited about this?
Woman: Yes, I am, I am, yes, definitely, especially the closer it's gotten towards the end ... heaps more excited ... yes. (B-MGP4)

Another example where their storytelling created this positive outlook was when the midwife and couple talked about the benefits of taking a supply of food into the hospital for the partner. In this segment of storytelling the midwife was focused on the partner and his experience of being in the hospital during the woman's upcoming labour. She was intent on informing or educating him when she said, 'How to bring your snacks and stuff. So you can be awake and alert.' However, her use of both discussing and storytelling moved it to more than a linear action of educating and drew the couple in and aroused their attention to the importance of this topic. Again, she uses a personal story of working with couple during labour and the issues of there being no access to healthy food in the birth unit:

Yeah. Suddenly it's a big thing. When I used to work in the birthing unit no-one used to bring food for the partners and they'd always be going out to the vending machines, like that's healthy, and getting chips and chocolate ... coz nothing else is available. (B-MGP4)

She then introduced another point with another story about her experiences, which is that support people can miss important labour events when they leave the birth unit to access food or other comforts:

Then they'd miss things, like you'd go outside. Some people don't want to go to the toilet because they're worried they're going to miss something there. (B-MGP4)

Her action of sharing of stories encouraged the couple to reciprocate with their story:

A good friend of ours, we were at his wedding the other week, he said to Chris they tell you pack sandwiches ... make sure ... [laughs] that you do it. ...Yeah he was in the corner making sandwiches ... [laughs]. (B-MGP4)

Another feature of appointment B-MGP4 was a level of equality between the
midwife and woman. This was demonstrated by the midwife interacting with the woman as a peer by sharing stories about her personal experiences and her personal views. Her use of personal stories enabled the woman to have better understanding of a situation that was foreign to her and enabled them to identify commonalities and create connection. The first example of this was evident early in the appointment when they started talking about a self-help or self-care book sitting on the coffee table, which the midwife had noticed:

Midwife: Yeah. I was just looking at that book over there ... are you like liking that book or...
Woman: Yes, I love it. It's from Liz ... she's a doula and she does the gentle birth method. Yeah. She's really good. Have you heard of her?
Midwife: I have, yes. I've seen that book in other people's houses actually ...
Woman: Oh really? I love it, I love it. It's awesome. So it tells you – you know about all different foods to eat. And what to eat.
Midwife: Oh really? It goes into that much detail.
Woman: Yeah. Yeah. That's what she – she's very, very strict, the lady who wrote the book. Liz was a student ... She's trained with her, but she's – and they do like reflexology... all about stomach massage. That's why I remember the olive oil ...

[B-MGP4]

6.4.3 'How long did he think it was going to take?'

Also, in the next stage of their conversation, from appointment B-MGP4, about the benefits of taking a supply of food into the hospital for the partner, their storytelling shows a level of mutuality and connection and humour. In this next example, it was the woman and her partner who were sharing their story with the midwife listening and asking for more of the story to be told.

Partner: A ... loaf of bread ...
Woman: He took a full loaf of bread!
Midwife: [Laughs] How long did he think it was going to take?
Woman: Yeah, they were there for a while
Partner: It was lifesaving.
Midwife: Where? Did she have a baby recently?
Woman: A year and a half ago.
Partner: ... yeah he took ham and cheese
Their shared humour, laughing and mutuality created a relaxed anticipation and optimism for the future labour and birth. They had a stronger sense of being part of a social interaction than a standardised healthcare interaction. As described with the above examples from appointment B-MGP4 and in the earlier section about appointment A-SMC13, page 228–229, mutuality and reciprocity were fundamental features of storytelling. For storytelling to take place, both individuals needed to be engaged and focused on each other to interact and be active; one to story-tell and one to story-request, listen, and then respond. The actions of the requester required their use of open-ended question and ongoing interaction with the other person as they told their story.

6.4.4 'It just tends to flow a bit more naturally'

Storytelling interactions included not only a sharing of conversation, but the midwife and woman needed to be attentive to each other and not focused on other objects in the room. As a consequence of their engagement with each other, the interactions during the storytelling were more complex. There was more shared conversation, a greater variety of body language and topics of conversation compared to a one-sided telling style of communication.

When storytelling occurred, there was more sharing and inclusion that reflected a level of respect. At her interview the midwife from Hospital A (MGP) commented that the appointment, 'flow[s] more freely and I think things spontaneously come up more' and 'it just tends to flow a bit more naturally'. She thought these interactions were 'more relaxed'.

For example, during the storytelling interaction from appointment B-MGP4 about bringing the loaf of bread to the labour, which lasted for 69 seconds, all three participants looked towards each other as they spoke. Figure 21 (next page) is a still clip from this interaction. The midwife is looking towards and smiling at the partner, who is not seen in this still clip, but was sitting next to his wife’s left shoulder, and
the woman was smiling at the midwife. The midwife and woman had their bodies turned towards each other and the partner on a chair close to them and facing them. This formed a triangle of interaction for this period of time. Their body language involved the listener/s physically leaning in and attentively looking towards the other individual/s who was talking. It was also relaxed, with a mirroring of actions that included smiling, laughing, nodding, frowning, shaking of their heads and the use of their hands to embellish.

Figure 21: Still clip from B-MCP4 showing storytelling interaction

6.4.5 ‘Yeah, that's right and you don't feel like it'

The moderation of worry in this segment of storytelling from appointment B-MGP4 was associated with a level of empathy. Their use of stories individualised the information, shared and promoted optimism and created a sense of hope for the future labour and birth. In contrast, the one-way telling communication style resulted in one-word responses that had minimal detail or explanation. Much of the information was not individualised and as a result the person listening did not appear to gain as much benefit as when a story was being shared.
6.5 Hope

In this study hope was identified to be the positive outlook expressed by the women, and at times the midwives, in the appointments. It was a positive expectation and optimism for the upcoming labour and birth or parenting period. Storytelling and, to a lesser extent discussing, were the most transformative communication styles that moderated the worry and had the potential to create hope. In a number of appointments, when the midwives were woman-centred and focused on the woman's worry rather than the system's, then the midwife and woman were able to moderate the woman's worry. On occasion, and as a consequence of worry being moderated, hope was created.

6.5.1 'I don't anticipate needing it now'

In appointment B-MGP3 hope was evident and associated with the communication style of storytelling. A third of the midwife-woman conversations in this appointment were storytelling, 45% discussing and 25% telling. The amount of storytelling in this appointment resulted in the conversations between the midwife and woman often being complex, nonlinear, and covering a variety of issues at any one time. In total 62% of the conversation included topics about social or personal issues, and these overlapped with the other topics. For example, 62% of their conversation related to clinical issues and 23% related to system issues. This resulted in some conversations being about all three topics, as the midwife and woman told personal stories about a clinical issue or a system issue or both.

Storytelling in appointment B-MGP3 moderated many of the worries raised and created hope in some instances. One example took place five minutes into the appointment and is presented in table 27 (next page). Also included in this table are the non-verbal midwife-woman interactions that took place during the conversation. These illustrate how the midwife and woman's physical interactions, or body language influenced the way they communicated.
Table 27: Analysis examples from appointment – B-MGP3 – I don’t’ anticipating needing it now

<table>
<thead>
<tr>
<th>Time Stamp</th>
<th>Midwife-woman interaction</th>
<th>Speaker</th>
<th>Conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:28-5:33</td>
<td>Midwife has her back to the computer is leaning on desk with one elbow, the chair and her body are turned to woman who is leaning back in her chair with one arm leaning on the desk. They are both looking at each other and woman is nodding as midwife talks.</td>
<td>Midwife:</td>
<td>I guess you said to me the last couple of times you gave birth on the bed and that’s not really what you want.</td>
</tr>
<tr>
<td>5:33-5:43</td>
<td>Woman is using both arms to gesture and shaking her head as she talks. Midwife is looking at woman, still leaning on the desk with her left elbow and her chin is resting on her hand of the bent left arm that is resting on the desk.</td>
<td>Woman:</td>
<td>Yeah, when I say on the bed, I was told to lay back and that's it. Like, I said, I want to go to the toilet, they said no. They wouldn't let me get off the bed. I said, ...</td>
</tr>
<tr>
<td>5:43-5:46</td>
<td>Midwife looks at woman and shakes her head</td>
<td>Midwife:</td>
<td>OK ...</td>
</tr>
<tr>
<td>5:43-5:54</td>
<td>Woman is using both head (nodding and shaking) and arm movements to reinforce her point. Raising eyebrows and grimacing. Midwife continues to lean on the desk and look towards woman and her face is focused on looking towards the woman’s face.</td>
<td>Woman:</td>
<td>... I need to go to the toilet. They're going, no you don't. I got really shitty, I said, I need to go to the toilet. Then they gave me a bedpan. They wouldn't even let me get off the bed.</td>
</tr>
<tr>
<td>5:54-6:04</td>
<td>Midwife moves her body to a more upright position and then settles back to her leaning position</td>
<td>Midwife:</td>
<td>Oh, that's very unfortunate.</td>
</tr>
<tr>
<td>5:55-6:04</td>
<td>They both smile at each other.</td>
<td>Woman:</td>
<td>Yeah, and then of course I couldn’t go, so then they wanted to take it away but I wouldn’t let them because it was kind of comfortable.</td>
</tr>
<tr>
<td>6:04-6:21</td>
<td>Woman smiles and uses both hands to gesture and continues to lean on the desk.</td>
<td>Midwife:</td>
<td>Just feels comfortable, yeah.</td>
</tr>
<tr>
<td>6:12-6:16</td>
<td>Woman laughs and turns to her support person. Midwife is nodding and smiling and continues to lean on the desk.</td>
<td>Woman:</td>
<td>So yeah, that's – and I was just – it was just, you had to lay there and that was that. So this time I'd rather be moving around and...</td>
</tr>
<tr>
<td>6:16-6:31</td>
<td>Woman leans back on desk and mirrors midwife's leaning position.</td>
<td>Midwife:</td>
<td>We will not have that problem. I'm pretty sure we will not have that problem.</td>
</tr>
</tbody>
</table>
| 6:21-6:31 | | Woman: | Yeah, I don't want to be kind of stuck. I don't want to be stuck like that [Doula: bed will be out of the room] I think most of the births that I've recently had were in the bathroom,
She has her right arm resting on her elbow with her hand of this hand near her face and the midwife has her left elbow resting on the desk with her chin resting in her left hand. Both are nodding in unison. and I think at least half of them would have been on the toilet.

6:31-6:36 They continue to nod, then laugh and smile at each other and woman then shakes her head and smiles.

Woman: That's fine. Well this last — they wouldn't let me do anything else.

6:36-6:50 Both mirroring each other's leaning action on the desk and nodding and smiling.

Midwife: So we want to be doing — what we want to be doing, as far as all the other things that are available for pain relief, you've done very well without anything before, so I don't expect any demand for...

6:49-7:06 Woman leans back and uses her hands to gesture her points: she grabs her little finger to signify a point and then waves her hands with each other point. Midwife is nodding and continues to lean on desk.

Woman: Yeah, what I've gone through the last times, and same philosophy this time, is if I really need it, I'll give something a go, but I haven't needed it in the past so I don't anticipate needing it now. What's happened the last — they've given me pethidine before and I don't think it did anything.

In this conversation a number of the woman's worries about her upcoming labour were revealed and moderated, leading to her becoming hopeful and optimistic. These worries included a concern about her upcoming labour and birth, her having the right to choose, the effect of the standardised health care system and the clinical care she receives.

During this short segment (1.38 minutes) the midwife and woman's conversation and body language demonstrated congruence and connection with a shared concern or worry about the woman's past negative labour and birth experience. Connection was seen in the symmetry of their physical interactions and with the mirroring of each other's body language. For a large proportion of this conversation and other parts of the appointment they looked at each other while they talked, they nodded and shook their heads in response to each other's comments, and they leaned in towards each other while they talked and listened.

In the majority of appointment B-MGP3 and in this segment of the conversation the
midwife conversed and connected with the woman about her individual worries. It was also evident that the woman had raised these worries previously. For the majority of this appointment the midwife's conversation and body language were relaxed, open and focused solely on the woman. In this segment of conversation presented in table 26 (previous page), for example, the midwife listened to the woman more than she talked. She also provided a receptive space or environment for the woman to share her experience by positioning her back to the computer, leaning on the desk and on the medical record and leaning and looking towards the woman. By creating this space, the woman was able to talk and share her stories about her worry. These stories enabled the midwife to gain a greater understanding of what the woman was worried about. With this shared understanding they were then able to make a plan that provided reassurance and created a level of hope for the woman's upcoming labour and birth. The woman started with stories of worry about her previous births and by half way into this conversation she was able to state what she wanted this time: 'So yeah, that's – and I was just – it was just, you had to lay there and that was that. So this time I'd rather be moving around ...'

The midwife initially attempts to reassure with comments such as, 'We will not have that problem. I'm pretty sure we will not have that problem,' but with minimal effect as the woman reiterates, 'Yeah, I don't want to be kind of stuck. I don't want to be stuck like that'. However, the woman becomes more hopeful when the midwife shares with her that she is a midwife who encourages women to labour off the bed: 'I think most of the births that I've recently had were in the bathroom, and I think at least half of them would have been on the toilet.'

At the end of this conversation the woman's anticipation of not needing any analgesia was associated with her having a level of hope and optimism.

In this appointment B-MGP3 the midwife led many other episodes of storytelling and discussing, which also reflected her positive approach to childbirth. For example, the midwife used a recent work experience to reflect positively about childbirth:
I was looking at this baby today that was born yesterday, and she was really alert and just had a bit of a breastfeed and kind of lying – the three of us sitting on the bed and she was just lying in between us and we’re all watching her, and she just looked so surprised. Like, you could see this little face going, what just happened? What's going on here? (B-MGP3)

The sharing seen between the midwife and woman, in their conversations and interactions, transformed and influenced this appointment to be a place of humour, laughter and hope creation. It was embedded in positive and optimistic social interactions rather than routine standardised healthcare interactions. Frequent episodes of laughter occurred. During this next statement by the woman they were both smiling and laughing as she shared a story about one of her children.

My youngest son, we were watching TV last night, and I just couldn't get comfortable, you know, whatever, and he's leaning on me. I'm like, don't lean on me, but he's leaning on me anyway. Then he's whack [hits the woman's stomach]. He's gone, oh. I said, you better get used to that. (B-MGP3)

Later in this appointment, during the blood pressure assessment, the midwife, woman and her support person laughed and joked together about space on the card and space for the baby:

Midwife: See. It's not just me who is uncomfortable. OK, let's check this [blood pressure]. Beautiful. Wonderful about 118 over 55, so very good. You're running out of space, you really need to have a baby.

Woman: Yeah, I'm running out of space everywhere, love. It's not confined to the card [shared laughter].

Midwife: You know, it's not really looking that big. It's not really that spectacular.

Woman: Laughs ... It feels it.

Midwife: I think you're just ...

Support person: Because we're not carrying it, that's all.

Midwife: That's right. It always looks better on somebody else than on yourself, doesn't it? [shared laughter]

Woman: I was talking to someone today, she laughed when I said I went on the treadmill, she laughed at me. I felt like saying, it's not funny. It wasn't funny [shared laughter]. (B-MGP3)

In appointment B-MGP16 the transformation of worry to hope was also seen when
the midwife and woman were planning for the upcoming labour and birth. The midwife-woman interactions and conversations had similar features to those in appointment B-MGP3 where hope was created. For example, as is shown in the next conversation segment, the woman was main talker and the one who raised most of the worries. These worries were hers and not those imposed on her by the midwife or the system. Here her worry was about recognising the start of labour.

Woman: OK. With posterior baby, if it still stays posterior, there's a chance it breaks earlier in labour – is that correct or not?
Midwife: Not in my experience but it could be.
Woman: Oh OK.
Midwife: I don't see a reason why it would break earlier.
Woman: Only because it happened with James, I just thought ...
Midwife: Yeah. That's why it is a new experience because your [water's] broken and things started happening from there. Hopefully this time will be the other way around.
Woman: OK. Contractions first and then – but it's not a big deal if I'm like three or four minutes apart and then they break – that's normal?
Midwife: Yeah.
Woman: OK. I'm so happy. I'm getting a bit nervous.
Midwife: Don't be too nervous.
Woman: All right. So I'll just ring when that – and you're on from Monday next week? All right, cool. So hopefully not over the weekend. I don't know, I don't think so but I'm always wrong.
Midwife: Well let's hope this time you're right. (B-MGP16)

In this appointment the woman showed a lot of worry and asked many times 'is it normal'. However, in this appointment the midwife and woman relied on episodes of storytelling and discussing to moderate these worries. It was these interactions that transformed many of the woman's worries to hope. At the end, for example, the woman was seen to be hopeful about the upcoming labour when she stated, 'OK. I'm so happy. I'm getting a bit nervous'.

Likewise, in appointment B-MGP19, where there were many personal topics raised, a strong sense of hope and optimism was seen. In total 35% of the conversation included the communication style storytelling, 55% discussing and 10% telling. Their conversations were relaxed, for example in the next conversation segment they
chatted about the woman's due date and the midwife being away on holiday.

Woman: I thought everyone was kind of close to my date but we're kind of spread out, are we?
Midwife: Yeah, you're spread out because I'm actually going away for a week for my brother-in-law's wedding.
Woman: Oh that's good.
Midwife: So like I didn't have anyone due for a little while, while I'm going to be away. Then you're my next after I get back.
Woman: Yes, because I'm still a few weeks away.
Midwife: Yeah.
Woman: Oh no, it's good for you to have a holiday because you do such long hours.
Midwife: Yeah, well this one is not really a holiday it's just...
Woman: Where are you going, Queensland or something?
Midwife: It's Malaysia...
Woman: Oh.
Midwife: ... because he's getting married here and then because our family's over in Malaysia, we have a wedding over there, well, not a wedding but like a big banquet with all our Malaysian family.
Woman: Yeah. (B-MGP19)

In appointment B-MGP19 the woman was again the main speaker, which was also linked to her raising her worries and for these to be moderated. In this appointment the woman talked for 66% of the conversation.

Another example of the association between worry generation and moderation and the creation of hope occurred towards the end of appointment B-MGP19 when the woman shared a story about her birth classes and revealed the hope she had for her birth and becoming a family.

Woman: Oh yeah. So do you have many more appointments now?
Midwife: I do, actually, I've got a couple more back at the hospital and want to make sure my women who had babies on the weekend, make sure they're OK.
Woman: Oh yeah, that's exciting stuff.
Midwife: Nice.
Woman: Actually, when we were in that birth unit thingy, for me, it was all quite real and it is what it is and there was a woman probably just further down [the corridor] giving birth. A few
people in the class were like 'oh wow, we've got to get out of here.'

Midwife: Because she was screaming?
Woman: Yeah, yeah, but I thought to myself, you're going to be going through this soon. But Graeme, he was quite funny because he's said to me, looking at the bed, anyway, when we came back he goes to me, oh, looking at that bed makes it really real. He goes what about for you? For me I'm just like it is what it is, like we're having a baby. I'm going to be on that bed, I'm going to be all over the place kind of thing, but for him, it really hit home. It really made him go oh; gee we're really having this baby.

Midwife: It's close now.
Woman: Yeah, yeah.
Midwife: It's only a month away.
Woman: We're really excited, actually. Like he even wrote a little thing — not — to me the other day going hurry up, baby, like this, so yes, quite sweet but yeah, just sort of makes our family complete — well, not complete, it's the beginning of our family. Yeah, because we only want two kids. Then when we have our second child you know, we've got two kids, a doggy and we're just ...

