

**School of Nursing and Midwifery
Faculty of Health Sciences**

**The Relationship is Everything:
Women's Reasons for, and Experience of Maternity Care
with a Privately Practising Midwife in Western Australia**

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**This thesis is presented for the Degree of
Master of Philosophy (Nursing and Midwifery)**

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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signed:

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Date:

ABSTRACT

Background: Childbearing women residing in Western Australia (WA) may choose from a number of options for their maternity care. While the majority of WA women opt for either private or publicly-funded obstetric-led care, a small but stable number choose to employ a privately practising midwife as their lead maternity caregiver.

Aim: The aim of this descriptive qualitative study was to investigate women's reasons for, and experience of maternity care with a privately practising midwife. Factors that facilitate and inhibit their choice and experience were also explored.

Methodology: Fourteen women participated. The analysis drew upon data from in depth interviews and data collection ceased once saturation was achieved. Constant comparison, modified from grounded theory methodology was used to analyse data.

Findings: The findings were grouped into two parts; women's reasons for choosing a private practising midwife to provide maternity care and women's experience of that care.

Analysis of the data revealed that central to women's choice of a privately practising midwife was knowing what they wanted; they had a clear idea of how they wanted their care and their birth experience to be, and went about searching the available care options that could best facilitate their preferences.

The three major categories characterising reasons for choosing private midwifery care were identified and thus labelled as **I knew what I wanted from my care provider; I knew what I wanted from my pregnancy and birth experience** and **I was willing to do the research to get what I wanted.**

Data analysis revealed one major category to depict women's experience of birth with a privately practising midwife, this was labelled **I had an amazing and empowering birth experience.** All the women who were interviewed indicated that

they had an extremely positive experience of their birth with a privately practising midwife.

The factors that influence women's experience and reasons for choosing a privately practising midwife were identified as **Positive and negative previous experience** and **My community**. The term my community was used to describe the influences on the women from their friends, family, the community they lived and socialised in, and the media.

Conclusion: The findings of this study provide new knowledge as to why women choose their maternity care with a privately practising midwife and their experiences of doing so. Understanding these phenomena may provide maternity health care providers with strategies that may improve care and choices for women accessing maternity care in all settings.

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This thesis is dedicated to the memory of Marsden Wagner, whose words inspired me at the very beginning of my journey as a midwife and continue to do so every day.

"Humanizing birth means understanding that the woman giving birth is a human being, not a machine and not just a container for making babies. Showing women - half of all people - that they are inferior and inadequate by taking away their power to give birth is a tragedy for all society. On the other hand, respecting the woman as an important and valuable human being and making certain that the woman's experience while giving birth is fulfilling and empowering is not just a nice extra, it is absolutely essential as it makes the woman strong and therefore makes society strong."

Marsden Wagner (2000)

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CHAPTER 1: INTRODUCTION

Introduction

In this thesis, the study of women's reasons for, and experiences, of maternity care with a privately practising midwife in Western Australia, using a modified Grounded Theory Methodology will be presented. Chapter one will begin with a brief description of the author's background and decision making process around the research topic. The chosen methodology will be presented. The context of the research will also be provided which will include an overview of the study setting, Perth, Western Australia: a brief history of maternity care; and a description of maternity services in the Perth metropolitan area. Privately practising midwives (who may also be referred to as independent midwives) and caseload midwifery will also be explained. The aim and objectives of the study plus significance will be outlined. Chapter one will conclude with an overview of the thesis and a brief explanation of each chapter.

Background and decision making process relating to the study

The author's decision to pursue a higher degree by research came from a meeting with an inspiring woman who had recently completed her PhD and was visiting the hospital where the author was working. The author had recently graduated as a midwife and was working in a public hospital. Prior to this she had been a senior nurse for twelve years. She had a naturally inquisitive mind and rather than "just do something because she was told to," she would research why she was doing something and if this was the best way to do it.

During her midwifery education she had discovered that many things, for example, induction or augmentation of labour, sometimes seemed to be done without a real understanding of the implications to women. For example, a woman who is being induced may not be aware that the process of induction could include the use of syntocinon infusions (synthetic hormone infusions), which would involve continuous electronic fetal monitoring and the increased risk of caesarean birth that this brings

(Alfirevic, Devane & Gyte, 2013) and that this could impact hugely on the woman's expectations and wishes for her labour and birth. It was observed that many of the health professionals were aware of the indications of conducting an induction or augmentation, but there was not the same understanding or appreciation of the impact of this decision on the woman, and the potential consequences of having the intervention was rarely explained to women prior to their induction.

She also came to realise that although the measurable outcomes around women's experiences such as mode of birth, blood loss, or length of labour was commonplace and used to provide evidence to practice, it did not provide the full story without including the women's thoughts, feelings and perceptions related to their experiences.

Childbirth is a life changing experience (Morison, Percival, Hauck, & McMurray, 1999; Kitzinger, 2011) and regarded as more than just a biological process. Traditionally, research relating to childbirth has focused on the physiological aspects of labour and birth, such as the length of labour and the mode of birth. What has been less well reported is the impact of the birth experience on the woman's psyche, or of her experience on her family's well-being. However, there is a growing body of more recent evidence that focuses on women's perceptions of their maternity experience, for example women's perceptions of experiencing a scheduled caesarean birth (Bayes, Fenwick & Hauck, 2008; Bayes, Hauck & Fenwick, 2012); those experiencing a vaginal birth after a previous caesarean (VBAC) (Godden, Hauck, Hardwick & Bayes, 2012); those wanting a VBAC but experiencing another caesarean birth (Kelly, Hauck, Bayes & Harwick, 2013); those experiencing a homebirth (Morison, Hauck, Percival & McMurray, 1998; Morrison, Percival, Hauck & McMurray, 1999); those attending a birth centre (Coyle, Hauck, Percival, & Kristjanson 2001a, 2001b); and finally, women's experience of caseload midwifery and continuity of care (Williams, Lago, Lainchbury & Egar, 2010).

Ten years ago Hofmeyr and Hannah (2003) suggested that little is known about the evolutionary importance of the birth process to women's personal development, emotional wellbeing and adaptation to parenting. Gaining insight into women's subjective experiences may begin to contribute to increasing our knowledge around

the influence of birth experiences on women's psychological wellbeing. More recently Pairman (2006) suggests that the ripple effects of birth experiences are far reaching and cannot be underestimated or generalised as two seemingly identical birth outcomes can be experienced in totally different ways. Although experiences are very personal, where common themes can be extracted to particular experience within a context, rich description of these findings do add to our body of knowledge and may be transferable to other contexts.

Childbirth is often portrayed as a rite of passage into womanhood (Nelson, 2003; Davis-Floyd, 2003; Kitzinger, 2011) that influences the women's sense of self and her place in society (Brown & Lumley, 1998; Davis-Floyd, 2003; Kitzinger, 2011). A positive birth experience is likely to give women a deep sense of accomplishment and well-being that increases their confidence as new mothers and, in turn, strengthens families and society (Hildingsson, Johansson, Karlström & Fenwick, 2013; Nilsson, 2013). Likewise, a negative birth experience also has lasting effects. A negative experience is known to have a detrimental effect on bio-psycho-social health and well-being in the postnatal period and beyond (Goodman, Mackey, & Tavakoli, 2004; Waldenström, Hildingsson, Rubertsson & Rådestad, 2004; Mercer & Marut, 1981; Hay, Pawlby, Sharp, Asten, Mills, & Kumar, 2001; Sinclair & Murray, 1998; Thomson & Downe, 2008; Nilsson, Bondas & Lundgren, 2010).

It was with the limited of research evidence around women's experience of birth with a particular type of caregiver in mind, that the idea formed to do qualitative research related to women's experiences of maternity care within the midwifery context.

Maternity care

Midwives have assisted women in childbirth since the beginning of history. It is recognised as one of the oldest professions. Midwives are mentioned in The Bible, featured on Egyptian papyrus and in ancient Hindu text. Until the seventeenth century childbirth was the responsibility of midwives but the gradual emergence of man-midwives, then barber-surgeons and obstetricians led to a more medical model

(Donnison, 1988; Ehrenreich & English, 2010; Allotey, 2011). Childbirth practices in industrialised countries changed throughout the twentieth century leading to a move from midwifery-led care at home to doctor-led care in the hospital (Donnison, 1988). Freeman, Adair, Timperley, and West (2006) suggest that when medical care became more dominant than midwifery care, the decision process changed and what was once women-led and community supported, became patriarchal and medically orientated. Wagner (2006) suggests that the medical model and the midwifery model are two different ways of looking at women and birth. Doctors deliver babies and some tend to see having a baby as something that happens to a woman, whereas midwifery-led care focuses on pregnancy and birth as normal processes, and midwives assist birth under the belief that giving birth is something a woman does.

The study's setting, Western Australia, Australia



Figure 1: Map of Australia (<http://www.lonelyplanet.com/maps/pacific/australia/>)

Australia is the largest island in the world; covering an area of 7.69 million square kilometres (see Figure 1). To put this into context Australia's land mass is almost the same as that of the United States of America, about fifty per cent bigger than Europe,

and thirty two times bigger than the United Kingdom. (<http://australia.gov.au/about-australia/our-country/the-australian-continent>).

Australia's population is approximately twenty three million, and of this number over eighty percent live within one hundred kilometres of the ocean. Australia is divided into six states and two territories (Australian Bureau of statistics (ABS), 2013). Western Australia (WA) is the largest of the states and territories, with a population of nearly two and a half million people. Of this number three quarters of the population live in Perth, the capital and the surrounding metropolitan area (ABS, 2013). Western Australia has a diverse landscape from forests in the south to the tropical north and desert areas of the east. Western Australia is divided into eight regions called the Kimberley, the Pilbara, the Goldfields, the Midwest, the Wheatbelt, the South West, the Great Southern and the Perth metropolitan area. Perth's metropolitan area extends approximately one hundred and sixty kilometres north to south and approximately fifty kilometres inland (See Figure 2).



Figure 2: Regions of Western Australia with the Perth metropolitan area identified in black (http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=2240)

Maternity care in Western Australia

In Australia there are four different options of maternity care: private hospitals; public hospitals; government funded midwifery led care; and private midwifery-led care. These will now be discussed in more detail in relation to the care options available in Western Australia.

1. Private hospitals

Private hospitals provide continuity of care with a private obstetrician for antenatal care, care in labour from midwives employed by the hospital, attendance at the actual birth by the private obstetrician and care on the postnatal ward by the hospital midwives. The private system generally does not include any postnatal home care (St. John of God n.d.). This option is covered by private health insurance. However there may be an out of pocket fee for some services. There are nine private hospitals in Western Australia, all but two of which are in the Perth metropolitan area. The two private hospitals in regional WA are located in the Midwest region about four hundred and thirty kilometres from Perth, and in the southwest approximately one hundred and seventy five kilometres from Perth.

2. Public hospitals

Public hospitals are where government funded maternity care is provided by teams of obstetricians and midwives. The obstetrician is generally the lead carer and defines the care requirements of the woman. Depending on the risk status of the woman, some appointments antenatally are with midwives, and some are with doctors. Care is provided by both midwives and doctors during labour and birth. Postnatal care is provided by midwives in the hospital wards and a small number of home visits by midwives during the first week postpartum. Most women are discharged from hospital between one and three days and domiciliary midwifery care is provided up to day five following the birth.

Within the metropolitan area of Perth there are eight public hospitals providing maternity services. Amongst these eight public hospitals is the main tertiary hospital in WA, King Edward Memorial Hospital (KEMH) located in the inner suburbs of Perth. KEMH provides maternity care for women deemed high risk from all areas of WA. The other seven public hospitals are spread around the metropolitan area (<http://www.health.wa.gov.au/havingababy/home/>).

The Next Birth After Caesarean (NBAC) clinic also falls into the category of public hospital maternity care. The NBAC clinic is based at KEMH, and offers midwifery led antenatal care for women who have had a previous caesarean section. However the service is only offered antenatally with one follow up telephone call or visit on the postnatal wards by the NBAC midwives. The women are cared for in the labour and birth suite by the midwives and doctors working on the day, and after the birth on the postnatal wards as previously described.

There are eighteen public hospitals in the regional areas of WA. There are three hospitals in the Kimberley; two hospitals are in the Pilbara; two in the Goldfields; two in the Midwest; six in the South West; and one in the Great Southern. However not all of these regional hospitals provide intrapartum care, so women may be expected to birth at another hospital and in some cases of women with high risks, they may be expected to birth at KEMH. This may involve women from some parts of Western Australia leaving their homes for a significant period of time before their due date and travelling to Perth.

3. Government funded midwifery-led care

Government funded midwifery led care is also available in some areas of WA, but only for low risk women who meet the strict eligibility criteria, which excludes women who have had a previous caesarean section, a BMI over 35, and a pre-existing medical problem (Women and Newborn Health Service n.d.) (See Appendix 1). According to Wagner (2006) the World Health Organisation's evidenced based research shows that seventy to eighty percent of all women may be classed as low risk. Wagner (2006) believes that low risk women do not need obstetric care, which

focuses on the pathology of pregnancy and birth; they need midwives who believe that pregnancy and birth are normal life events.

There were three different types of government funded midwifery-led care offered at the time of the study in Perth, Western Australia. King Edward Memorial Hospital, the tertiary hospital in Perth offers team midwifery to a small number of low risk women who are cared for throughout the pregnancy, labour, and birth, and postnatally by a small team of midwives. The Family Birth Centre (FBS) situated on site at KEMH also offers this type of care for a small number of low risk women who plan to birth at the Family Birth Centre. However, if the risk status of the woman changes they would have to birth at KEMH, and this would also apply if they requested some forms of pain relief such as epidural anaesthesia, as they are not available in the birth centre. Thirdly, the Community Midwifery Program (CMP) also offers a small number (approximately 300) of low risk women the choice of a homebirth or an option of domiciliary in and out (DOMINO) hospital births. The number of women who choose this option is approximately one third of the women birthing on the CMP (Midwives Notification System, 2014). DOMINO care programs come from the United Kingdom (UK) model, whereby the community midwives look after the woman throughout pregnancy, attend a woman in early labour at home, accompany her into hospital for the birth, and then resume the care at home post hospital discharge (Macdonald & Magill-Cuerden, 2011). Wagner (2006) believes that the key elements of midwifery-led care are normality, facilitation of natural processes with minimal intervention (all evidence based) and the empowerment of birthing women.

4. Privately practising midwives

Privately practising midwives (also known as independent midwives) in WA offer caseload midwifery for a small number of women choosing either home or hospital birth. Caseload midwifery is considered to be the gold standard of midwifery-led care (Warren, 2003; Andrews, Brown, Bowman, Price & Taylor, 2006). Andrews et al (2006) describe caseload midwifery as an organisational model of care, in which the midwife is the primary caregiver and is responsible for the planning and execution of midwifery care for an agreed number of women. In Perth, self-

employed privately practising midwives offer continuity of carer antenatally, during labour and birth, and for up to 6 weeks postnatally. The midwife is employed and paid by the woman to provide the care. The midwife provides one to one individualized care for women. The midwife must practice according to the accepted standards of the profession, but is not beholden to any specific hospital policy. This independence enables the privately practising midwife to individualise the care to each woman. As previously mentioned, privately practising midwives are sometimes referred to as independent midwives. For the purpose of this study, the author has referred to midwives who practice in this model as privately practising midwives or private midwives. During the period in which the research participants experienced their care, a privately practising midwife in WA was unable to provide private midwifery care in the hospital setting. This was because no midwife in private midwifery practice had admitting rights to the hospital setting. However the option to birth in hospital was still offered by the midwife, with the understanding that the midwife would not provide the midwifery care in the hospital setting, and would become a support person for the duration of the hospital admission.

The author was particularly interested in women's experiences of maternity care with a privately practising midwife. At this time, in late 2009, impending legislative changes to the registration of health practitioners in Australia meant that from 1st July 2010, all midwives in Australia would be required to hold professional indemnity insurance (PII) to be able to register and practice as a midwife (Nursing and Midwifery Board of Australia (NMBA), 2013a). However, while privately practising midwives would be able to purchase insurance cover for their work with women in the antenatal and postnatal periods, none was available for intrapartum care in out-of-hospital environments such as the home. There was a temporary exemption clause in place, initially for two years which has now been extended for five years (until 2015), so that privately practising midwives who conduct home births could remain registered (NMBA, 2013b). The situation means that women who choose to home-birth with a privately practising midwife will have no recourse to compensation should there be an adverse outcome.

Privately practising midwives were also required to demonstrate a collaborative relationship with a medical practitioner, who effectively must 'approve' the woman's

suitability for midwifery-led care and home birth (National Health Determination (Collaborative arrangements for midwives), 2010). The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), however, has overtly and publicly stated its opposition to, and lack of support for home birth (RANZCOG, 2009), and it was thus unlikely that privately practising midwives would be able to fulfil this requirement. In fact this was the case with very few medical practitioners entering into a collaborative agreement with privately practising midwives. This set of circumstances was anticipated to pose extremely detrimental implications for women who prefer private midwifery care and homebirth. If the midwife was unable to fulfil these requirements, she would be unable to provide private midwifery care and homebirth, therefore women would be left without this option. It was with this background that the author decided to conduct qualitative research into the area.

There have been some changes in relation to private midwifery over the last three years since the study began. More information regarding this will be provided in the epilogue.

Privately practising midwives and the caseload midwifery model

The privately practising midwives during the study period (2009-2014) worked within a one to one midwifery continuity of care model, identified as partnership caseload midwifery (Pairman, 2006; Pairman, Tracy, Thorogood, & Pincombe, 2010; Walsh, 1999; Benjamin, Walsh & Taub, 2001). Within this model, the midwife cares for up to forty women and works in pairs or small groups to provide continuity of care to women through the antenatal, intrapartum and postnatal period (Walsh, 1999). The caseload midwife promotes pregnancy and birth as normal life events and works in partnership with women (Pairman et al, 2010). The UK report Changing Childbirth (Department Of Health (UK), 1993) and the WA Maternity policy Framework (Department of Health WA, 2007) highlighted the importance of the continuity of carer during labour and birth. Studies of caseload midwifery have found increased satisfaction by women of their childbirth experiences. Continuity of carer provides the opportunity for a trusting relationship to develop between midwives and women (Walsh, 1999; Pairman et al, 2010; Warren, 2003). Walsh

(1999) found women's perceptions and experiences were influenced by the relationship they had with their midwife, and that caseload midwifery has a positive impact on women's experiences in childbirth.

Walsh and Devane (2012) define midwifery-led care as autonomous care by a midwife of healthy women of low risk for complications during pregnancy and birth. The Cochrane review by Sandall, Soltani, Gates, Shennan and Devane (2013) compared midwifery-led continuity of care models with other maternity models. The review did not differentiate between different types of midwifery-led care. They included thirteen randomised controlled trials involving 16,242 women. They found that the women who experienced midwifery-led continuity models of care were more likely to experience a spontaneous vaginal birth, had less analgesia in labour, and had less episiotomies and instrumental births. They were also less likely to experience preterm birth and fetal loss before twenty four weeks. There were no differences in fetal or neonatal deaths (Sandall et al, 2013). Walsh and Devane (2012) conducted a metasynthesis of midwifery-led care to describe and interpret qualitative research, to try to understand why women experienced fewer medical interventions with midwifery-led care. They reviewed eleven articles in the review and the three themes that emerged suggested that the greater autonomy that they describe as "agency", experienced by midwives and women, contributed to the reduction in interventions, and that the agency was primarily due to the relationship formed between the women and the midwife.

Walsh (1999) conducted a study of caseload midwifery in the UK, and found that when continuity of carer was combined with a problem solving approach, women's experience of care was enhanced. The study also showed that women valued being looked after by a midwife who knew them, who they had formed a relationship with, and knew about their previous birth experiences and what their expectations of birth were. In another UK study, Benjamin, Walsh and Taub (2001) compared women receiving partnership caseload midwifery care, as described above, to women receiving conventional team midwifery, which was maternity care provided by a community midwife, one of a large team of twenty five and a general practitioner (GP). They found that care provided by caseload midwives had many benefits including less intervention during labour and birth, more vaginal births, a more likely

adoption of an upright position during delivery, less episiotomies, more homebirths and early hospital discharges. Andrews et al (2006) suggested that there was growing evidence that caseload midwifery was associated with higher numbers of vaginal births and less intervention during childbirth. These outcomes are attributed to the continuity of carer in all phases of maternity care, particularly during labour and birth. Two recent studies confirmed this suggestion. McLauchlan et al. (2012) conducted a randomised trial (RCT) of 2314 low risk women at a large tertiary hospital in Melbourne, Australia. The study, named the COSMO trial, found that women allocated to the caseload model had more spontaneous vaginal birth, less intrapartum analgesia and fewer episiotomies. This study was followed by Tracy et al (2013), who challenged the belief that only low risk women are suitable for, and benefit from caseload midwifery. Tracy et al's (2013) RCT of 1748 women at two large metropolitan hospitals in Australia compared caseload midwifery care with standard maternity care for women of any risk. They found that women in the caseload group were significantly more likely to have a spontaneous onset of labour, less likely to have labour induced or augmented than the standard group. Overall the study found no difference in caesarean rates between the two groups. A common theme discussed in the literature around caseload midwifery is the partnership with women. Pairman et al (2010) suggests that this partnership is entered into for the purpose of receiving and giving midwifery care, and together sharing the women's experience of birth and the postnatal period, and that without partnership, midwifery would be just another professional/client relationship where the midwife holds authority as the expert.

Caseload midwifery focuses on women-centred care, described by Freeman, Adair, Timperley, and West (2006) and Johnson, Stewart, Langdon, Kelly and Yong (2005) as encouraging women to take control and make choices and reach decisions about their care. The care revolves around the woman and her family, and the midwife provides support and assists in providing continuity of care by including information and education as required. The care provided is holistic and unique as it applies to individuals and may be different from woman to woman. Pairman et al (2010) states that rather than directing care, the midwife works with the woman so she can direct and control her own birthing experience, and feel confident in her new role as a mother.

Another benefit of caseload midwifery is that most of the antenatal care usually takes place in the woman's home (McCourt, Page, Hewison & Vail, 1998). Care delivered in the home means that the whole family can be involved in the care and decision-making. This promotes the normality of pregnancy and birth, acknowledges it as a family event and encourages the family to discuss any concerns with their 'known' midwife. They are in their own environment and will be more relaxed, less embarrassed, and more likely to ask questions. Walsh (1999) states that women appreciated home antenatal visits, because it allowed families to meet their midwife. Although some evidence is available on the subjective perceptions of women's birth experiences in particular circumstances, such as the previously mentioned, women's perceptions of experiencing a scheduled caesarean birth (Bayes, Fenwick & Hauck, 2008; Bayes, Hauck & Fenwick, 2012); and those experiencing a vaginal birth after a previous caesarean (VBAC) (Godden, Hauck, Hardwick & Bayes, 2012), there is no Australian evidence on why women select maternity care from a privately practicing midwife, or how they then describe their actual pregnancy and childbirth experience.

Research methodology

The author chose to conduct a qualitative study as she believed that it was the best-suited style to the phenomenon of interest, and was the most appropriate method to answer the research question. Numerous authors have supported the notion that qualitative methods are ideally suited to explore those topics where little is known and greater insight is desired from the perspective of those undergoing the experience (Stern, 1980; Maxwell, 2013; Schneider & Whitehead, 2013; Groves, Burns & Gray, 2012).

The research presented in this thesis was conducted using grounded theory techniques; Grounded Theory Methodology was originally developed by sociologists Barney Glaser and Anselm Strauss in the mid 1960's (Glaser & Strauss, 1967). Grounded theory will be discussed in more detail in chapter three.

When using a grounded theory approach it is important to refrain from asking too specific a research question. Cutcliffe (2005) believes that at this stage the aspiring

grounded theory researcher has no preconceived idea of what the key issues will be, as these will emerge during the study. The question posed was “what influences a woman’s decision to choose a privately practising midwife during a recent pregnancy and birth and how does she describe that experience?”

The aims and objectives of the study

The overall aim of this qualitative study was to generate new knowledge to describe and explain the reasons for, and the experiences of, women choosing maternity care with a privately practising midwife in Western Australia. To achieve this aim the following research objectives were identified:

- Explore the reasons women choose maternity care with a privately practising midwife.
- Describe their experience of receiving maternity care from a privately practising midwife.
- Identify factors that facilitate that choice and experience.
- Identify factors that inhibit that choice and experience.

Overview of the thesis

This thesis will present a qualitative descriptive study of fourteen women’s reasons for, and experiences of, maternity care with a privately practising midwife in Western Australia from 2007-2013. The thesis, beginning with this introduction, is presented in six chapters.

In Chapter two, the literature review completed prior to the study’s commencement and it’s relation to the chosen methodology of grounded theory will be presented.

In Chapter three, the chosen methodology will be presented. First, two opposing research paradigms and their relation to the two research methods, ‘quantitative’ and ‘qualitative’, are outlined. Then the background and origins of grounded theory will be described before a discussion of different approaches of using grounded theory

techniques is provided. This chapter will discuss the investigative process followed in the study.

In Chapter four, the findings related to women's reasons for, and experience of, maternity care with a privately practicing midwife will be presented. The reader will be provided with the major categories and sub-categories that represent the essence of the women's experiences. The influencing factors relating to the women's reason for, and experience of, maternity care with a privately practising midwife will also be discussed.

In Chapter five, the study's findings are discussed within the relevant literature.

In Chapter six, the implications of this study in regard to maternity care providers and clinical practice will be discussed, and recommendations for further research will be suggested.

Conclusion

In this chapter, the aim and objectives of the study of Western Australian women's reason for, and experience of, maternity care with a privately practising midwife were presented. The significance and purpose of the study was outlined, along with a description of the author's background and decision making process around the research topic and the chosen methodology. The context of the research and a description of the study's setting in Western Australia were provided. A brief history of maternity care, and a description of maternity services in Western Australia, private midwifery and caseload midwifery were explained. Finally an overview of the thesis and a brief explanation of each chapter were provided.

Chapter 2: Literature Review

Introduction

In this chapter the role of the literature review in grounded theory methodology will be outlined. The initial academic literature review conducted for this study will then be presented and discussed. A more in-depth review of the existing literature will be drawn upon in the discussion chapter when the relevance of the findings are presented within the context of current literature are presented in this thesis.

Literature review in grounded theory methodology

Grounded theory (GT) as a research methodology was developed by Barney Glaser and Anselm Strauss in 1967. The aim of conducting research using grounded theory methodology is to generate the “discovery of theory from the data” (Glaser & Strauss, 1967, p1). The emphasis is on developing a theory that is relevant, works, fits and is modifiable (Glaser & Strauss, 1967; Glaser, 1978).

The purpose of conducting a literature review prior to conducting a research study is to provide clear justification that a new research project on the subject is warranted. However, this is not advocated within the grounded theory methodology. Glaser (1978) believes that the researcher must enter the research setting with as few preconceived ideas as possible. Glaser (1998) goes on to say that he believes it is “appropriate to deliberately avoid a literature review” (Glaser 1998, p68) at the beginning of a research project. Dunne (2011) states this stance contradicts most methodologies, as they dictate that a detailed literature review must be conducted prior to any research and this is the essential foundation upon which the study builds. The rationale for avoiding the literature prior to doing grounded theory research is to ensure that the researcher remains sensitive to the data without pre-existing hypotheses and biases directing his or her findings (Glaser, 1978). Charmaz (2006, p135) suggests that the literature review in grounded theory has “long been both disputed and misunderstood”. She advocates for delaying the literature review to “avoid importing preconceived ideas and imposing them” (Charmaz, 2006, p165) on

the researchers work and therefore encouraging the researcher to articulate their own ideas. Although many have continued to advocate for the absence of the literature review, (Glaser, 1978; Lincoln & Guba, 1985; Strauss & Corbin, 1994; Charmaz, 2006), others for example Patten (2002) and Hutchinson (1993) advocate an early review of the literature to identify gaps within the existing knowledge and provide justification for the study. As this study was the basis of a higher degree by research it was also a requirement of the university, in accordance with the Australian National Health and Medical Research Council (NHMRC), that justification of the study be presented (NHMRC, 2007). It was with this in mind that the following basic preliminary literature review was performed.