Midwife: Happy little family.
Woman: Yeah. It's really good. (B-MGP19)

6.5.2 'She's client focused. It's about your experience'

Midwife investment that is woman-centred, as I have presented in these appointments, enabled the woman to share her worries and for these to be moderated and transformed to hope. In her postnatal interview, the woman from appointment B-MBP3 found her midwife and the way she interacted with her to be 'client focused' compared to other experiences she had with midwives who were 'protocol' driven. She felt the midwife did not tell her what to do and was focused on her experiences and her rights:

The other midwives ... just seem to be, or the typical type of scenario seems to be, this is what you do, this is the protocol, blah blah, we follow one, two, three, four, five. That's it, and stiff shit about anything else really. But she doesn't seem to be like that at all. I mean I get that she follows protocol, of course she follows protocol, but she's client-focused. It's about your experience, and a couple of time I've said what do you think about
this? She goes hey it's your baby, you're having the baby, it's not my birth, you do what you want. (PNI-B-MGP3)

6.6 Conclusion

This chapter reports on my findings that the communication style storytelling, and at times discussing, enabled worry to be transformed to hope. Worry, as presented in Chapter Four, however, persisted when telling was the principal action and style of communication used by the midwife. Hope was found less frequently in the appointments than worry, but when it was found it was seen in appointments where the midwife and woman's interactions included discussing and storytelling. The examples of these more shared interactions and a midwife who had woman-centred investment were also more evident in MGP appointments and those situated away from the OPD. As reported in Chapter Five, the environment and time factors of the appointment and model of care mattered. A model of care such as MGP that is based around a relationship and focused on the woman appears to alter the way that the midwife and woman interact, enabling them to moderate worry and in some instances create a sense of hope and optimism for their future childbirth events.
Chapter 7 – Discussion

As presented in the Findings chapters, I found a number of differences between midwife-woman interactions in the MGP appointments and the SMC appointments. The MGP midwives had more opportunity to adapt their practice than the midwives in the SMC system. The capacity to adapt resulted in the MGP midwives being less system-focused, more woman-centred and able to facilitate more shared midwife-woman interactions. This resulted in a greater potential for both the women and the midwife to moderate worry and create hope. In this chapter I draw on these findings and examine contemporary literature to discuss how the MCOC model, in MGP, potentially affects midwife-woman interactions.

The aim of this study was to gain a better understanding of how the MGP might influence midwife-woman interactions in an attempt to understand why MCOC models improve outcomes for women and their newborns. To do this I focused on midwife-woman interactions in antenatal appointments at 36 weeks or beyond. Using a critical ethnography and a feminist approach, I observed and video-recorded midwife-woman interactions in appointments from the SMC system and those with the MGP model. I also used focus groups and interviews with the midwives, women and managers to gain their perspectives.

I focused on the late pregnancy appointment to develop an appreciation of the cumulative effect of continuity of care during the antenatal period. Observing the appointment at this stage of pregnancy enabled me to examine how the continuity of care relationship affected the midwife and woman’s outlook for the upcoming labour and birth and postnatal period.

I applied a feminist and critical lens to the data, because even within maternity care where women are the focus of our work, women and midwives are often silenced or invisible in the machinations of a maternity care system that is informed by a medicalised and patriarchal approach (Brodie, 2002; Matthews & Scott, 2008; McAra-Couper, Jones, & Smythe, 2012). My desire was to give voice to a way of
working that prioritises the needs of women over those of the system and to assess the interactions between the midwives and women from the perspectives of the less enfranchised individuals within maternity care (Ackerly & True, 2010).

In this chapter I examine my findings in an attempt to explain how such an apparently simple strategy of knowing and having a relationship with your midwife can make a difference for mothers and their newborns (Sandall et al., 2016). In the first section I set the scene by considering the worry I identified in the antenatal appointments and reflect on how it dominated the midwife-woman interactions and the midwives’ practice. In the next section of this chapter I report on the adaptive qualities of the MGP that enabled the midwives to adapt the standard factors of the antenatal appointment: environment, time and investment. I found that these factors were fundamental to the nature of the midwife-woman interactions. As part of this section I also focus on the optimal interactions of discussing and storytelling. This then leads to a section about hope, which is the outcome of a midwife-woman interaction able to transform the ever-present worry of the antenatal appointment. The chapter then concludes with the limitations and implications of the study and recommendations for the future.

7.1 Worry, a central focus of the antenatal appointment

In this study worry emerged as a central feature of every observed appointment and informed how the midwives and women interacted. Both midwives and women brought worry to the antenatal appointment. It was seen in their individual actions and in their interactions with each other. They also talked about it in their focus groups and interviews. It was characterised by their phrases 'is it normal?'; 'making sure' and 'doing the right thing' and accompanying actions. The worry 'is it normal?' reflects the concerns many women report when pregnant. Including being worried about their pregnancy, the uncertainty of labour and birth and the transition to motherhood. The other worry the 'making sure' and 'doing the right thing', however, related to the midwives more than the women, reflects the standardised
and medicalised system of maternity care more than it reflects a 'woman-centred' practice.

Worry is considered to be a chain of thoughts and images or set of behaviours that often occur simultaneously or act as triggers for each other (Borkovec, Robinson, Pruzinsky, & DePree, 1983). This worry process is believed to represent an attempt by the individual to problem solve when they are exposed to issues of uncertainty, such as risks or the possibility of negative outcomes. Consequently, worry is not only an aspect of anxiety, but also relates to the fear process (Borkovec et al., 1983) and an inability to tolerate uncertainty (Ladouceur, Gosselin, & Dugas, 2000). Fear is seen as a central aspect of human nature and is what triggers worry (De Becker, 1997).

The worry identified in the antenatal appointments was both functional and dysfunctional. As described by Breznitz (1971) and Bruhn (1990) worry has both of these qualities. When worry was functional it helped the women to manage their thoughts about their upcoming childbirth events and the transitions associated with these. Dahlen (2010) reports that functional worry is a productive and positive process assisting people to manage painful, threatening situations or change and is a protective mechanism, as it motivates individuals to avoid danger and seek safety. In this study I observed that when the midwife worry was functional and focused on the woman and her worries, it activated the midwife to become woman-centred. In these situations, the midwives adapted the standardised and medicalised features of the antenatal appointment and how they interacted with the woman.

In contrast, the dysfunctional worry I saw in the antenatal appointments was linked to a state of helplessness, passivity and a lack of authority. This type of worry is recognised to increase levels of anxiety and depression for women during their childbirth experiences (Affonso, Liu-Chiang, & Mayberry, 1999; Austin, Priest, & Sullivan, 2009; Maier, 2010). For the midwives’, their experience of dysfunctional worry was linked to their practice being standardised and routine. Although not reported in the literature as a direct causal factor, dysfunctional worry is associated
with burnout, a mismatch between what you aspire to in your work and ability to achieve this and the emotional burden of maternity care work and poor work retention (Catling, Reid, & Hunter, 2017; Curtis, Ball, & Kirkham, 2006; Hildingsson et al., 2016; Hunter, 2004). In part, this level of dysfunctional worry can be seen as an 'iatrogenic' product of the standardised and medicalised system, an inadvertent outcome associated with medical treatment or diagnostic procedures (Merriam-Webster, 2017).

7.1.1 Functional worry: 'Is it normal?'

The identification that pregnant women worry is not new and is recognised as a common characteristic of how they manage the changes associated with pregnancy (Affonso et al., 1999; Homer, Farrell, Davis, & Brown, 2002; Maier, 2010; Statham, Green, & Kafetsios, 1997). Although women asked the question 'is it normal?' frequently in this study this action reflected more functional aspects of worry than dysfunctional.

Worry, in its functional capacity, has been described as 'the work of pregnancy' (England & Horowitz, 1998, p. 6) or an action of reasoning and rationalising that women do to find knowledge about their fears and to gain reassurance. It can be undertaken by pregnant women through examining media, writing or talking about worries with others (Melender, 2002). Affonso et al. (1999) reports the worry that women show in pregnancy is a cognitive activity to better understand, cope with or adapt to their transition. Likewise, Rubin (1976) with her ground-breaking work describes worry as a normal function of pregnancy that women engage in to internally prepare themselves for motherhood and to ensure a safe passage for themselves and their baby.

The worry women exhibited and reported in this study reflected this understanding of pregnancy being a subjective experience and a time of internal contemplation. As Rubin (1976) reports worry is how women adapt to and accept this new child into their lives and is related to the woman's maternal ability to give of herself to this
new child once born. As described by Soutter (2005), women in this study appeared keen to prepare for labour, birth and the postnatal period. This they did by gaining certainty and reassurance with the physical discomforts of pregnancy, wellbeing of their unborn baby and the uncertainty for what lay ahead for them and their baby. As Larsson, Wärnå-Furu, and Näsmann (2016) reported, women experience a number of emotions and thought patterns associated with the uncertainty of pregnancy and the upcoming labour and birth, which creates a sense of isolation and a need to gain guarantees or reassurance. In addition, the findings from this study also confirm what other have found: women worry about pregnancy affecting their body image; their relationship with their partner; their employment and their finances; whether their baby will be normal and healthy; and the upcoming birth (Affonso et al., 1999; Petersen, Paulitsch, Guethlin, Gensichen, & Albrecht, 2009).

For the women in this study the antenatal appointment was the place where they could bring their worry, problems or questions and gain information and reassurance from the midwife. This is similar to what Novick (2009) identified with an integrative review of 36 studies that examined women's experiences of antenatal care. Women seek information during their antenatal care to dispel myths, assist with decision making and to gain reassurance. In light of such evidence, a study that examined the midwife's role in Australia from the women’s perspective reported it was important for midwives to provide reassurance (Homer et al., 2009).

**7.1.2 Iatrogenic worry: 'Making sure' & 'Doing the right thing'**

In contrast to functional worry, in this study, the women's use of the phrases 'making sure' and 'doing the right thing', and more so the midwives use of these phrases, represented a level of dysfunctional worry. I have suggested that, as noted by Prosen and Tavcar Krajnc (2013), this is an 'iatrogenic' effect of the standardised and medicalised system that characterises today's maternity care, resulting in significant influences on a midwife's practice and on a woman's experience.
Dysfunctional worry reduced a midwife's capacity to place the woman at the centre of her care. Instead, by 'making sure' and 'doing the right thing' the midwife's focus was on the needs of the system. Appointment tasks and antenatal assessments became medicalised and constructed around the belief that childbirth is risky, in need of surveillance and that midwifery practice needs governance and regulation (Annandale, 1988; Chadwick & Foster, 2014; Lupton, 2012; Scamell, 2016). At times when the midwife was so focused on the system the woman's worries were dismissed and the midwives' actions reflected what McCourt (2006) reports as the ritualised, prescribed and predictable performances of a professional expert – the midwife – with the woman as the audience.

When women used the phrases 'making sure' and 'doing the right thing' they were seeking reassurance about navigating the system and maintaining the role of a 'good patient' (Campbell et al., 2015; Taylor, 1979). As Kay, Downe, Thomson, and Finlayson (2017) found, with their examination of the effect of birth stories, women, particularly first-time mothers felt a responsibility to be a 'good patient' and 'good parent'. These first-time mothers felt the pressure to make the right choices by endeavouring to 'tick all the boxes and get it all perfect' (p. 12).

This iatrogenic effect on the midwife-woman interactions was most evident in the SMC antenatal appointments situated in the OPD, where midwives interacted more with the computer and maternity care records than with the woman, resulting in women having less interaction time with the midwife and, as a consequence, less opportunity to raise their worries. Some women also felt this lack of the midwife’s focus on them increased their worry. Likewise, in an examination of genetic screening and counselling services, women reported more worry when the doctor was focused more on the procedure than on them and provided no information or choice (Kenan, Smith, Watkins, & Zuber-Pittore, 2000). As Maier (2010) suggests, as in any health care setting, focussed support and care plays a vital role in assisting women to manage their worries.

The 'iatrogenic' worry I identified in this study is not about the undertaking of the
antenatal assessments and tasks. Instead it relates to the negative impact of the
standardised and medicalised antenatal appointment on the nature of the midwife-
woman interactions associated with these tasks and assessments. It is well
recognised that the provision of information and choice are fundamental aspects of
effective and exemplary healthcare provider communication (Iedema & Manidis,
2013; Kirkham, 2004). However, as I found in this study, the inclusion of these in
maternity care interactions is often impeded by the prevalence of the standardised,
task-orientated practices attached to appointments (Jenkinson et al., 2017;

7.1.3 Managing uncertainty & risk in the antenatal appointment

The phrases 'making sure' and 'doing the right thing', reflect the contemporary
construct of childbirth being risky and needing to be managed (Kotaska, 2017;
The midwife-woman interactions associated with these also correspond to a focus
on risk or pathology rather than physiology, which Scamell (2011) describes as a
hunt for abnormality instead of facilitating the normal. As Iedema and Manidis
(2013) identified, the patient (or the pregnant woman in this study) is described as a
source of uncertainty for the health professionals. They attribute this phenomenon
to the rising level of complexities and comorbidities that many people now
experience with their health/illnesses and the complexity with working and
communicating with the multi-disciplinary team needed to manage these complex
issues. Similarly, the women's comments of 'making sure' and 'doing the right thing'
in this study reflect the growing expectations of today's patients (pregnant women)
that their illness or pregnancy is a situation of uncertainty that a healthcare
provider needs to manage (Seely, 2013).

This aspiration that contemporary healthcare will manage the ever-present sense of
uncertainty and risk can be seen as underpinning the increased standardisation and
medicalisation of practice (MacKenzie Bryers & van Teijlingen, 2010). For example,
clinical governance as an organisational risk management strategy is now a core
component of healthcare in Australia (Braithwaite & Travaglia, 2008) and other countries (Alaszewski, 2003; National Institute for Health and Clinical Excellence, 2008). This ever-present need to manage uncertainty and risk has created the situation where antenatal care is focused on standardised medical tasks, screening, assessment and surveillance (Barker, 1998; National Institute for Health and Clinical Excellence, 2008) and is reliant on intervention to fix problems (Soltani & Sandall, 2012). Critics of contemporary midwifery care see it being more focused on providing certainty through diagnosis, prognosis and treatment than garnering a sense of safety and comfort for the individual women during her pregnancy (Barker, 1998; Leap, 2010; Walsh, 2006a; World Health Organization, 2016).

The midwives' worry about 'making sure' in this study was linked to their obligation to solve the pregnant woman's worries or issues. In many of the SMC appointments, however, the midwife's use of this phrase and her accompanying actions prioritised the assessment, screening and documentation tasks set out by the standardised antenatal care procedures over conversing with the woman about her personal issues or worries. Davis-Floyd (2001) labels this behaviour as 'technocratic' and a reflection of the core values of Western society which are 'orientated toward science, high technology, economic profit, and patriarchally governed institutions' (p. 55). In addition, the midwife's worry about 'doing the right thing' often resulted in the completion of the computer database or the medical record 'checklist' before time was given to interacting with the woman and finding out what her individual issues or concerns were. Rather than the midwife's practice being determined by the worry or issues the woman had it was determined by the computer and the maternity care records: artefacts of the governing system (Blumer, 1969).

7.1.4 The dominance of medicine and politics in antenatal care

In today's society risk and the actions to avert or manage it are commonplace (Beck, 1999) and embedded in how antenatal care is provided (Skinner, 2008; Soltani & Sandall, 2012). The critical ethnographic approach of this study enabled the
association to be drawn between system-focused and standardised actions and the midwives and women's worry of 'making sure' and 'doing the right thing', reflecting the powerful position of biomedical politics in today's maternity care and the drive to determine and manage risk (Benoit et al., 2005; Downe, 2010; Scamell & Stewart, 2014). Two recent Australian studies examining midwifery practice also identify this risk-focused culture. Newnham, McKellar, and Pincombe (2018) showed how policies in a maternity unit normalised medical intervention such as epidurals and constructed non-medical practices such as water birth as 'risky' practice. In similar vein, Dove and Muir-Cochrane (2014) found that midwives working in a midwifery continuity of carer program needed to adapt their practice to maintain a woman-centred approach, as the dominant obstetric risk discourse opposed the authority of both midwives and women.

As Browner and Press (1996) and Davis-Floyd and Davis (1996) first suggested, the trust that midwives and women have historically had in their embodied knowledge and experiences has become replaced with a customary compliance to the dominant biomedical model and medicalised risk discourse. A recent examination of women's decision making of where to labour and birth in the UK also explored this (Coxon, Sandall, & Fulop, 2014). It was identified that even when government and consumer groups promoted birth at home and in birth centres as appropriate for healthy women with healthy pregnancies, women continued to choose to give birth in high technology labour wards. Featherstone (2004) explains this phenomenon, suggesting that antenatal care is a process of medical socialisation: the activities of getting and giving information to a woman about the state of her body and the unborn child influence her to have greater trust in healthcare systems and providers, particularly doctors, than herself.

These system-focused approaches and standardised actions of the midwife and the woman 'making sure' and 'doing the right thing' have a long historical antecedent related to control by the medical profession and the state in the establishment of antenatal care. In the UK during the early twentieth century, the government
established doctor-led antenatal care programs to combat the impact of poverty and the high perinatal mortality of that time (Piper, 2016; Villar et al., 1993). Thus began the tradition of the antenatal appointment as the place to manage risk and risky behaviours. Likewise in the USA, a historical analysis of the publication, 'Prenatal Care' in 1913, illustrates the pervasive influence of the biomedical model on pregnancy and childbirth (Barker, 1998). As a government publication it systematically introduced to millions of women the concept that pregnancy was medically problematic and that antenatal care was the solution.

The medical and political position during these formative years of antenatal care was that pregnant women needed supervision to ensure the health of the baby (Wagner, 1994; Wrede, Benoit, & Sandall, 2001). Since its inception antenatal care has focused on the production of a healthy baby by 'making sure' the health and the behaviours of the mother benefit the pregnancy and the unborn child (Oakley, 1984). This idea that pregnancy is risky, needs surveillance by self and the experts, and that a mother has the moral responsibility for mitigating a range of risk factors for herself and her child was socially constructed during this time. A historical analysis of late nineteenth century and early twentieth century self-help pregnancy and motherhood guidebooks from North America and the UK showed women were socially exposed to these ideas (Hallgrimsdottir & Benner, 2014). In Australia it was a similar experience with wide-scale antenatal care programs founded on the idea that surveillance of the pregnant mother and ensuring maternal health is necessary for fetal health (Featherstone, 2004). This continues to be enacted by Australian governments today, for example on the New South Wales public website 'NSW Health':

A healthy mother is essential to ensure the best outcomes for newborn and child health as well contributing to good health throughout the life cycle. Antenatal care in pregnancy provides a key opportunity to promote healthy behaviours and parenting skills, and to ensure that the woman and her family are linked with appropriate services within the health system. (NSW Health, 2016)

The 'making sure' and 'doing the right thing' phrases and actions of the midwives
and women in this study reflect the worldwide phenomenon that antenatal care is an accepted and standardised health care strategy (Australian Health Minister's Advisory Council, 2014; National Institute for Health and Clinical Excellence, 2008; World Health Organization, 2016). Although it delivers 'effective and appropriate screening, preventive, or treatment interventions' (Carroli et al., 2001, p. 1569) it rarely functions well at providing care based on the individual needs of the woman. For some women antenatal care is unpleasant and dehumanizing and experienced by them as mechanistic and routine with clinicians focused more on medical needs than on providing advice and emotional support (Novick, 2009).

Recent policy efforts have attempted to encourage antenatal care to be more focused on the woman; her worry and her sociocultural needs (Australian Health Minister's Advisory Council, 2014; World Health Organization, 2016). In the new WHO antenatal care guidelines, for example, respectful communication is recommended as an important aspect of providing a positive pregnancy experience for the woman (World Health Organization, 2016). Similarly, in Australia recent clinical guidelines for antenatal care promote health care that focuses on the individual woman's needs and preferences, collaboration and continuity of care (Australian Health Minister's Advisory Council, 2014).

Regardless of these recommendations, the common experience of the antenatal appointment, as seen in this study, is that it remains part of the fragmented, standardised and medicalised healthcare system. In Australia, for example, most women who access maternity care through the public health system still experience fragmented maternity care (Australian Institute of Health and Welfare, 2015). In comparison, the private health system in Australia does enable women to have access to continuity of carer, whether it is with an obstetrician or midwife. Private care is, however, expensive and often restricts women's choices. MacColl (2009) identified that women’s choices, particularly in private healthcare, were inhibited either by the authority of the obstetrician or by the midwife's resistance to this medical authority.
The fragmented approach to antenatal care in the public healthcare system has been framed as an unintended consequence of the funding model for maternity care in Australia between state and federal governments (Commonwealth of Australia, 2011). Likewise, fragmented ways of providing care can be seen as a consequence of the prevailing organisational culture within hospitals (Allaire & Firsirrotu, 1984). Furthermore, external cultural and social factors and norms are reported as mitigating factors to how an organisation or institution and its members, midwives and staff, promote and reinforce the way that childbirth is practised (Behruzi, Hatem, Goulet, Fraser, & Misago, 2013). Individuals who govern maternity care, particularly in Australia, still do not value the importance of relationship-based midwifery care in addressing the needs and moderating the worries that women have. Instead they continue to foster and promote a schedule of antenatal appointments where assessments, screening and education persist rather than establishing woman-centred care (Horton & Astudillo, 2014; Renfrew et al., 2014; ten Hoope-Bender et al., 2014).

Patriarchy and social control over women within Australian society, as described by Summers (1975) in her historical analysis of the colonisation of women in Australia, continue to be evident in contemporary maternity care in Australia and around the world. Women’s pregnant bodies are seen as leaky, uncontrolled and the women themselves are seen as emotional and out of control, particularly when pregnant and in labour (Callaghan, 2002; Lupton, 2012). This can have profound effects on women. In a study by Carter (2010), women reported their body being out of control in pregnancy and labour but they also experienced a loss of control over their total self, reflecting expectations that they needed to be in control themselves or controlled by others.

7.1.5 Authority and power

The midwives' use of the phrases making sure' and 'doing the right thing' in this study symbolised their powerlessness within the system their need to protect themselves from criticism, being ostracised or misunderstood. Equally, their actions
accompanying these phrases reflected a level of subservience or obligation to the system, as they often prioritised the system's artefacts (computer or the maternity care records) over the woman. Comments during focus groups and interviews illustrate the pressure they felt to comply with the organisation and its policies and standard operating procedures. The midwives' sense of powerlessness, self-surveillance and scrutiny in this study aligns with Foucault's descriptions of disciplinary power and surveillance, often attributed to the rise of industrialisation within our sociocultural contexts (Dykes, 2005a; Vaz & Bruno, 2003).

The concept of self-surveillance or self-regulation (Vaz & Bruno, 2003) relates to the way a person focuses their attention on their own behaviour when feeling or being observed by others, especially by those whose opinion they believe is relevant or when the observer is a person of the same or a superior social position. These issues of disciplinary power and surveillance can be strong motivators influencing how midwives practice. Copeland, Dahlen, and Homer (2014), for example, found midwives' working in the birth room often had a fear of the system that they worked in. This fear included being reprimanded, being watched and having their clinical judgements checked. Dahlen and Caplice (2014), also report that after fear of a baby death and damage to women, midwives' main fears were linked to this sense of scrutiny; they feared missing something, causing harm and being watched. The fear of missing something appears to coalesce with the midwives' actions of 'making sure' in this study, whereas the fear of being watched links closely with the concept of 'doing the right thing', where the midwives complied with standardised procedures of the antenatal appointment.

Midwives fear of scrutiny from those in management, their peers and the 'system' was evident particularly in their adherence to the completion of checklists on the computer and in maternity care records. However, it was also evident in midwives' comments about needing to conform to current institutional and medicalised norms of practice with restrictions on appointment times and discussion topics. Resulting high levels of anxiety and lack of confidence can jeopardise midwives’
ability to function autonomously (Morris 2005).

Hood, Fenwick, and Butt (2010) found high levels of self-reported stress and fear by midwives when they examined the events around an external review of obstetric services in one hospital. This had taken place in response to unacceptable rates of adverse outcomes, clinical errors and complaints about care. They found midwives working at the time of this review described their work becoming increasingly stressful and permeated by fear; they developed a lack of trust in birth even though no midwife faced litigation. To counteract this stress midwives protected themselves by engaging in decision-making that was based more on fear than clinical evidence. They described how they had redefined 'safe practice' to be in line with the medical model of care. They now anticipated problems, resulting in a greater use of midwife-led interventions. A rigid adherence to clinical practice guidelines and soaring intervention rates contributed to an increase in the disempowerment of the midwives. Similarly, in Scotland, Styles et al. (2011) reported an atmosphere of anxiety and loss of confidence by midwives in their capacity to practise within their scope after the publication and media criticism of adverse events that occurred in their health service.

In this study, the midwives’ attempts to be 'doing the right thing' was sometimes an act of obligation to their organisation and their profession. This obligation was also described in a synthesis of three different studies of how midwives and child and family health nurses approach their practice (Schmied, Burns, and Dahlen, 2016). One study focused on implementation of routine psychological assessment and depression screening in the perinatal period, another focused on the facilitators and barriers to physiological birth positioning, and the third focused on the implementation of principles and strategies to support the initiation and establishment of breastfeeding. In all three studies, midwifery and nursing practice was aided or inhibited by the organisational culture and structural barriers to evidence-based practice. When midwives and nurses did not have relationships with the women they often cajoled and coerced women to comply with institutional
norms or practices. Like the midwives in this study they were being self-protective. They adjusted and adapted their practice to protect themselves from the criticism of their colleagues, managers and the medical profession and were concerned about the ramifications if something went wrong or if they had not complied with policies.

In this study, women’s lack of authority was observed in their antenatal appointments and described by them in their interviews. This was associated with their use of the phrase ‘doing the right thing’. Their use of the accompanying phrase, ‘is it normal?’, showed that along with seeking reassurance they were also seeking expert knowledge from the midwife. This deferring to the authority of the midwife was described by Kirkham et al. (2002) in their examination of the use of informed choice pamphlets in antenatal appointments. Instead of relying on the evidenced-based information in the pamphlets the women actively sought out the midwives’ opinions to inform their decision-making or to gain reassurance.

In describing the sociocultural context of childbirth, Lupton (2012) describes how a woman’s action of seeking and complying with the authoritative knowledge of the midwife can be seen as an action that both responds to and in turn, reproduces the effect of the biomedical model of healthcare. Dahlen, Barclay, and Homer (2010) describe this as women having a ‘novice’ status, particularly associated with first time mothers. In this study, however, ‘novice’ status behaviours were sometimes also seen in the midwife-woman interactions where women were not first-time mothers. In such interactions women were passive and spoke very little.

7.2 Adapting and Enabling: moderating worry in the antenatal appointment

Along with the observed and reported worry in this study there were midwife actions and midwife-woman interactions that moderated worry. These required a midwife to adapt and optimise her actions and the interactions with the woman. Along with this midwife quality of adaptation there were three factors of the
antenatal appointment that moderated worry; environment, time and midwife investment. Some midwives were able to adapt environment and time features of the standardised antenatal appointment, inspired by their investment in the woman rather than the system. These midwives were seen as 'adaptive experts', which, in the context of labour and birth care, Annandale (1988) describes as a balancing act involving consideration of: obstetrical norms and authority; the woman's anxieties and expectations, and the midwife's own ideology. In this study, it was the influence of the MGP model that mostly informed a midwife's investment in the woman, enabling her to adapt or alter the standardised and medicalised environment and time features of the antenatal appointment.

These adaptive actions by the midwives in the appointment were generated by and also created through acts of discussing and storytelling and resulted in midwife-woman interactions being bidirectional and shared, creating an antenatal appointment more woman-centred than system-focused. Through their mutual sharing, the midwives and women generated worry and also moderated it. Associated with these bidirectional and shared interactions was a greater opportunity for the midwife and woman to connect or build on the connection they already had. With more sharing there was also more capacity for their worry to be transformed into hope.

7.2.1 MGP model design: enabling midwives to adapt

This study deepens our understanding of the association between midwifery practice, environment and time and the ability of some midwives to adapt these to create a woman-centred rather than system-focused interaction. The MGP model provided opportunities for midwives to adapt the antenatal appointment and their practice that the SMC model did not. The location (environment) of the MGP antenatal appointments, for example, were based on a decision or choice by the midwives and women and were often conducted away from the traditional antenatal clinic situated in the OPD. In contrast, the midwives in SMC were often restricted to working in the OPD or in 'outreach' locations established on the
standardised antenatal clinic model.

The midwives in SMC were not able to manage their own time in the same way as the MGP midwives. In the SMC system rosters governed the midwives work hours and shift patterns and the antenatal appointments they conducted were scheduled at a predetermined time and allocated a limited length of time. In contrast, the opportunity provided by the MGP model for midwives to choose the appointment location (environment) provided more control and flexibility with how the antenatal appointment was conducted; this also altered the power relationship between the midwife and woman. Likewise, the continuity of carer feature of MGP provided the midwife and woman with the opportunity to have repeated time in the antenatal period and also across the course of the woman's pregnancy, labour and birth and postnatal period. The effect of repeated time was that it created connection between the midwife and woman and fostered a midwife's investment in the woman and her worries instead of the system.

7.2.2 Adaptive Expert

The consistent level of woman-centred investment enacted by MGP midwives was in contrast to the system-focused investment enacted by most of the SMC midwives. Although the philosophy of woman-centred care is fundamental to the way midwifery is now promoted and educated, there were a number of midwife behaviours seen, particularly in the SMC system, that did not reflect this philosophy. The differences in the midwives' practice between the models and to a certain extent between the hospitals may relate to a 'community of practice' (Eckert & McConnell-Ginet, 1992) where individuals come together around a mutual engagement or endeavour. As a concept, 'community of practice' encompasses the idea that the way that certain groups of people habitually do things, ways of talking, beliefs, values and the power relations, emerge during the course of a mutual endeavour (Lave & Wenger, 1991).

Some midwives in the SMC system did not follow the consistent pattern of actions.
of the group they worked with; they practised as ‘adaptive experts’ in spite of the constraints of SMC. Unlike many of their peers, they demonstrated the capacity to adapt their practice, including modifying the environment and time associated with the standardised antenatal appointment, reflecting more investment in the woman than the system.

The MGP midwives appeared to gain agency and a capacity to adapt from working in a small group, strengthened by the relationships they developed with women; this enabled them to function in different way to most of the midwives in the SMC. In contrast, the 'adaptive experts' identified in SMC gained agency not from their peer group but from other personal motivations. For one midwife it was an allegiance and obligation to the unique needs of the local community in which she lived and had grown up. For other midwives it was having an awareness of the impact their everyday practice had on the woman and being able to adapt this practice to benefit the woman.

The self-awareness of the 'adaptive expert' midwives in this study appeared to be related to the ability of the individual to critically evaluate and reflect on their own responses to everyday practice situations described by Finlay (2008). Dewey (1933), an early thinker on reflection, contends that reflective thinking moves people away from routine thinking and action, controlled or guided by an external authority to reflective action. Fifty years later Schon (1983) identified a reflective practitioner as one who not only reflects-on-practice but reflects-in-action; a person who thinks while doing and who has the capacity to reflect on their own views, beliefs and experiences.

Iedema & Carroll (2011) identify that 'reflexive practice' is a valuable skill in contemporary healthcare as it 'is the crux of progressive change and practical safety in highly complex organizational settings' (p 175). Within midwifery care, reflective practice epitomises the essence of woman-centred care where a midwife enables her care to always be situated on the woman (Berg et al., 2012; Fleming, 1998).

In this study, midwives who adapted their practice in the antenatal appointments
engaged in discussing and storytelling in ways that were specific and related to the individual woman's context. They achieved this through engaging in discussions with the woman or by seeking out the woman's stories, which then informed what information or advice they shared with her. Midwives who did not display adaptive qualities did not seek out the woman's stories and their approach relied mostly on a midwife-woman interaction based on didactic ‘telling’. They appeared not to see the woman and her individual needs.

7.2.3 Investment

Midwives’ worry, reflected in their use of the phrases 'making sure' and 'doing the right thing' and in their accompanying actions, was seen to operate along a continuum of investment from system-focused to woman-centred. When the midwives exhibited system-focused investment their worry and actions of 'making sure' were unidirectional, included more telling; often they did not focus on the woman's worry or appear to reassure her. The appointments were shorter, the midwife's focus was on the completion of clinical assessments and tasks set out by the computer. They invested in 'getting the information', 'making sure there is nothing there' and preparing the woman to 'fit into the system'. In these situations, the appointments remained a standardised medicalised event and midwives rarely adapted or altered the status quo.

In contrast, the less frequently recorded action of woman-centred investment occurred where midwives prioritised conversations and interactions with the woman rather than simply focusing on the standard antenatal tasks and assessments. In these occurrences the midwife invested in the woman's worry; 'making sure' about the 'woman's wellbeing' and helping the woman to 'navigate the system'. These women centred actions were recorded more frequently in the MGP appointments and associated with the discussing and storytelling midwife-woman interactions rather than telling. They resulted from the opportunities provided by the MGP or the actions of some 'adaptive expert' midwives.
7.2.3.1 System-focused – ‘telling’ midwife-woman interactions

A system-focused approach involving unidirectional actions (midwives ‘telling’ the woman rather than sharing through a two-way process of discussion and storytelling) is characteristic of the typical healthcare interactions experienced in many of today’s acute healthcare settings (Iedema & Manidis, 2013). It has also been described in maternity care (Olsson & Jansson, 2001; Stapleton, Kirkham, Curtis, & Thomas, 2002b). The unidirectional telling pattern in this study was characterised by a midwife answering a woman's question by telling her information, or a midwife asking a clinical assessment question in order to get information. This was often achieved with closed-ended questions that created structured clinical conversations that reported and recorded facts, but rarely dealt with the worry generated in the appointment.

These telling actions were associated with information gathering, education, diagnosis, treatment plans and clinical outcomes and revolved around the completion of the computer database and maternity care records. Iedema and Manidis (2013) label these actions and interactions as clinician driven, creating a 'patient as object' situation. The clinician is focused on pathology and body ailments rather than communicating with the patient as a person. Within contemporary maternity care Davis-Floyd (2001) and Wagner (1994), like many others, define these actions as technocratic or mechanistic, where the health professional actions construct the woman's body as a machine operating independently from her mind (Cahill, 2001). As discussed earlier, such approaches reflect the medicalisation of healthcare as a whole and the reliance on scientific and technological approaches to manage disease and illness (Kingdon, 2014).

Critics have described this biomedical approach to healthcare and the human body, particularly the woman’s pregnant body, as being rationalised, controlled and disciplined through the use of scientific knowledge and technology (Davis-Floyd, 1994; Prosen & Tavcar Krajnc, 2013). In the context of antenatal care the effect of women being subjected to this biomedical approach constructs the maternal body
and childbirth as risky; women are socialised into a system in preparation for labour and birth that is also framed by a biomedical approach. This results in women accepting what is offered rather than challenging the status quo and exploring all options (Petrovska, Watts, Sheehan, Bisits, & Homer, 2016).

To some extent every observed antenatal appointment in this study included the features of a system-focused approach, but this approach was more evident in the SMC appointments. For some midwives in this study, and particularly in the SMC, it appeared that their worry about the system, as discussed earlier in this chapter, overrode their ability to focus on the woman. When exploring the practices of midwives and doctors in antenatal appointments Kirkham et al., (2002) identified that midwives were 'focus[ed] more on the 'rules' and 'the stuff I'll get the rap for' than on the women's needs' (p. 449). In this study, a typical system-focused interaction involved the midwife spending more time interacting with the computer or maternity care records than the woman. Morris (2005) describes this as 'just in case' practice, which like the concept in this study of 'doing the right thing', demonstrates the increased expectation and pressure on midwives to document and justify their decisions in contemporary maternity care.

‘Telling’ midwife-woman interactions symbolised the unequal power relationship where the midwife is the authority figure (Strong & Dingwall, 2001), reflecting the sociocultural expectation that the antenatal appointment is simply a venue for clinical information sharing (Browner & Press, 1996). Midwives gained information from the women to complete their clinical assessment and women sought advice and information from the midwife in an attempt to gain reassurance. A study undertaken by Olsson & Jansson (2001), which observed and filmed 58 antenatal appointments, also showed a ‘telling’ pattern of relating between the midwife and woman. This involved a midwife leading and dominating the conversations and interactions and the woman and her partner mostly following the midwife’s lead passively. Similarly, Risa, Friberg, & Lidén (2012) found midwives in midwife-led antenatal appointments for women with diabetes commonly had ‘a professional
expert' communication pattern. Like the telling midwife-woman interactions in this study, the objective patterning reported by Risa, Lidén, and Friberg (2011) was characterised by a midwife talking in general and objective ways that informed the woman about routines and procedures and did not take the woman's individual experience into account or enable opportunities for the women to freely express any concerns.

7.2.3.2 Woman-centred – 'discussing' and 'storytelling' midwife-woman interactions

The woman-centred approach undertaken by some midwives in this study included discussing and storytelling, influencing the midwife-woman interactions to be bi-directional and shared. Typically, these shared interactions took longer than a telling interaction and involved the midwife and woman interacting with each other more than the midwife interacting with the computer and maternity care records. In contrast to the storytelling, the discussing interaction was bounded by the clinical purpose of the antenatal appointment. Regardless of there being any storytelling in the midwife-woman interactions or not, the simple action of a midwife encouraging a woman to discuss her care and choices was beneficial as it moved the focus of the appointment onto the woman instead of it simply being about a standardised medicalised act. Guilliland and Pairman (1994) found that when midwife-woman partnership included 'shared dialogue' it had the potential to alter the authority and power dynamics in a positive way for both the woman and her midwife. Similarly, Banks-Wallace (1999) showed how the shared action of storytelling and discussing enabled a woman's opinions and experiences to be included. Such communication skills counteract the traditional hierarchical healthcare interaction of provider and recipient still apparent in medicine and midwifery today (Edwards, 2001; Ellingson & Buzzanell, 1999). As Iedema and Manidis (2013) have indicated, the patient becomes a 'person' rather than an 'object', when there are shared interactions. The ability of midwives to engage in the two-way sharing of stories is fundamental to relationship maintenance, or what Davis-Floyd (2001), Fahy and Parratt (2006) and Banks-Wallace (1999) describe as 'connection and integration'.

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Discussing and storytelling interactions link closely to the relational approach and feminist perspectives described by Canadian midwives; autonomy and choice are prioritised, enabling women to develop an understanding and motivation necessary to take on responsibility for and control of their own health (Thachuk, 2007). Such approaches link closely to what Klima (2001) sees as actions of contemporary feminism where the woman is more than an object and someone of value. Shared interactions are more than what Gilligan (1995) sees as simply the ways that women converse and interact; rather they are fundamental actions of a model of care based in feminist principles where the woman becomes central to the interaction rather than being peripheral to it (Leap, 2004).

The storytelling midwife-woman interactions, as described by Banks-Wallace (1999), were interactive shared experiences between story teller and story listener that created connection through the identification of commonality or common experience with their stories. When this occurred, the midwife led stories about her practice, her professional perspectives and also about personal experiences. Within midwifery practice, storytelling is beginning to be recognised as fundamental to how midwives share and connect with the women they care for, as well as their peers and the institutions that govern their practice (Kirkham, 1997; Skinner & Dahlen, 2015). Stories are recognised to have multiple purposes: education; recording of facts; demonstrating cultural values; identifying personal attributes and identifying common experience (Gulich & Quasthoff, 1986).

The benefit of a midwife sharing of stories was only seen when she also listened to and encouraged the woman to tell her stories. As the women reported in a study undertaken by Kennedy (1995) it was the way the midwife behaved that laid the foundation for how the woman perceived their care and their experience. Through their increased listening to the woman’s stories, midwives gain important knowledge and an appreciation of the woman’s experience (Gidman, 2013). This active listening also reflects the woman-centred quality of ‘nurturing’ (Walsh, 2006a), evident when midwives listen to the woman’s stories and tell their own to
The sharing and listening to stories in this study were akin to the communication skills described by Hunter (2006) as important, based on ‘reciprocity’, ‘balanced exchanges’ and ‘give and take’.

The inclusion of discussing and storytelling in the midwife-woman interaction in this study enabled both individuals to find solutions through discussions. These bi-directional and shared interactions not only required the midwife to be focused on the woman and her worries, but they also enabled the woman to articulate matters that were important to them. This act of sharing stories about cultural values, personal experiences and beliefs, are fundamental characteristics of storytelling (Banks-Wallace, 1999) and health care interactions that enable reassurance and the issue that matter to the patient to emerge (Iedema and Mandis 2013). This ability of a midwife to be woman-centred through her use of storytelling as a communication strategy links closely to the concept of 'matrescent' care, described by Walsh (2006a), where through her approach a midwife actively supports a woman to learn and gain confidence about herself and with her maternal transition or 'becoming mother'.

Through their discussing and storytelling the midwife and woman shared information, learnt about each other by listening to the other's stories and planned for issues associated with the woman's upcoming labour and birth and parenting, in a way that has the potential to promote women’s confidence in their abilities to give birth and be mothers (Leap et al 2010; Huber and Sandall 2006). The identification of discussing and storytelling interactions as an important part of woman-centred care not only informs feminist theoretical appreciation of this essential midwifery skill, but also better illustrates how midwives can be woman-centred in their practise (Buch & Staller, 2007).

7.2.4 Environment

The inclusion of a variety of antenatal appointment locations in the observations also generated an appreciation of environment as an important factor. In all of the
appointments observed in this study the environmental factors of location, room setup and décor were seen to affect how the midwives practised and their interactions with the women. As found in studies of midwifery practice in postnatal ward (Burns, 2011; Dykes, 2005a) the busyness and clinical nature of the OPD led to midwifery practice being standardised and system-focused. Women in Australia and the UK have reported dissatisfaction with their postnatal care, because midwives were too busy and their advice was either unhelpful of not offered at all (Dykes, 2009b; Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010; Schmied & Bick, 2014; Schmied, Cooke, Gutwein, Steinlein, & Homer, 2009). In contrast, the appointments in the woman's home in this study were associated with more social interactions and woman-centred practice.