The research question and rationale behind the proposed research

On commencement of the research journey, the author had just graduated as a midwife and was working as a midwife in a public hospital in the Perth metropolitan area in Western Australia. Although she was working in all areas of midwifery care, antenatal, intrapartum and postnatal, the care was fragmented with no continuity of care between the women and the midwives. The initial question that formed in the authors mind was “what kind of experience do women choosing private midwifery have?” The author was aware that a privately practising midwife would usually practice caseload midwifery. As discussed in the introduction, caseload midwifery is considered to be the gold standard of midwifery-led care (Warren, 2003; Andrews, Brown, Bowman, Price & Taylor, 2006).

As outlined in Chapter One, Andrews and Associates (2006) describe caseload midwifery as an organisational model of care in which the midwife is the primary care giver and is responsible for planning and executing midwifery care, throughout the antenatal, labour and birth, and postnatal period, for an agreed number of women. The research on continuity of carer and positive outcomes for women demonstrates that continuity of carer leads to a more positive experience for women (Hildingsson, Johansson, Karlström & Fenwick, 2013). The UK report titled ‘Changing Childbirth’ (Department of Health UK, 1993) and the ‘WA Maternity Policy Framework’ (Department of Health, WA, 2007) highlighted the importance of the continuity of

carer during labour and birth. Warren (2003) suggests that continuity of carer provides the opportunity for a trusting relationship to develop between midwives and women. This stability has a positive impact on the woman's experience of labour and birth. Walsh (1999) found women's perceptions and experiences were influenced by the relationship they had with their midwife and that caseload midwifery has a positive impact on women's experiences in childbirth. Women who have constant support in labour reduced the likelihood of requiring medication for pain relief, the duration of labour, operative and caesarean section deliveries and these women had a more positive overall experience of labour and birth than they expected (Hodnett, Gates, Hofmeyr & Sakala, 2013).

Literature review

The preliminary literature review was conducted during the first two weeks of September 2009. The search was done via the Curtin University library website. A search on private midwifery care and women's reasons for choosing private midwives was conducted using the 'PubMed', 'Sciencedirect' and 'CINAHL' databases, as well as an extensive search of midwifery and social science journal back catalogues. The terms used in the search were 'private midwives', 'privately practising midwives' and 'independent midwives'. Nine articles were used for the preliminary literature review. During the literature search it was discovered that, most of the research around private midwifery was related to homebirths and that this was the focus rather than the care provider. The reason for the literature review was, as previously mentioned, to identify the gap in the knowledge and justify the research study.

Symon, Winter, Inkster and Donnan's (2009) large United Kingdom retrospective study compared outcomes for all risk births booked under a privately practising midwife and all risk births booked with the National Health Service maternity care providers (the UK government funded maternity service). They found that clinical outcomes across a range of variables were significantly better for women booked with a privately practising midwife. No significant differences in mortality and morbidity were found between the low risk women in each group, however the

authors found a significantly higher mortality rate in the privately practising midwives' group for women classified as high risk (for example, those having a vaginal breech birth and those with twin pregnancies). Symon and team (2009) attempted to match two groups of women. Matching two different groups of women can cause problems when trying to compare the two groups, as the women choosing privately practising midwives were a self-selecting group and many differences between the two groups were apparent, such as nutritional status, smoking, socio-economic factors, previous obstetric history and medical problems. This quantitative study did not explore the experiences or reasons the women chose their model of care.

A study conducted in Australia a decade earlier than that reported by Symon et al (2009) found similar issues in regard to high-risk birth, Bastian, Keirse and Lancaster (1998), who compared data on planned homebirths from 1985-1990 and found a perinatal death rate of 7.1 per 1000 total births. However when the high-risk cases were excluded the mortality and morbidity of low risk homebirth women was comparable to low risk hospital women. Again the research did not explore why women had chosen homebirth with a midwife.

Positive outcomes for women choosing to have homebirths have also been reported in Western Australia. The review of homebirths in Western Australia (Homer & Nicholl, 2008) examined homebirth and in particular assessed essential health outcomes including morbidity and mortality; the report also identified areas of concern and recommended ways in which the safety of homebirth could be improved. A sample of women and their partners were interviewed as part of the review, and those who took part spoke of the value of midwifery continuity of care and the importance of a known caregiver. They also stated that a lack of access to other options such as continuity of carer, water birth, and vaginal birth after caesarean (VBAC) in health service environments, were drivers to them pursuing homebirth with a midwife. This report however did not explore the women's experiences of birth with a private midwife.

Most of the research regarding homebirth has been quantitative, concerned with the measurement of outcomes such as maternal and infant mortality and morbidity, and has clearly demonstrated that morbidity and mortality in planned homebirth for low

risk women is comparable to low risk hospital births. Furthermore, observational studies demonstrate low risk planned homebirth to have lower intervention rates, less use of pharmacological pain relief, more unassisted vaginal births and greater maternal satisfaction than low risk hospital births (Wiegers, Keirse, Van der Zee & Berghs, 1996; Olsen, 1997; Bastian et al, 1998). None of these studies around homebirth differentiated between government funded homebirths or homebirths with private midwives.

Why women choose maternity care with a privately practising midwife has yet to be comprehensively reported in-depth in the literature. Gamble, Creedy and Teakle (2007) conducted a small Australian study examining women's preferences for maternity care using a self-report survey of a convenience sample of sixty-three women. Their results showed that 24.2% would prefer a homebirth and half of the respondents preferred their birth care to be from a chosen midwife.

Some qualitative work with this group of women also exists, however it is concerned with the experience of homebirthing, rather than with the choice for, and experience of birth with a privately practising midwife. Morison, Hauck, Percival and McMurray (1998) and Morison, Percival, Hauck and McMurray (1999), for example, conducted a qualitative study using a phenomenological approach to provide an understanding and insight into 10 couple's experience of homebirth in WA. They concluded that the experience of birthing at home involved the couple actively creating an environment that enabled them to assume control and responsibility for the birth. Furthermore, these couples believed homebirth to be a multidimensional experience that extended beyond the physical aspects of birth. Birth was seen as a momentous life experience and achievement by the couples, who also believed that birth was a natural process. The women in the study were recognised as the experts in their birthing. All the couples' experiences of homebirth exceeded their expectations. Similar findings were found by a more recent study conducted by Boucher, Bennett, McFarlin and Freeze (2009) whose qualitative descriptive study examined why women in the USA choose homebirth. A convenience sample of 160 women completed an online survey about homebirth. The five most frequently identified themes were 'safety and better outcome'; 'intervention free'; 'negative previous hospital experience'; 'control' and 'comfortable environment'.

Limited existing literature around women and couples' experiences of homebirth has been published in Australia and the United States. Although American women's reasons for selecting homebirth were studied, this does not specifically address the selection of a privately practising midwife. Within Australia, there is clearly a gap in knowledge around women's reasons for selecting this model of care. Given the issues with legislation, collaboration and insurance that are challenging the future of birth with a privately practising midwife in Australia (outlined in Chapter One), it is imperative for midwifery to discover what it is about that model of care that is attractive to women, so that those features may be incorporated into available future options. To that end, a qualitative descriptive study of women's choice and experience of private midwifery was felt to be timely and warranted.

Summary

In this chapter the nature of the literature review in grounded theory research was outlined. The preliminary literature review leading to the justification for a study of women's experiences and reasons for choosing maternity care from a privately practising midwife in Western Australia was presented. In the next chapter the methodology employed for the study will be presented. Research paradigms and their relation to the two research methods, 'quantitative' and 'qualitative', will be outlined. The background and origins of grounded theory will be described and the rationale for using this approach will be provided. The research aims and objectives will also be provided.

Chapter 3: Using Grounded Theory Techniques

Chapter overview

This chapter provides details of how a study of fourteen women's experiences of, and reasons for choosing maternity care from a privately practising midwife in Western Australia, was conducted using grounded theory techniques. First, two opposing research paradigms and their relation to the two research methods, 'quantitative' and 'qualitative', are outlined. Then the background and origins of grounded theory will be described, before a discussion of different approaches of using grounded theory techniques is provided.

The second part of the chapter highlights the investigative process followed in the study. A brief outline of the study's context, along with the researchers thought process prior to embarking on the study, is described. The bracketing exercise and identification of pre-conceived ideas completed prior to the data collection is discussed. The research study's aim and questions are outlined. The participant sample, sample recruitment process and ethical considerations are described. The process of data collection, and analysis are all explained within the context of the grounded theory technique used by the researcher during the study.

Positivism and naturalistic paradigms

Sarantakos (2005) describes a paradigm as a worldview, a set of propositions that explain how the world is perceived. Two main scientific paradigms exist, commonly these are referred to as 'positivist/post positivist' and 'naturalistic / constructivist' (Polit & Beck, 2014).

The fundamental assumption in the positivist paradigm is that there is one single reality that can be studied based upon the belief that an objective reality exists independent of human observation, awaiting discovery. The world is not assumed to be a creation of the human mind. In the positivist paradigm, the object of study is believed to be independent of researchers. Researchers working in this tradition

practice in an orderly, disciplined, procedural way; tight controls are maintained over the research process. Knowledge is discovered and verified through direct observations or measurements. Post-positivist researchers still believe in an objective reality; however they recognise the impossibility of total objectivity. They see objectivity as a goal and they strive to achieve it (Krauss, 2005; Streubert & Carpenter, 2011; Polit & Beck, 2014).

In the late 19th century the naturalistic/constructivist paradigm began as a countermovement to positivism. Naturalistic writers such as Weber (1864-1920) asserted that reality is not fixed but is a construction of the individual who is participating in the research. According to the naturalistic worldview, reality exists within a context and therefore, many constructions of reality are possible. The world that people experience in everyday life is an active process where people construct their reality based upon personal interpretation (Sarantakos, 2005). Knowledge (that is, what people 'know', or believe to be true, about a situation) is established through the meanings they attach to phenomena. For naturalistic/interpretive researchers, therefore, people's interpretations of specific phenomena are the key to understanding those phenomena and subjective interactions are the primary way to access them (Krauss, 2005; Polit & Beck, 2014; Sarantakos, 2005; Streubert & Carpenter, 2011).

Qualitative and quantitative research

Sarantakos (2005) suggests that research methodologies are closer to research practice than paradigms and in general, researchers describe their studies in this way. Positivist/post positivist research is usually conducted using quantitative methods. Quantitative researchers gather empirical evidence that is rooted in objective reality. There is a recommended distance between the researcher and research participants to ensure objectivity and minimise potential contamination of the results. The aim of quantitative research is to yield data that is quantifiable and replicable and can be applied to a population (Sarantakos, 2005; Polit & Beck, 2014; Schneider & Whitehead, 2013).

In contrast, researchers who adopt a naturalistic/constructivist paradigm usually conduct research using qualitative methods. These studies yield rich, in-depth information from the real-life experiences of the research participants who have lived experience of the phenomena under study. Krauss (2005) suggests that one major advantage of the qualitative approach is that we are able to see the point of view of the research participant. Lincoln and Guba (1994) support this view, and further suggest that qualitative data can provide rich insight into human behaviour. In addition, they endorse the use of the researcher's 'self' in the research process. The term 'the human instrument' describes the way in which qualitative researchers use their experience, background and knowledge to clarify and summarise information, to arrive at a final product that reflects the researcher and participants interaction with the findings, rather than the application of mathematical formulae as used in quantitative methods (Lincoln & Guba, 1994).

Strauss and Corbin (1990) define qualitative research as any research not based on the use of statistical methods and analysis. A number of different qualitative methodologies exist and can be described as interpretive including grounded theory, phenomenology, ethnography or critical such as action research (Taylor, 1995; Rapport, 2003). Streubert and Carpenter (2011) suggest that qualitative researchers subscribe to a number of common assumptions and attributes. They describe these as 1) a belief in multiple realities; 2) a commitment to identifying an approach to understanding that supports the phenomenon studied; 3) a commitment to the participant's viewpoint; 4) the conduct of inquiry that limits disruption of the natural context of the phenomena of interest; 5) acknowledged participation of the researcher in the research process; and finally 6) the reporting of the data in a literary style rich with participant commentaries (Streubert & Carpenter, 2011,p.21).

Grounded theory methodology

The grounded theory approach has been described as a comprehensive, integrated and highly structured, but also flexible, process that takes a researcher from the first day in the field to a finished written theory (Glaser & Holton, 2004). The grounded theory approach is both a way to do qualitative research and a way to create

inductive theory. An inductive method is where the theory emerges from the data; in comparison, when using a deductive method the researcher commences the research with a theory and tests it.

Sociologists Barney Glaser, who was trained in quantitative research, methodology and theory generation at Columbia University, and Anselm Strauss from the Chicago School of Qualitative Research, developed the grounded theory research method while working together on a study of the experience of dying in an American hospital in the 1960s. Their subsequent book, *The Discovery of Grounded Theory* (1967), was directed towards closing the gap between theory and research, therefore improving social scientists' capabilities for generating theory rather than the previous trend of verifying theory (Glaser & Strauss 1967). The emphasis was on achieving a theory that is relevant, works, fits and is modifiable (Glaser & Strauss, 1967; Glaser, 1978). Initially, the methodology was called 'constant comparative analysis'. In this earliest version, the 'grounded theory' was the finished product.

These concepts can be summarised as follows: The researcher collects and analyses data simultaneously; 'constant comparison' between data is done in a systematic and continuous effort to check and refine emerging categories. The data shapes the processes and products of the research rather than prior assumptions, other research or existing theoretical frameworks. Developing ideas are clarified with theoretical sampling, which is used to determine the direction data collection will take. The aim is to discover a core category or a basic social process, which all other categories revolve around to explain behaviour rather than a description of the situation. Memo writing is used to elaborate categories, define relationships between categories, and identify gaps. Finally, a literature review is conducted after the analysis of the data begins (Glaser & Strauss, 1967; Glaser, 1978; Charmaz, 2006). Glaser (1978) suggests that a core problem is always present in grounded theory but a basic social process (BSP) may not be. Glaser (1978) identifies two different types of BSP: the basic social psychological process (BSPP) and the basic social structural process (BSSP). A BSPP is a process that occurs for individuals and groups and a BSSP refers to social structure changes (Glaser, 1978, p.102).

In other words, the emphasis behind grounded theory methodology is one of ‘new’ theory development. The theory evolves during the research process itself and is a product of the continuous interplay between data collection and analysis of the data. Similar to other qualitative research methods, the researcher does not wait until data collection is completed before analysing the data. The analysis begins as soon as the first data is collected and what is discovered leads the way to further data collection (Glaser & Strauss, 1967; Glaser, 1978, 1992; Strauss & Corbin, 1990).

Two types of grounded theory can be generated using this method: substantive theories are usually concerned with real-life empirical areas (contexts) such as patient care; while formal (‘Grand’) theory, which is more abstract, conceptual and challenging to apply, is concerned with, for example, organisations and authority (Glaser & Strauss, 1967).

Background and origins

Grounded theory’s roots lie in Symbolic Interactionism (SI) (Heath & Cowley 2004). SI originated in the early 20th century from the work of Max Weber (1864-1920) and George Mead (1863-1931) and was further developed by Herbert Blumer, a former student of Mead’s at the University of Chicago, in the early 20th century. SI is both a theory about human behaviour, and an approach to enquiry about human conduct. SI explores how people define reality and how their beliefs are related to their actions. The basic tenet of the theory is that reality is created by attaching meanings to situations (Anells, 1997). Blumer (1969) explains SI as follows;

Human beings act towards things based on the meanings that the things have for them; the meanings of such things is derived from the social interaction that the individual has with his fellows; and meanings are handled in and modified through an interpretive process and by the person dealing with the things they encounter (p. 2).

Blumer (1969) centralised the concept of self, viewed as a unique human attribute that is constructed through social interaction, within this theory, his three basic principles were as follows:

- 1) The meaning that things (such as persons, objects, situations and combinations of such) have for persons will determine what actions will occur towards these things;
- 2) The meaning is derived from social interactions;
- 3) An interpretive response is used to direct and modify the meanings as the situation is dealt with by a person (p. 2).

Early research based on these assumptions took the form of field studies in which the researcher would observe, record, and analyse data obtained in the natural setting. They would then use the data to provide a theoretical explanation of the events (Pascale, 2011). Commonly, however, no reference was made to the process of how the SI researchers came to their conclusions and this led to criticisms from the scientific community who wanted to see the process of the methods. Another criticism levelled at SI is that it assumes human behaviour and interaction to be motivated by the interpretation of environmental signs and symbols. The process of interpretation of these signs, however, is highly individualised and is often dependent on context (Streubert & Carpenter, 2011).

Co-existing within the SI-based perspective are principles and systematic steps for building theory. These are based on the principles of quantitative mathematics and the concepts of index formation that Glaser was exposed to as a student of Paul F. Lazarsfeld (1901-1976) at Columbia University (Strauss & Corbin, 1998; Merton & Coleman, 1979). The empirical social research model developed by Lazarsfeld, a mathematician and sociologist, is demonstrated in his investigation into the effects of unemployment in a Viennese village during the 1930s (Lazarsfeld, 1932; Jahoda, 1987). In contrast to any other approach at the time, the study employed a wide range of techniques to collect information on individuals and families from many different sources. Lazarsfeld's approaches to data collection and analysis was that these techniques would lead to the discovery of the essential (or 'core') human problem,

and that this would reveal the human processes around that problem. These are the foundations of grounded theory methodology (Glaser, 1978; Polit & Beck, 2014).

The development of grounded theory

Following their initial collaboration Glaser and Strauss parted and each followed their own paths of grounded theory methodology. Glaser maintained a commitment to the original methodology and has continued to refute comments that the methodology was “loose, lacking verification and had a tangled description” (Stern, 1994, p. 214). Strauss began working with nurse researcher Juliet Corbin, to develop their own version of grounded theory. The publication of their book *The basics of Qualitative research* in 1990 simplified and described the methodological steps and provided a framework within which the theory should be constructed. Glaser’s reaction to this was to devote a whole book to critique it, urging Strauss to withdraw his text that he stated was not grounded theory but an exercise in dense codification. Glaser (1992) states that Strauss and Corbin’s methods “produce a forced, preconceived, full conceptual description, which is fine but it is not grounded theory” (p 3). Glaser maintains his position on grounded theory, believing that a method with too much structure has the potential to force the data; he remains faithful to the original works (Glaser, 1978; Glaser, 1992) and in his subsequent publications, claims that if the researcher follows the total methodological package outlined in the original works, only then can the researcher call the work grounded theory (Glaser, 1999).

Objectivist vs constructivist grounded theory

More recently, American sociologist, Cathy Charmaz developed her version of grounded theory. Charmaz asserts that “a constructivist approach places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants” (Charmaz, 2006, p130). The original grounded theory methodology is based on the presumption that the theory is already in the data waiting to be “discovered” (Glaser & Strauss, 1967; Glaser 1992.) This belief assumes that the data would be discovered in the same way and that the same

conclusions would be reached whoever did the research. Charmaz (2006) argues that this approach assumes an external objective reality and an objectivist stance. Charmaz (2006) believes the researcher's thoughts, feelings and knowledge should be included as data, as equally as other data provided by participants. Glaser (2002) again argues that this research methodology is not grounded theory but a type of research that he condemns, as no more than qualitative data analysis. He continues to stand by the original objectivist position.

Choosing to conduct a qualitative enquiry using grounded theory techniques

For the beginning researcher, the discussion and controversy around what is, or is not, grounded theory can be confusing and frustrating. In the early stages of reading, the Strauss and Corbin (1990) grounded theory was selected, as this gave a clear and prescriptive outline of how "to do" grounded theory. However, on further reading of Glaser's work (Glaser, 1978; Glaser, 1992) it was concluded that both the Strauss and Corbin (1990) and Charmaz (2006) versions were too prescriptive in their data analysis procedures. The author disagrees with Charmaz (2006) who believes that the researcher imposing his or her beliefs and values on the research, and therefore influencing the research findings is unavoidable, and supports Morse and Field (1995), who assert that the researcher can remain objective, by identifying any preconceived ideas and beliefs that could influence the developing theory prior to commencing the study. It is the author's belief that it is possible to remain outside the research data and let the data speak for itself. Thus, the author identifies more with the original version of grounded theory, the aim of which is to explain what is going on in the participant's reality (Glaser, 1998).

Glaser (1998) states that grounded theory is neither a qualitative or quantitative method, as he believes that if the researcher can accept that all is data, from which theory can be generated by constant comparison, then the researcher accepts that grounded theory is a general method that can be used with all data. However, the author chose to conduct a qualitative study, as she believed that it was the best-suited style to the phenomenon of interest, and was the most suitable method to answer the

research question. Stern (1980) supports this decision, suggesting that qualitative methods can be used to gain insight into areas about which little is known.

Grounded theory methods and analysis

Glaser (1998) advocates not conducting a literature review until the initial findings of the study have emerged; this is so that the researcher is not influenced with preconceived views. It is important, however, from an ethical standpoint, to ensure there is a need to conduct a study, (that is, a gap in knowledge exists that the findings of a new study will address). Therefore a brief literature review was conducted prior to the study's commencement for two reasons: Firstly, to discover if other research had already been done on the subject, and secondly, to satisfy university research committee requirements that the research topic was of relevance.

Study aims and research objectives

Glaser (1992) believes the researcher moves into an area of study with no specific problem, and with an abstract wonderment of what is going on and how it is handled. Prior to developing the research proposal, discussions with the supervisors took place to identify the research question. The research area was chosen because the author had an interest in midwifery-led care and in particular private midwifery. At this point in time the researcher was a newly qualified midwife who was interested in becoming a privately practising midwife. The researcher had an interest into why women chose to employ a privately practising midwife for their maternity care. No other questions were identified at this point. When using a grounded theory approach it is important to refrain from asking too specific a research question. Cutcliffe (2005) believes that at this stage the aspiring grounded theory researcher has no preconceived idea of what the key issues will be, as these will emerge during the study ensuring the theory will have more "fit and grab" and that this openness enables the researcher to be more responsive to the participants' experience.

Following discussions with the researcher's supervisors the research question initially identified as:

Western Australian women's experience of private midwifery care: A grounded theory study.

The title of the study changed as the research process commenced, as once the researcher commenced the data collection, she realised that the experience was not the only phenomena of interest. The reasons leading the women to choose a privately practising midwife as their care provider became an area of high importance and interest. The aim of the study changed to the newly identified purpose:

Women's reasons for, and experience of, maternity care with a privately practicing midwife in Western Australia: A modified grounded theory study.

To generate a substantive-level theory using grounded theory methods is generally recognised as requiring a PhD thesis and was therefore beyond the scope of this Master's thesis. A substantive theory determines basic social processes and is usually presented with a conditional matrix that identifies the central phenomenon, strategies, context and intervening conditions and consequences which highlight the relationships (conditional propositions or hypotheses). In fact, Sandelowski (1995) in her classical work, asserted that to "discern the essence of experiences" within a grounded theory study, between 30 and 50 interviews or observations may be required (p. 182). This modified grounded theory study sought to determine main categories and subcategories around the phenomenon but not to the level of a substantive-level theory. Sample size was estimated to be between 10 and 20 participants once data saturation was achieved.

The overall aim of this qualitative study was to generate new knowledge to describe and explain the reasons for, and the experience of, women choosing maternity care with a privately practising midwife.

To achieve this aim the following research objectives were identified:

- Explore the reasons women choose maternity care with a privately practising midwife;
- Describe their experience of receiving maternity care from a privately practising midwife;
- Identify factors that facilitate that choice and experience;
- Identify factors that inhibit that choice and experience.

Context

Women in Western Australia can choose from an array of maternity care options. These include: private and public hospitals where a team comprising obstetricians and midwives provides care; a Family Birth Centre; midwifery-led hospital-based services; a government-funded Community Midwifery Program that supports homebirth for 'low risk' women; and privately practicing midwives who provide caseload midwifery. Around 1% of Western Australian women birth at home with a midwife as their primary carer (Midwives notification system, Department of Health, 2014). A small but stable number of women in Western Australia choose a privately practicing midwife as their primary maternity care provider. In Western Australia in 2013, one hundred and ninety five women birthed at home: sixty six of these women birthed under the care of a private midwife (Midwives Notification System, Department of Health WA, 2014). There is no official record of how many women who received maternity care from a privately practising midwife, birthed in hospital, as the birth notification system would record this as a hospital birth. As privately practising midwives do not have admitting rights to maternity units in WA at this point, it was assumed both that the women who access this type of care largely intend to birth at home, and that privately practising midwives usually accept clients on that basis.

Bracketing and explicating the researcher's beliefs prior to data collection

Bracketing typically refers to the researcher's identification of vested interest, personal experiences, culture, and prior assumptions that could influence the way

they view the research data (Fischer, 2009). Bracketing is generally associated with phenomenological research, however Glaser (1978) directs the researcher to “enter the research setting with as few predetermined ideas as possible,” as this enables the researcher to “remain sensitive to the data by being able to record events and detect happenings, without first having them filtered through and squared with pre-existing hypothesis and biases” (Glaser, 1978, p.2- 3).

Streubert and Carpenter (2011) believe it is in the researchers best interest to make clear his or her thoughts, ideas, suppositions, or presuppositions about the topic as well as personal bias as in doing this the researcher becomes aware of the potential bias that may occur during data collection and analysis, as the researcher may make judgments on the researcher’s belief system rather than the actual data.

Prior to the commencement of the data collection, the researcher chose to identify her preconceived ideas and assumptions of why women would chose to have maternity care with a privately practicing midwife. As the researcher was now working as a privately practicing midwife, it was essential that she perform this exercise to reduce bias from her own lived experiences of providing private maternity care.

Reflexive bracketing was used to facilitate the process of personal reflection by the researcher. Ahern (1999) describes reflexive bracketing as a process to make the researcher’s personal values, background and cultural suppositions transparent. The researcher identifies his or her personal suppositions and ideas about the phenomena prior to the data collection. In doing this it potentially allows the researcher to reduce the influence of their lived experience on the phenomena under investigation (Fischer, 2009).

During this process the researcher identified herself in two ways: as a midwife and as a woman. As a midwife she identified that her preconceived view of the reasons for choosing a privately practising midwife for midwifery care were multiple. She identified these as: the woman wanting continuity of carer: wanting a natural vaginal birth: and wanting a homebirth. As a woman she identified her own experience of midwifery-led care and birth, and her own lived experience of the births of her two

children. Her first birth was a hospital birth with multiple carers and the second birth was a homebirth with a government funded midwifery program providing continuity of carer. She identified that her own personal experiences highlighted that she valued the continuity of care and homebirth experience with her second child, and had chosen this as she believed in natural birth.

Doing this exercise enabled the researcher to acknowledge these views and beliefs and to bracket them and put them to one side, so that she felt able to commence the research without imposing her views on the data analysis and that she would feel able to listen to women's experiences objectively (Ahern, 1999).

Sample

The aim of qualitative research is not to generalise to the population, but to obtain insights into a phenomenon. Therefore the first step in qualitative sampling is selecting a sample that will provide information richness and maximise the researcher's understanding of the phenomenon under study (Patton, 2002; Polit & Beck, 2014; Schneider & Whitehead, 2013). This research study required information from women choosing maternity care with a privately practising midwife. Three types of sampling were used in the study. **Snowball sampling** was initially used to access the women. The researcher contacted privately practising midwives via email. The email contained information about the study and the request to pass the information on to women who had experienced this type of care, and who may be interested in participating in the study. **Purposive sampling** was then undertaken, as the study was asking questions specific to a particular group and sample cases were needed to provide rich information specific to these questions (Teddie & Tashakkari, 2009). The researcher also wished to select participants who would best contribute information to address the four research aims (Polit & Beck, 2014). The snowball effect of sampling continued after the initial contact from the midwives, as women who had participated in the study contacted women that they thought might be interested, and these women then contacted the researcher.

Once coding and analysis commenced, **theoretical sampling** was employed. This technique enabled the researcher to collect, code and analyse data and concurrently

decide future data collection to expand understanding of the emerging categories (Glaser & Strauss, 1967). The researcher specifically targeted participants who could add depth, variation and density to the concepts that are relevant to the emerging categories (Charmaz, 2006). Glaser (1978) believes theoretical sampling to be “controlled” by the emerging theory as only data relevant to the study is sought. As the processes and major categories start to emerge the technique of theoretic sampling continues until saturation is achieved. Theoretical sampling was done after it became clear during analysis of the interviews and development of the tentative categories that the majority of participants were multiparas and women seeking a vaginal birth after caesarean (VBAC). Therefore theoretical sampling was used to guide the researcher to seek more primiparas women to see if the categories would hold for the decision making for these women who did not have a previous pregnancy and birth.

When employing grounded theory techniques in keeping with Glaser (1992), it is impossible to determine sample size prior to the start of data collection, as the continual analysis of results determines whether more data is needed. Data was collected until ‘saturation’ was reached. Based on studies of a similar nature (that is with small but information-rich populations) and guidelines within the literature, it was anticipated that meta-themes would present after interviews with 6 participants, with saturation occurring after between twelve and twenty-five participant interviews (Guest, Bunce, & Johnson, 2006; Luyburg & Fleming, 2005; Onwuegbuzie & Leech, 2007). In this study fourteen interviews were completed between July 2010 and July 2013. After twelve interviews it was felt that saturation was achieved, however two more interviews were done to confirm this.

Inclusion criteria

As the phenomena of interest were women who birthed with a privately practising midwife, these were the women who were recruited. The study was conducted with women residing in Western Australia, specifically in the homes of participants. Women were invited to participate in the research by emailed letter outlining the research aims and objectives, privacy and ethical issues and consent form. Women who had given birth with a privately practising midwife as their main maternity care

provider within the last five years were included. The criteria of giving birth within the last five years was used, as recall of life events has been demonstrated as reliable within this time frame (Moreton & Ward, 2010).

Recruitment of women

The privately practising midwives were contacted via email after accessing their details from a publicly available database of privately practising midwives working across WA (<https://cmwa.worldsecuresystems.com/our-services>). No women who had been cared for by the researcher were recruited into this study. The potential participants were sent an introductory letter by their midwife written in plain English, containing information about the study, research aims and benefits, an explanation of selection, confidentiality issues, an indication of what the results would be used for, and requesting consent to participate (Appendix 2). The letter also indicated that any questions that women wished to ask would be welcome, and that they could withdraw from the study at any time. It was also indicated that counsellor's contact numbers would be provided, in case women became distressed during interviews. The researcher also contacted a free government service that provided counsellors, and informed them of the study and the chance that women may be referred. The research teams contact details were included in the information, so that it was up to the women to contact the researcher if they wished to participate in the study. A consent form to participate in the research was also included, requiring signature of both the participant and the researcher (Appendix 3). This was completed prior to the commencement of the interview.

Emails were received from nine women who had been contacted by their midwife and received the information about the study and wished to participate in the research. The researcher then telephoned the women to make an appointment to conduct the interview. All interviews were either conducted in the participant's home or by telephone at a time chosen by them. A further five women emailed the researcher to volunteer for the study; these women had found out about the study from the women who had already participated. All women who contacted the researcher were interviewed.

Data collection

Interviews with women: Minichello, Aroni, Timewell and Alexander (1995) describe interviews as a “conversation with a purpose” (p. 61). Interviews are a powerful data collection strategy, because they use one to one interaction between researcher and participant. Interviews also allow ample opportunity for interviewers to ask for explanations of vague answers, or provide clarification of questions (Teddlie & Taqshakkari, 2009). A semi-structured in-depth interview using an interview guide (see Table 1) was used to collect data from the women. Minichello et al (1995) suggests that in-depth interviews can be used in research “to gain access to, and an understanding of, activities and events that cannot be observed by the researcher” (p.70). In this case, the experience of birth with the private midwife had occurred in the past and it was also the women’s experience being studied not the researcher’s perception of the observed event. In-depth interviews allow the researcher to gain insight into the experiences of the people who have directly participated in the phenomena under study. Minichello et al (1995) believes that in-depth interviewing is an appropriate method to gain access to the individual’s words and interpretations.

Interviews lasted between thirty and sixty minutes with an average of forty five minutes. However the researcher generally spent approximately two hours with the participants, as it was important for the researcher to establish rapport with the interviewee prior to the commencement of the interview. This was essential as although the author was a privately practising midwife, she was not familiar with any of the participants of this study. Streubert and Carpenter (2011) believe that the researcher must trust the researcher before they will feel comfortable revealing information and Broom (2005) suggests that taking time to chat and get comfortable is crucial to a successful interview.

- a) The interviews began with the opening question “tell me about your birth experience?” Using this broad question allowed the participant to talk freely on a subject that was very familiar to them and in doing so reduce anxiety in the interview process. This question yielded a huge amount of data as generally the birth experience they spoke about was not only the experience

of the birth with the privately practising midwife, but also the experience of other births the women may have had, and the reasons that led them to seek care with the privately practising midwife. This first question also frequently answered the other questions on the interview guide (Table 1); however the researcher continued to ask the questions and this enabled clarification and added further detail (Teddlie & Tashakkori, 2009). Within axial coding the context and intervening conditions for the phenomenon are explored within grounded theory methodology. The ‘identifying factors’ were not predetermined but were a component of the intervening conditions that were sought around women’s reasons for choosing a privately practising midwife.

As the participants in this study, all engaged the support of a privately practising midwife, rather than traditional care models within the public system, the question ‘what suggestions could you make to improve the care’ was included to suggest further research areas.

Table 1: Interview guide questions

- | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Tell me about your birth experience? • What was it like receiving care from a privately practising midwife? • Can you offer some examples of what you liked about the care? • What suggestions could you make to improve the care? • What made you decide to seek care from a privately practising midwife? • What reaction did you receive for this decision from your partner, family, and friends? • What reaction did you receive for this decision from other health professionals (eg your general practitioner)? |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Communication is a two way process and involves verbal and non-verbal processes, so the researcher used active listening skills and employed an open posture (Sarantakos, 2005; Minichello et al, 1995). Prompts were used as needed, either to make it easier for the respondents to answer questions, or to encourage them to continue speaking. Broom (2005) believes that the ability to prompt effectively is probably the most important skill to have in a qualitative interview. Prompts such as nodding, smiling, using language such as “mm” or “yes” indicate that you are listening and understanding what is being said. Prompts can also be used to

encourage the respondent to extend or amplify their answer to a question without affecting the direction of their thinking or causing bias (Sarantakos, 2005; Broom, 2005). For example, in many instances after a woman had shared her story, the researcher sought clarification by stating “earlier you said....., can you tell me more about that?”.

All the interviews were conducted by the researcher and took place at the place and time chosen by the respondents. Thirteen of the interviews took place face to face in the respondents’ home and one took place via telephone as the woman lived at a distance too far to travel to conduct a face to face interview. In-depth interviews have traditionally taken place face to face (Teddlie & Tashakkori, 2009) however, telephone interview have been employed to access otherwise unavailable populations. Qualitative research with childbearing women and clinical nursing research has been successfully completed over the telephone (Fenwick, Hauck, Downie & Butt, 2005; Musselwhite, Cuff, McGregor & King, 2007). Musselwhite et al (2007) suggest the benefits of telephone interviews may include the ability for the researcher to take notes during the interview without making the participant feel uncomfortable. They also point out that as the researcher and the participant are unable to see each other, they are less affected by each other’s presence and that this could reduce response bias, through non-verbal communications such as facial expressions and that this may also increase the level of comfort and result in a more relaxed interview. However, the researcher felt that being unable to “pick up” on non-verbal clues such as changes in body language and facial expressions were a disadvantage to the interview. All the interviews were digitally recorded and transcribed verbatim.

Prior to the interviews a short questionnaire was emailed to the women to obtain demographic details, such as the woman’s age at time of receiving care from the privately practising midwife; what number baby she received care for; where she lived in relation to Perth (the capital of Western Australia); the highest education level completed; if she had any pre-existing medical or obstetric conditions whilst receiving care from the privately practising midwife; and previous modes of birth if she was a multiparous woman.

Data analysis using grounded theory

The process used for analysis of data adhered to the coding, categorisation and memoing principles, underlying logic and procedures originally set down by Glaser and Strauss (1967) and expanded by Glaser (1978, 1992). The researcher who has chosen to follow Glaser's grounded theory techniques moved through a number of sequential phases during the analysis of data (Glaser & Strauss 1967). There are two types of coding in Glaserian grounded theory: substantive codes and theoretical codes (Glaser, 1992). The first type, substantive, which combines open and selective coding, is the initial step to identify common themes and categories. This involves analysing the data, word by word, sentence by sentence, to identify codes and categories. These categories are then put back together to form newly identified categories and subcategories; the data can then be linked systematically and related to each other (Glaser & Strauss, 1967; Glaser, 1978; Glaser, 1992).

The second type of Glaserian coding is theoretical coding, and this is the discovery of the relationship between each of the substantive codes and categories. This process continues until the researcher identifies the core category and the interrelation of the other categories to the core category. Throughout analysis of the data the researcher is encouraged to document their ideas and thought processes in relation to the data and emerging theory development. These memos are a key support structure to grounded theory. Glaser (1978) describes memos as the "theorising write up of ideas about codes and their relationship as they strike the analyst while coding" (p 83). Information contained in memos can contribute a significant amount of data from the planning stage right up until the publication. The comprehensive pattern that is formed will be the grounded theory (Glaser & Strauss, 1967).

Analysis of the in-depth interviews with women

Substantive coding

Within twenty four hours of being conducted, the first interview was transcribed, and open coding, as described previously, commenced. The researcher transcribed the interview using a laptop and earphones and entered all the data in to a Microsoft

Word document. Initially it was thought that a qualitative tool such as NVivo would be used but the researcher found she was more comfortable using Microsoft Word, as it was familiar, and also allowed for careful systematic analysis of the interview transcripts. After transcribing the interview, the researcher printed a copy and commenced coding. Each word was read and areas highlighted that were thought to be relevant. Figure 3 provides an example of open coding employed during preliminary analysis of interview two (see Figure 3).

these problems started happening umm and umm ended up having the caesarean umm and afterwards I had a lot of problems mentally from it yep grieving, um I think the biggest thing, the big thing that added in on that was being separated from my family yeh I, the 10 weeks before really I don't know it just, it did something to me and um you know cos I'm a how special pregnancy is and you don't want to be separated from your children and um (pause) so he was, everything went well in the surgery, just very, very shy of a transfusion, very weak umm took a long time to recover umm I would say he was born very fragile, my other babies came out robust and they were strong little creatures but he was born early and yeh, yeh, it was just completely, the whole experience that I didn't want. With him, the fourth baby, I wanted a completely different experience, I wanted as much interaction with my family as I could handle I wanted them there um I went to the NBAC clinic at king Edwards umm and I actually saw a midwife umm that, she actually counseled me after my third baby was born, she was the midwife on the day, and I was very, I was lucky enough to be very blatant and ask her all the questions I want and would I get what I want in the hospital knowing full well that I wouldn't so I said I wanted, if possible I wanted my children there and she said well that's just kind of not going to happen umm you know and it was just lots of little questions and I said you know I will not I just don't want the cannula, I don't want monitoring I just want to be left alone and she kind of kept looking at me and going yeh, that's not going to happen here your going to have to fight and I didn't want that so then I started looking in to the homebirth midwife option umm I had a lot of struggle with my husband probably for about the first 4 months cos he couldn't get in his brain that if I could go to hospital and have a baby for free (laughs) why would I want o pay \$4000 to have um a private midwife and we met a few, there was about 4 midwives around that time or 3 um the first 2 didn't, just weren't for us and then I said look this is the last option we'll meet emma and she walked in our door and we both fell in love with her, instantly, just I think cos she was the same age as us, her beautiful manner her, um the way she spoke to frazer I think he just loved that and umm from that day on that she walked in I had 100%

Figure 3: Example of open coding

The researcher continually asked questions whilst reading the transcript data. Grounded theorists need to ask neutral questions when beginning to code the data. Glaser (1978) suggests asking these questions: ‘What is this data a study of?’, ‘What category does this incident indicate?’, ‘What is actually happening in the data? The constant comparison and questioning during coding ensures that the researcher does not force the data and will allow concepts to emerge (Glaser, 1992). Following the reading and highlighting manually of the transcribed interview the researcher then went back to the computer, and using the cut and paste function in Word moved all the highlighted data into a new Word document named coding 2. Open coding continued with the data in the coding 2 document, then being regrouped into “like”

codes, where the highlighted data that was of a similar meaning was regrouped together, to form the third Word document coding 3 subcategories. Glaser (1978) believes that open coding allows the researcher the full range of his theoretical sensitivity, as it allows the researcher to “take chances on trying to generate codes that might fit and work” (p.57).

The same process as described above was completed with the second interview, and all subsequent interview transcripts commencing the constant comparison analysis. As open coding progressed the researcher looked for similarities and differences and then grouped these together to create categories and subcategories. The researcher then concurrently conducted interviews and continued to analyse the data. In keeping with constant comparison, the researcher continually compared codes against the previously identified subcategories to see how and where they fit. Continually asking the questions previously mentioned throughout the process ensured that the researcher did not lose sight of the research question, and how the data was providing insight to the topic under exploration. Glaser (1978) states that these three types of questions: “what is this data a study of?; what category does this incident indicate?; And what is actually happening in the data here?; keep the researcher “theoretically sensitive when analysing, collecting and coding data” (p.57).

Memoing/field notes

Field notes are generally associated with ethnography, however Streubert and Carpenter (2011) believe that other qualitative research can benefit from the use of field notes, as not everything observed during an interview is captured on an audio file. No notes were taken during the interview as the researcher preferred to focus all her attention on the participant. She felt that the taking of notes may distract herself or the woman from the interview, and influence the flow of the interview. Following the interview the researcher occasionally made additional notes containing information such as the demeanour of, and the type of communication used by the participant, others that may have been present, for example the woman’s children, and the impact they had on the interview.

Notes and memos were made on the printed sheets during coding as Glaser (1978) believes that in using memos, the researcher is encouraged to slow down the pace of

analysis, forces the researcher to reason through and verify categories and their integration and fit, relevance and work for the theory, so that she does prematurely conclude the findings (p. 88). Figure 4 provides a copy of a memo made during coding (see Figure 4).

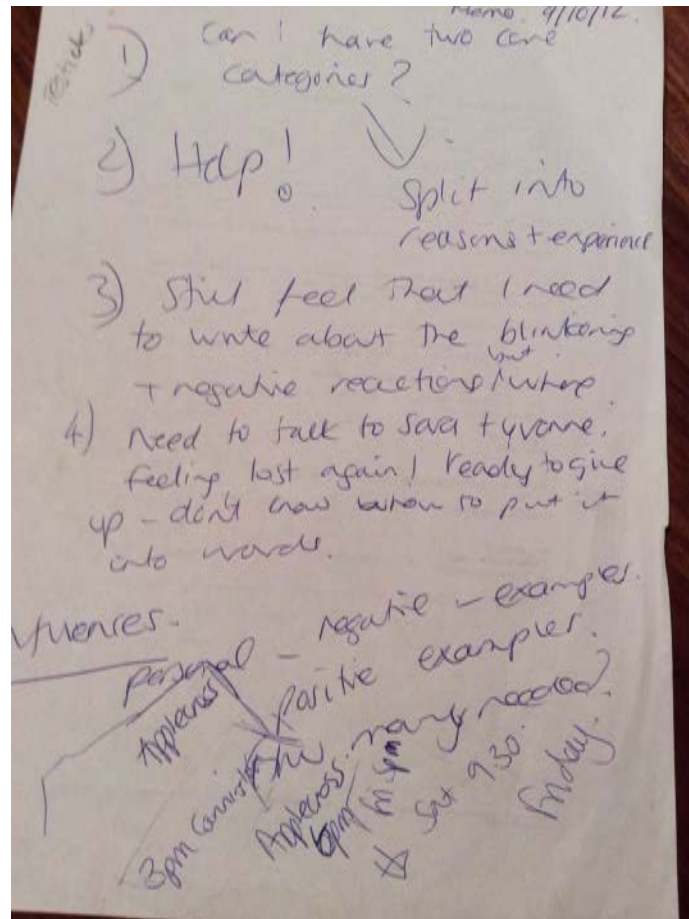


Figure 4: Memo made during coding

Theoretical coding

Theoretical codes conceptualize how the substantive codes relate to each other. In open coding the data is taken apart and studied word by word. During theoretical coding the researcher “weaves the fractured story back together” (Glaser, 1978, p.72). This process is done by relating and integrating the substantive codes into theoretical codes. To assist the researcher with this process, Glaser (1978) identified and described 18 coding families to assist the researcher to think about the relationship between the categories (p.74). Theoretical codes form the basis of the grounded theory so it is important that findings emerge from the data (Glaser, 1978).

This process of coding, categorisation and memoing continued until the core category was identified. After twelve interviews the major category “I knew what I wanted” was identified and will be presented in detail in chapter four.

As the process of data analysis continued using constant comparison, selective sampling and coding were then used. The researcher purposefully looked for codes relevant to the identified major category and subcategories. Figure 5 provides an example of selective coding (see Figure 5.) This data analysis process continued until saturation occurred. It was felt by the researcher that saturation occurred after twelve interviews. However, it was agreed with the researcher and her supervisors that the final two interviews would be done to confirm saturation and allow women who wanted to share their story the opportunity to do so.

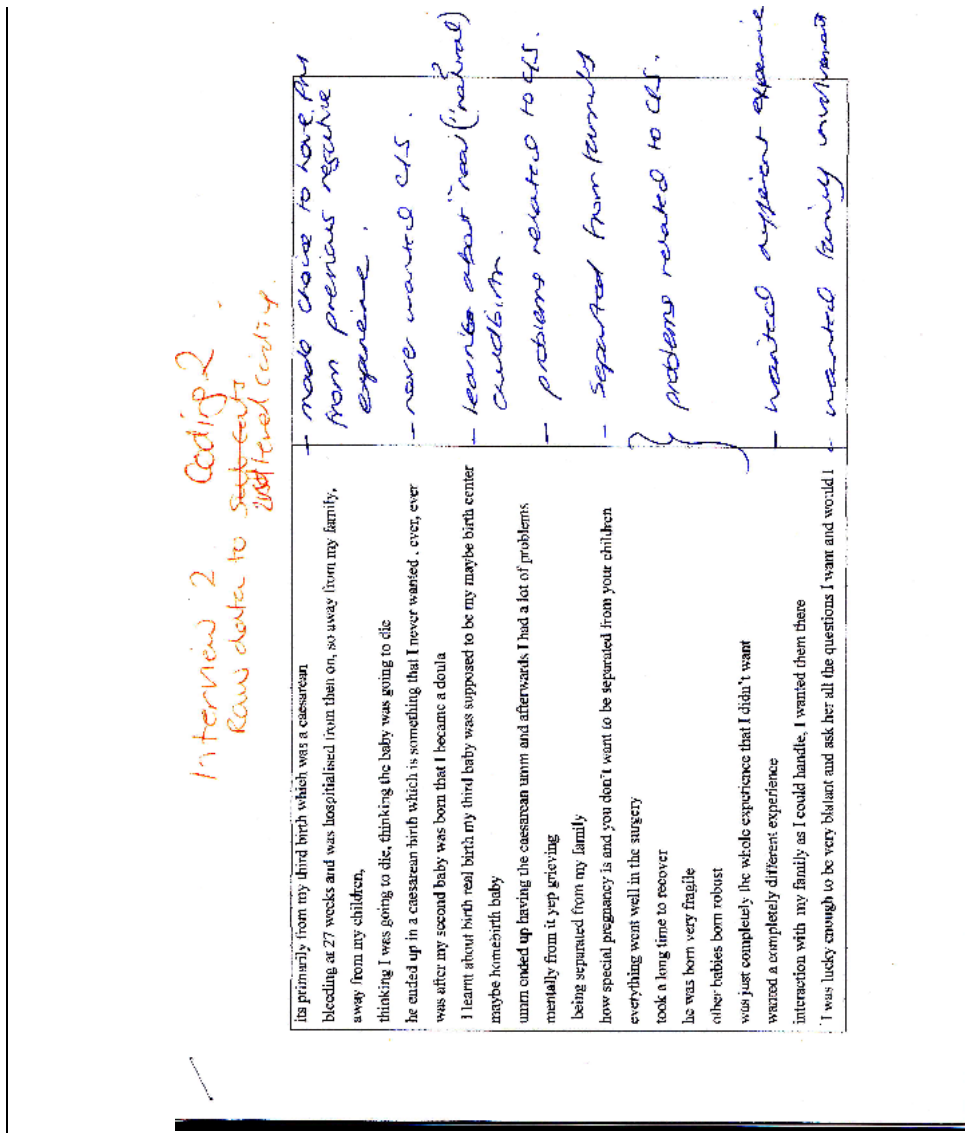


Figure 5: Selective coding

Ensuring trustworthiness of the data

Lincoln and Guba (1985) suggested four criteria for establishing trustworthiness of qualitative data: credibility, dependability, confirmability and transferability. Polit and Beck (2014) describe these criteria as the “gold standard” for qualitative researchers. A number of strategies were undertaken to ensure trustworthiness of the analysis of this study’s data. To avoid investigator bias in the data collection and analysis, and to ensure credibility, the researcher performed the “bracketing exercise” as discussed earlier in this chapter, prior to recruitment of participants. Bracketing is a way of clearing one’s view by recognising one’s beliefs, perceptions and assumptions about a phenomenon, and putting them aside (Sokolowski, 2000). This strategy involves the researcher acknowledging and recording her own preconceptions and experiences about the phenomenon of interest to significantly reduce the likelihood of her ‘forcing’ the research to meet expected findings. Patton (2002) supports suggesting that the researcher should report any personal or professional information that may affect the data collection or analysis.

Credibility and dependability can also be increased with prolonged engagement, triangulation, and external checks (Polit & Beck, 2014). The data was collected over three years from July 2010 to July 2013. Triangulation was achieved by the researcher’s supervisors coding and analysing three interview transcripts separately, and the research team coming together to present and discuss their tentative interpretations. In addition, numerous, regular meetings were held between the researcher and her supervisors to discuss and monitor the progress of the data analysis and generation of categories and sub-categories. Emerging categories were discussed with academic supervisors who were familiar with the interview transcripts and on-going analysis from open, selective and theoretical coding. Any disagreements with preliminary interpretations were referred back to the transcripts for verification. These discussions served to confirm the analytical decisions made by the researcher.

Streubert and Carpenter (2011) suggest that researchers document the confirmability of the findings by leaving an audit trail, which they describe as “a recording of

activities over time that another individual can follow” (p. 49). Selective examples of the memos, open and selective coding provided in Figures 3, 4 and 5 provide evidence of the audit trail developed for this study. The process of data collection and analysis is clearly and carefully documented to enable justification of conclusions drawn. Interviews were transcribed verbatim and transcripts were checked for accuracy by listening back to the audio recording. The researcher also discussed data transcripts and findings with the research participants to confirm findings were an accurate interpretation (Chiovitti & Piran, 2003; Guba, 1981; LeCompte & Goetz, 1982). Finally, transferability, which refers to whether or not the study findings have meanings to others in similar situations, is an expectation of whether the findings fit with the potential users of the findings and not the researcher (Streubert & Carpenter, 2011). Rich description of the major categories and sub-categories within the Western Australian context are provided in chapter four.

Ethical consideration

If people participate in research studies it is expected that their rights are protected (Polit & Beck, 2014). This study was conducted within the National Health and Medical Research Council (NHMRC) guidelines for the ethical conduct of research with humans (NHMRC, 2007). All women provided informed consent to participate in this study. Permission to conduct the proposed research was sought and granted from the Human Research Ethics Committee at Curtin University, and assigned the ethics code number HR 52/2011. No-one other than the research team had access to the data. No names have been recorded or used in reporting of the data and only the researcher knows the identity of the participants.

Data storage

All interviews both digital recordings and transcripts are stored on the master computer file which is password protected. The researcher is the only person to have access to these files. No identifying information will be used in written reports, presentations or publications. All data will be managed in accordance with the National Health and Medical Research Council (NHMRC) guidelines (NHMRC,

2007). Data will remain securely stored in a locked filing cabinet at the researcher's home office for a period of no less than five years.

Summary

This chapter presented how a study was conducted using a modified grounded theory approach of women's experiences of, and reasons for choosing maternity care from a private midwife in Western Australia. Research paradigms and their relation to the two research methods, 'quantitative' and 'qualitative', were outlined. The background and origins of grounded theory was described and the rationale for using this approach was provided. A brief outline of the study's context along with the researchers thought process prior to embarking on the study was described. The participant sample and sample recruitment process were described. The process of data collection, analysis and interpretation of categories and sub-categories were all explained within the context of the grounded theory approach used by the researcher during the study. Finally measures taken to ensure trustworthiness of the data and ethical considerations were provided.

In the following chapter the findings from the data analysis of the fourteen women's reasons for, and experience of, birth with a privately practicing midwife will be presented.

Chapter 4: Women's Reasons For, and Experience of Maternity Care with a Privately Practising Midwife

Introduction

In this chapter the findings from the data analysis of fourteen women's reasons for and experience of maternity care with a privately practising midwife will be reported.

It was the author's initial intent to present the findings related to women's reasons for choosing a privately practising midwife and women's experience of maternity care with a privately practising midwife in separate chapters; however it was felt during writing that both aspects of the findings were so closely related it would be more beneficial for the reader to have both aspects presented in one chapter.

In the first part of this chapter the findings related to women's reasons for choosing a privately practising midwife will be presented. The reader will be provided with the major categories that represents the essence of the women's experiences, and the sub categories and influencing factors. All categories and sub categories are presented in sentence format with the first word capitalized and in bold print. Direct quotes from the women's interview transcripts are offered in italics with quotation marks to illustrate the women's perceptions and demonstrate support for the category or subcategory being presented. Each participant was assigned a pseudonym and this will be used to indicate who provided the quote but also ensure confidentiality of the participants.

In the second part of this chapter the findings related to women's experience of maternity care with a privately practising midwife will be presented. Again, the reader will be provided with the major category that represents the essence of the women's experiences, and the sub categories and the influencing factors. The findings will be presented in the same format as described above.

At the end of the chapter the influencing factors relating to the women's reasons for and experience of maternity care with a privately practising midwife and will be discussed. All women's names have been changed to protect the identity of the women and ensure confidentiality.