Environment, however, was not an independent factor in informing how a midwife practised. A strong association between environment and model of care was also identified. In contrast to the SMC system, the MGP model provided greater opportunity for a midwife to adapt the accepted standardised antenatal appointment environment, whether that involved a change in location from the OPD, alterations with room décor or how the midwife interacted with the computer/maternity care records.

Time factored in the antenatal appointment and midwife investment were also important factors in midwife-woman interactions. With the interplay of these factors in mind and to aid clarity I have divided the next sections of this chapter into an examination of the influence of environment and then an examination of the influence of time.

7.2.4.1 Changing the location

The influence of antenatal appointment location on midwife-woman interactions has rarely been examined. In this study, like other studies of midwifery, the location of the appointment framed the midwives' practice and their interactions with the women. The existing order of the power and authority of medicine (Campbell & Porter, 1997; Hyde & Roche-Reid, 2004) was seen most often in the OPD. Where
the midwife-woman interactions took place in the woman's home, midwives demonstrated greater woman-centred investment.

Most studies have examined the influence of labour and birth settings (Havill, 2012) and to a lesser extent, postnatal settings (Dykes & Flacking, 2016). Walsh (2006b) identified that women had a sense of safety and comfort in the free-standing birth centre compared to the larger maternity where they felt staff were focused on risk and uncertainty, while with planned homebirth women report improved experiences and more autonomy (Dahlen et al., 2010; Lindgren & Erlandsson, 2010; Sjöblom et al., 2006). Equally, midwives report greater autonomy when caring for a woman during a homebirth than in the hospital (Davis-Floyd & Davis, 1996). The experience of postnatal care in the woman's home leads to midwives and women reporting more authority compared to the hospital (Johansson, Aarts, & Darj, 2010; Lock & Gibb, 2003) and women being more relaxed because midwives have more time and greater ability to provide individualised information (Fenwick et al., 2010). Women also report greater satisfaction with their postnatal care when it is in their own home (Gagnon, Dougherty, Jimenez, & Leduc, 2002; Zadoroznyj, 2006).

In the labour and birth room the environmental factors identified to influence a midwife's practice include tangible factors such as equipment or how the space is designed (Hammond, Homer, & Foureur, 2014). Less tangible factors that have been identified include hospital practices and policies and the woman's passivity reflected in their assuming of the patient role (Hyde & Roche-Reid, 2004). Also the authority of the medical model of care and the validation and support it is given by the entrenched and accepted hierarchy of doctors and midwives in the hospital system (Keating & Fleming, 2009) are seen as influential.

In this study the hospital appointments, and in particular those in the OPD, appeared to influence more midwife telling than shared discussing and storytelling in midwife-woman interactions. The midwives were also 'making sure' and 'doing the right thing' more, which reflected midwife investment in the system rather than the woman. Similar findings occurred in a study by Kirkham et al. (2002) where
there was more midwife 'checking' than 'listening' to women in antenatal appointments situated in the standard public antenatal clinic. In the OPD the midwives also spent more time interacting with the computer and maternity care records than with the woman and undertook many tasks associated with the day-to-day functioning of the hospital. Homer, Davis, and Brodie (2000) found that women reported negatively about long waiting times and busy OPD waiting rooms, which they also attributed to midwife busyness and a lack of midwife focus on them.

The midwife busyness in this study, like others, is not just a manifestation of workload but stems from the obligation a midwife feels to the hospital, the system or the doctor. A number of studies of postnatal care attribute a midwife's lack of focus on the women to midwives prioritising the demands of the hospital and the system above those of the woman rather than simply being an issue of a busy workload (Brown, Davey, & Bruinsma, 2005; McInnes & Chambers, 2008; Passant, 2012; Rayner, Forster, McLachlan, Yelland, & Davey, 2006). Meanwhile in the labour room women report negative experiences when midwives prioritised their relationship with the doctor rather than with them when they were directed to stop pushing until the doctor arrived (Bergstrom, Seidel, Skillman-Hull, & Roberts, 2008). Sadly, Australian Aboriginal women also describe experiences of bullying by midwives when they have been transferred to larger regional or metropolitan maternity hospitals (Dietsch, Shackleton, Davies, McLeod, & Alston, 2010).

The negative effect of the location of the antenatal clinic in the OPD on midwifery practice in this study reflects Strong and Dingwall’s (2001) perspective on the authority of institution over the autonomy or agency of the individual. The typical midwifery practice of 'making sure' and 'doing the right thing' relates to an obligation and lack of authority that Brodie (2003) attributes to the invisibility of midwives’ professional identity. As midwives reported in a study by Copeland et al. (2014), their professional authority to promote normal birth has been undermined by the dominant obstetric model that relies more on technological interventions
than midwifery skills.

Compared to the OPD appointments the midwife-woman interactions in the woman's home included more episodes of discussing and storytelling. Like midwives in a Canadian study that examined their practice in the hospital and the home (Bourgeault et al., 2012) the midwives in this study reported the experience of conducting an antenatal appointment in the woman's home affected them positively. They felt 'like a guest in the woman's home', which suggests they felt they had less authority in the woman's home and the power dynamics between them and the women was altered. As Lock and Gibb (2003) state a person's experiences of a place, the concept of 'spatiality', how they react to, act in or feel about it, reveals the power of place. The symbolic meaning of a place is defined by more than the physical environment and incorporates the way that we act within it (Merleau-Ponty, 1962). These components of power or authority are evident not only in the physical aspects, but also the symbolic elements of that place (Jordan, 2014).

Women in this study showed higher levels of authority when they were in their own home and were more passive in the hospital OPD. In their own home they invited the midwife in, directed her where to sit, offered refreshments and on occasion took control of the discussion by referring to their own notes and checklists. Even with all the antenatal clinical tasks getting done in the woman's home the midwife-woman interactions reflected a shared social interaction with the midwife focused on the woman and her worry, while in the OPD antenatal appointments women waited while the midwife interacted with the computer; they waited to be asked questions or to be directed by the midwife to the next task. As Stapleton, Kirkham, et al. (2002b) found, the midwife's actions in an antenatal appointment, her busyness, her lack of focus on the woman can influence the woman to be passive and silent.

7.2.4.2 Altering the décor

The alterations to the décor of the clinic rooms in the hospitals was a positive
environmental influence, as this moderated the standardised and medicalised feel of the appointment. Changes to hospital décor such as soft furnishings and home-like touches are reported to influence the experiences and outcomes of healthcare recipients and providers within maternity care and across the broader healthcare system (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004). However, in this study, such alterations to the hospital décor, as singular or isolated environmental factors, did not appear to affect any major changes to the nature of the midwife’s practice or the midwife-woman interaction. Compared to the appointments undertaken in the woman’s home, the Community Health Centre and the MGP clinic room the midwife-woman interactions in the OPDs, continued to be more medicalised and standardised, regardless of décor changes that had been made to make a more friendly environment.

In the OPD at Hospital A, where no alterations had been made to the standard clinical décor, the clinic room and waiting area felt impersonal and were not conducive to shared midwife-woman interactions focused on the individual woman. As a purpose-built space the design of this OPD accommodated a number of different clinics rather than being designed specifically to meet the needs of childbearing women. It had a clinical and 'institutional feel' (Foureur, Davis, et al., 2010; Symon, Paul, Butchart, Carr, & Dugard, 2008) that related to function and purpose of the institution rather than the individual midwife and woman.

In contrast, the changes that had been made to the clinical décor in the MGP clinic rooms and in the OPD in Hospital B did alter the feel of the space and softened the clinical and institutional feel. However, even though the décor changes observed in this OPD align with factors that positively enhance the experiences of childbearing women and midwives (Singh & Newburn, 2006; Symon et al., 2008) they did not appear to affect how individual midwives and women interacted in the appointments. This may simply be that the décor changes to these clinic rooms did little to alter the functional or physical space; where the midwife and woman sat in the room and how they interacted with each other, or the other artefacts of the
standard medicalised antenatal appointment such as the computer and the maternity care records. It may also be that other factors are more powerful in shaping interaction than simple alterations to décor.

7.2.4.3 Adapting of the standard antenatal appointment environment

Regardless of the model of care or the environment some midwives in this study managed to adapt little things in the environment that positively influenced their interactions with the women. These adaptations included how they used and interacted with the computer and the maternity care records and also how they interacted with the woman. The actions of these midwives are particularly interesting, and more attention needs to be paid to studying such adaptive experts who, despite the non-conducive models they work in still manage to provide woman-centred care. Having said this, they were rare, and most midwives seemed to be unaware of the importance of the environment in shaping practice. As Hammond, Foureur, and Homer (2014) report, the aesthetics of birth room design is important, but the midwives’ ability to function and to meet the needs of the labouring woman in the environment also matter; this relates to the placement of hospital equipment, or the midwives’ ability to be able to move, adapt or alter how this equipment is used or when it is used.

7.2.4.3.1 The computer

In comparison to the woman's home where there were no computers used in the appointments, the presence of the computer in the OPD appointments was symbolic and powerful. Regardless of appointment location, many of the tasks observed in the appointments were based on standardised practices, rituals and needs of the institution rather than the needs of the woman. The standardised approach of the midwife to these tasks, however, were more evident in the OPD appointments than in the woman's home and were associated with midwife actions or practises that favoured the computer and the medical record more than the woman.
As artefacts of the hospital and healthcare system the computer, especially, but also the maternity care records, symbolise the standardisation and medicalisation of the antenatal appointment (Barker, 1998) and a reliance on technology. In comparison to the OPD appointments, the midwife practice and the midwife-woman interactions in the woman's home, where there were no computers, were shared, relaxed and social and manifested in more discussing and storytelling than telling. Likewise, greater social connection was seen in the appointments not situated in the woman's home when midwives adapted their practice and the standard set up of the clinic room to interact more with the woman than the computer.

In many of the OPD appointments and the appointment in the birth suite the midwives relied on the computer/maternity care records to direct their actions and their interactions with the woman. As Davis-Floyd (1994); Katz Rothman (2014); and Lupton (2012) report, midwives often prioritise medical tasks over their interactions with the woman. The midwife's investment in these standardised and medicalised tasks and systems, privileges pathology rather than wellbeing and reflects the common concern about modern day maternity care not meeting the needs of women (Chadwick & Foster, 2014; Donnison, 1988; Downe & McCourt, 2008; Van Teijlingen, Lowis, & McCaffery, 2004).

Consistent with this study is the emerging understanding that the computer reflects the dominance or authority of the institutional systems over the practice of health professionals and their interactions with patients (Bar-Lev & Harrison, 2006; Campbell, Sittig, Ash, Guappone, & Dykstra, 2006). Limited midwifery research has reported on the influence of the computer. One exception was a study by Rollans, Schmied, Kemp, and Meade (2013), which reported the computer regularly directed the midwife's attention away from the woman when conducting the first antenatal appointment or hospital 'booking' visit.

The influence of the computer on doctor-patient interactions and nurse-patient interactions, particularly with the implementation of electronic maternity care
records (Campbell et al., 2006) has been reported. A study of doctor-patient interactions found the computer impacted on how the doctor interacted with the patient (Ventres et al., 2006). This was evident when the doctor’s focus was directed away from the patient to a computer located at the other corner of the desk from the patient. Similarly, Street et al. (2014) identified that this distraction of the computer decreased the quality of the doctor-patient interactions and created a doctor who was less patient-centred and an appointment that had more silence. Ventres et al. (2006) suggest the computer in healthcare interactions has become the third party with its own identity.

The adaptive actions of some of the midwives to not use the computer or to put their back to it highlighted the negative influence of the computer in other appointments and also the capacity of some midwives to interact more with the woman. As Asan, Young, Chewning, and Montague (2015) identified, some doctors actively incorporated the computers into their interactions with the patient. They categorised this adaptive action 'active information sharing' as positive. It involved doctors shifting the computer monitor so the patient could see it and could also share information with the doctor as they interacted with the computer.

In this study, the presence of the computer in the OPD, compared to the woman’s home where there was no computer, symbolised the authority and dominance of the medicalised model of care. This has as much to do with the midwife's reliance and inclusion of the computer in her practise and her interactions with the woman, as it did with the power and authority of the hospital. Equally, the actions of some midwives to adapt or remove the computer from their interactions with the women demonstrated that some midwives sought to prioritise the woman rather than the computer.

7.2.5 Time

The concept of time permeates every aspect of our lives, it is often taken for granted and rarely discussed as an independent and informative concept in social
interactions or within a specific cultural context (Adam, 2004; Frankenberg, 2009; Grosz, 2005). In this study time was an important factor. Midwives, women and managers involved in the study all emphasised the importance of time. Time during the appointments was a facilitator and barrier of midwife investment. Few researchers have examined how continuity of care and the concept of time affect midwife-woman interactions (Freeman, 2006). Other midwifery researchers, however, have identified time to be an important influence on and a reflection of quality woman-centred care (Dykes, 2009b; Kirkham, 2010; McCourt, 2009; Walsh, 2006b).

Two aspects of time identified in this study also illustrated a midwife's capacity to adapt. These were 'use of time', what she invested her time in, which closely links with the concept of investment, and the concept of 'repeated time' associated with the continuity of carer principle of the MGP model. The MGP created opportunities for the midwives enabling them to adapt the standardised and medicalised environment of the appointment and the temporal constraints that govern their practice. However, the midwife's capacity to adapt time and individual practice was not always associated with the MGP model. Regardless of model of care some midwives used time in the appointments to invest in the woman and be woman-centred rather than system-focused. This can be seen as an attribute of the adaptive expert.

Time is socially constructed (Davies, 1996). The conceptualisation and cultural application of time is also shaped by the governing beliefs or structures of that era (Adam, 2004; Hall, 1989; Thompson, 1967). In today's world life and work are constructed around timekeeping tools – the calendar and the clock, and industrialisation and capitalism. The production or assembly line, that came with the establishment of the factory and the reliance on clock time were crucial mechanisms and symbols of change associated with industrialisation (McCourt & Dykes, 2009; Thompson, 1967), while the post-industrialisation innovations of technology and the production and efficiency demands of capitalism have also
compressed time through fragmentation and timing of tasks (Hassard, 2002). This also relates to healthcare or what some now call the healthcare industry, where care has increasingly become time dependent, fragmented and shaped by the authority of medicine (Frankenberg, 2009; Simonds, 2002), the technology revolution (Perlow, 1999), the reliance on organisational structures and bureaucratic processes (Montenegro et al., 2011; Orlikowski & Yates, 2002). This has resulted in the measuring of cost benefit of interventions becoming a standard practice and seen as a benchmark for quality healthcare (Tracy & Tracy, 2013; Tracey et al. 2014; Victoria University, 2012). Hospitals, particularly maternity units, are busy places where, as I discussed earlier, women feel staff have minimal time for them (Brown et al., 2005; Fenwick et al., 2010; Overgaard, Fenger, & Sandall, 2012; Schmied & Bick, 2014). A woman’s journey through the standard fragmented maternity care system is also likened to the industrialised production line or conveyor belt (McCourt & Dykes, 2009; Walsh, 2006b).

### 7.2.5.1 Midwife use of time – adapting institutional time

The way a midwife approached time in this study, how she perceived time and worked with time, impacted on the interaction she had with the woman and other people in the appointment. Her approach to time shaped her practice, in what she invested her time, or with whom or what she interacted. Her ‘use of time’ also determined whether she was invested in the system (system-focused) or woman-centred. The way midwives construct or manage their practice has been described as being along a continuum between ‘linear’ and ‘relational’ time (Deery, 2008; McCourt, 2009). ‘Linear’ time is aligned with the system where a time driven production line thinking dominates and promotes work practices that rely on the clock and tasks (Walsh, 2006b). ‘Relational’ time is the alternative or resistant discourse of time that is bound by relationships, both with women and with their colleagues (Choucri, 2012; Thachuk, 2007).

### 7.2.5.2 Linear time

Midwives who demonstrated system-focused investment constructed their practice
around the standardised and medicalised system and relied on the use of 'linear' time. They were task focused, interacted more with the computer/maternity care records than the woman and were bound by the length of the appointment and the demands of the hospital or the OPD. In these encounters, which were mostly in the SMC appointments, there were more telling midwife-woman interactions than discussing and storytelling.

Women in this study reported that the antenatal appointment was a place to seek expert knowledge and reassurance. However, often midwife interactions were more about reassuring the midwife and the system than the women. Although some women reported that the midwife solved their problems by simply answering their questions, other women reported their antenatal appointment was standardised and reliant on checklists with no focus on their own individual worries. It was in these time limited interactions that the telling midwife-woman interaction was seen more commonly used and reflected routine and ritualistic midwife practices.

In the contemporary hospital the prevalence of 'linear' time is constructed on objective and subjective understandings and experiences of work time (Orlikowski & Yates, 2002). An objective understanding of time, for example, is that the antenatal appointment has a beginning and end, is mechanical and measured and valued by the clock or the measurement of time. In Australia, the objective understanding of healthcare practice and time has created the financial reward and reimbursement of healthcare provision through 'activity based funding' that is based on a unit of time per healthcare event (Independent Hospital Pricing Authority, 2017). On the other hand a subjective experience of time often creates events that become ritual and routine and are products of norms, beliefs and customs of individuals or groups (Orlikowski & Yates, 2002). The subjective experience of time is also reflected in the commonly heard statements of 'we have always done it that way' or this is 'how we do it here'.

In the context of postnatal care, Lock and Gibb (2003) identified that hospital
routines and rituals controlled the time women had access to midwives, whereas when the postnatal care was in their own home the women were the ones who prescribed or controlled the time they had with the midwife. Routines, rituals and tasks in the postnatal wards are reported to impact not only the one-to-one time between the midwife and woman (Schmied et al., 2009), but also impact on the amount of time given to supporting women to breastfeed (Burns, Fenwick, Sheehan, & Schmied, 2013). In the context of labour and birth the influence of routines and rituals is evident with the continuing reliance on restricting the length of labour with activities such as active management or restricting the length of pregnancy with induction of labour (Australian Institute of Health and Welfare, 2005; Simonds, 2002).

It is these taken for granted aspects of day to day midwifery work (Deery, 2008), constructed through repeated use of temporal structures and used to reproduce and legitimise the organisation, a person's awareness of how their social interactions or their practice can affect others can be diminished (Schmied et al., 2016; Stevens, 2009; Youngson, 2012). This is particularly pertinent with the establishment of antenatal appointment times and schedules that relate more to ritual and routine than evidence (Oakley, 1982; Tunçalp et al., 2017; Villar et al., 1993). For example, in her examination of midwives' work practices in the hospital and in caseload midwifery, Stevens (2009) identified it is how time was conceived and used by the midwives in these two areas of midwifery that influenced the nature of the service provided. Midwives employed in the standard hospital setting were governed by the modern ideas of time framed by needs of the institution, its shift patterns and its tasks. The midwives the caseload model, in comparison, owned their time and could spend the time facilitating the needs of the woman and the physiological timing of childbirth.

Women in this study reported that the busyness of the midwives, and their reliance on telling midwife-woman interactions in the antenatal appointment was negative, unhelpful and in some examples disempowering for them. Stapleton, Kirkham,
Curtis, and Thomas (2002a) similarly found that midwife and doctor’s busyness and their lack of awareness of women’s non-verbal cues inhibited the women’s capacity to ask questions or discuss information that was presented to them in information leaflets.

**7.2.5.3 Relational time**

At the other end of the investment continuum woman-centred investment reflected midwife practice constructed on 'relational' time. The midwife was focused and bound by the relationship with the woman. In these encounters, which were mostly in the MGP appointments, the midwife interacted more with the woman than the computer/maternity care records and there were more discussing and storytelling midwife-woman interactions than telling. Browne and Chandra (2009) conceptualise this enhanced sharing between the midwife and woman as 'slow midwifery' where the activities of timekeeping and counting in contemporary medicalised midwifery practice are replaced with practices that are more adept at enhancing the midwife-woman relationship. Stevens (2009) and Deery (2008) found this involved spending more time relating and connecting with the woman. In an Australian study that aimed to improve the care women receive on a postnatal ward several important principles of postnatal care were described that were all based around a midwife’s use of time. They included 'listening to women', 'being there', and providing 'one to one time' (Schmied, Cooke, Gutwein, Steinlein, & Homer, 2008).