Participant's profile

Demographic data were obtained from the women who were interviewed between August 2011 and July 2013. Eleven of the fourteen women were aged between twenty-six and thirty-five and three were between thirty-six and forty-five years of age. Eleven of the women lived within thirty kilometres of Perth city and three lived within one hundred kilometres of Perth. One woman had completed year twelve at school, eleven women had completed an undergraduate university degree and two women had completed post graduate degrees. Three of the women were experiencing their first pregnancy. One woman identified an existing medical condition as essential hypertension (increased blood pressure). Only two women stated a previous obstetric problem, which they identified as previous caesarean section, however, half of the women interviewed had previously given birth by caesarean section. Out of the fourteen women interviewed, all the women had a vaginal birth with their most recent pregnancy. In their recent birth experience with their privately practising midwife, twelve women gave birth at home as a planned homebirth. One woman gave birth in hospital as a planned hospital birth but laboured at home with her midwife prior to attending hospital and one woman transferred in to hospital due to a delay in the second stage of labour and therefore had an unplanned hospital birth.

Table 2: Participant demographic data (N=14)

Variable	n
Maternal age	
26 to 35 years	11
36 to 45 years	3
Place of residence	
Within 30km radius of Perth	11
Within 100km radius of Perth	3
Maternal education level (highest level achieved)	
Completed year 12	1
Undergraduate degree	11
Postgraduate degree	3
Parity	
Primipara	3
Multipara	11
Pre-existing obstetric concern	
Previous caesarean birth	7
Pre-existing medical condition	
Essential hypertension	1
Planned place of birth	
Home	13
Hospital	1
Actual place of birth	
Home	12
Hospital	2

Aim and purpose of the research and an overview of the findings

The overall aim of this qualitative study was to contribute to midwifery knowledge by exploring the reasons for and the experience of women choosing maternity care with a privately practising midwife. To achieve this aim the following research objectives were identified:

- Explore the reasons women choose maternity care with a privately practising midwife;
- Describe their experience of receiving maternity care from a privately practising midwife;
- Identify factors that facilitate that choice and experience;
- Identify factors that inhibit that choice and experience

As indicated above the research aim was to explore and describe both the women's reasons and experience of maternity care with a privately practising midwife therefore the findings will be presented in two parts.

Women's reasons for choosing a privately practising midwife

Women's reasons for choosing a privately practising midwife as their care provider will now be discussed. An overview of the major categories and subcategories are outlined in Table 3.

Table 3: Women's reasons for choosing a privately practising midwife: categories

Major categories	I knew what I wanted from my care provider			I knew what I wanted from my pregnancy and birth experience		I was willing to do the research to get what I wanted	
Sub categories	I wanted continuity of care	I wanted a relationship with my care provider	I wanted a care provider with the same childbirth philosophy as me	I wanted a natural, active, intervention-free pregnancy and birth	I wanted my partner and family to be included	I researched my care options	I researched my care provider options and the evidence around pregnancy and birth to be actively involved

Analysis of the data revealed that central to women's choice of a privately practising midwife was knowing what they wanted; they had a clear idea of how they wanted their care and their birth experience to be, and went about searching the available care options that could best facilitate their preferences. The three major categories characterising reasons for choosing private midwifery care were identified and thus labelled as **I knew what I wanted from my care provider; I knew what I wanted from my pregnancy and birth experience** and **I was willing to do the research to get what I wanted**.

Sub categories in relation to the three major categories were also identified. The major category **I knew what I wanted from my care provider** had three sub categories these were labelled as **I wanted continuity of care, I wanted a relationship with my care provider** and **I wanted a care provider with the same childbirth philosophy as me**. The two sub categories relating to the major category **I knew what I wanted for my pregnancy and birth experience** were thus identified as **I wanted a natural, active, intervention free birth**, and **I wanted my partner and family to be involved**. The final major category in relation to women's reasons for choosing a privately practising midwife, **I was willing to do the research to get what I wanted** had two subcategories; these were labelled as **I researched my care options** and **I researched my care provider option and the evidence around pregnancy and birth so that I could be actively involved**. The factors that influenced the reasons why women chose to have a privately practising midwife for this recent pregnancy and birth were also identified and these were labelled 1) **positive and negative previous experiences** and 2) **my community**. These will also be discussed in their relation to the research carried out by the participants at the end of the chapter.

I knew what I wanted from my care provider

The major category **I knew what I wanted from my care provider** and its related subcategories will now be discussed. The women knew what they wanted from their care provider; however they still had to go and try and find it. This will now be outlined below and includes the sub categories of **I wanted continuity of care, I**

wanted a relationship with my care provider, and I wanted a care provider with the same childbirth philosophy as me. Participant quotes will be provided under each category and subcategory to support the analysis and reflect the stories shared by the women. A pseudonym has been allocated to each of the participants to ensure their confidentiality but to allow the reader transparency to see that final categories and subcategories reflected the stories of all women interviewed.

I wanted continuity of care

Continuity of care can be defined as care provided from one or more care givers throughout the maternity period (Pairman, Tracy, Thorogood, & Pincombe, 2010). It can mean two different things, the continuity of a particular type of care for example; midwifery care as opposed to obstetric care or it can go further and include continuity of care and continuity of carer. Continuity of carer can be defined as the care being provided by the same care giver throughout the maternity period (Pairman et al, 2010). All the women interviewed wanted both, that is, continuity of care to be provided by the same care giver throughout the maternity continuum across pregnancy, labour and birth and the post natal period.

Catherine explained why she was looking for continuity of care “*continuity of care is so so important... you can read, you can read someone's file, you can read the same information but for two different people it will be different because they are different people, this idea that you have someone to see regularly was just really important to me*”. Ellie and Rachel also believed that continuity of carer was a priority in choosing a care provider. Ellie said “*I wanted the one care provider I knew that that was really important* “, and Rachel suggested “*I just knew that she would be there from start to finish and it would be a constant and someone that I could rely on and that was really important to me*”.

For Catherine, continuity of carer was the most important thing in choosing a care provider “*so that you're not meeting a stranger when you're in labour, people that you actually know who have understand... that's the whole continuity of care but I guess I've just elaborated on it*”. Olivia believed “*the biggest thing for us (in relation to private midwifery care) was I thought after the experience with an*

obstetrician, a GP obstetrician in a hospital, was the one on one care". Rachel wanted to know her care giver in labour: "I liked that I knew that she (private midwife) was the one that was going to be there for my birth so that was probably one of the main reasons I just wanted someone who would be there for the whole labour".

Ellie, who initially wanted midwifery- led care in the public hospital system for her first pregnancy was refused this option as she had an existing medical condition. She was not supported by her GP who believed she required doctor-led care in hospital *"when I told my GP at 6 weeks or something that I wanted midwifery led care.....at that she said no way you have to go to hospital so she was not supportive at all".* Ellie booked into the hospital as recommended by her GP but soon realised that the care she was receiving was not what she wanted: *"I was really not happy with it at all you feel like cattle going through basically".*

Jasmine wanted to make sure for her recent pregnancy that she had continuity of care as when she birthed previously with the Community Midwife Program (CMP) her midwife was changed at the end of her pregnancy; she said, *"I chose an independent midwife over the community program which I'd had my second child with because with my second child my midwife was removed from the CMP when I was forty (weeks) plus nine (days pregnant) and it was very disruptive and I didn't want that to happen again."* Jasmine wasn't given any reason why her midwife was taken from her and was not able to contact her directly. She found it difficult to form a relationship with her newly allocated midwife so late in her pregnancy. Choosing a self-employed private midwife with her subsequent pregnancy guaranteed that this would not happen again.

Jude had birthed her first baby with the CMP, when she found out she was pregnant for the second time she discovered the midwife who had cared for her during her first pregnancy was now working as a privately practising midwife. She decided to book her as her care provider to ensure the relationship continued during this pregnancy and the continuity of care and carer continued.

“I wanted to birth with her (midwife) again for continuity of care and because I knew her, I felt comfortable with her, I definitely wanted to home birth again and so I chose her (midwife) for continuity care and you know familiarity.” Jude

Rebecca chose a privately practising midwife for her second and third births after having a traumatic birth with her first baby. She believes that *“continuity of care is so important for so many women but especially women that have had a traumatic birth regardless of whether or not it has been a vaginal or a caesarean”*. Laura engaged a privately practising midwife for her third baby *“the main thing that I liked just knowing that she was, I had engaged her as a midwife and she was there solely for me which was good”*. Rachel, who was planning a homebirth also talked about the reassurance of the continuity of care in the event that things might not go to plan *“and I also really liked the idea of if something did happen that would cause me to go into hospital or to you know need a more medicalised birth that I still had her as that constant figure”*. Rachael commented that this may not have been the case if she had booked with the CMP as once the accompanying midwife had completed her 12 hour shift she would be no longer allowed to stay with the woman.

Nancy had four children, all born at home. Her first child was born with the CMP and the others were born at home with privately practising midwives. She chose a privately practising midwife instead of the CMP because she wanted individualised care *“I wanted to make the decisions, not the program”*. She also wanted to be able to trust the person caring for her during this intimate time *“I just wanted to have that one on one, which is more intimate. It helped me to trust”*. Nancy believed continuity of carer enabled the dialogue to flow between visits; there was no need to explain herself or her circumstances to different midwives or doctors at each visit. She describes the importance of this continuity *“Having continuity of carer was really important because I didn't want to have to tell my stories to lots of different people”*.

I wanted a relationship with my care giver

The second subcategory captured the women's preference around the connection and bond they wanted to form with their caregiver. These women did not want an

acquaintance or stranger providing care which would offer a superficial connection. Instead, they wanted a relationship that involved depth wherein the care provider knew the woman as an individual with unique needs and expectations. In addition, the women also wanted to feel comfortable with their care provider by having this two way relationship where each party knew each other.

All of the women interviewed shared how they had developed a positive relationship with their privately practising midwife. Catherine describes this as *“you just get comfortable with them and also the time they spend with you, you know you spend half an hour to an hour each appointment so by the time you have your baby you’ve got you know 10-20 hours under your belt, a decent amount of time”*. Catherine felt this also applied to the relationship with the backup midwife *“and even with the backup midwife you’ve got a few hours there”*.

Nancy also believed that the amount of time she spent with her midwife enabled a positive relationship to develop: *“I liked the time, we had long conversations. It wasn’t just a quick session and off you go. It was an hour at least of talking and getting to know each other each time”*. Rachel’s story also supports the value of time together as she reflected that she wouldn’t have developed such a relationship with the hospital staff: *“I don’t think going into a hospital would have given me the same relief that having the midwife come here cos we had such a good relationship from the times that we’d met and the appointments we’d had”*.

Nancy wanted a solid relationship based on trust so that if she experienced any complications during her labour and birth she could trust the midwife caring for her to assist her in any decision making. *“I wanted to really know that person and trust them so that in that birth situation I would trust them and what they were going to say so that if there were any big decisions to be made I would believe them”*.

Rachel believed that this relationship based on mutual trust and respect enabled her to be sure that if medical intervention was needed during her pregnancy or birth she could be confident in making a decision with the aid of her midwife: *“not that we wouldn’t go medically if we had to but more that we’d do it as informed people rather than just scared people, so that’s probably the main things that I really liked.”*

Ellie wanted more from her care giver than was offered within current Western Australian care options when she was researching her care giver options; she wanted control in choosing “*someone that I liked and trusted*”. Jude wanted the midwife who had cared for her during her first pregnancy to care for her during her second as she already had a relationship with her: “*We already had done the whole first pregnancy and birth with her and loved her, and just love her. Love, love, love her*”. Amanda describes characteristics that were an important aspect of her desired relationship with her midwife: “*for me she was there and able to listen and be sympathetic and that's what you want from them a lot of the time, someone you feel is on your side and can understand what you need.*” Rachel also described how sometimes she wanted more than medical care from her midwife and that connection with her privately practising midwife was something she benefited from; she said, “*I think I just needed to talk to someone that I had a relationship with who I also knew had the training*”. Jade felt the relationship with her midwife enabled her to confidently ask questions: “*the care that you get with an independent midwife you don't feel like you've got that time restriction, you can ask anything at all and you never made to feel silly or inadequate or anything like that*”.

Having a special relationship with the privately practising midwife allowed for a more holistic approach to care that included the woman's family and respected her individual social context. For example, Olivia felt she had been “*forced*” into the caesarean section birth of her first child; she was told things that she felt to be untrue and was quite distrustful of the hospital system.

“I was coerced somewhat into having an elective caesarean main reasons being that my blood pressure was elevated, that my baby wasn't engaged and had a high head at term and possibly somewhat posterior, really just a number of things that the obstetrician thought were not conducive to birthing vaginally and I kind of believe that I was pressured into having the Caesar” Olivia

Olivia wanted a natural birth for her first pregnancy and the desire to birth vaginally remained important to her following the caesarean birth of her first child; her experience of the obstetric-led first birth led her to believe that this option was not

supportive of natural vaginal birth. Therefore she subsequently chose a maternity care provider who she believed would provide individualised care and support her to have a vaginal birth after caesarean (VBAC).

A number of the women liked that their midwife not only knew about their medical history but that she was known by the midwife as a “whole” person and not just as a pregnant woman. This included an appreciation of her family circumstances. Not only did the midwife have an understanding of the needs of the woman for her pregnancy and birth but she also had an awareness of her place in the family and the roles of other family members and friends. Jayne felt this was an important aspect of the reason she chose a private midwife for her care during her second pregnancy *“just the fact that she knew my history and my family circumstances so that, by the time it came to deliver the baby I wasn't just someone new that she'd met”*. Jasmine and Laura liked that their midwives had also formed a relationship with their families and in particular their children. Rebecca described this as *“it's getting to know a person and them becoming a part of your family”*.

Laura found this reciprocal relationship reassuring after her previous traumatic births *“she knew my kids, I knew her kids. She would bring her kids to my appointments because our kids are roughly the same age and I liked that the kids knew her (the midwife) and they knew that she was going to be there for the birth and they were comfortable with her”*. Jasmine also felt safe and assured in the strength and closeness of her relationship with her midwife: *“She knew what I was like and what I wanted and what I didn't want. You know she listened to my other stories in my other birth so she knew what had happened there and there was a relationship”*. Olivia was comfortable with the relationship she had formed with her midwife as it enabled the reassurance that she had a constant support: *“knowing that I could ring up my midwife for anything big or small and not feel that I was putting them out”*. Emily also believed that the relationship formed had a positive impact on all aspects of her pregnancy and birth because her caregiver knew her she knew what to say to encourage her: *“I think that they understand you quite well and they know how to get you motivated and how to treat you cos they know you as a person.”*

Rachel described how intimate having a baby is; she believed the most important aspect of choosing a caregiver was being comfortable with them: *“the most important thing for me was having one person that I had that really good connection with because you know it’s quite a personal thing (laughs) you want to make sure that you’re comfortable with them”*. Jude experienced breastfeeding issues with her second baby, although she had been discharged from her private midwife’s care at 6 weeks post-partum she felt able to call her privately practising midwife for advice. She felt this was due to the relationship she had formed with her. She reflected, *“Like I could do that. I couldn’t get help anywhere else and obviously I’m not under her care anymore but you know she was more than happy to take the call and to try and help me because you know the relationship you build is so special”*.

Rachel felt that her midwife became more than just a care giver she describes this as a professional friend and because of this professional friendship she felt she could talk about things that she wouldn’t have done with a doctor: *“friend sounds like a weird thing cos you sort of want that professional thing as well but yeh I just feel like she was a friend and I could tell her other things that you just wouldn’t tell your doctor”*. She also felt that ultimately this was because she cared about what happened to her which she felt she hadn’t experienced from any other caregiver; this was the one of the reasons she chose her midwife: *“I think that was when it just really cemented in for me that she cared more than other providers like everyone else saw me more as just another patient”*.

I wanted a care provider with the same childbirth philosophy as me.

Not only did the women want to choose their care provider they wanted someone with the “right philosophy.” They wanted a care provider that shared the same views and opinions around pregnancy and childbirth that they held.

Lucy originally booked a place with the CMP then engaged one privately practising midwife before changing to another privately practising midwife when it became apparent to her that what she wanted from her care giver was much more than a midwife providing homebirth services. She wanted a midwife who could provide these services in a way that she felt was acceptable to her own individual beliefs and needs.

“first I hired a private midwife because I'd heard such amazing things about her through other doulas and women who'd had her as a midwife and for reasons that I don't need to go into found that it wasn't going to be the right fit.....we kind of attempted to get the midwife we wanted...and the reason I chose someone in particular is that (midwife) philosophically was coming from the old school thinking of midwifery... I didn't want a midwife who had come straight out of hospital training and straight into homebirth I'd heard that there were quite a lot of midwives working that way at the time and I knew that wasn't going to be what I wanted”. Lucy

Amanda's research initially led her to the CMP, the only publically funded homebirth option in Perth; she found this was not quite what she was looking for. *“I just didn't like the tone of it....they wouldn't agree to be your midwife unless you signed this saying that you would agree to do as they say when they say it, so I thought no, I don't feel happy with this”*. Laura felt her privately practising midwife's philosophy enabled her to be treated as an equal who could make her own informed decisions, something that she had not experienced with her previous care givers: *“ she just gave me a lot of support and information and never pressured me”*.

Jude was looking for a care provider that would give her something she describes as *“joint control”* she wanted to be given information so that she could make her own decisions, *“it's a joint control of the process it's not all about what the midwife thinks or wants. You know like so many times she said to me what do you think and how do you feel about that and what do you want to do.”* Jude also felt that other care providers were not suitable because their care was based on policy and not necessarily the best care for the individual. She discussed that although she had previously birthed on the CMP and that her husband was initially disappointed that there was a financial cost involved with care from a privately practising midwife; they ultimately chose the continuity of care with the privately practising midwife as not only did they already have a relationship with the midwife, they also had a shared philosophy. This was apparent when the back-up midwife was unable to attend the birth and a midwife Jude had never met before attended in her place: *“I trust her judgement that she wouldn't bring anyone into my birth space who didn't follow you*

know our philosophy and our wishes and also (the midwife) and I were still in control.”

Hannah wanted a homebirth but also knew that who provided the care made all the difference. *“I wanted to be in my own home from the get go and I think finding the right midwife just amplified that 100%”*. Olivia felt her negative pregnancy and birth experience with her first pregnancy contributed to her developing post natal depression. Therefore finding continuity of care from a private midwife with the same childbirth philosophy was a priority: *“finding that support was one of the biggest things for us and then I think having that support on call constantly was a huge thing”*. Olivia felt that she had been coerced into the caesarean birth of her first child *“and I needed to apart from trusting myself I needed to trust someone who was truly there for me and looking after my best interests maybe not necessary their own interests and the hospitals interests”*.

I knew what I wanted from my pregnancy and birth experience

The second major category **I knew what I wanted from my pregnancy and birth** and its related subcategories; **I wanted a natural, active, intervention free birth** and **I wanted my partner and family to be included** will now be discussed. Women had to find the care provider who could give them the care they wanted during the pregnancy, birth and the postnatal period. All the women interviewed knew exactly what they wanted across their childbirth continuum.

The women in this study indicated that they wanted the best chance of having a natural, active, intervention free birth and they felt that the best chance of achieving this goal involved engaging a privately practising midwife as their main care provider.

I wanted a natural, intervention free birth

The women interviewed confirmed that they wanted a natural, intervention free birth. They wanted to achieve a spontaneous labour without pharmacological pain relief

and actively participate in labour and birth without intervention unless it was medically indicated. To achieve these goals, the women felt they needed to be removed from the restraints of hospital protocols that they perceived to be invasive and unnecessary.

After having five normal vaginal births Amanda felt that she knew what she wanted and this was low intervention. *“I really didn't want a fuss, I didn't really feel there was anything to concern me during the pregnancy and I just wanted to keep it like that”*. Jayne was planning a VBAC (vaginal birth after caesarean). She chose a privately practising midwife to care for her during her pregnancy and labour and then went to hospital for the actual birth. She made this decision as she felt this type of care would give her the best chance to achieve the natural, intervention free birth she wanted:

“I remember thinking quite strongly that the only way I'm going to get a natural birth is if I did most of my labour at home because I didn't have the confidence to labour by myself at home for as long as possible before going in and also I think having that support for my husband he would have just wanted me, to take me in there straight away and I think that's what happened with my first child so I think a lot of interventions got planned just because I was there too early” Jayne

Hannah already had three children and had also worked as a doula supporting women during childbirth. Her first two children had been vaginal hospital births and her third child had been born by planned, medically necessary caesarean section due to a condition called placenta previa. In placenta previa the placenta covers some or all of the cervical os making vaginal birth dangerous (Henderson, 2012). Hannah had found the third pregnancy and birth very distressing and disempowering therefore she knew exactly what she wanted for her fourth pregnancy and birth, once confirming that this pregnancy did not have the previous dangerous medical condition: *“this pregnancy I just wanted a completely natural experience and I had full faith in my body...that it knew what it was doing so and it did a damn fine job”*. She was aware that most hospitals have protocols relating to length of labour and dilatation expectations and invasive procedures such as routine vaginal examinations.

Hannah felt these protocols would be unsatisfactory to her expectations: *“you’re interrupting a woman’s natural flow and I didn’t want that and I didn’t want them putting timeframes on me and I didn’t want them saying you’re not dilating enough, I didn’t want any of that”*.

Amanda had definite opinions about women’s ability to birth recognising it was a natural process and questioned the creditability of health professionals who followed protocols or guidelines where women could be encouraged to go against natural processes such as sitting or lying in a bed to give birth:

“I absolutely had a firm belief that women had been doing this for god knows how many thousands of thousands of years, its natural.... I went out of way to look at books on natural childbirth... I can understand the basic biology of your body, that’s important I just believe that anyone that comes up with a system that says go have a baby lying on your back is, is an idiot” Amanda

Lucy knew what she wanted from her birth experience; she believed birth to be a normal process and had always wanted a natural birth at home. *“I had known since I was quite young probably around 14 that I wanted to have a homebirth”*. In her view, hospital is a place that sick people go to: *“who feels comfortable going into a hospital it’s always a bad scenario if you’re in a hospital so if you go in and you’re well and you’re just doing a normal thing like having a baby for me that wouldn’t have worked”*. She knew she had two options for homebirth in WA, CMP or a privately practising midwife. She chose the privately practising midwife as she wanted a homebirth with continuity of care and carer with a midwife with a similar philosophy. Jude decided on a homebirth with the CMP with her first baby and after experiencing a natural intervention free birth she wanted the same with her second pregnancy. The midwife who had cared for her during her first birth was now a privately practising midwife and with some changes to the policies at the CMP she felt that her best chance of having a natural intervention free birth was to book a privately practising midwife.

Olivia wanted to have a natural vaginal birth after her first caesarean birth: *“I think that once I’d had the Caesar I seemed almost more determined to have a vaginal birth”*. Jasmine chose a private midwife to get the birth she wanted. She had a hospital birth with her first baby and then a home water birth with the CMP with her second. For her third labour and birth she knew exactly what she did and didn’t want. *“So I really wanted to be able to define what I wanted in my birth”*. Rebecca chose a privately practising midwife because she felt that the care options available in the “system” didn’t support natural birth. She suggested *“if the system supported real birth... it would be better and supported women and the midwives that believe in it, it would be a different place to be”*.

I wanted my partner and family to be included

All participants in this study believed that birth was more than a medical event. They felt that the childbirth experience was a significant life event that should involve the whole family. Choosing a privately practising midwife as their caregiver enabled the women to involve their partners, children and other family members and friends as much as they wanted. There were no rules on who could attend the antenatal appointments or who could attend the birth. It was the woman’s choice. In comparison, most labour and birth units have a restriction on the amount of people who can accompany the woman in labour and be present for the birth. Most hospital policies will allow two people in labour and birth suite. Some maternity units in WA will not allow children to be present for the birth.

When Hannah chose a privately practising midwife who offered a homebirth option for her fourth baby she believed that not only was she creating a life event for her family: *“this was going to be an experience for the whole family”*. She was also giving her sons and daughter a beneficial experience. *“I’ve only got one daughter, she’s my oldest I wanted her to see real birth, as a gift to her later on in life”*. She felt that in normalising the birth and being involved in the whole process the children would not be frightened. Hannah felt that the home environment and relaxed atmosphere of birth with her midwife would assist her children to also feel relaxed about the noises she made during her labour and birth. *“When I was making noises my seven year old was reassuring my four year old (children) saying that’s ok mums”*

just working really hard that's why she's making that noise, you know I never said things like that that's just the way they interpreted it.". Catherine also talked about her daughter's reaction to her when she was labouring: *"I was making noises and she was like 'oh mums just making noises cos she's having a baby today' that was absolutely fine"*. Catherine talked about involving her daughter in the process by reading books about birth given to her by her midwife: *"there was a book about homebirth for babies and ... we read that to her every night"*. As the antenatal appointments also took place at home her daughter was always included in the appointments. By including the whole family the women believed that they were normalising birth and this was encouraged by their midwives: *"so my boys have now seen that it's ok to for a woman to have her baby in the home and it's all safe"* (Hannah).

Nancy also felt that the experience was one that the whole family enjoyed, again she talked about how the antenatal home visits by her midwife involved her other children in the process; *"the kids are involved, and look forward to the check-ups and hearing the baby's heart beat and they learn a lot from that"*. She also talked about how the experience of having the birth of the new baby at home with a privately practising midwife ensured the other children became a part of the process and were not excluded in anyway. She felt this was beneficial in the bonding process for all of them: *"(the kids) become a part of it so it's not a separate thing where I'm taken off to hospital and come back and there's a baby. They're part of it, they watch it, they know what to expect and we talk about it for ages after it"*.

The women talked about the joint decision to choose a privately practising midwife as their care giver with their partner resulted in partners who felt more involved in the process: *"My partner was very supportive and we sort of went on the journey together to find something that would suit us"* (Emily). Rebecca's husbands' experience of pregnancy and birth of his third child had a significant impact on him: *"my husband actually said that the third time he actually felt like he got to be a real dad now because he was able to be so much more involved this time"*. Hannah talked about the inclusion of her partner, who actually caught their child as he was born: *"(my husband) was the first person to touch him was apart from myself, he was born into my husband's hands"*. Hannah describes this intimate experience positively:

“him being born into my husband’s hands was a very special moment for me, that it was just him and I”. Olivia talked about her husband’s absolute support in choosing a privately practising midwife for the birth of their second child. He had been devastated with the effects of the first birth on Olivia and her subsequent postnatal depression.

“My partner was so, was supportive from the start of it, absolutely no convincing him because he had witnessed and been part of the first birth and just how badly we were treated and how it was all taken out of our hands and also the effect it had on me with depression and breastfeeding issues and stuff so he was, he was willing to do anything to not have that happen again” Olivia

I was willing to do the research to get what I wanted

The third major category **I was willing to do the research to get what I wanted** and its related subcategories **I researched my care options** and **I researched my care provider options and the evidence around pregnancy and birth to be actively involved** will now be presented.

I researched my care options

As previously discussed in the introduction chapter, women in Western Australia can access four different types of maternity care: Public and Private Hospitals, Government funded midwifery led care and privately practising midwives.

For some women during the process of doing the research into care options they discovered that they were not eligible for some types of care for example the public midwifery-led care options of the Community Midwifery Programme (CMP), team midwifery at KEMH and the Family Birth Centre have strict eligibility criteria which excludes women who have had a previous caesarean section, women with a BMI over 35, and those with a pre-existing medical problem (Women and Newborn Health Service, n.d.) (see Appendix 1 and 4). These exclusion criteria ruled out this

option for eight of the women in the study as seven of the women had given birth previously by caesarean section and one of the women had an existing medical problem of essential hypertension.

Interestingly, all the women interviewed discovered privately practising midwives through their own research, either word of mouth with friends and or family or by researching their options themselves. Maternity health professionals were not actively informing women of birthing options in WA. One woman attended a VBAC (vaginal birth after caesarean) workshop offered by Community Midwifery WA (CMWA) renamed The Bump WA in 2013. The Bump WA is a not for profit organisation which offers information via their website and face to face sessions in relation to birth choices in WA (<http://thebumpwa.org.au/about/>). During the information session she attended regarding VBAC, she found out about private midwives. The internet also played a part with women “googling “the options available in WA. Women shared that accessing a privately practising midwife was never promoted as a model of care through the women’s GP’s or the hospital systems.

When researching her options, Amanda found the system different to the models of care options available in the United Kingdom where she had previously birthed:

“this whole emphasis on huge amount of obstetric intervention arm which, it seemed to me from what I looked at over here (compared to the UK) they were much more like the United States like that ... it was such a bad, bad way to go for the mother and the child.” Amanda

Olivia researched her options for a VBAC birth “*and I was soon realizing from stories that I heard that it was more likely to happen at home than in a hospital...*”. When Hannah was researching her options for the VBAC birth of her fourth baby, she went to the Next Birth After Caesarean (NBAC) service in WA’s tertiary public hospital, once she started telling the midwife what she wanted she soon realized that she wasn’t going to get the experience she wanted;

"so I said I wanted, if possible I wanted my children there and she said well that's just kind of not going to happen you know and it was just lots of little questions and I said you know I will not I just don't want the cannula, I don't want monitoring I just want to be left alone and she kind of kept looking at me and going yeh, that's not going to happen here you're going to have to fight and I didn't want to fight" Hannah

During her job as a doula Hannah had supported women choosing VBAC in hospital and observed what interventions and policies were considered normal practice. She shared that *"I've stood by and I've seen what they've done to women and I don't consider being strapped to a machine or putting a cannula in a woman or vaginal examinations I think that all that is quite dangerous... to me personally"*. Following her research Hannah believed the only care option suitable to her needs was with a privately practising midwife who offered homebirth. Emily had also had a previous caesarean birth and wanted a natural vaginal birth with her second baby: *"second time I decided to stay away from the hospitals and I looked around for my options"*. She felt the only option available to her was to birth at home with a privately practising midwife. Catherine opinion on private and hospital births options were challenged when she did her research around pregnancy and birth. *"I thought that the private (hospital) birth was better than the public (hospital) birth but then I did research and I found out that that was just my interpretation was wrong"*.

Jasmine looked at her options for birth and although she was considered low risk and eligible for all options she chose a privately practising midwife *"and I didn't want to be going through CMP again even though I was, would still fit in their criteria and everything"*. Some women researched their options before even getting pregnant. Rachel researched her care options for the birth of her first baby: *"when we were first considering having a baby I was one of these woman who said I want to have a homebirth but I want to have it in hospital"*. Rachel defined this *"homebirth in hospital"* as wanting a natural intervention free birth in the hospital setting. She researched her care options *"once I'd made the decision that I wanted a homebirth but in hospital it was about finding a care giver that would give me that"* She continued to research her care options via telephone calls, knowing exactly what she wanted from her care giver: *"so I started calling around and trying to find an*

obstetrician that would support me in an all-natural birth but in a hospital setting". Following her conversations with the private obstetricians Rachel soon realised that what she was looking for was not an option *"and it finally came down to the point where I realised that I wasn't really going to find an obstetrician in Perth who would give me the birth I wanted"*.

As discussed in the previous categories the women wanted a relationship with their care giver based on a shared philosophy and this was something that doing the research enabled them to assess. Jude initially felt that she would employ a private obstetrician for her first birth because that was what *"everyone did"*. After doing some research she realised that a natural birth was the best way for both mother and baby: *"I said yeah book me in for an epidural from 35 weeks and all the rest of it and then I did 30 seconds of Googling and realised that wasn't what I wanted and that wasn't the way"*. Ellie had researched her options and wanted midwifery-led care with her first baby however she had a pre-existing medical condition. *"When I told my GP at 6 weeks or something that I wanted midwifery-led care.....at that she said no way you have to go to hospital so she was not supportive at all"*. This condition, essential hypertension, although well controlled and unmedicated, ruled out the government funded midwifery-led care options. Ellie initially tried engaging with the hospital system as recommended by her GP but soon realised it was not a care option she was comfortable with: *"you don't have any say with what team you're in or who you see or anything like that you're just sort of a number really going through"*.

I researched my care provider options and the evidence around pregnancy and birth to be actively involved

After researching the care options the women had to consider who they wished to engage for their maternity care based upon models of care available in WA and the inclusion criteria for each model. They also researched the evidence around pregnancy and birth as they wanted to be actively involved in their care. This desire to be actively involved in their care impacted on who they would choose to provide their care provider.

As discussed in the above description of care options, maternity care in Western Australia is provided by three main healthcare professionals: Obstetricians, GP obstetricians and midwives. Obstetricians and GP Obstetrician acting as the lead clinician in a woman's care work in both the private and public hospitals. Midwives can also be the lead clinician in both hospital and homebirth settings, however, as previously discussed privately practising midwives do not have admitting rights to any hospital in Western Australia, although they are able to accompany the women and provide support in the hospital setting. As seven of the women had previously had a caesarean section and one of the women had a pre-existing medical condition the available care providers were restricted. Due to the criteria of the government funded midwifery led options eight women would not have been eligible for these options.

When Ellie was refused midwifery led care through the public system due to her pre-existing medical condition, high blood pressure, she continued to do her research on care providers and then eventually found her private midwife. This medical condition had been well controlled and she was told by her doctor that it shouldn't impact on her pregnancy and birth, but she was still declined government funded midwifery led care in both hospital and home birth settings: *"it made me really grateful that I picked the path that I did and made the effort to keep searching when I thought that I had no more options"*. Olivia did her research on care providers *"having researched VBACs in particular after my first birth and realising that the best outcomes were with one on one midwifery care"*.

Amanda knew that she wanted midwifery care with a privately practicing midwife who offered a homebirth as although she was able to meet the inclusion criteria for the CMP model of care she was not confident that the CMP could offer the individualised care she wanted.

"the impression I got was that anything that deviated from whatever they'd had in their minds was a normal delivery would mean they would push you to go to hospital at that point and I didn't like the sound of that because my experience in having, especially having as many children as I have had and knowing what I do" ...Amanda

After researching her options Olivia knew that she wanted a privately practising midwife to care for her throughout the pregnancy and birth of her second child: *“in my head I thought next time I get pregnant I want a VBAC but with an independent midwife beside me”*. Upon further research she realised that *“from what I had heard from other women and from my experience was you know was that having a midwife at home was gonna be the best option for us.”* Rachel wanted a care provider who would support her in the birth she wanted. After realising she wasn't going to get an obstetrician to support her birth choices *“so I started calling around and trying to find an obstetrician that would support me in an all-natural birth but in a hospital setting but they all kept saying well we'll let you try or we'll see how it goes ah well but if I have any issues”* Rachel decided to research her midwifery-led care options and as a low risk woman she was eligible for all care options, however she wanted continuity of carer and the other midwifery led options did not offer this: *“you know in a team there will be people that you get on better than others and I didn't want it to be one of the others that turned up when I was birthing just because she was on roster or anything like that”*. She researched the Family Birth Centre *“but they had a very high transfer rate”* and the CMP *“I looked at the community midwifery but I didn't like the idea of a team of midwives”*. Rachel also felt that some of the CMP policies were unsuitable for her *“and I started looking into some of the regulations that they had to follow I wasn't comfortable with all of those”*.

Ellie researched her options which were limited due to her pre-existing medical condition. She was not eligible for the CMP or publicly funded midwifery led options. She felt that the only option suited to her needs and beliefs was engaging a privately practising midwife: *“I think there are still too many restrictions and guidelines and policies and hoops that you have to jump through”*. She knew what she wanted and she felt she could not find these in the other available options: *“that's just not what I want and I don't think I would get what I want from them either. It would have to be an independent midwife”*. Emily's first baby was born by planned caesarean section for breech presentation and she felt she was never given any other option therefore second time around she explored other options and in doing so discovered the option of a privately practising midwife. *“So the second time I decided to stay away from the hospitals and I looked around for my option”*.

Jude chose midwifery led care with a privately practising midwife after her research of care providers led her to the only option that she felt fit her criteria for what she wanted. Her main priorities were to avoid medical interventions, have continuity of carer and privacy: *“the reason I wanted to go with the midwifery led care was several reasons. One I was afraid of cascading interventions, another reason was for continuity of care....And the third reason was privacy”*.

The women were well informed about what they wanted from their pregnancy and birth experience. They researched the evidence to ensure they could be actively involved in making the decisions around their care. This process of researching not only provided information but led to a feeling of empowerment that some of the women had felt was lacking in their previous experiences. *“ I think I just found there was more a feeling of being empowered in making decisions you know it was what you wanted”* (Jayne). Rachel also researched pregnancy and birth, again signally how she expected to be actively involved in her care: *“I’d done a lot of research so I knew what the body was going to do“*.

In this section the findings relating to women’s reasons for engaging a privately practising midwife to provide maternity care have been presented. In the next section the findings around women’s experience of maternity care with a privately practising midwife will be presented.

Women’s experience of maternity care with a privately practicing midwife

The findings related to women’s experience of maternity care with a privately practising midwife will now be presented. An overview of the major category and subcategories are outlined in the Table 4.

Table 4: Women’s experience of maternity care with a privately practicing midwife

<i>Major category</i>	I had an amazing and empowering birth experience	
<i>Sub categories</i>	I felt safe and in control	The experience benefited the whole family

Data analysis revealed one major category, entitled **I had an amazing and empowering birth experience** with two related sub categories **I felt safe and in control** and **The experience benefited the whole family**.

Women's experience of maternity care with a privately practicing midwife will now be discussed. Participant quotes will be provided under each category and subcategory to support the analysis and reflect the stories shared by the women.

The major category in this section of the study was labelled **I had an amazing and empowering birth experience**. All the women who were interviewed indicated that they had an extremely positive experience of their birth with a privately practising midwife. They described their birth experience with words such as "*mind-blowing*" "*awesome*", "*amazing*", and "*empowering*".

The reasons the woman chose the privately practising midwife, as previously discussed, all had an effect on their overall experience of the birth. The positive relationship formed and continuity of care based on a shared philosophy facilitated women to be more involved in their care. They had the time to develop a relationship based on mutual respect and trust. The individualised antenatal care ensured the women had the time to talk through their fears and hopes. The women had the opportunity to talk about the birth expectations and to build their confidence and trust in their midwife and their own abilities as women.

Regardless of the women's previous birth experience or parity all participants in this study described their birth experience positively. This was also true for the women who described long and challenging births; they still referred to their birth experiences positively. Lucy, who birthed her first baby with a privately practising midwife, exemplified this view when she described her experience thus "*my birth experience (was) really positive, really empowering, really beautiful, mind-blowing*". Ellie, also having her fist baby, believed her experience was everything that she wanted: "*(my birth experience) it was really good, It was great it was pretty much everything that I wanted, I don't have any regrets or anything from it all so it was really, excellent really*".

Emily who had her second child with a private midwife after the caesarean birth of her first child described her birth experience as “*an amazing experience*” and “*the best thing that I’ve ever done.*” Jude felt her birth experience “*was completely amazing, like I just, I cannot believe how amazing it was, it was just ridiculous it was just so brilliant.*”

Laura had two previous births in hospital, her first a caesarean and her second a traumatic instrumental birth; her third birth with a privately practising midwife was much more positive, “*yeah it was wonderful. You know it was a really good birth even, even if I hadn’t had two shitty births beforehand it still would have been a really nice birth*”. She continued to describe her third birth with the private midwife positively as “*it was beautiful and everything was fine*”. Olivia described the birth of her third baby with the private midwife as “*fine, perfect birth*”. Emily also reflected on her “*amazing*” experience of birth: “*I love the memories that I have of, that I had our child in a room in our house, I think that that is so special and amazing*”. Hannah loved her birth experience “*I loved every bit of it, I love it, love it love it!*”

Even if the birth didn’t go to plan the women still felt positive about their birth experience. Jasmine described her birth experience as “*awesome*” even though she developed complications post birth that led to her being hospitalized for a short period for a blood transfusion. Catherine was planning on birthing at home with her second baby; however complications in her labour led to her transferring to hospital. Her private midwife stayed with her throughout the transfer and subsequent medically assisted vacuum birth of her baby. She still felt positive about her birth experience: “*yes it was good, and in the end I had to transfer to hospital but that was still, that was still fine*”.

It was evident from the data that a key contributing factor to women experiencing birth so positively was the empowerment they received from their midwives. The women felt empowered by their experience and by their midwives. Jayne described this empowerment as “*feeling of being empowered in making decisions you know it was what you wanted*” and Jude felt the privately practising midwife aided this empowerment, “*you know you’re so empowered by your midwife*”. The women also discussed how “*proud*” they were of their births and talked about the experience in

terms of "*achievement*". Rachel had a long and challenging posterior labour at home with her first baby; she reflected on her birth experience with the privately practising midwife: "*(I) think on reflection I'm probably a lot more proud of it now than I was a few months afterwards, I didn't really understand what an achievement it was*". Rebecca also felt really proud about the VBAC birth of her third child. "*I'm really proud to say I had my son at home but I'm really, really proud to say that I was able to have my VBAC*".

Nancy, who had private midwifery care with three of her four pregnancies, reflected on her experiences as follows: "*(the experience) always left me feeling great about the birth really and wishing that it could go on again, not the birth (laughs) but the whole, overall experience of being pregnant and being taken care of by a midwife it's just the best thing about it.*" She and the other women who were interviewed felt that after the positive experience of maternity care with a privately practising midwife that if they became pregnant again they would choose the same option. Nancy said that although the monetary cost was considered expensive by some of her friends and although she was eligible for all midwifery led options including the government funded community midwife program (CMP), she felt birth with a privately practising midwife was the only suitable option for her. Nancy considered the experience worthy of the cost, "*it's worth every cent and I wouldn't do it any other way*". Hannah also talked how the positive and empowering experience of birth with a private midwife outweighed the cost of hiring the midwife. "*I would pay four times what we paid and even after the experience (my husband) said the money just doesn't come into it once you've gone through the experience it ... that just all goes out the window, the importance of the experience ... its priceless*".

Following the positive experience of birth with a privately practising midwife, the women all stated that they would choose a privately practising midwife for any subsequent pregnancies. Jayne stated "*I'd definitely have a midwife (for my next baby); I think I just found there was more a feeling of being empowered*". Rachel was clearly happy with her experience, "*it was awesome, I honestly can't imagine doing it any other way*". She went on to explain that due to the relationship she built with her midwives she would choose to birth in the same way with the same

midwives: *“if I have it my way it will probably be about here on my kitchen floor (laughs) with the same midwives”*.

The women also shared that if the option to birth with a privately practising midwife was not available they would not choose the mainstream care. Lucy said *“I’m not just defaulting to going to hospital”* The women concluded that they felt their only option to achieve their aims would be to birth without the assistance of a health care professional (freebirth). Ellie shared *“It would have to be an independent midwife or no-one”*. Lucy described how she would consider an unregistered care giver rather than birth in the mainstream system *“I would consider finding a, a birth attendant, like a lay midwife, someone who’s not you know bound by, who has knowledge, but isn’t bound by making decisions just out of fear”*

Hannah also shared that mainstream hospital care was not an option she would consider, if maternity care and birth with a privately practicing midwife was unavailable.

“I would not go to hospital, full stop, so I don’t know if that would push me more underground and I would freebirth because I would not set foot in a hospital again, knowing what I know now, I wouldn’t put myself into an environment that I don’t trust and I don’t trust the hospital system full stop, I think that they do too much to women and I don’t agree with it”.

Hannah

I felt safe and in control

The sub category **I felt safe and in control** will now be presented wherein the women in the study shared how they were involved in all aspects of their care and felt care was individualised to their needs. The mutual respect and relationship formed with the midwife led the women to be confident in voicing any concerns or worries. This led them to feeling safe and in control as they knew the midwife was there solely for them and had their interests at the forefront. Women perceived their midwife was present to keep them safe and would let them know if they had any concerns. Safety was not just about physical safety; the feelings of being safe also

related to emotional and psychological safety. Amanda describes this as *“the understanding of the process from a, from an emotional point of view as well as the technical point of view and I think that that’s crucial to having a safe effective delivery”*.

Feelings of safety and control were related to the women having a say in their care as they felt they were partners with the midwife having *“joint control”*. Jude discussed how the respect shown by the midwife involves the woman in her care and this enables and empowers the woman to be an active party in the choices around her labour and birth. She describes her experience as *“(it’s) to do with the respect, the way midwives empower you, the way that, it’s a joint control of the process it’s not all about what the midwife thinks or wants.*

Having a private practicing midwife provide continuity of carer meant that the women and their partners had already discussed any issues that they felt might affect the birth. Nancy felt that having had the time during her pregnancy to discuss any concerns such as reasons for transfer or what would happen in an emergency situation made her able to trust her midwife implicitly: *“I didn’t ever question, I didn’t ever feel scared or anything because I knew my midwife was there”*. As the women trusted the midwife they could get on with the business of birthing their babies. Rachel describes how building a trusting relationship was one of the main things she liked about the experience of birth with a privately practising midwife; knowing that should the need to have medical intervention arise that she would feel safe as she would be supported by her midwife: *“not that we wouldn’t go medically if we had to but more that we’d do it as informed people rather than just scared people. So, that’s probably the main things that I really liked.”*

Ellie described the feeling of being safe as knowing that the midwife would respect her requests and desires during labour and that because of the relationship they had formed her midwife knew her well enough to read her signals for privacy: *“I think I felt supported and safe and I think I knew that she would, she came whenever I wanted her to come and she also left as well, she left me alone to do what I needed to do”*. Amanda talked about how she felt her midwife made her feel safe from intrusions because her midwife understood her needs: *“if somehow intruding on or*

into that space or not listening even within the family so that she can say to them look come on, you know do this or please, you know don't do that, because she understands what I need." Nancy shared how important it was for her to feel safe *"Yes I felt safe, which is really important during birth and during labour."* The women commented on the research they had undertaken acknowledging how important the feelings of safety were to the birth process, knowing that fear and anxiety could affect the progress of their labour.

Throughout the pregnancy, women's stories highlighted how the privately practicing midwife allowed time to discuss any issues or concerns which facilitated the woman's perception of control and comfort with letting go of some control in the safe presence of her midwife. Catherine describes how she felt that she needed to be in control of her situation; she described herself as someone who liked to be in control. The experience of having a privately practising midwife as her care giver during birth enabled her to have control over her birth; she could chose who would be present and care for her during her labour and birth and she could define what she wanted and didn't want during her labour and birth. She also felt safe to lose control as she believed that during birth the woman needs to submit to the process and let go of the control. *"It's about control, I like to be in control and to give birth you have to lose control and for me to be able to do that I need to feel safe with the people with me so that I can lose control"*.

Hannah felt she had lost control in her previous birth when an obstetric condition known as placenta previa resulted in her being hospitalised for a medically necessary but unwanted caesarean birth. Therefore, when no complications arose during the pregnancy she discussed for this study, having control over the birth of her fourth child was important to her *"this birth was like I'm in control now"*. Emily described her experience of the birth of her second child as feeling *"totally in control"*. Jayne also compared the lack of control in her first birth to feeling supported by her private midwife and *"in control"* during the birth of her second child. *"I think probably the big thing for me was just comparing the two and I think that I was very not in control in my first experience like they made all the decisions and I didn't really have the information"*.

The women in this study felt that their midwife supported their decisions and choices. The women felt confident in asking questions and requesting information that would aid them in their decision making. They described having never being made to feel uncomfortable or inadequate and this led to feelings of empowerment in their overall experience. Laura felt empowered by *“not having to justify anything to her (midwife)”*. Jude said that her midwife would *“never make a client feel stupid by asking questions even if they know the answer you know.”* Rebecca recalled that she felt comfortable asking her midwife anything; *“you can ask anything at all and you never made to feel silly or inadequate or anything like that”*.

The experience benefited the whole family

The sub category **The experience benefited the whole family** will now be discussed. As previously reported, one of the reasons for women choosing to birth with the privately practising midwife was because the women wanted their partner, their other children and their wider family to be included in the process. All participants in this study believed that birth was more than a medical event. They felt that the childbirth experience was a significant life event that should involve the whole family and they believed that being involved subsequently benefited them as a family.

Hannah wanted her family to be involved in the birth of her fourth child. In particular she wanted her children present for the birth and for her husband to be physically, as well as emotionally involved. A particular benefit for Hannah was that her husband got to see her birth naturally: *“for (my husband) to see and hear how a woman does things when she does it naturally, cos I’ve never had that experience before”*. Another highlight of the experience for Hannah was sharing the new baby straight away with her other children: *“being in my own bed and having my own children climbing up with me looking at our own special new person”*. She felt that the experience benefited the whole family and made the transition from a family of five to a family of six a smooth one.

Amanda also commented on the benefits to the family from the positive and empowering birth that she experienced with the privately practising midwife: *“I just*

think the benefits are from what I can see they're just huge for everybody, the family gets to become closer". She had her sixth baby at home with the privately practising midwife and the children had the option to come and go as they pleased. Her seventeen year old son chose to stay and experience the birth of his brother. *"I ended up with one of my big children at home cos he wanted to be there, the others wanted out of the house (laughs) and that's fine you know."* Hannah enjoyed sharing her experience with her sister who had not had any children of her own: *"I wanted my sister here, she's 42 and never had kids and I don't think she ever will, I wanted her to be around a woman having a baby so she could see what it's like"*. Jasmine also talked about sharing the experience with her sisters: *"none of my sisters have children. So it was really nice for her to see a natural, normal birth progress and how it all works"*.

Rebecca described how her husband's confidence as a father increased as a result of the positive birth experience with a private midwife. Jude felt her husband and son also benefited from the experience of maternity care with the privately practising midwife as she described the labour and birth process with the private midwife as *"more of a celebration of the birth"*. Rachel talked about how she and her husband felt reassured that if something happened during the birth that required intervention she knew that her husband would be supported by the midwife: *"whereas I knew that at least if I had my midwife there she'd be able to sit down with him if I wasn't in a capacity or with both of us and just explain and help us make decisions"*. She felt this was beneficial as he could relax and not worry about being responsible for her medical care or decisions and therefore could concentrate on being emotionally and physically supportive during the birth.

The factors that influence women's reasons for, and experience of maternity care with a privately practising midwife

As previously mentioned the factors that influence women's experience and reasons for choosing a privately practising midwife were identified as **Positive and negative previous experience** and **My community**. These will now be presented with supporting quotes from the participants (see Table 5).

Table 5: Influencing factors

<i>Influencing factors</i>	Positive and negative previous experiences
	My community

Positive and negative previous experiences

For the multiparous women interviewed the choice of a private midwife was a direct consequence of previous experiences of birth which may have been negative or positive. This past experience contributed to the some women looking for a different model of care than they had previously experienced and for others they were looking for the same care options. However for some women particular choices were no longer available within the WA context during the study period. Amanda had lived in the UK and all her other children had been born under the UK free government National Health Service (NHS) with four of them at home: *“5 out of my 6 were born at home with midwives only, so in the UK, they would be with the community midwife and that worked very well”*. She had positive experiences of homebirth and midwifery-led care she had received in the UK and was looking for that option when she became pregnant for the sixth time shortly after her arrival in Australia from the UK. Jasmine and Jude also talked about their previous positive experiences of midwifery led care and homebirth.

Jasmine's previous birth experiences in a birth centre in the Eastern States of Australia and a government funded homebirth with the CMP in WA led her to choosing a privately practising midwife for her third and final birth. *“I knew that my third child would be my last child so I wanted to have everything, I didn't want to compromise, I wanted to have everything how I wanted it”*. Catherine previously experienced midwifery-led care during her first pregnancy with the CMP. With her second pregnancy she again wanted the continuity of care with a known midwife. However, now that she was planning a vaginal birth after caesarean (VBAC) she realised that the only option was a privately practising midwife as none of the other midwifery-led care options supported women choosing VBAC.

As mentioned earlier, Rebecca and Laura's previously traumatic births contributed to them wanting to pursue an alternative care model than they had experienced with

their other children's births. Laura had two previous hospital births, one caesarean and one VBAC, that she describes as traumatic. *"There's no way I would have gone back to the hospital where I had the other two. No way in hell"*. She felt the only suitable care option available to her was a private midwife.

"I was terrified of having another hospital birth.....because even now the thought of having to go to the hospital makes my heart race. Not only the birth but just the treatment I got during my second pregnancy. The grief that they gave me, I couldn't deal with that again" Laura

Olivia believes that her previous negative birth experience influenced her choice to employ a privately practising midwife for this current pregnancy. *"I never set out to go down that path"* but as her previous experience had resulted in a caesarean she felt she had no other option if she wanted to have continuity of care from a midwife who was support her desire for a VBAC: *"I was kind of forced because of my, after having a caesarean my desire to not have another one and to have a vaginal birth I was actually left with very little choice but to hire a midwife"*.

Lucy had a different negative experience, as this was her first pregnancy she had no previous birth experiences to bring into this pregnancy with her. However, during a routine GP visit she felt "frustrated" and "unsupported" when discussing her pregnancy and birth plans. This was in total contrast of the way she felt during her visits with her privately practising midwife.

"she said (GP) 'well where are you birthing' and I said at home and she said 'you know you haven't had any ultrasounds, you know what if your baby has two heads how are you going to homebirth that, it's all well and good that you want this homebirth but what if your baby has two heads how are you going to homebirth that' pretty frustrating that I'd made my decision and that she couldn't at least support the fact that I'd made an educated decision" Lucy.

My community

The influencing factor “**My community**” is used to describe the influencing factors from the community surrounding the women's reasons for and experience of midwifery-led care with a private midwife. This term is used to describe the influences from their friends, family, the community they lived and socialised in and the media.

Women interviewed in this study indicated that the media usually portrays childbirth as a life-threatening event; these women did not accept this picture of birth for their reality. These women were not passively accepting of the media portrayal but were critically questioning of how the media presented birth. Based upon their own research they were also well informed and able to refute inaccuracies around these media images. Catherine discussed the way in which the media influenced her: *“seeing the way popular culture presents childbirth, you know women on her back screaming and stuff I was just thinking I don't want to be part of that”*.

Catherine was also influenced by her sister's and sister in laws births which she attended: *“my sisters birth experiences and my sister in laws had her baby less than a year later at King Edwards (public maternity hospital), they had two completely different experiences”*. Olivia's decision making around the pregnancy and birth of her second child was also influenced by friends: *“I soon realised that after discussing it with other people I knew that had had VBACs I knew my best bet was to probably have a homebirth (with a private midwife) as opposed to a hospital birth”*. Olivia also highlighted that during these conversations she discovered that due to the limited options of VBAC the women in her community felt they had no other option but to birth at home *“and I know other women who have said the same thing that they were not interested in having a homebirth but after having the first caesarean they were left with no choice.”*

Lucy chose a homebirth with a privately practising midwife after talking to the women in her community: *“I met lots and lots of women who were having homebirths so I got some information from people in my community”*. Laura

similarly knew women choosing homebirth as their birth choice in her community *“most of my friends are home birthy type people”*.