In this study being woman-centred was linked to spending more time with the woman and interacting and relating through discussing and storytelling, which facilitated worry moderation and reassurance. Women in this study appreciated a midwife who used her time in the appointment to focus on her and her needs or worries as well as the assessments and tasks. The simple action of the midwife spending time relating to the woman through more discussing and storytelling than telling provided reassurance for the women, a finding that has been identified by other studies. For example, with the examination of communication practices in
antenatal care in a London hospital (Raine et al., 2010) women reported positive experiences and were reassured when the midwife and doctor spent time talking through concerns and talked in an open and empathetic way. In contrast these women from the London study reported negatively when the midwife or doctor did not pay attention to them, was abrupt and discourteous and lacked compassion. Likewise, in a study that examined women’s decision to disclose domestic violence, women reported that their decision to disclose relied on a number of factors that included the midwife spending more time relating to her. For example, being asked in a way that the midwife showed she 'cared' and that they 'trusted' her enough to disclose (showed interest and was non-judgemental) (Spangaro et al., 2016).

Additionally, in an Australian study that examined midwifery practice in the antenatal appointment, midwives reported using a number of communication techniques to maintain a wellness focus, to be woman-centred, to facilitate a woman's capability, to employ worry usefully and to reduce anxiety (Browne et al., 2014). These communication techniques relied on 'relational' time that included being 'calm' and 'unhurried', using 'chat' about 'nice stuff' and stories to communicate to women about the broad range of normal in pregnancy to balance out the 'risk stuff'. From a feminist perspective a relational model of midwifery care where the individual and the relationship are prioritised highlights that the way a midwife interacts with a woman is also key to a woman's ability to become empowered and able to maximise her autonomy (Thachuk, 2007).

7.2.5.4 Repeated time – what makes MGP different to SMC

Additionally, in this study in the MGP and the SMC midwife-led clinics appointments 'relational' time was enhanced by the 'repeated' time that a midwife and woman had together during the antenatal period and over the course of the woman's pregnancy. Both these models of continuity of care altered the 'linear' time of the fragmented model of SMC antenatal care by enabling the same midwife and woman to meet throughout the woman’s pregnancy and schedule of antenatal appointments. The examination of the late pregnancy appointments in this study
showed the effect of 'repeated' time associated with the continuity of care principle. It facilitated connection and familiarity between midwife and woman that was not seen in the SMC appointments where there was no continuity of care. When there was a connection between the midwife and woman the midwives were more focused on the woman's individual experience of childbirth and her needs rather than the system's needs.

The content analysis of the video recordings enabled me to appreciate the macro influence of the healthcare system and MCOC model on the micro time events of the appointments and midwife-woman interactions. More appointment time included shared midwife-woman interactions that involved discussing and storytelling rather than midwife-computer/medical record interaction that involved the unilateral midwife-woman interaction of telling. In a review of continuity of care Haggerty et al. (2003) describes continuity of care as a coherent, connected and consistent way for healthcare professional and recipients to connect. Researchers who have examined continuity of care models in other disciplines also describe this benefit of 'repeated' meetings between care provider and recipient as enhancing the 'relational' (Burge et al., 2011; Kemp & Sandall, 2010) and 'interpersonal' (Saultz & Lochner, 2005) aspects of that care and their connection.

The effect of 'repeated' time enables the midwife and woman to also have a connection across the continuum of the woman's childbirth experience: her pregnancy, her labour and birth and her early postnatal period (Homer, Brodie, & Leap, 2008; NSW Government, 2012). This enhanced connection and ongoing or 'repeated' time associated with the MGP model in this study fostered even more changes to the 'linear' routines and rituals of the standard antenatal appointment creating greater 'relational' time between the midwife and woman. In the MGP appointments a familiarity and connection between the midwife and woman was evidenced in their conversations. Through their discussing and storytelling interactions the midwife and woman were able to refer back to previous conversations and also plan for future conversations, events and experiences.
Minimal amounts of appointment time were allocated to the midwife interacting with the computer or the maternity care records, as the midwives remembered the things that were important to the woman, her worries, her plans and her hopes for the upcoming labour and birth or postnatal period.

These shared and bidirectional midwife-woman interactions create what has been described as a relationship based on mutual trust, respect and reciprocated exchanges (Hunter, 2006; Lundgren & Berg, 2007). This relationship changes the power dynamics of the traditional hierarchical midwife-woman relationship, enabling a relationship that has been described as a professional friendship (Walsh, 1999). As Leap et al. (2011) describe, the relationship between a midwife and woman in a MCOC model across the continuum of childbirth is 'the glue that holds it together'. This may explain some of the changes in midwifery practice identified in this study as woman-centred investment. A study by Allen et al. (2017) that examined the characteristics of caseload midwifery and standard midwifery found women characterised their caseload midwife as someone who 'went above and beyond'. Similarly, the women in Walsh's study described that their caseload midwife 'went the extra mile' (Walsh, 1999). Moreover, a sociological reflection of friendship relationships see them as forming a 'social glue' (Pahl, 2000).

The greater amount of woman-centred investment seen in the MGP antenatal appointments was reported by the midwives to be a consequence of their connection to the woman through their 'repeated' antenatal time and to her upcoming birth and the early postnatal period. The MGP midwives described having an awareness of both wanting to and needing to be focused and invested in the woman during the antenatal appointment. Not only did they want to care for and support the woman because of their already developed relationship and connection, but they also anticipated they would be caring for the woman for her labour and birth and postnatal period.

It may be that the MGP midwife's anticipated involvement in the woman's ongoing care inspires her efforts to focus and invest in the woman, her needs and her
worries during the antenatal appointment. The midwives in this study reported that when they focused on the woman and her worries in the antenatal appointment there was the potential the woman would gain power and confidence, as their shared interactions enabled her to be less worried and more hopeful. With less worry, more hope and confidence the midwives reported the women become less reliant on their midwife’s input going into her labour and birth and early parenting. This conceptual understanding that 'repeated' time enhances midwife practice is not simply a reflection of the midwife work ethic where 'the more you do now the less you have to do later'. Instead it shows that 'repeated' meetings between the same midwife and woman facilitates an understanding and appreciation between them enabling the midwife to more easily assist the women to become strong and confident (Leap et al., 2010), less worried and more hopeful as they approached their labour, birth and parenting. As other studies have shown, women value getting to know their midwife and value and gain power from having a known midwife for their labour and birth (Allen et al., 2017; Forster et al. 2016; Walsh, 1999).

7.2.5.5 Cyclical time

In the situation of the SMC system and contemporary antenatal care there is little connection afforded to the midwife and woman between appointments. A woman's antenatal appointments are scheduled at certain gestational weeks and often there is no continuity of carer unless a private practitioner is caring for them or they have access to a midwife's clinic. In her review of time and midwifery practice, Choucri (2012) describes the competing concepts of 'linear' and 'cyclical' time and how these shape midwifery practice. In contemporary maternity care 'linear' time is associated with the reality that the majority of maternity care is undertaken in hospitals, where 'linear' organisational or institutional frameworks govern midwifery practice and the role of the midwife by standardising it and fragmenting it into antenatal, intrapartum and postnatal areas (Deery, 2008; McCourt & Dykes, 2009).
In a number of SMC appointments in this study I observed macro 'linear' institutional time in action when the computer/maternity care records governed the midwife’s practice instead of the woman and her needs governing the midwife’s practice. In these appointments the computer/maternity care records directed the midwives to what clinical assessment or education tasks needed to be done at that present time. However, these midwife-computer interactions provided minimal direction to the midwife to consider the woman from the perspective of her past experiences or her future needs and desires.

For women their childbearing experiences are embedded in 'cyclical' physiological and sociocultural transitions rather than 'linear' and fragmented organisational or institutional time frames (Van Teijlingen et al., 2004; Wray, 2006). 'Cyclical' time relates to physiological and sociocultural rhythms or an inner flow, such as the sun rising every day or in the case of this study a woman's experiences of reproduction and motherhood (Bartlett, 2010; Davies, 1996; Hauck, Fenwick, Downie, & Butt, 2007; Maiburg, Væth, & Dahlen, 2016). In addition, 'cyclical' time relates to the concept of temporality and how time is experienced within or phenomenologically through the connection of experiences to past, present and future (Berger & Luckmann, 1966; Dykes & Flacking, 2016; Grosz, 2005).

In the MGP appointments the 'repeated' midwife-woman interactions across the schedule of antenatal appointments and across the woman’s other childbirth experiences enabled the midwife and woman to 'cycle' through and revisit the woman's worries and her experiences. It connected the midwife and woman across the phrases of time; the past, the present and the future (Haggerty et al., 2003). 'Repeated' time of the MGP model also enabled the midwife and woman to focus on the 'cyclical' effect of childbirth where physiology and individual social factors are altered through the course of the pregnancy and childbirth, which often have lifelong effects or impact on later childbirth events (Guardino & Dunkel Schetter, 2014; Maier, 2010). These midwives were more likely to use discussing and storytelling enabling them to focus on the needs of the woman instead of their
interactions being informed by the 'linear' checklist of tasks set out in the computer/maternity care records. These shared interactions, particularly storytelling, enabled them to relate to each other’s issues of the past and present that then informed their expectations and aspirations for the future labour and birth and postnatal period.

The micro examination of antenatal appointment time undertaken in this study adds a level of understanding to what informs positive and beneficial midwife-woman interactions and quality woman-centred midwifery care. Likewise, the examination of time from a macro perspective and how midwives approach their practice adds to the knowledge of the benefits associated with MCOC models. The observed adaptive practices of the midwives in the majority of the MGP appointments and in a small number of the SMC appointments created greater awareness for me about the negative effects of the standardised and medicalised approach to antenatal care and to how midwives practice. Their adaptation of the standardised tasks, especially with the computer/maternity care records, and the creation of more 'relational' time with the woman through enabling more discussing and storytelling midwife-woman interactions resulted in the 'linear' time set out by the hospital being altered to prioritise the woman and her needs or worries. The actions of these midwives to adapt how they invested their time were seen to alter the authority, power and control ubiquitous with contemporary standardised and medicalised maternity care. In addition, the 'repeated' time associated with the MGP model enabled midwives to ‘cycle’ through the childbirth experience with the woman, which appeared to moderate the woman's worry and foster a greater sense of hope and optimism for the woman for her future childbirth events and is discussed in more depth in the next section.

In the next section of the chapter I examine the concept of hope in relation to relevant literature. Unlike worry, which emerged as a central feature of every observed appointment and influenced the overall nature of the midwife-woman interactions, hope was less frequently seen. Hope was mostly observed in the MGP
appointments and the appointments with the midwives who were seen as adaptive experts.

7.3 Hope

The creation of hope in the antenatal appointments was the notable difference between SMC and MGP and appears to relate to the influence of the continuity of carer principle. Midwives working in the MGP, for example, told me that they had hope or 'hoped' for each woman. A midwife's hope appears to relate to the level of investment she had in the woman, while the creation of hope by the midwife and woman was linked to their efforts in the appointments to moderate the worry the woman had by generating positive expectations and experiences for her upcoming labour and birth and postnatal period. More importantly hope was associated with the discussing and storytelling interactions not the telling interactions. The increased sharing, problem solving, and positive messaging created by these shared interaction seems to facilitate the midwife and woman to jointly moderate or replace worry with more hopeful thoughts and aspirations. As Perakyla (1991) identified 'hope work' and hopefulness are created when there are enhanced interactional processes involving conversations between healthcare professional and patient.

In the literature the creation of hope is characterised as a goal-orientated process in response to a threat or barrier (Nweze, Agom, Agom, & Nwankwo, 2015). It is seen as a cognitive, action-oriented process, which creates a positive expectation or anticipation for a future goal or outcome, and is stimulated by negative feelings, such as uneasiness or uncertainty (Haase, Britt, Coward, Leidy, & Penn, 1992; Tutton, Seers, & Langstaff, 2009). It is also recognised that these goal and action orientated processes associated with the creation of hope are aided by 'pathway thinking' and 'agency thinking' (Snyder, 2000) and 'social support' (Herth & Cutcliffe, 2002).

Hope is also reported to have a number of similar features. Through a process of
concept analysis Benzein and Saveman (1998) identified that hope had seven critical attributes: future-orientation, positive expectation, intentionality, activity, realism, goal-setting, and inter-connectedness. Similarly, Morse and Doberneck (1995) linked the creation of hope to seven universal elements, which they identified by doing interviews with four different groups of individuals who were all experiencing uncertain or worrying life experiences (heart transplant, spinal cord injury, breast cancer, breastfeeding and returning to work). Although the people in these groups were facing different threats or worries their comments about their hope were similar and were characterised as:

1) Realistic initial assessment of threat or predicament, 2) Envisioning alternatives and goal setting, 3) Bracing for negative outcomes, 4) Realistic assessment of personal resources and external conditions/resources, 5) The solicitation of mutually supportive relationships, 6) The continuous evaluation for signs that reinforce the selected goals, 7) A determination to endure (Morse & Doberneck, 1995, p. 282).

In this study the discussing and storytelling midwife-woman interactions reflected a number of these hope features identified by Morse and Doberneck (1995) and Benzein and Saveman (1998). Through these shared midwife-woman interactions many of their interactions and conversations reflected the hope activities of 'goal setting' and 'intentionality' identified by Benzein and Saveman (1998). Within many of the discussing and storytelling episodes the midwife and woman were actively engaged in and intentionally focused on creating goals or potential solutions to moderate the woman's worries. In particular with their storytelling interactions, a number of the hope elements, purported by Morse and Doberneck (1995) were observed. For example, an 'assessment of the threat' occurred when the women told stories about their worry or concern and the midwives reciprocated with their stories of similar experiences or actively requested more information/other stories from the woman. Through their sharing of stories and listening they generated and established 'alternatives and goal setting', which also enabled the woman to make
'assessment of personal and external resources' available to her to assist her with managing the worry/threat. Many of these shared interactions in the MGP appointments were also what (Benzein & Saveman, 1998) described as having a 'future orientation' and 'positive expectation', as many of the woman's worries not only related to current concerns, but also those linked to her upcoming labour and birth and postnatal period.

In addition, the hope element 'realism', identified by Benzein and Saveman (1998), and the hope features a 'realistic nature' and a 'determination to endure', identified by Morse and Doberneck (1995), were evident in the discussing and storytelling midwife-woman interactions. Instead of the midwife simply telling the woman objective information, the midwife-led stories reflected honest and realistic information about the threat or predicament the woman was envisaging. Through sharing stories of endurance and positive outcomes about women she had cared for the midwife created a sense of optimism and hope. However, the element 'bracing for a negative outcome' identified by Morse and Doberneck (1995) was rarely evident in the midwife-woman interactions in this study. This may be due to the women in this study having a pregnancy deemed to be low risk; the upcoming labour and birth were not associated with end of life, but instead were a joyous part of life.

The influence of the MCOC model in the MGP appointments, as the 'repeated' time provided by this model facilitated and enabled many of the hope attributes identified by Benzein and Saveman (1998) and the remaining elements identified by Morse and Doberneck (1995). The 'repeated' meetings between the midwife and woman aligned with Morse and Doberneck (1995) findings, as these antenatal interactions enabled the midwife and woman to undertake 'continuous evaluation for signs that reinforce selected goals', which in this study were related to the woman's labour and birth and the early postnatal period. For example, in many of the MGP appointments the midwife and woman referred back to conversations or topics they had talked about in previous appointments as they attempted to
moderate worry and create hope. These 'repeated' meetings also enabled more time for the 'solicitation of mutually supportive relationships' or what Benzein and Saveman (1998) describe as 'inter-connectedness'. In addition, with the MGP midwives the effect of them being available for the woman in labour and then providing her postnatal care reinforced the midwife and woman's joint investment in and creation of hope for these future goals. The creation of hope identified in this study, as reported by Morse and Doberneck (1995) and Perakyla (1991), relies on a process of interaction between the health professional – the midwife, and the recipient – the woman.

Regardless of this important conceptual work, hope remains a difficult concept to understand and one that is often reported to be an unhelpful emotion or concept in healthcare. This is partly due to it being seen as a human phenomenon that is vague, has no distinct boundaries and could be simply a reflection or voicing of expectation and desire (Benzein & Saveman, 1998) rather than a quantifiable outcome of effective healthcare practice. Also, the premise of 'hope work' relates to social interactions and inter-connectedness, which are at odds with the dominant medicalised model of care that informs many of the principles that govern our professional behaviours as contemporary midwives.

As Gilligan (1982) explains, the ability for a healthcare interaction to enable those involved to be autonomous, and thereby proactive and intentional in moderating and adapting the worry of the antenatal appointment to hope, is associated with the interaction being 'relational', socially situated and contextualised.

From what I have observed and identified in this study I credit the ability of the midwife and woman to being hopeful to them being able to discuss and story tell. However, I also realised that the individual abilities of these midwives and women to undertake these activities related mostly to the MGP model of care or a midwife who had the self-belief to actively adapt the standardised and medicalised model of care. As Sherwin (2000), states the ability of an individual to be autonomous rests not only on the interpersonal interactions and relationships of the private space,
but is also reliant on the multiple public relationships and political influence that govern it. In essence as Thachuk (2007) the MGP midwifery model of care, by its very nature protects, supports and advocates for midwives enabling them to go against the dominance of the medical model of care and put the woman and her worries first.

7.3.1 Invisibility of hope in midwifery practice

In maternity care the need to focus on or create hope is rarely talked about or reported on. Stereotypes associated with pregnant women and pregnancy (Green, Kitzinger, & Coupland, 1990; Morrissey, 2007) are of assumed joy. However, in reality many pregnant women experience anxiety and worry about their upcoming labour, birth and postnatal period (Alderdice, McNeill, & Lynn, 2013; Maier, 2010). In general, interactions and activities in maternity care and particularly in antenatal care rarely promote, support or enable women to have hope or hopeful aspirations for their upcoming labour, birth and postnatal period.

Obstacles to the development of hope in midwifery practice include being time poor and having practice restricted and shaped by the standardised and medicalised healthcare system (Dykes, 2009b; Hyde & Roche-Reid, 2004). It appears that the standardised and medicalised tasks of the antenatal appointment in the fragmented system of maternity care have little basis for enabling women to discuss and plan for their future childbirth events. Instead the focus of the short, standardised antenatal appointment is on the physical aspects of the pregnant body, which limits a midwife's ability to focus on and work with the woman on her worry or enable her to feel hopeful.

Furthermore, within maternity care it has become common practice for much of this preparation and planning work for the woman's labour and birth and postnatal period to be outsourced to antenatal or childbirth education programs (Svensson, Barclay, & Cooke, 2007). This, again, fragments the woman's childbirth experience and leading to concerns that childbirth education is founded on the needs and
agendas of the system and does not facilitate parents becoming active participants in their care or confident (Declercq, Sakala, Corry, & Applebaum, 2007).

Due to the future orientation element associated with hope the midwives in the SMC had little opportunity to be involved or able to work with the woman to create hope. The SMC appointments were often short, task-focused and the midwives had no expectation of being a part of the woman’s future experiences.

Some authors have argued that midwives’ practice and professional behaviour is being pushed to align with the task based nursing philosophies of practice that are out-dated in a technocratic model of healthcare that endorses mind-body separation and the body as a machine (Davis-Floyd, 2001). This results in the shunning of midwifery practice that promotes and enables social and emotional connection with the pregnant woman. A recent example of this is the newly released Australian Midwifery Standards where risk and legal accountability are given a higher emphasis than woman centred care, which has been moved down the list of priorities underpinning midwifery practice (Nursing and Midwifery Board of Australia, 2018). There are those who work in the professions of midwifery, nursing and medicine, for whom equality and connection between a midwife and woman is not valued or seen of benefit (Green et al., 2000).

There is also the opinion that pregnant women are vulnerable to the powerful and persuasive attitudes of midwives who create harm through creating unrealistic expectations or desires (MacColl, 2009), which aligns with the debate about whose hope it really is. Is it the expectation and desire of the healthcare professional (midwife) (Olsman et al., 2014) or the patient (pregnant woman) and her family (Benzein & Berg, 2005)? Contrary to these two opinions there is also the unspoken supposition that equality and connection between a midwife and woman undermines the professional boundaries that govern midwifery practice (Hays, 1996; Jordan, 1997).