When Emily was researching her options she spoke to the women in her community. She discussed her options at the mothers group she attended with her first child *“and I'd never known that there was such a thing as a homebirth really I don't think until one of the girls from mothers group she had a homebirth and so she told me a lot about it and she went through an independent midwife that's how I found mine”*. Rachel had friends that had birthed with the privately practising midwife that she ultimately booked with. These friends' positive opinions also influenced Rachel's decision to choose a privately practising midwife as she explains:

“especially with other people in my circle of friends knowing this midwife and other independent midwives it became sort of what seemed right for me I suppose and I'd never known that there was such a thing as a homebirth really I don't think until one of the girls from mothers group she had a homebirth and so she told me a lot about it and she went through an independent midwife that's how I found mine” Rachel

Amanda talked about women she met and their experiences of birth. *“Women I've known had difficult births, really difficult births, the effects on them personally afterwards and their attitude towards themselves as mothers and as women had a very bad knock on effects”*. She felt talking to these women and being exposed to their stories around negative birth experiences influenced her decision to initially birth at home with the community midwives in the United Kingdom (UK) and choose a privately practising midwife for her birth in Australia.

Nancy had been influenced by her family's birth choices; her mother had a homebirth with a privately practising midwife and she had attended her sister's birth with a privately practising midwife. Therefore she felt that the choice to birth at home with a privately practising midwife was unchallenged and supported in her community: *“most of my circle of friends and family are into that anyway so I don't really have any problems with people thinking it's strange or crazy or anything”*.

Summary

In this chapter the findings related to women's reasons for, and experience of choosing a privately practicing midwife have been presented. The major categories and their sub categories have been identified and explored. The influencing factors relating to the women's a reasons for and experience of choosing a privately practising midwife have also be discussed. The women arrived at the decision to choose a privately practising midwife from different paths but ultimately they knew what they wanted for all aspects of their pregnancy and birth. The major categories highlighted the different aspects of what women expected from their maternity care experience as they knew what they wanted from both their care provider and their pregnancy and birth. A consequence of them "knowing what they wanted" resulted in the women making the decision to do the research as they needed to ensure that they could find the care option that would enable them to achieve their aims. The women interviewed knew exactly what they wanted from their care giver and their pregnancy and birth so they set out to find a care giver who could provide the care they wanted. The relationship they built with their midwives enabled them to feel safe and in control. The aim of the study covered the whole maternity episode, and exploring it on this basis did identify factors relating to the whole experience. In particular women knew at the beginning that they wanted from the whole care experience and this led them to choosing the midwife and ultimately to an empowering and positive birth. They wanted the continuity of care throughout pregnancy, labour and birth and postnatally and in particular wanted their family and children involved. This is described in detail in the categories however analysis focused more on the birth experience as this was what the interview data generated.

In the next chapter the study's findings will be discussed within the existing literature.

Chapter 5: Discussion

Introduction

In the previous chapter the reader was provided with the findings related to the study of fourteen women's reasons for, and experience of, maternity care with a private midwife. The purpose of this discussion chapter is to provide a brief overview of the study's findings, and situate the findings within the existing literature to highlight the unique contribution of this study. The limitations of this study will also be noted.

Study aim and objectives

The overall aim of the research study was to contribute to midwifery knowledge by exploring the reasons for, and experience of, women engaging in the care of a privately practising midwife. The identified objectives of the research were to:

- Explore the reasons women choose maternity care with a privately practising midwife;
- Describe their experience of receiving maternity care from a privately practising midwife;
- Identify factors that facilitate that choice and experience;
- Identify factors that inhibit that choice and experience.

Limitations of the study

A limitation of this study is that the participants were all from the same geographical area in Australia, as the study was conducted within the state of Western Australia with women who lived within a hundred kilometers of the state's capital city of Perth. The sample number was small which is appropriate for the qualitative design chosen, however, the findings may not be generalisable to a wider population as would be expected for a quantitative design. The aim of this research was to gain understanding of the phenomenon in a specific Australian context, whilst providing rich description to enable the reader to determine the findings' transferability to other

contexts. Another limitation is that the findings provide insights that reflect a specific time period (2007-2013) in community maternity care options in Western Australia.

Overview of the findings

As presented in the previous chapter the findings were grouped into two parts; women's reasons for choosing a private practising midwife to provide maternity care and women's experience of that care.

Women's reasons for choosing a privately practising midwife

The data revealed three major categories and their related sub-categories that characterised women's reasons for choosing a privately practising midwife. The first category was conceptualised as 'I knew what I wanted from my caregiver', which included sub-categories of: continuity of care; a relationship with my care provider; and a care provider with the same childbirth philosophy as me. The second major category encapsulated 'I knew what I wanted from my pregnancy and birth experience,' with two sub-categories clarifying that women wanted, a natural, active, intervention free pregnancy and birth, and for my partner and family to be involved. The final major category related to women's reasons for choosing a privately practising midwife and was labelled 'I was willing to get the research to get what I wanted'. This major category incorporated two sub-categories outlining how the women researched care options, and care provider options, and the evidence around pregnancy and birth to be actively involved.

Women's experience with a privately practising midwife

The second part of the findings related to women's experience of the maternity care received from their privately practising midwife. Data analysis revealed one major category defined as 'I had an amazing and empowering birth experience', with two sub-categories confirming that the women felt safe and in control and how the experience benefited the whole family.

Factors influencing choice and experience

During the analysis of the data, two factors that influenced women's experience and reasons for choosing a privately practising midwife were identified as positive and negative previous experiences, and my community. The term my community, is used to describe the influences on women from friends, family, the community they lived and socialised in and the media. Both factors could facilitate or inhibit the woman's choices relating to her pregnancy, birth and choice of caregiver, and they also contributed to the women's perception of her birth experience.

The discussion

This section will be divided into three areas of discussion with notable relevance to the study findings. These important points will be discussed under the following headings that reflect key messages: 1) the relationship is everything; 2) feeling in control is paramount to having a positive experience; and 3) if I can't have what I want, then no assistance would be better than medically-led care.

The relationship is everything

The first topic of discussion is labelled 'the relationship is everything', and refers to the relationship the women wanted with their care provider, and the reasons the women chose their privately practising midwife. The women in this study knew exactly what they wanted from their care provider, as they also knew what type of care they wanted to receive, and what kind of experience they wished to have. The women in this study had researched extensively within the available care models and providers within WA at the time, to find the care provider that would be best suited to their requirements. This care provider had to be able to provide continuity of the right type of care and support, be the right care provider with the same childbirth philosophy, and provide individualised care that would support the woman through her pregnancy and birth, whilst promoting involvement of the whole family. Having fulfilled all these requirements the woman and her midwife would then have the relationship and support that could provide everything the woman needed.

Everything in the women's decision to engage with a privately practising midwife revolved around the relationship they wanted with their midwife, and the support they felt this relationship would provide. Being able to achieve this desired relationship was essential to women, and related to the reasons they engaged the midwife to care for them throughout the maternity period, and to the positive experience they had of their pregnancy and birth.

A continuous relationship

Several international studies support the importance of the relationship between the midwife and woman as being essential for a positive birth experience. Leap, Sandall, Buckland, and Huber's (2010) study, conducted in the UK, evaluated the link between women's use of pharmacological pain relief in labour and the relational continuity of care they experienced. They found that the women, who were engaged in continuity of care with their midwives, built a relationship of trust that led to them feeling more confident in their own abilities to overcome self-doubt and fears about pain in labour, resulting in an empowered birth. A more recent Australian study evaluated mothers' satisfaction with a caseload-midwifery scheme and explored whether this varied according to the extent of continuity of care provided by the midwives (Williams, Lago, Lainchbury & Eager, 2010). Based upon the findings of this Australian study, the authors concluded that the development of supportive relationships between women and midwives, led to the high levels of maternal satisfaction with their birth experience. Swedish researchers have also explored the reasons behind women's negative birth experiences (Hildingsson, Ruberstson & Radestad, 2004). Findings from this investigation identified many risk factors related to the women's medical and social history, but suggested that the most effective way to improve women's birth experiences was to improve the support and relationship between the woman and her care providers. Japanese work exploring non-hospital birth confirmed that when midwives strive towards building a relationship with the women in their care, so that they could discuss their birth preferences, this relationship enabled the woman to be autonomous in her birth, and led to greater satisfaction with the experience (Igarashi, Wakita, Miyazaki & Nakayama, 2014).

Furthermore, international studies demonstrate that women benefit from a continuous relationship with their midwife. To illustrate, findings from an Irish study similarly

concluded that continuity of care enables women to feel better prepared for birth, leading to improved confidence and positive birth experiences (Sandal, Devane, Soltani, Hatem & Gates, 2010). Similarly, the findings of a Norwegian study on the effect of interpersonal relationships and continuity of care on women's birth experiences found that having an established relationship with the caregiver in labour and birth improved confidence and trust, which were key factors to a positive birth experience (Dahlberg & Aune, 2013). Additionally, Dahlberg and Aune (2013) found that where the relationship was seen as negative, women did not feel taken care of, and subsequently this had a detrimental effect on their experience. These international studies support the notion that it is not enough to have a caregiver that is known to the woman. Women get the most benefit during pregnancy and birth when they have a high quality established relationship with their caregiver.

Relationships are formed in many ways. For example, it could be argued that a relationship is formed between a woman and the midwife caring for her in labour, even if they had only met that day. However, the women in this study wanted more than a limited, superficial relationship. They wanted a relationship that involved depth based on mutual trust and respect that developed over a prolonged time period. They also needed to believe their caregiver had the same goals as them, and would work together with them to achieve these. As indicated in chapter one, the women in this study received caseload midwifery from their privately practising midwives. However, these women were not allocated a random caseload midwife; they chose their midwife. This practice meant that although they chose a particular model of care, it was important to them to also choose a particular midwife.

United Kingdom (UK) researchers Thomson and Downe focused upon how women prepared for and experienced a positive birth following a previous traumatic birth (2010). The team proposed that a positive birth experience is more likely to be achieved by preparing women and providing opportunities for them to build trust in themselves and their caregivers. This UK study extended their earlier qualitative work with British women who had experienced a self-described traumatic birth (Thomson & Downe, 2008). The authors concluded that the experience of trauma was in fact not related to the mode of birth, but to the interpersonal relationships with the women's caregivers. The women experienced fragmented, inadequate, and

abusive care that contributed to them feeling their personal values and self-knowledge were not acknowledged; this resulted in them expressing emotions such as helplessness and isolation, and ultimately left them disconnected from the whole experience. In a secondary analysis of the data relating to their studies around birth trauma and subsequent positive births, Thomson and Downe (2013) suggest that women have more positive experiences when services are designed to maximise authentic relationships based on mutual trust and respect between caregivers.

As discussed in the previous chapter of this thesis, the women in this study knew exactly what they wanted from their care provider and their pregnancy and birth. They wanted a natural, active, intervention free pregnancy and birth; to be actively involved in all aspects of that care; and for their partner and family to also be included.

A Norwegian study published in 2013 found that relational continuity and quality of relationships are key elements in a positive birth experience, and that they promote the wellbeing and potential for personal growth for the childbearing woman, as well as subsequently empowering the whole family (Dahlberg & Aune, 2013). Similarly, findings from an Australian study that explored women's experience of birth in the tertiary hospital in WA, suggest that satisfaction with the birth experience is related to what women want and expect from childbirth (Bayes, Fenwick & Hauck, 2008).

Philosophy of maternity care

The women in this current WA study wanted continuity of carer with someone who shared the same childbirth philosophy as they had. This philosophy was a belief in a natural, intervention-free birth involving the whole family, wherein the woman was involved in the entire decision making process around her pregnancy and birth. Having this type of relationship with their caregiver led the women in this study to have a positive and empowering birth, which they felt strengthened the whole family. Acknowledging the importance of family involvement in a woman's care is an important aspect of midwifery care. The midwife-woman partnership model is described as one that encompasses continuity of care and enables the building of a supportive relationship between the woman and her family throughout pregnancy

and childbirth (Pairman, Tracy, Thorogood & Pincombe, 2010). Within the midwife-woman partnership, the woman is at the centre of the care. Having the woman at the centre of her own care enables her to decide how she wants her family to be involved. Iida, Horiuchi and Porter (2012) studied the relationship between women centred care and women's birth experiences in Japan. They described the four elements of women centred care as respect, safety, holism, and partnership, and its goal as the general wellbeing of the woman, potentially leading to the woman's empowerment.

The women in the current study knew what type of care they were looking for, and an essential element was that their lead maternity carer was someone who shared the same childbirth philosophy as them. The women felt they had to do research to discover what type of care provider shared their philosophy, and would be able to provide the type of care they were looking for. The women viewed pregnancy and birth as a normal part of life, a physiological process that required care from a woman-centred model. They wanted someone to support an intervention free pregnancy and the women's aim of an intervention-free, natural birth, in which the woman was an active participant.

To understand the reasons why the women in this study chose a particular privately practising midwife, the author looked into the differing opinions around the philosophy of childbirth. In having a positive supportive relationship with their caregiver, the women had to be satisfied that they had the same goals and beliefs around pregnancy and childbirth. For an appreciation of childbirth philosophies and models of care, the author looks towards the work of Professor Marsden Wagner, a respected American paediatrician and epidemiologist (2006) and Robbie Davis-Floyd, an American feminist anthropologist (1992). Wagner (2006) describes fundamental differences between the obstetric or medical model of care and the midwifery model of care. The medical model focuses on the pathology of pregnancy and birth, in other words potential adverse outcomes, the things that could and probably would go wrong. Within the medical model, birth is only ever normal retrospectively. In contrast the midwifery model, which Wagner (2006) describes as the social model, proposes that pregnancy and birth are for most women, a normal physiological process that will require minimal intervention.

Robbie Davis-Floyd experienced a traumatic caesarean birth, which prompted her to research why hospital birth in the western world was so focused on technology and intervention. She interviewed one hundred American women about their experiences of pregnancy and birth. The subsequent book, *Birth as an American Rite of Passage* (Davis-Floyd, 1992) describes the “technocratic” model of care. She describes obstetrics as an assembly line production of goods, with the woman’s reproductive tract treated like a birthing machine that requires management by skilled operators, usually male doctors, to deliver the most desirable end product, the baby. Davis-Floyd (2001) asserts that this metaphor, which defines the baby and mother as separate entities, implies that the men (doctors) become the producers of the product (the baby) thereby making the mother’s role in the whole process passive, and merely the vessel for the end product. This model also reinforces the validity of the patriarchal philosophy, the superiority of science and technology, and the importance of machines and institutions. This model does not place any emphasis on the positive relationship between the woman and her caregiver, and does not place the woman at the centre of the care experience. As such, this model of care would be deemed to be unsatisfactory for the women in this study.

Increasingly, faith in the science and technology available in the birth environment has led women and their caregivers to trust machines rather than women’s reported experience of their own observation. It is this attitude that has led to an erosion of the relationship between the woman and her caregiver. Lawrence-Beech and Phipps (2008) discuss normal birth and provide a common example heard in many labour wards in the western world, and recalled by women recounting their birth experiences. They describe the woman who knew her labour was progressing rapidly, but the midwives were not listening to her as they did not have the evidence provided by doing a vaginal examination. This classic scenario describes the failure to listen and work with women, and the failure to work within the partnership model of care wherein the caregiver and woman are equal. This approach described in the scenario also adheres to the technocratic medical model of care, which distrusts the birth process, unless it can control and define it with technology and science. The argument against this approach is focused on its inability to facilitate women coming away from these experiences feeling empowered and positive, on the basis that it

doesn't leave them feeling listened to, or that the relationship with the caregiver was an equal partnership.

The women in this current WA study shared how the importance of the relationship between themselves and their midwife was everything. The experience of maternity care revolves around the equal partnership between the woman and her midwife; being respected, supported, and listened to, and being involved in the decision making processes contributes to a satisfying and empowering birth. To achieve this partnership relationship, the women in this study shared how they had to continue their research to find the right model of care to provide what they wanted from their experience. This search for the type of relationship they wanted, led them to discover the holistic model of care practised by privately practising midwives.

In contrast to the technocratic medical model, the holistic model is based on the premise that the mother and baby form one integral and invisible unit until after the birth (Davis-Floyd, 1993), and if the emotional and physical needs of the mother are met, then the baby's needs are also met. Consequently, the best care for pregnancy and birth will involve meeting the mother's emotional and spiritual desires, as well as her physical needs. In following this holistic model the emphasis is on building the relationship with the woman and her caregiver, as it is within this positive and supportive relationship that the needs of the mother will be met. This model of care is in stark contrast to the technocratic model, which only focuses on the physical aspects of pregnancy, and only on pursuing the birth of a live baby. Women who want a supportive relationship with their caregivers, based on mutual respect, trust and shared philosophies, will find this unavailable in the mainstream maternity care provider within the fragmented hospital system that involves rushed appointments and multiple caregivers. Therefore, Davis-Floyd (2003) and Wagner (2006) assert that these women will generally choose to give birth with midwives either at home, or in free standing birth centres.

Additionally, WA women in this study wanted continuity of carer and a shared philosophy of childbirth. It is argued that the philosophy they wanted was based on the social/holistic model of care as described above, as this is the only way the women would be able to develop a relationship that would be supportive, and enable

them to experience their care in the way they desired. In general, it has been suggested by historical sociologists Oakley (1984) and Donnison (2011) that midwives rather than obstetricians would work within this kind of philosophy, as birth historically was a social experience.

The finding in the current study was that hospital maternity care was not what these WA women wanted from their pregnancy and birth experience, and that this contributed to their decision to research their care options. At the time of this study, birth centre and homebirth options in Western Australia were available in the family birth centre, on site at the main tertiary hospital, and the government funded homebirth program. A small number of privately practising midwives were also available, who provided antenatal, intrapartum and postnatal care at home, and would accompany a woman to birth in hospital if she wished. During the study period (2007-2013), however, privately practising midwives accompanying women in labour to hospital maternity units were only allowed to take the role of support person and were unable to provide clinical midwifery care in those settings.

Philosophy of maternity care and birth setting

Free standing birth centres have been associated with increased satisfaction compared to hospital as found in a recent Danish study that compared the experience of birthing women attending obstetric units or a free standing birth centre (Overgaard, Fenger-Gron & Sandall, 2012). Findings confirmed that the birth centre women had more positive experiences. Overgaard and associates (2012) suggest this difference in perceived birth experience was due to the homelike environment and the midwives attention towards psychological dimensions of childbirth. They describe this as effective communication between the caregivers and the woman and her partner, and the involvement of the woman and her partner leading to woman-centred and individualised care. Dahlen, Barclay and Homer's (2010) study of first time mothers' experience of birth at home and in hospital in Australia, also demonstrated that the supportive relationship between mothers and midwives has an influence on women's experience. The trusting relationship that the homebirth midwives in this study made with the women was viewed as more supportive than

could be found in other maternity care models, as it was individualised and based on a shared philosophy of birth. In contrast, lack of a supportive relationship and lack of communication is known to lead women to become fearful, leading to distress and less satisfaction in their birth experience (Dahlen et al, 2010).

A review of homebirths was undertaken in Western Australia in 2008, which clearly highlighted the differences in the philosophical approach and beliefs of hospital-based maternity staff and home-birthing women and their midwives (Homer & Nicholls, 2008). Two distinct maternity care philosophies were highlighted in this review: one was stated as “the purpose of the exercise is to have a baby - it does not really matter how it is born so long as it is safe”, and the other as “childbirth is more than just a physical experience and that the process is as important as the outcome”, was reported as frequently causing conflict (Homer & Nicholls, 2008 p. 24).

Standard hospital maternity care in Australia is based on a fragmented system wherein women will be cared for by multiple doctors and midwives (Tracy et al 2013), with very little, if any, continuity of care or carer. Women will see a team of midwives and doctors, and very few women will have the opportunity to form any kind of meaningful relationship with their caregiver. Within this system women generally do not have a say in what kind of care they receive. Appointments are brief and focus on the physical aspects of pregnancy and birth with very little, if any time put aside for the psycho-social aspects of the pregnancy and birth. Walsh (2006) suggests that the “context and person specific nature of birth physiology will not fit easily within a systemised production line model” (p.1333).

Continuity of carer

Further research that supports the importance of the midwifery relationship and concept of continuity of care for women includes Homer and associates’ (2009) exploration of the role of the midwife in Australia. In this study, the authors concluded there to be some confusion by the consumer as to what the midwife actually did. They surveyed both women and midwives, and their analysis found that the women in the study placed a high value on the relationship they built with their midwife. Three-quarters of the women interviewed made specific reference to

continuity of carer during pregnancy, labour and birth. Of the twenty- eight women surveyed by Homer's team, nine of the women had given birth at home with privately practising midwives. Two main categories relating to the role of a midwife emerged from data analysis: professional capacities and professional qualities. The professional capacities included being a skilled and expert practitioner, who was competent and up to date, able to keep the birth process safe and normal. The personal qualities that the women felt were particularly valuable and would contribute to building a positive supportive relationship, were excellent communication skills, the ability to collaborate well with other health professionals, and for the midwives to have greater visibility. Women expected to be partners in the sharing of knowledge, and expected the midwives to listen to them and accept their judgement and decisions (Homer et al 2009). This Australian study's findings also identified barriers to midwives practising to their full role of the midwife; in particular, the dominance of the medical model in maternity care and the institutional system of maternity care (Homer et al., 2009).

The women interviewed in the current study also wanted to work in partnership with their caregiver. The privately practising midwives worked within the caseload model, which revolved around providing women-centred care, and the premise that the midwife and woman will work together to build a positive relationship. This relationship that they formed became the foundation that everything else was built upon, so that if the woman said, as described earlier in this chapter, for example, that the baby was coming, her midwife would listen and acknowledge this, rather than telling her that she, the midwife, was the expert and knew better.

Shared decision making

A commitment to shared decision making is a fundamental aspect of the midwives role according to the peak international midwifery regulation board, the International Confederation of Midwives (ICM) (ICM, 2011a). The ICM is an accredited non-governmental organisation who represents midwives and midwifery to organisations worldwide, to achieve common goals in the care of mothers and children (ICM, 2011a). The ICM supports active decision making between the woman and her midwife. In their position statement on midwives and women, the ICM state that

midwives should support the woman's right to participate actively in decisions about their care and empowering women to speak for themselves (ICM, 2011b).

Women in this WA study highlighted how the relationship they built with their caregivers was enhanced by the midwife knowing their previous experiences, and their hopes and expectations for their recent pregnancy and birth. This 'knowing' enabled them to work together to achieve these aims, leading to empowerment and a positive and satisfying birth experience. Findings from an Australian study of mothers' views of caseload midwifery supports this view, acknowledging that women developing a relationship and experiencing the care of a known midwife, feel reassured that their caregiver knows and respects them and understands their previous experiences and expectations (Williams, Lago, Laichbury & Egar, 2010). In contrast, findings from a West Australian study of women's perceptions of not achieving a VBAC, revealed how the lack of a supportive, trusting relationship with caregivers can impact on the woman's experience (Kelly, Hauck, Bayes & Harwick, 2013). The women in the WA study shared how they felt the lack of support from health care professionals, in their ability to birth vaginally after caesarean section, as well as the disobliging attitudes and behaviours displayed by those allocated to care for them in labour, contributed to them not achieving a VBAC (Kelly et al., 2013). Another WA study, this one focusing on women's perceptions of contributing factors for successful VBAC, reinforced how these women felt supported by their caregivers (Godden, Hauck, Hardwick & Bayes, 2012). Women in this WA study described how they felt that most of the health professionals they encountered were confident, supportive and not fearful of VBAC, and contributed to them feeling confident in their caregiver's ability to support their choices (Godden et al., 2012). Similar to the women in this thesis, the WA women in Godden et al's (2012) study chose to research their options to ensure they would be actively involved in their own care. They also highlighted that they felt supported on the day of giving birth, and this had a considerable impact on their commitment to, and achievement of, a natural birth.

Results from international studies confirm the importance of a supportive and trusting relationship between women and their caregivers during pregnancy and birth. To illustrate, a systematic review conducted by Novick (2009) of women's experience of antenatal care included studies from England, Scotland, The United

States, New Zealand, Australia and Canada. The review findings were consistent with the findings in the current study, in that the women had better experiences of antenatal care when they experienced continuity of care with a caregiver that they had formed a relationship with, as this enabled them to be more involved in their own care. In addition, Sjöblom, Idvall, Lindgren and the Nordic Homebirth Research Group (2014) researched women's experience of midwife-attended homebirth in four Nordic countries and confirmed one key theme: 'safe haven'. The 'safe haven' created by the presence of the midwife was strengthened by the woman-midwife relationship created during the pregnancy. Another study undertaken in South Australia (SA) evaluated women's satisfaction with maternity care within a midwifery group practice (MGP), women who had received care in the MGP were invited to complete a questionnaire regarding their experience of the maternity care they had received (Fereday, Collins, Turnbull, Pincombe & Oster, 2009). Findings from this SA study highlighted the satisfaction and positive experience women experienced, following the ability to build a meaningful relationship with a midwife who understood her needs (Fereday et al., 2009). Findings from the current study are thus consistent with the findings in international literature, in that they all confirm, that for a positive birth to be experienced, a relationship must be formed between the woman and her caregiver. The foundations of this relationship are the women being heard, respected, and being in partnership with their midwife.

In developing this relationship with their midwives the women felt safe and in control. This was paramount to their positive experience of the maternity care, and subsequent empowering birth. The concept of feeling in control will now be discussed.

Feeling in control is paramount to having a positive experience

The second topic for discussion is labelled 'feeling in control is paramount to having a positive experience'. This key concept is related to the women in the current study knowing what they wanted from their pregnancy and birth, and caregiver. Participants wanted to have control over their experience, and specifically to have a say in what they did or did not want for their pregnancy and birth. As highlighted

previously, the perceived lack of autonomy and control in mainstream maternity services contributed to the women choosing the privately practising midwife as their caregiver. To achieve this, the women had to research and explore the care options available to them. As already noted, these WA women were able to experience women-centred care, and this in turn gave rise to joint control as they were informed and active in the whole process. Feeling in control made the women feel safe; safe that they would be respected, safe that they would stay in control and that their midwife was there solely for them, and would be a constant support throughout the whole experience.

The concept of control in pregnancy and childbirth can be related to many aspects. It can relate to the control of the woman's body; the provision of care; the pregnancy and birth environment; labour's progress; the perception of pain; and the woman's ability to cope with the pain of childbirth and the birth outcome (Meyer, 2013; Ford, Ayers & Wright, 2009). Findings from an American qualitative study of the meaning of control for childbearing women, suggested that women's use of the term control corresponds to five domains linked positively to birth: self-determination, respect, personal security, attachment, and knowledge. The researchers assert that as control is linked to the positive aspects of birth, lack of control is linked to the negative aspects of birth (Namey & Drapkin Lyerly, 2010).

The women in the current study knew exactly what they wanted from their labour and birth. They wanted to be supported to have an active and natural birth, that was free from any unnecessary interventions, and they felt this would enable them to feel safe and in control. Findings from a UK study exploring women's perceptions of control in labour, resulted in three different types of control in labour being described: feeling in control of what the staff does to you; feeling in control of your own behaviour; and feeling in control during contractions (Green & Baston, 2003). Additional findings suggest that all three types of control contributed to women's satisfaction with their birth experience, with feeling in control of staff actions being the most significant. This UK study from 2003 was built upon earlier work by Green, Coupland and Kitzinger (1990), which involved a prospective study of over eight hundred women's expectations and experiences of childbirth in England. Objective and subjective aspects in birth were examined, in particular the importance of control

and its relevance to psychological outcomes (Green et al., 1990). Findings confirmed that the more interventions a woman had during labour and childbirth, the less in control she felt, and the less satisfied she was with her birth experience.

The women in the current study had chosen their midwife; they felt safe in the knowledge that she would respect their wishes for an intervention-free birth. They also felt safe in the knowledge that they were in control of what staff could do to them, as they had the supportive relationship with their midwife, with whom they shared the same childbirth philosophy. This relationship had built up over time and was based on mutual respect and trust.