In contrast, in many nursing, medicine and psychology forums, where dealing with and managing illness and negative issues are the central tenet of their work, hope
and 'hope work' are promoted. This is particularly evident with end of life and palliative care treatment where people often feel they have little control or choice over their fate (Hawthorn, 2015; Herth, 2001; Rand & Cheavens, 2009; Snyder, 2000). For example, the UK National Health Service Cancer Plan reports that patients at the end of their life value a health professional who is willing to listen and explain and endorses the roll out of training to improve health professional communication skills. Situating the person at the centre of their care through the use of simple communication skills such as listening and explaining and enhanced awareness of the person's situation by being empathetic, authentic and having unconditional regard (Crisp, 2011; Rogers, 1951) are important features of sustaining hope in end of life care (Hawthorn, 2015), but not so for the beginning of life care.

7.3.2 Generating hope in midwifery practice

The actions by the midwives in this study challenge the negative opinions and assumptions that underpin the contemporary push for the role of the midwife to be detached from the woman. This was particularly evident in the MGP appointments and those where the adaptive experts featured. The midwives in these appointments demonstrated connection and sharing of power with the women and positivity and encouragement for the woman's future by facilitating shared midwife-woman interactions. As (Leap, 2009) reports these actions place the woman and her needs at the centre of her care and the use of enhanced communication by midwives shifts the locus of control away from the institution and the professionals to the woman.

The increased use of shared midwife-woman interactions in the MGP during the antenatal appointment and their joint investment and connection to the future childbirth events informed the transition from worry to hope. Through these shared interactions of discussing and storytelling the woman was able to raise her worries and the midwife and her were able to connect and work together to moderate the worries, and as a consequence they were able to create hope for the woman.
Rather than the MGP midwives simply treating the antenatal appointments as routine and mundane, they actively encouraged shared interactions with the women. It appears that their investment and their hope and positive expectations for the woman's future childbirth events informed or were informed by their interactions and communication with the women.

The discussing and storytelling midwife-woman interactions capture the art of positive persuasion by the midwife (Leap, 2005) enabling the woman to be confident and optimistic about her ability to labour, birth and parent (Leap et al., 2010). The adaptive experts also demonstrated this quality by being able to focus their practice and communication on more than just the pregnant body and the requirements of the antenatal appointment. However, the fragmented SMC system so evident in the OPD made it difficult for midwives to have ongoing investment in the women they cared for in the antenatal clinic.

Midwife investment and hope creation were enhanced by the opportunities provided by the MGP model. Not only were the midwife and woman meeting throughout the antenatal period, they were both investing in the woman's labour, birth and postnatal period, expecting the midwife to be involved. The creation of hope or being hopeful, as discussed above, is through having a goal and action orientated process aided by 'pathway thinking' and 'agency thinking' (Snyder, 2000) and aspects of 'social support' (Herth & Cutcliffe, 2002). Snyder (1995, 2000) theorises hope as a reflection of a person's motivation and capacity to strive toward personally relevant goals that involves both 'pathway thinking' and 'agency thinking', while Herth (2001) and Herth and Cutcliffe (2002) report that hope enhancement is associated with people's perceived social support, spiritual support, and sense of belongingness. From a feminist perspective these actions of 'pathway thinking' and 'agency thinking' factor more as acts of autonomy (Gilligan, 1995; Sherwin, 2000; Thachuk, 2007).

The MGP midwives commented in their focus groups that getting to know the women and being available for them inspired their investment in her and her future.
childbirth events and also inspired their hope for the women, while the women who had midwifery care from the MGP commented that the midwife worried for her and knew her and what her needs were. As in studies of midwife-led and midwifery continuity of carer models, improved outcomes and experiences related to midwives and women having opportunities to connect (Finlay & Sandall, 2009; Leap et al., 2010; Sandall et al., 2016).

As discussed earlier, hope creation aligns closely with autonomy or what is described as empowerment in much of the midwifery literature, where women become confident to make their own decisions (Prata, Tavrow, & Upadhyay, 2017). The association between hope creation and empowerment appears dependant both on shared interactions and interconnectedness between the midwife and woman. Snyder's (2000) ideal of hope creation informed by 'agency thinking', the capacity of an individual to be autonomous in thought and action, and the 'social support' aspect identified by Herth and Cutcliffe (2002) were both evident in the discussing and storytelling shared midwife-woman interactions, particularly those in the MGP appointments.

Hermansson and Mårtensson's (2011) examination of empowerment in the midwifery context identified criteria and attributes similar to those of hope and 'hope work', which were discussed in the previous paragraphs. They articulated, as others have, that empowerment within midwifery care is associated with enhanced communication, woman-centred care and the influence of the midwife-woman relationship developed across the midwifery continuity of carer experience (Berg et al., 2012; Carolan & Hodnett, 2007; Leap, 2009). For example, Hermansson and Mårtensson (2011) included in their modelling of empowerment a number of attributes that facilitate what I have associated with 'agency thinking' and are enhanced by 'social support' actions. These include the importance of developing a trustful relationship; enabling a process of awareness and reflection; acting on the parent's situation and own terms and enabling them to get involved, make informed choices; and confirming the personal significance of becoming parents.
Communication in healthcare settings, as it was observed in the antenatal appointments, is a complex process involving information gathering and sharing and the provision of social support. As reported by other research and by the women in this study, a person in receipt of care from a healthcare professional shows less anxiety and fear and are more hopeful when they are given opportunities to communicate (Hagerty et al., 2005; Wilkinson, Perry, & Blanchard, 2008). Optimal healthcare communication observed in the antenatal appointments included discussing and storytelling and that enabled the woman to talk, be involved in her care decisions and for the midwife to listen and not be scripted (Iedema & Manidis, 2013; Kurtz, 2002; Matusitz & Spear, 2014). Poor or ineffective communication by health professionals is a factor that leaves patients anguished and in despair (Fallowfield & Jenkins, 2004; Wilkinson et al., 2008) and this was reported by two women in this study as a negative factor in care they had previously received (not in this study). Within nursing and medicine, person-centred care, holistic care and therapeutic communication (Hawthorn, 2015) are reported as fundamental strategies for creating hope, coping mechanisms and reducing stress for patients and their families.

Finally hope enhancement strategies are often associated with the ability of the patient or client to be able to tell or share stories (Chelf, Deshler, Hillman, & Durazo-Arvizu, 2000; Hawthorn, 2015; Snyder, 1994; Weis & Speridakos, 2011) and this is what occurred in this study when the midwife-woman interactions included discussing and storytelling.

### 7.4 Limitations

My decision to use critical ethnography as the research methodology for this study in conjunction with a feminist approach provided a useful way to appreciate and examine this issue. I also believe the added use of video recordings, as well as traditional methods of data collection, observation, focus groups and interviews, provided rich data and was an innovative way to go back to the data repeatedly to
examine what was happening in the antenatal appointments. The findings demonstrate the positive influence a midwifery continuity of carer model has on midwife-woman interactions. It also provided an in-depth understanding of the features of the maternity care system and the antenatal appointment that shape how a midwife and woman interact. The choice of methodology for this study may be criticized by some as restricting the generalizability of the findings, as they may not represent the everyday social interactions of an antenatal appointment in other contexts. However, the transferability of the findings appears plausible given the findings affirm many of the reports produced by other research on the experience of maternity care throughout the developed world.

Newnham (2016) reflects, 'that ethnography can only present a version of the story, not the version.' (p229). This study involved two models of midwifery care (SMC and MGP) at two closely located metropolitan hospitals, the OPDs of these, one community health centre and a number of women's (participants) homes. As a consequence, it does not represent the antenatal appointment or midwifery care experience for women across Australia, let alone an international perspective. Due to financial and time restrictions, recruitment of participants was restricted to those who read English. This resulted in the majority of the participants being Caucasian, whose first language was English, and were educated to a minimum of secondary school education.

Regardless of these similarities between demographics and participant characteristics there were also differences seen. It is recognised within anthropology and sociology that the sociocultural context and the culture will vary considerably from place to place (Hammersley & Atkinson, 2007). This was evident even between the two hospitals involved in this study, with the differences in the layout and functioning of the OPD, in the models of care and how the midwives worked.

The self-selection of the midwife participants and their influence on which women were recruited may have led to an over representation of certain types of midwife-
woman interactions and these may not necessarily reflect the range of day to day experiences of both midwives and women in these settings (Hammersley & Atkinson, 2007). During the recruitment phase a small number of midwives approached for the video recording and observation phase declined to have their practice observed and video recorded. This may relate to a reluctance to be filmed and a concern that their practice would be critiqued or that aspects of their performance may be exposed to others. In contrast, the midwives who did agree to participate in the video recording and observation phase appeared confident and keen to showcase their practice and the model of care they worked in. The passion demonstrated by these midwives, in the MGP and the adaptive experts in SMC, and their decision to be involved in the study indicated a commitment to midwifery continuity of carer models and midwife-led care.

The inclusion of other data was one way that I was able to moderate this selection bias. These data sources, such as interviews and focus groups with a wide variety of other participants, also included the opinion and experiences of those not comfortable to be observed and video recorded. The use of a number of different sources of data in the study design enabled a number of perspectives to inform the findings (Thurmond, 2001). Also, the involvement of my supervisors in the early analysis of the video records and audio transcripts and throughout my writing up phase was important in questioning some of my assumptions (Shenton, 2004). In addition, as I reported in Chapter Three, I have relied on a high level of reflexivity in an attempt to balance my bias and ensure trustworthiness and rigour (Finlay & Gough, 2003).

Regardless of these limitations the findings from this study provide motivation for further work in understanding the intricacies of midwife-woman interactions to establish better support and care for women as they transition to motherhood. Already the findings from this study have been disseminated at local forums where the study was undertaken and at local, state-based, national and international conferences. A number of peer reviewed academic publications are planned and
will be written and published within two years.

7.5 Implications

How midwives and doctors communicate is important to women during their pregnancy (Dahlberg & Aune, 2013; Kozhimannil, Attanasio, Yang, Avery, & Declercq, 2015). As discussed throughout this thesis, MCOC models such as MGP provide women with quality midwifery care and enhance clinical outcomes for them and their babies. This study found that positive midwife-woman interactions optimised by the MGP enabled the midwives and the women to moderate the woman's worry and in some situations created hope. The moderation of worry and creation of hope for women as they approach their birth and parenting may be the fundamental reason why they, and their newborns, have better outcomes. How we are born matters. Evidence is now beginning to show an association between the way we are born and our future health (Dahlen et al., 2013).

With these thoughts in mind I put forward a number of recommendations. These include changes to how maternity and midwifery care is undertaken in Australia, in particular antenatal care, and how midwives and doctors are educated and trained in healthcare communication. They also include areas of research that can build on from this qualitative study and provide enhanced analysis of midwife practice through innovative research and practice development.

7.6 Recommendations

7.6.1 Policy and Service Design

7.6.1.1 Pregnant women in Australia must have access to a known midwife.

Regardless of demographics Australian women must have access to a known midwife through a midwifery-led model of care or a MCOC model. Even with recent increases in MCOC models in some metropolitan and regional hospitals the fragmented SMC system continues to be the typical way women access midwifery
care. To achieve greater uptake of MCOC models there needs to be commitment by federal and state governments. Healthcare and hospital policy makers need to be informed of what is quality midwifery care and how to establish it.

7.6.1.2 Locating the majority of antenatal care in the community.

Women to have the opportunity to have antenatal care in their own home. This would be a defining change in healthcare provision in Australia. It would enhance the quality of care women receive and decrease the burden on the OPD. In this study the woman's home was the optimum place for beneficial midwife-woman interactions to take place.

7.6.1.3 Design of an antenatal clinic in the OPD that enhances healthcare communication

To enhance healthcare communication and interactions changes to architectural design principles of OPDs where antenatal care takes place are needed. In this study the design of the OPD was a barrier to quality healthcare communication and interaction. Within Australia there has been a significant shift in the design of labour and birth spaces that has been inspired by the Birth Unit Design project (Foureur, Leap, Davis, Forbes, & Homer, 2010). A similar project that identifies and establishes a set of principles for optimising antenatal care spaces might be an important strategy to improve antenatal care.

7.6.2 Education and Practice Development

7.6.2.1 Educate and train midwives, nurses, doctors and allied health practitioners in enhanced communication and awareness skills.

Enabling healthcare practitioners to understand quality healthcare communication and to have greater awareness in their everyday interactions is an important strategy in improving healthcare. Skills-based education programs, for example, a healthcare communication improvement tool known as video reflexive ethnography (Iedema et al., 2013) enables health professionals to improve how they practise
through reflection, review and discussion of filmed practice.

This study demonstrated midwives are often not aware of how they communicate and interact with women and the impact this has. Women reported that some midwives and other healthcare practitioners struggled to communicate with them in a way that reassured them or enabled them to have confidence and hope. It also highlighted showed shared storytelling between midwife and woman created connection, moderated worry and had the potential to create hope. The principles of woman-centred care and person-centred care inform us that childbearing women and patients value being at the centre of their care and gain many benefits (Crisp, 2011; Pope et al., 2001).

7.6.3 Future Research

7.6.3.1 Information Technology research in healthcare interactions.

In this study midwife use of the computer was detrimental to midwife-woman interactions. Information technology (IT) is a necessity in today's healthcare facilities. In order to enhance communication when using technology for data collection in healthcare more research is needed into how computers or other smaller IT devices (for example smart phones), are best used in healthcare interactions.

7.6.3.2 A descriptive study of a woman’s journey of maternity care in Australia.

To inform a change in healthcare policy it is crucial to gather the perspectives of those who access healthcare. An effective way to gather this information is a descriptive study that collects and examines a number of women's journeys through different models of care and different types of hospitals in Australia. To transition and establish more MCOC programs we need to understand the factors that enhance a woman's experience and those that do not. Also seeing the maternity care experience from the woman's perspective will identify where changes to current standardised systems are needed.
7.6.3.3 Research examining the physiological benefit of MCOC on women, their supporters, midwives and other staff.

The findings of this study create a better understanding of what informs a quality midwife-woman interaction. These findings do not, however, illustrate the physiological benefits that may be occurring as a result of these enhanced midwife-woman interactions. Also, traditional research, which measures and compares clinical outcomes or experiences, struggles to define the benefits of a quality healthcare interaction. Research methods that rely on biological markers or simple instruments such as thermal imaging cameras may be the answer. Cortisol and Oxytocin are beginning to be seen as useful biological markers in measuring whether an event is stressful or calming (Nierop et al., 2006; Swain et al., 2014). Also, thermal imaging cameras are being used in innovative ways to examine how individuals respond in certain situations or events (Puri, Olson, Pavlidis, Levine, & Starren, 2005). These innovative methods have the potential to be used in research to examine what a quality and beneficial midwife-woman interaction is or the benefits of a MCOC model of care on the physiology of the woman and the midwife.

7.7 Concluding remarks

For me this research journey started from a logical and real-world perspective, informed by my practice-based healthcare experiences. Initially I viewed my research focus on midwives' practice as being located within 'practitioner research', as the fundamental intention was 'to develop an understanding about the nature of practice and ultimately to contribute to the body of professional knowledge' (Reed & Procter, 1995, p. 11). Although as this journey progressed I realised the endeavour of this doctoral study was more than this. By examining midwife practice through a feminist and critical lens I gained greater insight and understanding of the meaning of midwifery, its attitudes, its beliefs and values.

The findings from this study illustrate the positive influence and opportunities made available by the MGP model. I found that these opportunities enabled the midwife
to adapt the environment and time associated with the standardised and medicalised antenatal appointment and facilitated woman-centred investment instead of being system-focused. This investment in the woman enhanced midwife-woman interactions through discussing and storytelling. These shared and bi-directional interactions generated and moderated the woman's worry rather than the systems and on occasion transformed their worry to hope.

This study provides a better understanding of what quality midwife communication and interactions are and the potential these have in enabling a woman's worry to be moderated and generating hope for her upcoming labour and birth and early postnatal period. Women have personal expectations that they bring to their childbirth, they value the support and the relationships they have with their caregivers and they also appreciate being involved in decision making (Brown & Lumley, 1993; Declercq et al., 2007; Redshaw & Heikkila, 2010). Likewise, they see the qualities of a midwife as not just including information provision, but to provide continuity of care for their childbirth; to reassure, support and encourage them; and to have confidence in their abilities to give birth and to acknowledge the women's own strengths (Homer et al., 2009).

Midwifery, as we know, is a vocation that is age-old, but still a relatively young profession. Over the past three decades it has begun to re-establish itself as a discrete profession and academic discipline separate from nursing and is looking to seek peer respect from medicine, especially obstetrics. As a young academic discipline, midwifery is looking to the future and the establishment of its own theoretical foundation (Bryar & Sinclair, 2011). However, the midwifery profession in Australia and around the world is at a critical point, particularly in regard to scope of practice and autonomy. Many midwives are leaving this important profession due to burnout and being restricted and denied the ability to provide the type and quality of midwifery care that makes a positive difference for women (Hildingsson, Westlund, & Wiklund, 2013; Yoshida & Sandall, 2013). This study has opened a window into what informs quality midwifery care with a particular focus on
communication and interactions between the midwife and woman. It provides a better understanding of why knowing your midwife matters.
References


Burns, E. (2011). Mining for liquid gold: An analysis of the language and practices of midwives when interacting with women who are establishing breastfeeding. (PhD), University of Western Sydney, Sydney.


Dykes, F. (2004). 'Feeling the pressure – coping with chaos': breastfeeding at the end of the medical production line. (Doctor of Philosophy), University of Sheffield, UK.


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Teate, A. (2010). *The experiences of midwives involved with the development and implementation of CenteringPregnancy at two hospitals in Australia.* (Honours), University of Technology, Sydney, Sydney.


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Appendix A – Ethical considerations

Ethics application letter of response to Health Research & Ethics Committee

Written Information about study for staff

Letter from Human Research Ethic Committee identifying me as an approved researcher

De-identified Participant Information & Consent Form

Media release form

Letter requesting consent for use of personal images
HREC Executive Officer
WSLHD Human Research Ethics Committee | Research Office
Room 1072, Level 1, Education Block,
Westmead Hospital, Hawkesbury Road
Westmead NSW 2145
Tel 02 9845 8183 | Fax 02 9845 8352 |
tina.goodenough@swahs.health.nsw.gov.au

27th August 2012

Dear HREC Executive Officer,

RE: HREC2012/7/4.4 (3555) AU RED HREC/12/WMEAD/240

Project title: ‘Interactions between midwives and women during antenatal consultations in two different models of care: An ethnographic study.

Please find the requested responses from UWS to the HREC comments provided by the Western Sydney Local Health District Human Research Ethics Committee (meeting held on 31 July 2012). As requested, we have also included the clean and tracked copies for all Patient Information and Consent forms and Midwives’ Information and Consent forms.

We have endeavored to respond to all your comments.

Please do not hesitate to contact us if you require further information.

Kind Regards,

Hannah Dahlen | Associate Professor of Midwifery

School of Nursing and Midwifery | University of Western Sydney
Building EBLG Room 34, Parramatta South Campus
P: 9685 9118 | F: 9685 9599 | E: h.dahlen@uws.edu.au
www.uws.edu.au/nursing
Responses to: HREC2012/7/4.4(3555) AU RED HREC/12/WMEAD/240

Comment
Section 6 of the NEAF, Participants, has not been completed; the investigator should provide this information.

Response
Question 1
We have reviewed the NEAF and note we did not indicate each participant group.

Please correct the following inclusions for:
The Probable coincidental recruitment (b category):
Aboriginal and/or Torres Strait Islander peoples
People who may be involved in illegal activity
Are to be excluded as per c) category.
People in existing dependent or unequal relationships
People with a cognitive impairment, an intellectual disability or a mental illness

We wish to amend this Question 1 to indicate the probable coincidental recruitment / exclusion of these participants groups.

Comment
No explanation of what ‘MGP’ and ‘Standard Maternity Care’ is has been provided, the difference between the models should be outlined.

Response
It appears that the initial description of Midwifery Group Practice (MGP) and Standard Maternity Care that were included in Section 1. Question 2 had not been included due to the word limit. We apologize for this error.

The following description will assist with the delineation between these two groups.

Midwifery Group Practice (MGP):
Is a model of midwifery continuity of care whereby a woman is cared for by a known midwife for her pregnancy, labour and birth and early parenting. This midwife is supported by a small group of midwives to ensure the woman has her known or primary midwife or a backup midwife at every stage of her childbirth experience.

Standard Maternity Care:
Is the contemporary model of public hospital maternity care. It includes midwives’ clinics, doctor’s clinics and general practitioner shared care models. It does not enable the same carer or carers to provide care to women across the antenatal, intrapartum and postpartum periods.

Comment
As women will be recruited from the group they are already in there is no randomisation to the selection process and this self selection could affect the outcomes.

Response
This is a qualitative study using and ethnographic approach. Ethnography is a qualitative research design initially developed by anthropologist to explore and describe the social and cultural phenomena of those who are being studied. Data collection is often done through participant observation, interviews, and questionnaires and does not include randomization. Ethnography seeks
to find meaning to certain phenomena or culture, such as with the models of care chosen in this study. We are particularly interested in how interactions between midwives and women are different in MGP compared to standard maternity care. This new knowledge will inform a greater understanding of how continuity of midwifery care is able to improve outcomes for women and their babies.

Comment

The Committee have concerns about the analytical value of the video/audio recordings, as people who know they are being filmed naturally adjust their behaviour.

Response

We agree that the presence of any observer, as in any ethnographic study, has the potential to alter the standard process of care due to the 'Hawthorne effect', whereby the research method influences or predetermines its research findings. However, emerging evidence with video ethnography such as undertaken by Iedema et al (2008) conclude that staff get used to the presence of the camera as they do an observer as they often are too busy to modify for long what they normally do 'to create a positive impression'. We have undertaken a number of ethnographic studies using observation and audio or video recording and it is clear that health professionals while perhaps a little uncomfortable do not necessarily alter their practice.

The use of video in ethnography has also been recognized as having benefits (Carroll, et al 2008, Schaeffer 1995). These are that video footage has the potential to improve the research rigor as the video data retains the sequence of events observed for later analysis and as a result can increase quality and reliability of statements made regarding the activity. The video data also has the potential to be used to establish connections between researchers’ abstractions and inferences and the observed activities on which they are based. This strengthens the analysis and interpretation of the written data.


Comment

The Committee feel that if a video camera is not intrusive to the interview process then a Health Care Interpreter would not be either. Further consideration should be given to the value of the inclusion of NESB women especially given the demographic in the areas where the research is to be conducted.

Response

We appreciate the committees thought on this issue and considered at length the inclusion of women where they have a language other than English (LOTE). The difficulty with the inclusion of LOTE women is that we are also interviewing the women six weeks following birth and it would be difficult and expensive to organise interpreters for these interviews following the woman’s discharge from the health service. We, however, propose to include LOTE women who have an appropriate level of English to be able to consent to their participation in the study. It would be important in future work to explore this in relation to specific ethnic groups such as Indian women who are now the largest migrant group coming into Australia.
Comment

The HREC has requested that SAC re-review the selection method i.e. self selection and how this may impact the results achieved.

Response

We again understand the committees concern, but it is important to recognize that this is a qualitative study and self selection or self nomination for interview and observation is standard practice unlike in quantitative studies. This study has been peer reviewed at the University of Western Sydney and NSW Health and found to be of such an excellent standard that grant money has been awarded.

Comments for change in the ‘Participant Information and Consent Forms’

In addition to the above, the Participant Information and Consent Forms (Version 1 dated 13 June 2012) should be amended as follows. Clean and tracked copies with revised version number and date should be submitted.

(Reference National Statement 2.2) The Participant Information and Consent Forms do not conform to the WSLHD Standard Wording document. These should be reworked in line with that document.

As this is a multicentre study the Participant Information and Consent Forms should be submitted as Master documents.

On page 1 of 5 under the heading “What is the purpose of the Study?” there is no explanation of the two models of care, this should be included.

The information regarding voluntary participation appears in both Participant Information and Consent Forms in the “Do you have a choice?” section, the “Are there any risks or benefits?” section and the “Voluntary Participation” section. This information should appear only once as stated in the WSLHD Standard Wording document.

The “Compensation” section of the Participant Information and Consent Forms is missing and should be added to the document.

Response

We did not include this in the ‘Participant Information and Consent Forms’ as we followed the directions on the WSLHD Standard Wording document that states (This section should be included for all studies which involve medication, a device or medical and/or other procedure). This study is a qualitative ethnographic study using observations and does not involve medication/device and/or other procedure.

The complaints contact for the Pregnant Women Participant group is the Patient Representatives at [Patient Representatives] or [Patient Representatives]. The Secretary of the HREC is the contact for the Midwives Participant Information and Consent Form as stated in the WSLHD Standard Wording document.

On page 1 of 5 of the Participant Information and Consent Form, Midwife Participants, the heading “Do I have a choice?” should be moved over the page to sit above the information it relates to.

The flyer should include both the UWS and WSLHD logos.

Also the word ‘how’ should not be capitalized.
Written Information about study for staff

Midwives and Women’s Interactions study (MAWI) Information Sheet

Interactions between midwives and women during antenatal consultations in two different midwifery models of care.

Project researchers:

Hannah Dahlen, Virginia Schmied, Elaine Burns, Alison Teate, Julie Swain and Donna Garland

Midwifery continuity of care, such as midwifery group practice (MGP), is recognized as leading to improved outcomes for women and their babies compared to standard models of maternity care (1). It is described as being relationship-based and it is argued that the midwife-woman relationship is the key ingredient of care (2). Researchers have conceptualized the characteristics of the midwife-woman relationship (often referred to as a partnership) and these include trust, sharing of knowledge, advocacy and respect (3). What is not known or understood is how this approach influences the way midwives interact with women particularly around the provision of evidence-based information and care and how in turn, these practices result in improved outcomes.

There is a need for a greater understanding of the factors influencing the outcomes for women and babies in midwifery continuity of care models in order to disseminate and implement evidence-based models of midwifery care, as has been recommended by NSW Health in the recent policy document Towards Normal Birth in NSW (2010) (4).

The major aim of the project is to examine the dynamics of the interaction between midwives and women during antenatal consultations in two different models of care:

1) Midwifery Group Practice (MGP)

2) Standard maternity care.

The second aim is to ascertain if midwifery practice differs and if so, how this impacts on women’s experience of care, and pregnancy and birthing outcomes.

The MAWI study will use an ethnographic approach to examine the dynamics of the interaction between midwives and women during antenatal consultations in two different models of midwifery care. It will be conducted over a 12-month period commencing July 2012, with final report completed by September 2013. [Redacted] and [Redacted] hospitals from the Western Sydney Local Health District will be the study sites.

The study participants include:

20 Midwives: 10 midwives (5 at each site) working in MGP and 10 (five at each site) midwives working in standard maternity care.

20 Women: 10 women booked for care with the MGP midwives (5 at each site) and 10 women booked for care through standard maternity care (5 at each site).
Four Managers managing the maternity services (2 at each site).

Pregnant women who are attending each site for their antenatal care will be invited to participate in the study by the midwife at the antenatal visit. Information leaflets, posters and the attendance of the researchers at antenatal education sessions will provide extra information on the study. Midwives and managers will receive information about the study at a staff meeting provided by two researchers.

Observation data will be collected by a researcher who will observe two consecutive antenatal visits in the last month of pregnancy with each woman (20) recruited. A plan is to use video recording for this observation, but it has not been confirmed at this stage and researchers are keen to seek advice from midwives working at the two sites. Focus Groups will also be undertaken with five groups. Two focus groups with the MGP midwives and two with midwives working in antenatal clinics from both sites. A fifth focus group will be with managers from both sites. The women who participated in the observations (20) will be also be invited to participate in a post-birth face-to-face or telephone interview with a researcher.

All observations data will be analysed descriptively using frequencies and proportions. Data from the recorded interactions, interviews, focus groups and field notes will be transcribed verbatim by the researcher and coded. This data will be cross checked by the research team. All data will be de-identified and confidentiality maintained.

References


2. Homer C, Brodie P, Leap N. Establishing Models of Continuity of Midwifery Care in Australia: a resource for Midwives and Managers. Sydney: Centre for Family Health and Midwifery, Faculty of NUsring, Midwifery and Health at the University of Sydney; 2001.


Letter from Human Research Ethic Committee identifying me

as an approved researcher
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: The MAWI study
An ethnographic study of Midwives and Women’s Interactions during antenatal consultations.

Chief Investigator: XXXXXXXXXXXX
Clinical Midwifery Consultant
Women & Newborn Services – ??????? Hospital

Invitation
You are invited to participate in a research study exploring the interactions and conversations between midwives and women during an antenatal appointment.

The study is being conducted by the School of Nursing and Midwifery at the University of Western Sydney.

The researchers are:

Hannah Dahlen
Associate Professor of Midwifery

Virginia Schmied,
Professor of Midwifery

Alison Teate
Research Midwife

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
The main aim is to examine the interactions and conversations between midwives and
women during antenatal appointments in two different models of care:

1) Midwifery Group Practice (MGP). A model of midwifery continuity of care where a woman is cared for by a known midwife for her pregnancy, labour and birth and early parenting. This midwife is supported by a small group of midwives to ensure the woman has her known or primary midwife or a backup midwife at every stage of her childbirth experience.

2) Standard maternity care is the main model of public hospital maternity care. It includes midwives clinics, doctors clinics, general practitioner shared care models. It does not enable the same carer or carers to provide care to women across the antenatal, intrapartum and postpartum periods.

The second aim is to ascertain if midwifery practice differs in the two models, and if so, how this impacts on women’s experience of care, and pregnancy and their birthing outcomes.

Midwifery continuity of care, such as midwifery group practice (MGP), is recognised as leading to improved outcomes for women and their babies compared to standard models of maternity care. It is described as being ‘relationship-based’ and it is argued that the midwife-woman relationship is the ‘key ingredient’ of care. What is not known or understood is how this approach influences the way midwives interact with women and how in turn, these practices result in improved outcomes.

Who will be invited to enter the study?

Managers of the maternity services and the antenatal clinics where both models of maternity care operate.

Do you have a choice?

Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your employment or professional role now or in the future. Whatever your decision, it will not affect your relationship with hospital management. New information about the type of care being studied may become available during the course of the study. You will be kept informed of any significant new findings that may affect your willingness to continue in the study. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

What will happen on the study?

If you agree to participate in this study, you will be asked to sign the Participant Consent Form.

When you meet the research midwife she will talk with you about your participation in this study and what that involves for you. Your involvement is voluntary and includes:

Being asked to provide some general information about you such as age, education
background and previous work experience.

You will be invited to participate in a focus group with your peers who are also involved in the management of the maternity models of care being studied. This focus group will be held at the hospital and in a room that provides privacy and confidentiality. It will be audio-taped and will be with two of the researchers. You will be asked, as part of a group discussion, about your experiences as a manager of maternity services where Midwifery Group Practice and standard care operate. Questions such as 'what do you think inhibits or facilitates relationship-based care' will be asked. It will take about one hour.

**Are there any risks?**

As a participant of a focus group you may feel uncomfortable answering questions in a group environment. Remember that you can withdraw at any time without any consequences.

**Are there any benefits?**

This study aims to further medical knowledge and may improve the future treatment and care for pregnant women. We are unable to promise you any individual benefits from participating in this research.

**Confidentiality / Privacy**

All aspects of the study, including results will be confidential and only the above named researchers will have access to information on participants (in coded form). The consent form and the general information about you will be kept in a separate location from the observation and interview data. The data will be stored in a locked filing cabinet at the University of Western Sydney and destroyed 7 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project.

**Will taking part in this study cost me anything, and will I be paid?**

Participation in this study will not cost you anything, nor will you be paid.

**What happens with the results?**

As a participant of this study it is important to know that the research data collected from this study will be published in a report to NSW Ministry of Health and may be published in peer-reviewed journals, presentation at conferences or other professional forums. In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

**Complaints**

This study has been approved by Western Sydney Local Health District Human Research Ethics
Committee. If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact:

The WSLHD Research Governance Officer, Telephone: (02) 9845 9634

After hours Telephone: (02) XXXX XXXX

Contact details

When you have read this information, the research midwife Alison Teate will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on Mobile: 04288 45153 or email: a.teate@uws.edu.au. If you have any problems while on the study, please contact

Dr

Working hours Telephone No -

After hours Telephone No – (via switchboard for clinical trials or mobile for other studies)

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form.

This information sheet is for you to keep.
Study Title: The MAWI study
An ethnographic study of Midwives and Women’s Interactions during antenatal consultations.

CONSENT TO PARTICIPATE IN RESEARCH

Chief Investigator XXXXXXXXXXX

1. I understand that the researcher will conduct this study in a manner conforming to ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

2. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by ____________________________ (“the researcher”) and I, being over the age of 16 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

3. I acknowledge that I have been given time to consider the information and to seek other advice.

4. I acknowledge that refusal to take part in this study will not affect my employment.

5. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

6. I acknowledge that this research has been approved by the Western Sydney Local Health District Human Research Ethics Committee.

7. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

8. I understand my identity will not be disclosed to anyone else or in publications or presentations.

Before signing, please read ‘IMPORTANT NOTE’ following.

IMPORTANT NOTE:
This consent should only be signed as follows:
Where a participant is over the age of 16 years, then by the participant personally.

Name of participant ____________________________ Date of Birth __________________

Address of participant: ____________________________

Signature of participant ____________________________ Date: __________________

Signature of researcher ____________________________ Date: __________________

Signature of witness ____________________________ Date: __________________
# Media release form

**NSW Health Western Sydney Local Health District**

## MEDIA CONSENT FORM
### STAFF AND VISITORS

**Family Name:**

**Given Name:**

**D.O.B.:**

**Gender:**

**Address:**

**Location/Ward:**

### Media (Format)

- [ ] Photographs
- [ ] Film / Video
- [ ] Audio
- [ ] Interview

**Description:**

### Use and Purpose

- [ ] Patient Care
- [ ] Educational Material: Public | Patient | Staff
- [ ] Research
- [ ] Promotion / Display
- [ ] Legal
- [ ] Media

**Description:**

### Distribution

- [ ] Patient Record
- [ ] Media (inc. television, radio, print etc)
- [ ] Intranet/Internet
- [ ] WSLHD Publications
- [ ] Display / Promotion
- [ ] Third Party
- [ ] NSW Health and Local Health Districts

**Specify:**

**Consent**

Please note:
- You provide your consent by signing the consent form where relevant
- You do not have to consent to all or any of the options on the consent form
- Withholding your consent in no way affects the medical care you receive from WSLHD

I consent to the Western Sydney Local Health District using and publishing the photographs, videos, audio recording or other material detailed above to be used as specified.

### Patient, Visitor or Staff

**Name (Print):**

**Dept. / Address:**

**Telephone:**

**Signature:**

**Date:**

### Parent or Guardian (Parents or guardians must sign for people under the age of 16 years)

**Name (Print):**

**Relationship:**

**Signature:**

**Date:**

### Organisation Representative (Clinical Staff / Media Staff)

**Name (Print):**

**Title:**

**Signature:**

**Date:**

### Withdrawal or Modification of Consent

I also understand that my consent can be withdrawn or modified at anytime by writing to:

- Director, Media and Communications Western Sydney Local Health District

Any changes to consent will be effective from the date of receipt by the Western Sydney Local Health District. Any existing resources (including external media) in which the material is used may not be withdrawn from circulation.

**Filing**

Copy to Media and Communication

If the subject is a patient, place original in the patient’s record.
Cynthia Pseudonym

NSW

16\textsuperscript{th} September 2013

Dear Cynthia,

Thank you for your involvement in the Midwives & Women’s Interaction Study.

At our last meeting I asked if you would be interested in supporting the study and said I would contact you if this was needed.

I have been successful with getting a poster presentation at a conference in Hobart starting 29\textsuperscript{th} September 2013. It is the Australian College of Midwives National Conference and midwives from across Australia are invited to attend. They are expecting 300 midwives at this years conference. This poster would sit next to other posters in a room set aside for the conference and would only have access to people attending the conference.

If you are happy to have your photo on the poster please fill out the consent form, sign and post back to me in the postage paid envelope.

Thanks for your support.

Alison Teate
PhD Candidate
M: 0428 845 153
a.teate@uws.edu.au

University of Western Sydney
Locked Bag 1797 Penrith NSW 2751
www.uws.edu.au
Appendix B – Data collection

Original focus group questions for managers and CMC’s

Adapted focus group questions for midwife focus groups

Photo of adapted questions for midwife focus group

Example of Interview questions for women at 6-8 weeks postnatal: original and adapted

Field diary extract

Photo of field diaries
Original list of questions for focus groups submitted with Ethics application

Original questions developed for focus group for managers & CMC’s:

1. Do you notice anything different about the way midwives provide antenatal care in the different midwifery models?
   a. Please explain these differences.
2. What organisational and cultural factors facilitate midwifery care during the antenatal period?
3. What organisational and cultural factors inhibit midwifery care during the antenatal period?
4. Reflecting on how midwives work in different models what could be improved?
   a. What would be needed to facilitate this improvement?

Adapted focus group questions

Questions developed for Hospital A focus group

1. Explore your experiences / stories of working with midwives in both MCOC and SMC.
2. Do you notice differences between the way that individual midwives interact with the women the care for?
3. How would you describe a midwife who has exemplary midwifery skills?
   a. Does the include communication skills?
   b. If so how?
4. As a manager/CMC what are your experiences when working or supporting the midwives who work in the MGP/Caseload model?
5. How do you describe the midwives in caseload?
   a. Are they different?
6. Do you see barriers to increasing MGP/Caseload at your hospital?
   a. How can these be negotiated/changed?
7. If you as a midwifery manager had unlimited funds and authority what would you envisage for midwifery/maternity care at your hospital?
Questions developed for Hospital B based on the Hospital A focus group and early data analysis:

1. Explore your experiences / stories of working with midwives in both MGP and SMC.
2. What are the differences you notice with the midwives in these two models?
3. How do they interact (communicate) with women?
4. How they interact with colleagues and with you (as their manager)?
5. What about your experiences of managing the midwives in MGP?
6. Have you had any discussions/experiences with the midwives about them working in the community or women’s homes? What do they say?
7. If you as a midwifery manager had unlimited funds and authority what would you envisage for midwifery/maternity care at your hospital?
Adapted focus group questions for midwives
Original Questions women asked at 6–8 week postnatal interview

1) Can you tell me how many midwives provided your antenatal care?

2) Do you remember their names?

3) What did the midwife/midwives say and do during your antenatal care that helped?
   a. How did this help?

4) What did you find most useful?

5) What do you wish could have been different?

6) Did you feel you were given choices during your pregnancy and birth?

7) If you have another baby is there anything you would do differently regarding your care?

8) What would you advise friends to do about their care when they are pregnant?
   a. How would you describe your relationship with the midwives who provided care during your pregnancy?
Examples of researcher questions from interview with the woman from appointment A SMC1

Researcher: Okay. Here we go. Interview one, with ...
Researcher: Yeah. So you saw [...] the midwife who spoke very quickly.
Researcher: And when I saw you - when did you give birth to your baby? Was it...
Researcher: That's good. And you finished work the week, two weeks before that?
Researcher: So did you need to take anything for the pain [labour]?
Researcher: And how did you feel after you gave birth to Eve Lee?
Researcher: So did they have to help you to...
Researcher: So the midwives, you didn't get to know any midwives very well in your pregnancy appointments did you? Did you have a different midwife for each visit?
Researcher: You mentioned that you were worried about the pain of labour.
Researcher: And you couldn't get information to reassure you from anywhere. Do you think - looking back now - do you think you could have got any information that would have helped with labour?
Researcher: So, looking back now that you're a mother, and that you've given birth, and your labour was okay, but the giving birth was hard...
Researcher: ...is there anything about the way that your antenatal care - so your pregnancy care - was provided, that would be better for you?
Researcher: And when you had your first interview with the doctor, did you have any expectations about what your care, what you wanted your care to be like for pregnancy?
Researcher: So, when you found you were pregnant, you went to your GP?
Researcher: And your GP said, make an appointment at the hospital?
Researcher: So you followed their instructions, and then the hospital said, if you come on this day you can see the same midwife for your pregnancy care?
Researcher: But because you changed your day of appointment, you didn't see the same midwife.
Woman: Yeah, I didn't see.
Researcher: With your care, with the midwives, how did you find the midwives in the - when you had your pregnancy appointments?

Researcher: Yeah, how did you find them - how did you feel when you went to see them?

Researcher: Better than the GP?

Researcher: ...and not known the midwife who's looked after them in labour. If you could change, would you think it would be better for you if you had a midwife that you knew for your appointments and then looked after you in labour, or it doesn't matter?

Researcher: I was wondering, did you want to have a look at some of the film that I did from your appointment?

Researcher: How did you feel when the midwife said that?