In relation to the provision of maternity care, the patriarchal system that describes most mainstream maternity care assumes control over the childbearing woman; the childbearing body is viewed as a faulty tool that needs constant monitoring to ensure that it functions properly to produce the product, the baby (Davis-Floyd, 1993; Davis-Floyd, 2001). The childbearing body is seen as uncontrollable, unbounded, unruly, leaky and wayward (Carter, 2010). During pregnancy and birth, the unusual demands placed on the female body are perceived in this paradigm to render it constantly at risk of serious malfunction or total breakdown (Davis-Floyd, 2001).

The concept of the medical system assuming control over the woman's body, rather than the woman retaining control, is also supported by popular media. Television shows represent pregnancy and birth as leading to social embarrassment, highly stressed personal relationships and chaos. Labour starts with a sudden onset of agonising pain followed by a rush to hospital where the woman is dumped on the delivery table to be greeted by an eagerly awaiting gowned and masked medical team (Kitzinger & Kitzinger, 2001).

Universally the focus of childbirth generally centres on the assisted delivery of a healthy baby (Davis Floyd 1993) rather than the women's role in the childbirth process. Williams and Fahy (2004) analysed women's magazines to address the question 'whose interests are served by the portrayal of childbearing women in popular magazines for women?' They found that there was no suggestion that women are empowered when their birth experience is one that is controlled by

medical professionals, and that the way childbirth is portrayed in popular magazines contributes to the medical control over normal childbirth in Australia. A similar view is discussed in McIntyre, Francis and Chapman's (2011) critical analysis of childbirth articles published in an Australian newspaper, where it is presented that obstetricians argue they are the guardians of safety in childbirth; only they have the experience and training to achieve safe birth outcomes, and the introduction of non-medically led maternity services would threaten the health and safety of mothers and babies. In contrast, consumer opinion reported in the newspaper, supported non-medically led birth services to support women to give birth safely with minimal intervention (McIntyre, Francis & Chapman, 2011).

Feeling in control also contributed to feelings of safety as expressed by the women in this WA study. Women shared how the relationship they had formed with their midwife made them feel safe and enabled them to have an empowering birth.

It is well documented in the literature that feeling in control during childbirth contributes to a positive birth experience (Fair & Morrison, 2011; Waldenstrom et al, 2004; Hildingsson, Johansson, Karlström, Fenwick, 2013; O'Hare & Fallon, 2011; Overgaard, Fenger-Gron & Sandall, 2012). Furthermore, several international qualitative studies highlight the relationship between the loss of control in pregnancy and childbirth, and a negative experience and the subsequent detrimental effects on women's mental health (Goodman et al., 2004; Mercer & Marut, 1981; Hay et al., 2001; Sinclair & Murray, 1998; Thomson & Downe, 2008; Lundgren, 2010). Findings from a qualitative study on Western Australian women's fears around childbirth, highlighted how loss of control and disempowerment were associated with an increased level of fear for many of the women in their study (Fisher, Hauck and Fenwick, 2006). Psychological theories of depression, stress responses and Post traumatic Stress disorder (PTSD) emphasise the importance of control in physical and emotional responses to stress. Therefore, it is essential that we have a better understanding of these issues to minimise psychological distress post-partum (Maggioni, Margola, & Filippi, 2006; Ford, Ayers & Wright, 2009).

Another qualitative study involving thirty-one American women in their first pregnancies, investigated the techniques employed by women to facilitate control

during labour and birth (Fair & Morrison, 2011). These participants expressed an increased sense of control when they actively participated in the decision making process. The level of control experienced by the women during labour and birth was a significant factor in predicting birth satisfaction. However in contrast to the finding in this WA study, Fair and Morrison (2011) did not find a connection between birth satisfaction and antenatal control and childbirth expectations.

It is essential that we try and understand what a woman believes 'being in control' means rather than making assumptions. Caregivers must have an understanding of what contributes to women feeling 'in control' or 'not in control' (Green & Baston, 2003), so that we can provide women-centred appropriate care and promote a positive birth experience. Women in the current study revealed how their perception of control during labour was enhanced by researching, preparing and planning for labour and birth. The importance of this active preparation is supported by the findings of another WA study on the influence on childbirth expectations on Western Australian women's perceptions of their birth experience (Hauck, Fenwick, Downie & Butt, 2007). Their findings suggest that involvement and participation in decision making in labour and birth promote feelings of control (Hauck et al., 2007), whereby women perceived their birth as positive if they had fulfilled their childbirth expectations. However, women could also achieve a positive birth experience without their expectations being met if they felt supported, informed and part of the decision making process (Hauck et al, 2007). This finding is consistent with those of this current WA study, although this only applied to one woman, so may not have been a common experience. One woman did not have her birth expectations met as she had to unexpectedly transfer to hospital from a planned home birth; however, she shared how her birth was a positive experience as she felt in control and she was respected, supported, fully informed, and the decisions were ultimately hers to make.

Further international work on control also resonates with the findings of the current study. For example, O'Hare and Fallon's (2011) qualitative study on Irish women's lived experience of control in labour and childbirth, and Green and Baston's (2003) UK study also found that women's sense of control was closely related to being treated with respect, being treated as an individual, and participating in the decision making process. Finally, a recent systematic review by Meyer (2013) of thirty-four

studies relating to control in childbirth, found that most examples of control in childbirth correlated to the woman's sense of being an active member of the decision making process during labour and birth.

Place of birth

Although place of birth was not the focus of this current WA study, women's stories suggested that being at home was associated with their feelings of control. Thirteen out of the fourteen women who were interviewed in this study planned on birthing their babies at home under the care of their privately practising midwife. Twelve of the women in this study experienced a planned homebirth; one woman laboured at home with her midwife and transferred to hospital late in labour for a planned hospital birth; and one woman experienced a safe but unplanned, transfer into hospital as a result of a complication in the second stage of labour requiring a medically assisted vaginal birth. The women in this study who achieved a homebirth with their midwife, spoke about the feelings of safety and control they gained from being in their own home, in conjunction with being cared for by their chosen midwife. The importance of having this chosen midwife is supported by another Australian study examining women's preferences for maternity care using a self-report survey, with a convenience sample of sixty-three women. Results indicated a preference for homebirth in 24.2% of respondents and half expressed a preference for their birth care to be from a chosen midwife (Gamble, Creedy & Teakle, 2007).

Positive outcomes for women choosing to have homebirths have been reported in Western Australia. The review of homebirths in Western Australia examined homebirth and in particular assessed essential health outcomes (including morbidity and mortality) whilst identifying areas of concern. Recommendations from the review focused on ways in which the safety of homebirth could be improved (Homer & Nicholl, 2008). The sample of women interviewed as part of the review spoke of the value of midwifery continuity of care, and the importance of a known caregiver. The women also stated that a lack of access to other options such as continuity of carer, water birth, and vaginal birth after caesarean (VBAC) in health service environments, were drivers for them to pursue a homebirth with a midwife (Homer & Nicholl, 2008).

Eight of the women interviewed in this current WA study were deemed to have risk factors making them ineligible for midwifery-led care in the government funded maternity services. Therefore for these women, their only option for midwifery-led care was to engage the services of the privately practising midwife. Moreover, if these women wished for their midwife to provide midwifery care to them during labour and birth, they could only receive this care at home, as at the time of this study there was no provision for privately practising midwives to provide intrapartum care within the hospital setting. Therefore these women, who wanted to have control over their labour and birth experience chose to labour and birth at home with the support of the privately practising midwife.

In 2008, the Australian government conducted a national review of maternity care services with the aim of improving maternity care in Australia, by providing women with greater choice and access to maternity services. The Department of Health and Aging called for public submissions on the topic from interested parties and held roundtable forums with invited stakeholders. The review received over nine hundred submissions with the majority (54%) coming from consumers. Of these consumer submissions 60% mentioned homebirth. However despite this, the authors of the Report of the Maternity Service Review (2009) decided not to include homebirth in the reforms being proposed, as they felt it was a “sensitive and controversial issue” (Report of the Maternity Service Review, 2009, p.20-21).

In 2011 results from an Australian analysis of the Maternity Service Review (MSR) in relation to homebirth were published (Dahlen, Schmied, Tracy, Jackson, Cummings & Priddis, 2011). The report included the submissions relating to homebirth, which outlined the benefits and barriers to homebirth. The benefit of midwifery care was the most popular reason cited for women wanting a homebirth; the relationship between women and their midwives, which developed over the pregnancy and contributed to women feeling in control and empowered during their births, was also reportedly a factor. Other benefits were described as continuity of care, benefits to the whole family, and a positive birth experience. Barriers to homebirth were described in this report as problems accessing a midwife, funding the cost of homebirth, the lack of insurance available to midwives in Australia, and the lack of clinical privileges for midwives in public hospitals (Dahlen et al., 2011).

Women in the current study knew exactly what they wanted from their pregnancy and birth which was to maintain control, and to have a natural, intervention-free birth. International studies have demonstrated that women birthing with the assistance of a privately practising midwife have positive outcomes. For example, a retrospective UK study compared outcomes for births booked under a privately practising midwife and births booked with the National Health Service maternity care providers (Symon, Winter, Inkster & Donnan, 2009). These UK findings confirmed that clinical outcomes across a range of variables were significantly better for women booked with a privately practising midwife. Women were more likely to labour and birth spontaneously, less likely to give birth prematurely, less likely to have pharmacological analgesia, and more likely to breastfeed. No significant differences in mortality and morbidity were found between both low risk groups, however they found a significantly higher mortality rate in the privately practising midwives group for women classed as high-risk (for example, those having a vaginal breech birth and those with twin pregnancies). Symon and team (2009) attempted to match two groups of women, which was problematic as the women choosing privately practising midwives were a self-selecting group, and many differences between the two groups were apparent such as nutritional status, smoking, socio-economic factors, previous obstetric history, and medical problems. This quantitative study did not explore the experiences of women or their reasons for choosing a particular model of care. This 2009 study highlighted a higher mortality rate in the privately practising midwives group; however, a follow up study was undertaken to examine the midwives' management and decision making in the cases with poor outcomes (Symon, Winter, Donnan & Kirkham, 2010). This subsequent study concluded that the midwives' care was judged to be clinically acceptable within the parameters set by the mothers' choices (Symon et al., 2010).

A study conducted in Australia in the late 1990s also found an increased mortality rate in regard to high-risk homebirths. Bastian, Keirse and Lancaster (1998) compared data on planned homebirths and hospital births from 1985-1990. The data analysis revealed a perinatal death of 7.1 per 1000 total births in the homebirth group. However when the high-risk cases were excluded the mortality and morbidity of low-risk homebirth women was comparable to low risk hospital women.

As previously noted, WA women in this study shared how receiving maternity care from a privately practising midwife enabled them to feel safe and in control; their previous experiences, both positive and negative, and their surrounding community of family and friends, and their ultimate goal of an intervention-free natural birth, all contributed and influenced their decisions to birth with the privately practising midwife and their chosen place of birth.

Most of the research regarding homebirth has been quantitative and observational, and has been concerned with the measurement of outcomes such as maternal and infant mortality and morbidity demonstrating that morbidity and mortality in planned homebirth for low-risk multiparous women is comparable to low-risk hospital births (Wiegers et al, 1996; Olsen, 1997; Bastian et al, 1998; Johnson & Daviss, 2005; Dahlen, Barclay & Homer, 2010; Birthplace in England collaborative group, 2011). Furthermore, these observational studies demonstrate low-risk planned homebirth to have lower intervention rates, less use of pharmacological pain relief, more unassisted vaginal births and greater maternal satisfaction than low-risk hospital births (Wiegers et al, 1996; Olsen, 1997; Bastian et al, 1998; Johnson & Daviss, 2005; Dahlen, Barclay & Homer, 2010; Birthplace in England collaborative group, 2011). However, there is some discourse around the option of homebirth for women experiencing their first birth following the findings of The Birthplace study (2011) which assessed perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies in England. The findings of this prospective cohort study of over sixty thousand women, found that overall the incidence of adverse perinatal outcomes was low in all settings, showing the overall low rate of mortality and morbidity relating to childbirth in the UK. However, the study showed an increased rate of adverse perinatal outcomes with the planned homebirths of women experiencing their first births.

A number of qualitative studies have been undertaken in relation to parents' experiences of homebirth. For example, a qualitative study using a phenomenological approach to provide an understanding and insight into ten couples' experience of homebirth was undertaken in WA (Morison, Hauck, Percival & McMurray, 1998). Findings from this Australian study found that the experience of birthing at home involved the couple actively creating an environment that

enabled them to assume control and responsibility for the birth. Furthermore, these WA couples believed homebirth to be a multidimensional experience that extended beyond the physical aspects of birth. Birth was seen as a momentous life experience and achievement by the couples, who also believed that birth was a natural process. The women in Morrison and associates (1998) study were recognised as the experts in their birthing. All the couples' experiences of homebirth exceeded their expectations. The findings from this WA homebirth study are supported by a more recent study conducted by Catling, Dahlen and Homer (2014) of Australian women choosing a publicly funded homebirth. Key themes included choice related to the women's desire for control and power over events in their pregnancy and birth, their faith in normal birth and the desire to avoid medical intervention. In another Australian qualitative study focusing upon women having their first baby at home and in hospital, found that women talked about the importance of choice and control in their care. However, the women who experienced homebirths felt more in control of their births compared to the women experiencing hospital births (Dahlen, Barclay & Homer, 2010). Choice and control were closely linked to women and their families being involved in the decision making process, and good communication and information sharing between the women and their midwives (Dahlen et al., 2010).

A number of additional international studies also found that women who chose homebirth were more involved in decision-making and felt more in control. For example, a Swedish study involved a comparison between women choosing homebirth or elective caesarean section birth (Hildingsson, Radestad & Lindgren, 2010). They found that the women who chose to homebirth were more satisfied with their participation in decision making and the support of their midwife. They felt more in control, leading to a more positive birth experience, regardless of their actual place or mode of birth. Women in this Swedish study who chose homebirth were three times more likely to be satisfied with their sense of control than the women who chose caesarean section birth (Hildingsson et al., 2010). A qualitative study was more recently undertaken to explore women's decision making about place of birth in Canada (Murray-Davis, McNiven, McDonald, Malott, & Elarar, 2012). The key factors for women's choice of homebirth focused upon women wanting to optimise choice and control, be involved in the decision-making process, and have their

family involved in the birth. These Canadian women also discussed how the influence of friends and family impacted on their decision to birth at home (Murray-Davis et al., 2012). Furthermore, findings from another qualitative descriptive study examined why American women choose homebirth. This convenience sample of one hundred and sixty women completed an online survey about homebirth, revealing the five most frequently identified themes as: control; comfortable environment; safety and better outcome; intervention free; and negative previous hospital experience (Boucher, Bennett, McFarlin & Freeze, 2009).

Control and safety in relation to pregnancy and childbirth have different connotations for individual women. However, the evidence provided by the women in the current study and confirmed by existing local, national and international studies suggests that where a woman perceives that control is maintained as she wants, she experiences her pregnancy, labour and birth more positively, and this leads to the empowerment of the woman and her family.

In the next part of this chapter the findings and literature in relation to the point that ‘if I can’t have what I want, then no assistance would be better than medically-led care’ will be presented.

If I can’t have what I want, then no assistance would be better than medically-led care

The third and final element of this discussion in relation to the findings from the current study contextualises the finding that women felt ‘if I can’t have what I want, then no assistance would be better than medically-led care’. This topic refers to the conclusion arrived at by some women that if the option to birth with a privately practising midwife was unavailable, after considering the risks related to all aspects of their pregnancy and birth, and their fears and desires, they reached the conclusion that no assistance in pregnancy and birth would be better for them than the option of mainstream care.

The reasons these WA women chose a privately practising midwife were because they knew exactly what they wanted from their care provider and for their pregnancy

and birth. When they did their research they found that the only care provider that they felt would be able to provide them with the care and the experience they wanted was the privately practising midwife. Their relationship with the midwife, and the support and care they experienced, contributed to the women in this study sharing their experiences of having what they collectively reported, to be an amazing and empowering birth, that involved and benefited the whole family.

The concept of risk

The concept of risk has come to dominate all aspects of maternity care with women assessed and categorised according to their perceived risk level during their first contact with the maternity care providers. This risk label attributed to a woman will then define the level and type of care she should, in the broader maternity care system's view, receive; it also defines the expected place of birth (Smith, Devane & Murphy-lawless, 2012; Australian College of Midwives, 2013).

As previously highlighted, eight of the women in this WA study would have been classed as high-risk for a number of maternity care options available in WA at the time of this study. Seven of the women had previously given birth by caesarean section, and one of the women had a pre-existing medical condition which excluded her from the government funded midwifery-led options. All the women in this study, including the eight women with risk factors, wanted to have continuity of carer with a care provider with the same philosophy as them; they concluded, having done their research that this ruled out the medically-focused obstetrically-led care in the hospital system. These WA women also wanted an intervention- free natural birth and felt this would not be supported in the health care system at the time.

Risk means different things to different people and is defined in different ways between healthcare professionals and women in relation to pregnancy and birth. Pregnant women tend to view risk as an unusual event with the potential for loss or damage, whereas specialist obstetricians tend to view risk as a statistical calculation of odds and ratios (Carolan, 2009); what a health care professional defines as a risk may not be perceived as a risk by a woman and vice versa. An analysis of the literature was undertaken by Carolan (2009) following her attendance as a researcher

at a high-risk pregnancy clinic in Canada, when it became apparent to her that pregnant women and care providers viewed risk differently. She concluded that women employ a subjective appraisal of the risk, weighing it up against their personal values and their previous experiences; in contrast health professionals view risk objectively (Carolan, 2009). Another concept analysis on risk in maternity care concluded that risk is an ambiguous term, and is defined in accordance with multiple factors, including past experiences, knowledge and individual attitudes (Smith, Devane & Murphy-Lawless, 2012).

Eight of the women in the current study had risks (as defined by the medical system) that deemed them unsuitable for midwifery-led care and/or homebirth; the women, however, did not recognise themselves as at risk or see their condition as a reason to deter them from engaging a privately practising midwife. Thirteen of the fourteen women interviewed in this WA study planned to birth at home. The women in the study discussed how the medical system tends to focus on the physical risk factors in relation to the pregnancy and birth, whereas the women in this study considered all the risk factors, including emotional and psychological ones in relation to their pregnancy and birth. Some women in the current study perceived the risks associated with receiving mainstream maternity care as much higher than those associated with their obstetric status, as defined by the medical system. Differing perceptions of risk can be explained by Dahlen's (2010) discussion, in which she illustrates how presenting the same statistics in two different ways can have a massive impact on how the recipient 'hears' them. She asserts that an obstetrician will present a one in one thousand risk as focusing on the risk, whereas midwives will present it as the nine hundred and ninety nine times that the risk won't happen.

Consistent with other studies, a metasynthesis in relation to risk perception in women with high-risk pregnancies found that women and health professionals viewed risk differently (Lee, Ayers & Holden, 2014). Findings in this paper also highlighted that although women with high-risk pregnancies may not see the risks as the health care professionals do, and subsequently may not follow the advice given to them by the health care professionals, they are still highly committed to the wellbeing of their babies (Lee, Ayers & Holden, 2014).

Fear in childbirth

The more the health and maternity care system focuses on risk, the more women fear pregnancy and birth, and in some cases the medical system itself; the more fear the women have, the less able they are to trust their bodies and their ability to give birth. In turn, the less women trust themselves, the more vulnerable they become (Fisher et al., 2006; Dahlen, 2010 Lee et al., 2014). This loss of faith in their ability to birth safely may be particularly relevant to women who are already vulnerable such as those women who have had a previous negative or traumatic experience. As expressed by women in the current study, the risk of being in a system that is not women-centred and individualised creates a much greater sense of danger than for example, the risk of a uterine rupture, for women who have had a previous caesarean section.

American feminist writer, Hausman (2005) discusses her views on the medical management of risk and points out that as long as medical professionals are trained to see childbirth as a set of risks to be managed by technological processes; it is difficult for them to see birth as a normal process. Hausman (2005) emphasises that when women are classed according to risk status, mothers are always seen as sick patients, and while woman who are defined as high-risk are unlikely to decrease their risk status, women who are defined as low-risk can always increase their risk status. As previously discussed, the increased medicalisation of birth and the emphasis on risk can lead to women becoming fearful of childbirth. Fear in childbirth is a multi-dimensional and complex issue that is increasing among women in the western world (Fisher et al. 2006; Nilsson & Lundgren, 2009; Jackson, Dahlen & Schmied, 2011; Nilsson, Bondas & Lundgren 2010).

The reasons the women in the current study chose a privately practising midwife for their pregnancy and birth was influenced by their previous, both negative and positive, experiences. In a qualitative study of Swedish women's lived experience of childbirth fear, the findings of which, confirmed that out of the eight women interviewed, the six who were multiparous described their previous birth as emotionally and psychologically traumatic (Nilsson & Lundgren, 2009). The trauma

noted in this Swedish study related to pain, however notably, it was also founded in negative experiences related to the staff caring for them in labour and during birth.

An Australian qualitative study of women's experience of fear in childbirth reported two overarching themes: prospective fear and retrospective fear (Fisher, Hauck & Fenwick, 2006). Prospective fear had two dimensions: social dimensions, reported as fear of the unknown, horror stories and general fear for the wellbeing of the baby; and personal dimensions were reported as fear of pain, losing control and disempowerment, and the uniqueness of each birth. Retrospective fear, unlike prospective fear was only related to personal dimensions, which participants identified as previous 'horror' births and the speed of birth (Fisher et al., 2006). Two key factors were found to mediate against fear in childbirth for women: the supportive caring and empowering relationship between midwives and women; and the support women received from their partner, family and friends (Fisher et al., 2006). Similarly, in the qualitative Swedish study previously mentioned, Nilsson and Lundgren (2009) found that a positive encounter between women and their midwife had the potential to restore her trust in her herself, and increase the possibility of a positive birth. A positive encounter between women and their midwife also has the potential to decrease the risk of the effects of a negative experience, and the detrimental effects of the lack of perceived care and support during childbirth and the consequences of that suffering (Nilsson & Lundgren, 2009).

If the opportunity to have individualised care, continuity of carer, and to form a relationship with a chosen midwife had not been available for the women in this current study, acceptance of the medicalised and technocratic maternity care on offer in the mainstream options would not have been considered. For these women, maternity care in the technocratic maternity system, with its associated increased risk of intervention, lack of support and multiple carers, presented a higher and unacceptable risk than birthing with no assistance.

Freebirth

Unassisted birth, sometimes referred to as freebirth, is a planned homebirth without the aid of medical assistance (Stanley, n.d). Dahlen, Jackson and Stevens (2011)

argue that the rise in women choosing intentionally to birth at home, unassisted by any health care professional, is partly in response to the system not meeting the needs of women who want continuity of care and a non-medicalised birth. As already noted in Dahlen and associates' (2011) analysis of the Australian Government Maternity Service Review's (MSR) data related to homebirth, unassisted birth or freebirth was mentioned in three percent of the submissions to the review. Although it is acknowledged that some women will choose to freebirth regardless of the available options, in the submissions to the MSR freebirth was discussed as a direct consequence of the lack of access to affordable midwifery-led homebirth. It was concerning that twenty-six submissions in the MSR directly related to women's intention to freebirth or their previous experience of freebirth, due to lack of affordable accessible homebirth (Dahlen et al. 2011).

Although the actual numbers of freebirths cannot be verified due to the birth taking place away from the health system and the required reporting system, freebirth is reportedly becoming more common in Australia (Dahlen et al. 2011). Moreover, there is very little evidence to examine, as freebirth only comes to mainstream attention when extreme cases are reported in the media (Dahlen et al 2011), such as a the high profile case in Australia of a neonatal death during a freebirth in 2009; the mother, Janet Frazer, is the founder of the pro-homebirth website 'Joyous Birth' (<http://www.joyousbirth.info/forums/activity.php>) and has been a vocal advocate of freebirth. Janet Frazer's third baby died after an unassisted birth in 2009, and the case was subsequently examined by the coroner in her home state. The coroner's findings followed in 2012 and declared that the baby died because of the mother's choice to birth unassisted; and that the mother placed her socio-political views above the life of her baby. Janet Frazer has always stated that there are "no risk free options in birth" and that she chose the option for labour and birth that she felt was the most appropriate to her needs following her first traumatic hospital birth (Coroners report, Government of New South Wales, 2012).

The way Janet Frazer's story was generally reported in the Australian media, ignored the reasons she chose to freebirth and instead portrayed her as a woman who put her homebirth beliefs before her baby (Bercovic, 2012). In contrast, the Guardian newspaper in the UK reported the same story with the heading "Freebirth is not a

selfish choice” and suggested that Janet Frazer’s daughter had died because the system had let her down with its focus on the physical safety and lack of support for a woman’s psychological safety (Moorhead, 2012).

A recent Australian study was undertaken to explore how women, who make the decision to birth outside of the mainstream birthing system, perceive the risks associated with birth and place of birth (Jackson, Dahlen & Schmied, 2012). Twenty women were interviewed from four Australian states; of these women, nine chose to freebirth and eleven chose homebirth despite the presence of medically defined risk factors. A significant finding in this Australian study was that fifteen out of the twenty participants had a bachelor degree or higher (Jackson et al., 2012). This high level of education among the participants in this study is over represented when it is considered that the 2010 statistics show 26.9 % of Australians hold a bachelor degree or higher (Australian Bureau of Statistics, 2011). Three main themes were found in Jackson and team’s qualitative study: birth always has an element of risk; the hospital is not the safest place to have a baby; and interference is a risk (Jackson et al., 2012). In particular, these Australian women felt that the risk of going into the mainstream care was a higher risk than birthing their babies at home, with or without a trained health professional’s assistance. Many of these women had experienced a previous traumatic birth and this also influenced their decisions, as they wished to avoid this reoccurring. The women discussed how staying away from the hospital would minimise the risk of intervention and increase their control of external factors in relation to their births (Jackson et al., 2012). Similar issues were noted in another UK study of freebirth by Joanna Joy, who conducted an informal survey of two hundred and twenty freebirthing women (Joy, 2013). From the data gathered, Joy (2013) found that many women chose to freebirth as a direct response to the excessive medicalisation of birth, and the lack of suitable maternity care options. The women in her UK survey acknowledged the benefits of continuous care through pregnancy with a trusted midwife, but felt this was not an option within the free maternity care options, and although many thought that the option of a privately practising midwife would be the ideal choice, it was unobtainable for many due to the financial cost of this type of care (Joy, 2013).

Similarly, Edwards and Kirkham (2012), in preparation for a more extensive study on why women avoided maternity services in the UK, interviewed five women who had chosen to freebirth and found three participants' reasons to freebirth was based on their experience of previous traumatic births. All five women stated freebirth was not their first choice, but described feeling there was no other way that they could get the birth they wanted from the options available to them. What the women in this UK study (Edwards & Kirkham, 2012) wanted was consistent with what the women in the current study wanted: a midwife with the same philosophy as them, who they could build an equal relationship based on mutual trust, and who would respect and support their decisions around pregnancy and birth. The WA women wanted to gain the confidence to trust their bodies and experience an empowering, intervention-free birth that would benefit the whole family. If they hadn't been able to find this, they concluded that their only option to achieve their aims would have been to birth without the assistance of a health care professional.

Although the body of evidence is limited and mainly anecdotal, the very clear message is that if women do not get what they want from the maternity care on offer, they will look for it elsewhere, and if they feel that the risk of the mainstream maternity care is higher than the risk of freebirth, then many women may well choose to freebirth.