Researcher: Tell me what else you felt when she was doing the abdominal palpations and talking ot you? Do you remember?
Field Diary extract

23rd May 2013

At … ANC and starting to develop a rapport with the midwives – interesting conversations this morning about how important it is to engage with women – ‘build a relationship or partnership’ with the women. Another midwife who takes the VBAC/NBAC classes and clinic talked about the importance of debriefing with women about their births and that this isn’t about physical issues, but more emotional issues and often these arise after 6 weeks PN. We (midwives) need to engage with women and talk with them.

4th June Research Futures Forum – I have presented the issues of reflexivity and the importance of this social theory framework in both video ethnography and feminism, but what is of importance to me at this stage is the analytical method I am going to use to analyse the video data. Papers read to day identify issues of fixed versus roaming camera and with the films I have taken so far I have used a camera situated opposite the consultation that is being undertaken. I did start with the camera over /next to the computer in the clinic room – but found this did not provide me with enough full face time for both participants. Interestingly when I moved the camera some participants appeared to be more aware of the camera compared to when I had it situated on the desk and near the computer. Is this an issue of data collection as when I and the camera are less visible we have less impact on the participants?

Another issue that is raised in early reading of video challenges is the ‘frame’ of the event & with the camera used opposite the participants communication that captured where they were sitting and talking highlighted the social frame of a woman’s house – ie midwife and woman sat on the couch and palpation was undertaken on the couch – the social hub of the home whereas in the hospital the visit was taken in the clinic room with medical examination bed, wash basin, office chairs, desk, computer and other medical written information either as books, files, posters etc – a medical event!

- Spradley – ethnographic observations
- Conversation linguistics
- Interactions
- Fairclough
- Potter Weatherill
- Upton
- Habitus – Bordeaux
- Read Collier and Collier on 1967 Visual Anthropology: Photography as a research method
- Read about feminist film theory

5th June 2013 First viewing of video data (film) with Hannah

Watched:
I started with these videos to demonstrate to Hannah the diversity of midwife-woman interactions I have observed. I had chosen another video (A MGP_9 & B-MGP_3) to view at this sitting but were unable to view these due to time constraints.

With this viewing and early analysis we have endeavoured to gather a small number or parameters of categories with which I can then start to quantify or categorise the video data. This is the first step in analysis, as I believe I will need to then use these categories for all the first level of analysis. A deeper approach to analysis will be enabled after I have undergone a more in depth literature review around video analysis and the ethnographic and feminist approaches I have engaged with. An interesting discussion that Hannah and I had was about using a salutogenic approach to analysing which would look at the positive instead of the negative and also view the actions and interactions that enable the woman to decide/engage in health care decisions for herself.

Parameters/Categories:

- Chit Chat – amount and when does this happen in the appointment
- Midwife language that is positive/neutral/negative
- Reassuring language
- Viewing the influence of the system on the midwife
- Midwife focusing on computer compared to woman and discussion
- Closed/Open questions
- Languidness of movements by midwife – abrupt/calm
- How the women are ‘put’ onto the bed and then helped off
- Connection – connect – disconnect between midwife and woman
- Physical aspects: smiling, breathing, body situation, body language – open closed
- Privacy for woman
- Consent – Choice (we are going to do this)

Need to explore the autonomic system of control for body language – how is individual stress shown with body language – blinking, crossed arms, rapid breathing
Appendix C – Worry data examples

Table C-1: Percentage of worry conversation coded in the appointments
Table C-2: Use of the phrases ‘to make sure’ or ‘making sure’ in all data sources
Table C-3: Coding examples of ‘Is it normal?’ in the appointments
Table C-4: Examples of pregnancy discomforts women raised in the appointments
Table C-1: Percentage of worry conversation coded in the appointments

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Total number of words</th>
<th>Number of words coded as worry</th>
<th>Percentage of conversation coded as worry</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-SMC1</td>
<td>3279</td>
<td>2924</td>
<td>89%</td>
</tr>
<tr>
<td>A-SMC6</td>
<td>4492</td>
<td>1551</td>
<td>35%</td>
</tr>
<tr>
<td>A-SMC13</td>
<td>3754</td>
<td>959</td>
<td>26%</td>
</tr>
<tr>
<td>A-SMC14</td>
<td>1788</td>
<td>573</td>
<td>32%</td>
</tr>
<tr>
<td>A-SMC15</td>
<td>5915</td>
<td>3845</td>
<td>65%</td>
</tr>
<tr>
<td>B-SMC10</td>
<td>4104</td>
<td>1837</td>
<td>45%</td>
</tr>
<tr>
<td>B-SMC11</td>
<td>470</td>
<td>193</td>
<td>41%</td>
</tr>
<tr>
<td>B-SMC12</td>
<td>2680</td>
<td>1927</td>
<td>72%</td>
</tr>
<tr>
<td>B-SMC17</td>
<td>1189</td>
<td>620</td>
<td>52%</td>
</tr>
<tr>
<td>A-MGP2</td>
<td>5138</td>
<td>843</td>
<td>16%</td>
</tr>
<tr>
<td>A-MGP7</td>
<td>2682</td>
<td>1409</td>
<td>53%</td>
</tr>
<tr>
<td>A-MGP8</td>
<td>6203</td>
<td>1853</td>
<td>30%</td>
</tr>
<tr>
<td>A-MGP9</td>
<td>12812</td>
<td>5586</td>
<td>44%</td>
</tr>
<tr>
<td>B-MGP3</td>
<td>5632</td>
<td>1626</td>
<td>29%</td>
</tr>
<tr>
<td>B-MGP4</td>
<td>4662</td>
<td>1128</td>
<td>24%</td>
</tr>
<tr>
<td>B-MGP16</td>
<td>6157</td>
<td>4197</td>
<td>68%</td>
</tr>
<tr>
<td>B-MGP18</td>
<td>3440</td>
<td>1990</td>
<td>58%</td>
</tr>
<tr>
<td>B-MGP19</td>
<td>9629</td>
<td>1333</td>
<td>14%</td>
</tr>
</tbody>
</table>
Table C-2: Use of the phrases ‘to make sure’ or ‘making sure’ in all data sources

<table>
<thead>
<tr>
<th>Data source</th>
<th>Number of times the phrase ‘to make sure’ or ‘making sure’ were used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appointment</td>
</tr>
<tr>
<td>FG-A-Managers</td>
<td></td>
</tr>
<tr>
<td>FG-A-SMC</td>
<td></td>
</tr>
<tr>
<td>A-SMC1</td>
<td>5</td>
</tr>
<tr>
<td>A-SMC6</td>
<td>1</td>
</tr>
<tr>
<td>A-SMC13</td>
<td>1</td>
</tr>
<tr>
<td>A-SMC14</td>
<td>1</td>
</tr>
<tr>
<td>A-SMC15</td>
<td></td>
</tr>
<tr>
<td>FG-A-MGP</td>
<td></td>
</tr>
<tr>
<td>A-MGP2</td>
<td>1</td>
</tr>
<tr>
<td>A-MGP7</td>
<td>3</td>
</tr>
<tr>
<td>A-MGP8</td>
<td>1</td>
</tr>
<tr>
<td>A-MGP9</td>
<td>6</td>
</tr>
<tr>
<td>FG-B-Managers</td>
<td></td>
</tr>
<tr>
<td>FG-B-SMC</td>
<td></td>
</tr>
<tr>
<td>B-SMC10</td>
<td></td>
</tr>
<tr>
<td>B-SMC11</td>
<td></td>
</tr>
<tr>
<td>B-SMC12</td>
<td>3</td>
</tr>
<tr>
<td>B-SMC17</td>
<td></td>
</tr>
<tr>
<td>B-SMC18</td>
<td>2</td>
</tr>
<tr>
<td>FG-B-MGP</td>
<td></td>
</tr>
<tr>
<td>B-MGP3</td>
<td></td>
</tr>
<tr>
<td>B-MGP4</td>
<td>3</td>
</tr>
<tr>
<td>B-MGP16</td>
<td></td>
</tr>
<tr>
<td>B-MGP19</td>
<td>4</td>
</tr>
<tr>
<td>PNI 20</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
</tbody>
</table>
### Table C-3: Coding examples of ‘Is it normal?’ in the appointments

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Appointment Conversations</th>
<th>Worry concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-SMC1</td>
<td><strong>Woman:</strong> Good, pretty good. But just a few questions, because like yesterday and today I had a headache all morning <strong>Midwife:</strong> Oh right. <strong>Woman</strong> Especially I found that my leg here, so I can perhaps show you? <strong>Midwife:</strong> Is that right? <strong>Woman:</strong> I feel this side. Not here, this side feels numb like <strong>Midwife:</strong> Numb like? <strong>Woman:</strong> Yeah, only this part. It still lasts until now. So I'm wondering, ... <em>Is that normal</em>, because I haven't had that before, just start from yesterday ... <strong>Midwife:</strong> There is a lot of questions there. For sure. We'll see if I can answer most of them, all right.</td>
<td>Pregnancy discomforts</td>
</tr>
<tr>
<td>A-SMC10</td>
<td><strong>Woman:</strong> Then some days I have nothing [mucous loss]. <em>Is that normal?</em> <strong>Woman:</strong> I just wanted to know <em>is it normal</em> for it [reflux] to be here [pointing at throat]?</td>
<td></td>
</tr>
<tr>
<td>B-MGP16</td>
<td><strong>Woman:</strong> I’m getting these cramps at night. <em>That’s just normal, isn’t it, just to get that tightening right down there? That’s normal?</em> <strong>Midwife:</strong> Yeah. <strong>Woman:</strong> But that’s just at night. Sometimes during the day, not much. But that’s just normal?. <strong>Woman:</strong> Yeah, but I only had to use it twice because after that it just went away, <em>it must be normal</em>; it just goes away, *does it?</td>
<td></td>
</tr>
<tr>
<td>B-MGP19</td>
<td><strong>Woman:</strong> <em>Is it normal?</em> It feels so bruised. <em>Is ... and then they break - that’s normal?</em></td>
<td></td>
</tr>
<tr>
<td>B-MGP19</td>
<td><strong>Woman:</strong> Yeah. That’s like with Braxton hicks. I haven’t felt any...</td>
<td></td>
</tr>
<tr>
<td>B-MGP4</td>
<td><strong>Midwife:</strong> Yes, that’s fine. <strong>Woman:</strong> Oh that’s good. <strong>Partner:</strong> You’re about the only other person who worries about that ... [Laughter] <strong>Partner:</strong> I haven’t felt ... I don’t know... if everything’s never done it before so ... so it’s... [partner using humour to mimic his wife’s worry about no knowing] <strong>Woman:</strong> I would like to have normal, of course, but if some</td>
<td>Uncertainty about labour &amp; birth</td>
</tr>
<tr>
<td>A-MGP9</td>
<td><strong>Woman:</strong> That’s true. <em>What’s the normal, how many days I can</em></td>
<td>PTO</td>
</tr>
<tr>
<td>B-MGP8</td>
<td><strong>Woman:</strong> ... just not as crazy as normal. But I sort of think ...</td>
<td></td>
</tr>
<tr>
<td>A-MGP7</td>
<td><strong>Woman:</strong> Yeah, like the way - I don’t know - kicks, pushes. Yeah, it’s a bit painful, a bit. It’s unusual.</td>
<td>Fetal movements</td>
</tr>
<tr>
<td>B-SMC10</td>
<td><strong>Midwife:</strong> Sort of almost like bruising sort of feeling when it keeps moving? <strong>Woman:</strong> Feels like scratches, flicks. I don’t know, yeah. It’s a weird feeling, like I think it’s a jungle in there, I don’t know. <strong>Midwife:</strong> The movements are so reassuring to us</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>Yeah, it's a lot of movements, yeah. Some movements are really like painful. I don't know if that's normal.</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Sometimes, yeah. Sometimes women say it's painful, they've been moving around a lot.</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>Yeah, it's so much.</td>
<td></td>
</tr>
</tbody>
</table>
Table C-4: Examples of pregnancy discomorts women raised in the appointments

<table>
<thead>
<tr>
<th>Appointment Conversations</th>
<th>Pregnancy Discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A-SMC14</strong> Woman: Eating. Good. I feel like burning when I eat food but when I walk about five minutes or 10 minutes it...</td>
<td>Heartburn</td>
</tr>
<tr>
<td><strong>B-MGP2</strong> Woman:  Umm. So my feet are really – really solid, I thought I’d let you know, totally nothing that I am worried about but they’re quite sore.</td>
<td>Swollen legs</td>
</tr>
<tr>
<td><strong>A-MGP9</strong> Woman: No, I didn’t. I was just thinking to go and always something. I just feel tired.</td>
<td>Tiredness</td>
</tr>
<tr>
<td><strong>A-MGP16</strong> Woman: Really yucky, feeling really sick. I feel like I’m going to vomit all the time and faint. I really try to hold in being sick a lot. But I tried so hard on Saturday to hold it in. I was talking to my mother outside and I just started violently vomiting everywhere. It just happened that my dad walked in from the back gate and my husband at the same time. It was like, everyone has to see this.</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Midwife: Was that the only time you vomited?</td>
<td></td>
</tr>
<tr>
<td>Woman: No, I vomited a few times before but that was the worst. I try so hard not to because I just want to keep the food in. But I think that day I made it much worse</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D – Time data examples

Table D-1: Length of observed appointment by location and mode of care

Table D-2: Percentage of appointment time midwife, woman & support person look towards each other or not

Table D-3: Percentage of appointment time midwife looking at computer/medical record

Table D-4: Segment of appointment B-MGP16 where midwife listens, laughs & smiles.
Table D-1: Length of observed appointment by location & model of care

<table>
<thead>
<tr>
<th>Hospital &amp; Venues</th>
<th>SMC</th>
<th>MGP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPD</td>
<td>Community Health Centre Clinic Room</td>
</tr>
<tr>
<td>A</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>
### Table D-2: Percentage of appointment time midwife, woman & support person look towards each other or not

<table>
<thead>
<tr>
<th>Site</th>
<th>Setting</th>
<th>Length (seconds)</th>
<th>Percentage of appointment time</th>
<th>Not looking to</th>
<th>Looking to</th>
<th>Not looking to</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Woman</td>
<td>Midwife</td>
<td>Support person</td>
<td>Midwife</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Woman</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Woman</td>
</tr>
<tr>
<td>OPD</td>
<td>A-SMC1</td>
<td>1296</td>
<td>3</td>
<td>1</td>
<td>80</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>A-SMC14</td>
<td>1063</td>
<td>0</td>
<td>42</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>A-SMC15</td>
<td>2144</td>
<td>0.6</td>
<td>30</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>B-SMC10</td>
<td>1498</td>
<td>7</td>
<td>67</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>B-SMC11</td>
<td>444</td>
<td>49</td>
<td>2</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>B-SMC12</td>
<td>1731</td>
<td>21</td>
<td>48</td>
<td>34</td>
<td>55</td>
</tr>
<tr>
<td></td>
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<td>MGP room</td>
<td>B-MGP3</td>
<td>1625</td>
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<td>9</td>
<td>85</td>
<td>84</td>
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<tr>
<td></td>
<td>A-MGP2</td>
<td>1815</td>
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<td>59</td>
<td>51</td>
<td>43</td>
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<tr>
<td></td>
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<td>13</td>
<td>42</td>
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<td></td>
<td>A-MGP8</td>
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<td>11</td>
<td>73</td>
<td>51</td>
<td>79</td>
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<td></td>
<td>A-MGP9</td>
<td>4611</td>
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<td>87</td>
<td>83</td>
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<td>2235</td>
<td>3</td>
<td>73</td>
<td>74</td>
<td>11</td>
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<td>95</td>
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<td>16</td>
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<tr>
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<td>B-MGP4</td>
<td>1534</td>
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<td>10</td>
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</tbody>
</table>

### Women's homes

|                          | B-MGP3     | 1625             | 0                             | 9              | 85         | 84            |
|                          | A-MGP2     | 1815             | 11                            | 59             | 51         | 43            |
|                          | A-MGP7     | 1379             | 13                            | 42             | 33         | 39            |
|                          | A-MGP8     | 1903             | 11                            | 73             | 51         | 79            |
|                          | A-MGP9     | 4611             | 5                             | 87             | 83         | 16            |
|                          | B-MGP16    | 2235             | 3                             | 73             | 74         | 11            |
|                          | B-MGP19    | 2362             | 2                             | 95             | 79         | 16            |
|                          | B-MGP4     | 1534             | 4                             | 10             | 82         | 75            |

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Table D-3: Percentage of appointment time midwife looking at computer/medical record

<table>
<thead>
<tr>
<th></th>
<th>Midwife looking at computer</th>
<th>Midwife looking at maternity care records</th>
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<td>B-MGP4</td>
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<td>0</td>
</tr>
<tr>
<td>B-MGP19</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>B-MGP16</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>B-MGP3</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>A-MGP9</td>
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<td>15</td>
</tr>
<tr>
<td>A-MGP8</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>A-MGP7</td>
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</tr>
<tr>
<td>A-MGP2</td>
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</tr>
<tr>
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<td>30</td>
</tr>
<tr>
<td>B-SMC11</td>
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<td>31</td>
</tr>
</tbody>
</table>
Table D-4: Segment of appointment B-MGP16 where midwife listens, laughs & smiles

<table>
<thead>
<tr>
<th>Time stamp</th>
<th>Midwife-woman interaction</th>
<th>Speaker</th>
<th>Appointment conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:59-9:02</td>
<td>Midwife &amp; woman leaning on one elbow on the kitchen table looking at each other as they talk</td>
<td>Midwife:</td>
<td>So the same with the nausea and the stools in your last pregnancy?</td>
</tr>
<tr>
<td>9:02-9:06</td>
<td>Woman is using both hands, with both elbows on the kitchen table, and moving &amp; waving them around in front of her. Midwife continues to look towards woman as she talks with her hand of one hand resting near her chin &amp; the other arm resting on the table in front of her.</td>
<td>Woman:</td>
<td>That was every single day, yeah. But with this pregnancy it started...</td>
</tr>
<tr>
<td>9:06</td>
<td>Midwife looks towards woman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:07-9:17</td>
<td>Woman shakes her head &amp; then puts her head in her hands &amp; laughs. Midwife nods her head &amp; laughs as well, her body posture remains the same</td>
<td>Woman:</td>
<td>... I don’t want it anymore but it’s all right.</td>
</tr>
<tr>
<td>9:17-9:19</td>
<td>They look at each other &amp; smile and laugh.</td>
<td>Midwife:</td>
<td></td>
</tr>
<tr>
<td>9:19-9:28</td>
<td>Midwife continues to look at woman &amp; her smile is replaced by an attentive look which included talking to the woman &amp; nodding head at the woman as she states ‘you’. Woman’s posture remains the same &amp; she nods as she listens to the midwife.</td>
<td>Woman:</td>
<td>Yeah. Because I thought it was just cleaning out - towards the end it’s just cleaning out and then hopefully I’ll go into labour soon.</td>
</tr>
<tr>
<td>9:28-9:34</td>
<td>Midwife continues to stay in same posture &amp; nods as the woman talks. The woman uses one hand in a shaking gesture as she talks to emphasise her point. They are both looking at each other &amp; no smile, but focused and attentive towards each other.</td>
<td>Midwife:</td>
<td>Yeah. I think since you’ve had it before, then it’s probably normal for you to feel this way, unfortunately.</td>
</tr>
<tr>
<td>9:34-9:39</td>
<td>The both laugh as woman asks her question. Their body posture remains the same with head nodding by midwife &amp; head shaking by the woman.</td>
<td>Woman:</td>
<td>But how much can it clean out? I don’t have that much in me</td>
</tr>
<tr>
<td>9:39-9:41</td>
<td>They continue to laugh as midwife asks her question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:39-9:58</td>
<td>They lean backwards at the same time and laugh together as the woman talks. They then lean back in to each other &amp; their body posture of leaning on the tables resumes as it was before</td>
<td>Midwife:</td>
<td>Well you don’t think it’s diarrhoea?</td>
</tr>
<tr>
<td>9:58</td>
<td></td>
<td>Woman:</td>
<td>No, it’s not. It’s just constantly - like one day it was eight times. I was like, this is just ridiculous. I might as well just live on the toilet. I don’t</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:57-10:04</td>
<td>As midwife talks she is gently shaking her head and woman is listening &amp; nodding</td>
</tr>
<tr>
<td>10:03-10:08</td>
<td>Woman &amp; midwife nod together &amp; smile as the woman talks.</td>
</tr>
</tbody>
</table>
| 10:07-10:11 | Midwife: It's just the way that your hormones work. But yeah, just keep in mind that we're close to the end.  
Woman: Yeah, I know. I just keep drinking lots of water, which is good.  
Midwife: Yeah. Definitely stay - you've got to keep up the fluids. |