The concern is that if women's options for women-centred and holistic care continue to be reduced, and the option of midwifery-led care and homebirth continue to be 'allowed' in a context of a constantly moving definition of what constitutes low-risk, women will feel pushed further away from that which the current health care system offers. If the option of care from a privately practising midwife remains unavailable within the health service, and while women's wish to home birth continues to be judged as safe or unsafe according to others' criteria, as discussed above, women are highly unlikely to default to a mainstream maternity care system that does not meet their requirements.

The highly publicised inquest into the death of three infants in South Australia between 2007 and 2011, and the death of another infant in Western Australia in 2012 (which has yet to be investigated) highlighted that women will not default to

mainstream care if they do not find the maternity care they want. All the deaths took place during planned homebirths and were attended by former Registered Midwife and now birth advocate Lisa Barrett. All four women's pregnancies had medically defined risk factors and were classed as not suitable for government funded homebirth (Coroners report, courts administration authority, 2012; Founten, 2014).

Lisa Barrett had previously been registered as a midwife in the UK and in Australia but chose to deregister herself in 2011. During the inquest Lisa Barrett stated she was now a birth advocate and defined this as someone who advocates for women, providing them with information, education and help during pregnancy and birth (Coroners report, courts administration authority, 2012). Following the inquest the Deputy Coroner, Dr Anthony Schapel handed down his findings stating that the deaths could, and should, have been prevented. He recommended that homebirths should only be attended by registered health care professionals, and unregistered birth workers attending homebirths should be criminalised. He also suggested that health professionals should be duty bound to report the intention to birth at home with risk factors to the local health department. Then, a senior obstetrician could counsel the woman, and an education program could be implemented to highlight the risks of high-risk homebirths and dispel the misconceptions around home and hospital births (Coroners report, courts administration authority, 2012; Puddy, 2012; Keller, 2012).

Anthony Schapel dismissed the contention that, in implementing the strict regulation of privately practising midwives providing homebirth, this would drive women to freebirth. He counter-argued that women who chose to homebirth risky pregnancies do so without full knowledge and understanding of the consequences (Coroners report, courts administration authority, 2012). This assertion is in complete contrast to the findings of Jackson et al (2012), Edwards and Kirkham (2012) and Joy (2013) and the women interviewed in the current study. All the women in these studies confirmed that they were fully aware of all the risks inherent in their decision making around place of birth and caregiver, but felt that the risks of engaging the other maternity care options, rather than the one they chose, were greater and unacceptable to them.

The author proposes that it is likely that if a privately practising midwife was required to report women with risk factors to the health department for counselling, then the women may not access this option. This is because being required to be counselled by a senior obstetrician in relation to childbirth choices could be seen by some women as bullying and coercion (Edwards & Kirkham, 2012; Joy, 2013).

Regulation of midwifery practice

Another concern is that very few midwives in Australia offer private midwifery care. The numbers have steadily declined, with reports of the number of privately practising midwives offering homebirth in Australia dropping from two hundred and two in 2009, to just one hundred and four in 2010 (Puddy, 2012; Midwives Australia, Personal communication, 2011). This reduction in midwives offering this option of care coincided with the government's introduction of the midwifery reforms and the need for midwives to be insured to be registered. Since 2010, there has also been an increase in privately practising midwives being reported to their governing board for supporting women with medically-defined risk factors to birth at home, or to pursue vaginal birth in hospital against medical advice. A recent presentation by Jo Hunter, a privately practising midwife and member of the ACM Private Practice Midwives Advisory committee, at the 2014 Homebirth Australia Conference in Brisbane, highlighted an increase in the vexatious reporting of midwives in Australia during this period. Hunter (2014) collated the data from twenty-one cases of vexatious reporting from midwives in five Australian states, and spoke of her personal knowledge of at least twenty more reports. Hunter (2014) highlighted that the privately practising midwives who had been reported felt bullied, threatened and in one case suicidal, leading to a number of them ceasing practice as privately practising midwives. In some of the cases the midwives had been reported for supporting women choosing to birth at home with medically defined risk factors. The midwives were noted by Hunter (2014) to have also discussed having first-hand knowledge of women deciding to freebirth, due to their chosen midwife being unable to attend them during labour and birth.

The reporting and bullying of midwives is not a new phenomenon; midwives have been persecuted since the middle ages when they were labelled as witches

(Donnison, 1988; Ehrenreich & English, 2010). Kitzinger (1999) suggests that midwives who challenge the system are at risk of persecution. In 1995, Wagner described a global ‘witch-hunt’ which was part of a global struggle for control of maternity care, and that choice and freedom for the consumers of maternity care, the women and their families, was at stake. In his later work, Marsden (2006) points out that every attempt at ending the practice of midwifery has failed and he states “it seems that there will always be women who want to be midwives and women who want to attend them when they give birth” (Wagner, 2006, p.99).

Following the South Australian inquest in 2012 and the deputy Coroner, Anthony Schapel’s recommendations, the Health Minister of South Australia developed a proposal to ‘Protect Midwifery Practice in South Australia’. This proposal aims to “legislate for the restriction of midwifery services in South Australia to a registered midwife or midwifery student acting under the appropriate supervision of a registered midwife” (South Australia Health, 2013, p. 2) and make it illegal for anyone other than a registered health practitioner to attend a woman in labour and birth in South Australia. This proposal to protect the practice of midwifery also states that this intention “should not be confused with denying a woman the choice on whether their baby is born at home or in a hospital” (South Australia Health, 2013, p.2). However, as previously discussed if privately practising midwives are being reported to their governing body for supporting women in their birth choices contributing to them ceasing to practice midwifery, and it becomes illegal for unregistered health professionals to support women, this in fact leaves women with very limited choices and some, will feel their only option is to birth unassisted. Whether the proposed legislation in South Australia will extend to the rest of Australia remains to be seen; the proposal received over thirty submissions, the majority in support of the proposed legislation. The Australian Medical Association of South Australia’s (AMA (SA), submission not only supports the legislation but also suggests the potential for criminal charges such as reckless endangerment of life for unregistered attendees at homebirths, and strongly emphasises that pregnancy is about having a healthy baby (AMA (SA), 2013).

In contrast the submission from the Australian College of Midwives (ACM, 2013b) urges caution as although they agree in principle with the legislation, their

submission refers to the studies and potential consequences cited in this discussion chapter (Dahlen et al. 2011; Jackson et al. 2012). The ACM (2013b) point out that women in general do not seek to give birth with unregistered caregivers, but cannot find what they want in the mainstream options. The ACM (2013b) emphasise that women first seek the assistance of registered midwives, but often cannot proceed with this option as they either cannot access a midwife who will support their choices, or it is unaffordable (Dahlen et al. 2011; Jackson et al. 2012). The submission by the ACM (2013) suggests that legislation is missing to support the midwife who provides midwifery care to the woman choosing birth choices outside of recommended advice, such as those who wish to have a vaginal birth after a previous caesarean section (VBAC). This dilemma may result in midwives not supporting women in their choice, and leaving them with no other alternative than to employ an unregistered birth worker or freebirth, as confirmed by the women in the current study.

Conclusion

This discussion chapter provided a brief overview of the study's findings and discussed the key concepts within the literature. The unique contribution of this WA study highlighted three discussion areas which are well supported by the existing local, national and international literature.

The first discussion topic, 'the relationship is everything', discussed the continual, supportive relationship women want from their midwife. Women want continuity of carer from a caregiver with a shared philosophy of pregnancy and birth. Experiencing this type of care based on shared decision making and shared aims have the potential to contribute to an empowering and positive birth experience. The second discussion topic explored the concept of control in pregnancy and birth and was labelled 'feeling in control is paramount to having a positive experience'. This topic addressed the issue that when woman perceive that control is maintained as she wants, she experiences her pregnancy, labour and birth more positively which supports the empowerment of the woman and her family. Finally, the third discussion area 'if I can't have what I want, then no assistance would be better than

medically led care' discussed how women make educated and informed decisions around their maternity care. However, for some women after considering all the risks, according to their own definitions of risk and safety, they conclude no assistance in pregnancy and birth would be better for them than the option of mainstream care.

The following chapter concludes this thesis and provides the recommendations for clinical practice, education, and future research arising from the findings of this WA study.

Chapter 6: Recommendations

Introduction

Building on the discussion points highlighted in the previous chapter, in this chapter recommendations for clinical practice, education and suggestions for future research, which arose from the findings of fourteen women's reasons for, and experience of, maternity care with a privately practising midwife in WA, will be presented. Finally, a concluding statement will be provided.

Recommendations for clinical practice

The findings of this WA study highlighted the immense satisfaction that women reported from experiencing continuity of midwifery care and carer from their privately practising midwife. The women shared how they felt when they were working with their midwife towards their shared goal of an intervention free, normal birth. The women in this WA study discussed how, after researching all their options, they rejected the mainstream ones on the basis that the guidelines and policies were perceived to be too restrictive. They were also disappointed that the mainstream care options focused on medical risk status, rather than assessing the woman as an individual with unique needs.

Midwifery-led care has excellent outcomes for all risk women (Tracy et al., 2012; Sandall, Soltani, Gates, Shennan & Devane, 2013; McLauchlan et al., 2012), however, women get most satisfaction when they are able to build a positive relationship with their midwife. In this context, rather than directing care, the midwife works with the woman so that she can direct and control her own birthing experience, and in turn feel confident in her new role as a mother (Sandal, Devane, Soltani, Hatem & Gates, 2010; Dahlberg & Aune, 2013). Therefore it is essential that women of all risk levels are offered midwifery-led care, with the ultimate aim of enabling one to one midwifery care, within the mainstream maternity options.

The proven benefits of midwifery-led care and the positive relationship formed between the woman and her midwife is a cost effective option. Women who experience this type of care have less interventions and more normal births (Walsh & Devane, 2012). At present only a small amount of private midwifery care is funded by the Australian public health care system or private health insurance companies. Furthermore, many women are not entitled to any rebates for their private midwifery care, and at present there are no rebates for homebirths. It is essential that the government provides women and their families with affordable options to access private midwifery, including the option to birth at home with a midwife of their choosing.

At present, there is no legislation that supports midwives who are providing midwifery care to women who choose care outside of recommended guidelines. As explored in the discussion chapter, one of the reasons women may birth unassisted by registered health professional or employ unregistered birth workers, is that midwives may not feel able to support them in their choices for fear of reprisal (ACM, 2013). In contrast, midwives in the UK have a duty of care to provide midwifery care, and attend women who make an informed decision to birth at home. Regardless of their obstetric risk status, women in the UK have the right to have midwife attended homebirths (Birthrights, 2013). The midwife in the UK, rather than be reprimanded for attending a woman during a high-risk homebirth, would be held professionally accountable for leaving a woman in labour at home unattended (Thewllis, 2006). Legislation should be prioritised in Australia to support the midwife who provides midwifery care to women choosing outside recommended guidelines.

Thirteen out of the fourteen participants in this study chose home as their intended place of birth. One woman chose hospital as her intended place of birth, but laboured at home with her midwife until late in labour. Privately practising midwives do not have admitting rights to hospital in WA in mid-2014 despite the release of a Health Department Operational Directive mandating this measure in February 2014 (Department of Health WA, 2014). This means that privately practising midwives are unable to provide midwifery care to their clients in the hospital setting, and both must surrender to care that reflects the medical, not the social, paradigm. The clients of the privately practising midwives choosing to birth in hospital are admitted under

the care of the hospital obstetrician and his team of doctors, and midwifery care would be provided by a midwife employed by the hospital. In this scenario the privately practising midwife would be regarded as a support person. This situation is unacceptable, as women should be able to be cared for by their registered midwife, who they have built a trusting relationship with, either at home or in a hospital setting. This inability to receive midwifery care from their midwives may influence women choosing their place of birth. Privately practicing midwives should thus be given admitting rights to hospitals.

At the time of writing, mainstream maternity services focus on the physical aspects of pregnancy and birth and are influenced by technocratic medical philosophy rather than the social philosophy (Wagner, 2006; Davis-Floyd, 2001). The technocratic medical model does not place any emphasis on the positive relationship between the woman and her caregiver, and is not women-centred. This continual reliance on the technology available in the birth environment has steered women and their caregivers to trust the machine rather than the physiological process of birth. This attitude may contribute to an erosion of the relationship between the woman and her caregiver. As previously discussed, women consider risk factors that include more than the physical risks related to their pregnancy and birth when planning their pregnancy and birth.

The findings of this study highlight that women do not subscribe to the technocratic model of care. Women in this study wanted the social model of care, which included family centred, individualised and holistic care. As discussed, a positive birth experience can have a positive impact on the whole family. Likewise a negative experience has detrimental implications on the whole family (Goodman et al., 2004; Waldenström et al., 2004; Mercer & Marut, 1981; Hay et al., 2001; Sinclair & Murray, 1998; Thomson & Downe, 2008; Lundgren, 2010). The women in this WA study shared how they chose private midwifery care so that they could involve the whole family, including their children and that in doing this the whole family benefited. The emphasis on technocratic care in mainstream birthing environments needs to shift to a more family orientated practice that takes account of the individual needs of each woman.

The women in this WA study avoided the mainstream maternity care, as they felt the risk of interventions would affect their plans for an intervention-free birth. What many midwives and doctors perceive as minor interventions, such as continuous fetal monitoring, for some women, can be seen as equally invasive as a birth assisted with, for example, forceps (Clement, Wilson, & Sikorski, 1999). Interventions such as continual fetal monitoring and artificial rupture of the membranes are used routinely, and are often not evidence-based. The technocratic model only sees birth as normal retrospectively (Wagner, 2006). Normal birth is defined as “spontaneous in onset, low-risk at the start and remaining so throughout labour and birth, and after birth mother and baby are in good condition” (World Health Organisation,(WHO), 1997. p4). Seventy to eighty percent of women would be classified as low-risk at the start of labour (WHO, 1997; Wagner 2006). The WHO definition of normal birth does not only apply to low-risk women, as many women who are classified as high-risk can also experience a normal birth (WHO, 1997, p4). It is essential that hospitals and maternity care providers review their policies, guidelines and clinical practice to promote the social philosophy of childbirth. Childbirth interventions should only be used if necessary, and should always be evidence-based. Implementing and encouraging normal birth practices would maximise the opportunities for women to experience a normal physiological birth.

To summarise, the recommendations for clinical practice from the current study are:

- All women, regardless of risk status, should have access to midwifery-led continuity of carer, including privately practising midwives. These models of care should be easily accessible, affordable and fully supported by the government.
- Government rebates and private health insurance rebates should be available for women choosing privately practising midwives as their main care provider, including rebates for women to birth at home with their chosen midwife.
- Admitting rights for privately practising midwives to enable them to admit their women under their care, and enable them to provide midwifery care during their hospital stay.

- Affordable insurance should be made available for privately practising midwives providing homebirth services.
- Hospitals and maternity care providers to review their policies, guidelines and models of care and clinical practice, to promote the social philosophy of birth and promote and maximise the opportunities for normal birth.
- Legislative support for midwives providing midwifery care to women choosing outside of recommended guidelines.
- WHO ten principles of perinatal care are promoted and adhered to in all maternity practice settings (see Table 6):

Table 6: WHO ten principles of perinatal care

<ol style="list-style-type: none"> 1. Care for normal pregnancy and birth should be de-medicalised. 2. Care should be based on the use of appropriate technology. 3. Care should be evidence-based. 4. Care should be regionalised. 5. Care should be multidisciplinary. 6. Care should be holistic. 7. Care should be family-centred. 8. Care should be culturally appropriate. 9. Care should involve women in decision making. 10. Care should respect the privacy, dignity and confidentiality of women.

(Chambers, Mangiaterra & Porter, 2001)

Recommendations for education

The women in this WA study shared how the option to receive maternity care from a private midwife was never offered to them, and that they found their midwives through their own research. This highlights that midwifery-led care is not yet a recognised as a credible mainstream option in Australia. As previously discussed, normal childbirth and midwifery in Australia is often portrayed negatively (McIntyre, Francis & Chapman, 2011). The media depiction of pregnancy and birth has lasting implications on women. Fear is affecting women's views of childbirth, robbing women of self-belief, and leading them to hand over control and

responsibility (Dahlen, 2006; Fenwick, 2007). To restore women's birth self-belief and give them the confidence to take back control of birth, an intensive program of education is necessary. To reduce fear in childbirth, normal physiological childbirth and midwifery must be promoted as the norm. Including midwives in primary school education, as police officers, doctors and vets are included, would assist children to learn about and value the role from a young age. If children are taught that pregnancy and birth are normal, and the role of the midwife is also promoted at that time, the image and understanding of midwifery would be improved so that it can be seen as an essential part of maternity services (Hauxwell & Rees, 1995). Aiming marketing strategies at school-age children could be used to inform Australian society as a whole. Children would grow up to see childbirth as a normal life event, and one that benefits from having midwives to support it.

Pregnancy and birth are monumental occasions in the life of a woman and her family but are also, for most women, a normal part of life. It is essential that maternity care providers are provided with education to enable them to promote pregnancy and childbirth as normal. Midwives are already educated to promote and support normal birth, however they must be provided with ongoing post-registration education to ensure they maintain this focus; this is particularly important when working in the technocratic environments of mainstream maternity care. Therefore, it is essential that education of all maternity care providers, including midwifery and medical students, and registered health professionals, focuses on the social model of maternity care and the promotion of normal birth. The basis for this recommendation is that taking into account the physical, emotional and psycho-social aspects of the woman and providing individualised, women-centred care for the woman, is indisputably linked to a more positive birth experience. In educating the public and primary health care providers, women would be able to make an informed decision when choosing their maternity care provider.

Therefore the recommendations for education are:

- Educate the public, primary health care providers (for example, general practitioners, and child health nurses) and the private and public hospitals

about all models of maternity care, so that women can make a truly informed choice.

- Universities to incorporate and promote the social philosophy of maternity care and normal birth into their curriculums, and teach, support, and promote normal birth in the clinical component of their courses.
- Promote the benefits of midwifery care in the media.
- Educate school children on normal birth and midwifery care.

Recommendations for future research

The findings in this WA study support previous research relating to women's decisions about maternity care and their experience of birth. The findings of this study also support existing work that suggests the positive relationship between women and their midwives, developed over the pregnancy, contributes to women feeling in control and empowered during their births. Furthermore, the women in this WA study believed the experience of receiving maternity care from a privately practising midwife benefited the whole family; however this was not explored fully.

The first recommendation for further research therefore is:

- To explore women's families' experiences of privately practising midwifery, in particular the women's partners.

This WA study included women with 'obstetric risk factors' who experienced care from a privately practising midwife. These women would not have been accepted into the government funded midwifery-led homebirth options that were in place at the time of this study; this is significant as thirteen out of the participants planned to birth at home.

Caring for women with obstetric risk factors who choose homebirth is not, at the time of writing, well supported within the mainstream maternity services. Furthermore, midwives have been reported to their regulating body for what is judged to be unsafe practice in providing midwifery care and supporting women who

make this choice (Hunter, 2014). Anecdotally, privately practising midwives have also reported bullying behaviour by obstetricians and midwives they encounter in hospitals.

Therefore, there is a need for further research into:

- Privately practising midwives' experiences of providing caseload midwifery care including homebirth. A better understanding particularly of the decision-making process of the privately practising midwives caring for such women would be beneficial.

Conclusion

The aim of this descriptive qualitative study was to investigate women's reasons for, and experiences of, maternity care with a privately practising midwife. This thesis presented the findings related to the experiences of fourteen WA women who chose a privately practising midwife as their maternity care provider. The analysis drew upon data from in-depth interviews, and data collection ceased once saturation was achieved. Constant comparison, modified from grounded theory methodology was used to analyse the data. The findings were grouped into two parts; women's reasons for choosing a privately practising midwife to provide maternity care, and women's experience of that care.

Analysis of the data revealed that central to women's choice of a privately practising midwife was knowing what they wanted; they had a clear idea of how they wanted their care and their birth experience to be, and went about searching the available care options that could best facilitate their preferences.

Three major categories emerged to depict women's reasons for choosing to birth with a privately practising midwife: **I knew what I wanted from my care provider; I knew what I wanted from my pregnancy and birth experience; I was willing to do the research to get what I wanted.** One major category relating to women's

experience of receiving maternity care from a privately practising midwife emerged as: **I had an amazing and empowering birth experience.**

The findings of this study are significant, as they provide new knowledge as to why women choose to birth with a privately practising midwife, and their experiences of doing so. The findings highlighted that women knew exactly what they wanted from their caregiver and from their pregnancy and birth. When these women's needs were met, they had an amazing and empowering birth, where they felt safe and in control, and this benefited the whole family. Understanding these phenomena will provide maternity health care providers with strategies that will improve care and choices for women accessing maternity care in all settings.

Chapter 7: Epilogue

Recent changes

On 16 March 2010 the Australian Parliament passed the: Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010; Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010; and the Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2010 (Department of Health, 2012).

Medicare rebates are now available for midwives who are deemed eligible. An eligible midwife is a midwife who has been notated by the Nursing and Midwifery Board of Australia (NMBA) as meeting certain requirements (NMBA, 2013c). The midwife must have current registration with the NMBA, have at least three years post registration experience across all areas of midwifery practice, successfully complete an approved professional practice review program, complete an extra twenty hours continuing professional development, and complete an approved course relating to prescribing and diagnostics (NMBA, 2013c).

Once the midwife has attained these requirements she will receive her notation and be deemed eligible, this means that women will get some reimbursement for some private midwifery costs from the government. Some hospitals are moving towards accreditation of midwives in private practice, this will enable the midwife to obtain admitting rights and provide private midwifery in the hospital setting; although at time of writing no midwife had gained accreditation or admitting rights in Western Australia. Privately practising midwives have been granted admitting rights in some hospitals in Queensland (Australian Hospital Review, 2012).

As previously mentioned, insurance is required for all midwives to be registered. Most midwives will have insurance provided by their employer, however as private midwives are self-employed they must purchase insurance individually. At this point in time to maintain registration privately practising midwives are required to, and able to purchase antenatal and postnatal insurance. However, there is no available

insurance product for private midwives providing intrapartum care in a homebirth therefore they are exempted from the need for midwives to have professional indemnity insurance for intrapartum care in the homebirth setting until 30 June 2015 so that a solution can be found during this time (NMBA, 2013b).

Conversely, insurance for private midwives providing intrapartum care in a hospital is available. This insurance product is only available to the midwives who have eligibility status and there are restrictions to which women are able to be cared for within this insurance agreement (The Medical Insurance Group, MIGA, 2013).

There have also been some changes to maternity care in WA in the last year with a new team midwifery led care option similar to the Community Midwifery Program (CMP), which commenced early 2013, in the Southwest region of Western Australia. There are also plans for government funded team midwifery led care options to be implemented in some metropolitan and regional hospital.

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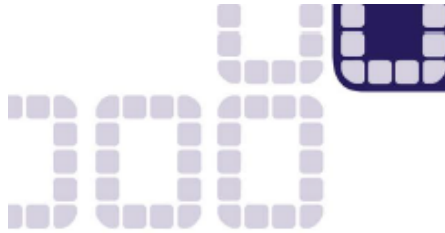
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Appendix 1: Exclusion for Midwifery Led Care KEMH



WOMEN AND NEWBORN HEALTH SERVICE
King Edward Memorial Hospital

CLINICAL GUIDELINES
SECTION B : OBSTETRICS AND MIDWIFERY GUIDELINES

1 ANTEPARTUM CARE

1.1 ANTEPARTUM CLINIC VISITS

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1.1.2.3 Exclusion Criteria to Low Risk Midwives Clinic
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1.1.2 MIDWIFERY CARE

1.1.2.3 EXCLUSION CRITERIA TO LOW RISK MIDWIVES CLINIC

KEY POINTS

- If a woman presents at the low risk midwives clinic with a condition on the exclusion list, a booking visit is done, and then her next antenatal visit is referred to the appropriate obstetric team antenatal clinic.
- Timing of the next appointment depends on the woman's medical/obstetric condition and gestation. This will be determined after consultation with the obstetric team (usually by phone).
- **TEAM MIDWIVES CLINIC**
In addition to the list on pages 2,3 and 4 women are excluded from this option of care if:
 - their initial booking visit is after 34 weeks gestation
 - they do not attend the booking visit on more than two consecutive occasions
- **FAMILY BIRTH CENTRE**
Ref to Clinical guideline [B.1.1.2.5 Exclusion Criteria to the Family Birth Centre](#)

EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<p>1. Medical Conditions</p> <ul style="list-style-type: none"> • Autoimmune disease • Cardiac disease • Chronic hypertension • Diabetes – requiring insulin • Drug or alcohol dependence/abuse 	<p>Specialised Diabetes Clinic is available for women with pre existing diabetes. Women with gestational diabetes requiring insulin will be managed by one of the obstetric teams</p> <p>The woman is encouraged to attend the Women's and Newborns Drug and Alcohol Service (WANDAS) clinic. If she declines then book to an Obstetric Team clinic.</p>



EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Endocrine disorders requiring treatment • Genetic conditions • Haematological Disorders: <ul style="list-style-type: none"> ○ Coagulation disorders ○ Anaemia – due to lack of iron ○ Anaemia—including Haemoglobinopathies ○ Thrombosis ○ Thrombocytopenia • Infectious Diseases: <ul style="list-style-type: none"> ○ HIV infection ○ Rubella ○ Toxoplasmosis ○ Cytomegalovirus ○ Parvo virus infection ○ Varicella Zoster virus infection ○ Tuberculosis- active tuberculosis or a history of tuberculosis ○ Syphilis • Malignant hyperthermia • Neurological: <ul style="list-style-type: none"> ○ Epilepsy – unstable ○ Brain abnormalities ○ Muscular dystrophy or Myotonic dystrophy ○ Spinal cord abnormalities ○ Subarachnoid/aneurysms, haemorrhage ○ AV malformations ○ Myasthenia gravis ○ Spinal cord lesions (para or quadriplegic) • Neuromuscular disease • Psychiatric disorders 	<p>Haemoglobin less than 100gm/L not responding to treatment.</p> <p>Platelets < 100</p> <p>Primary infection or positive serology not yet treated.</p> <p>Severe, unstable or extensive psychiatric disorders requiring medical supervision.</p>



EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Renal function disorder: <ul style="list-style-type: none"> ➢ Pyelitis ➢ Recurrent UTIs in pregnancy ➢ Pyelonephritis ➢ Acute or chronic renal failure ➢ Glomerulonephritis ➢ Renal transplants • Respiratory Disease • System/Connective Tissue • Thyroid disease <ul style="list-style-type: none"> ➢ Hyperthyroid on medication 	<p>Women with a past history of kidney / ureteric stones must be reviewed by a medical officer and the appropriateness of continuing care in the Low Risk Midwives Clinic documented in the medical notes.</p> <p>Severe asthma or lung function disorder.</p> <p>Women who are hypothyroid on medication may attend the midwives clinic provided they have an obstetric medical appointment at 24 weeks gestation.</p>
<p>2. Present Pregnancy</p> <ul style="list-style-type: none"> • Adolescent pregnancy • Fetal Death in utero • Malignant disease • Multiple pregnancy • No antenatal care prior to 22 weeks gestation • Placental Abnormalities e.g. <ul style="list-style-type: none"> ➢ Placenta praevia 	<p>Specialised Adolescent clinic available</p>
<p>3. Pre-Existing Gynaecological Conditions</p> <ul style="list-style-type: none"> • Cervical amputation • Myomectomy / hysterotomy • Pelvic deformities 	<p>Such as trauma, symphysis rupture, rachitis.</p>
<p>4. Past Obstetric History</p> <ul style="list-style-type: none"> • ABO incompatibility • Active blood group incompatibility • Cervical incompetence • Caesarean section • Eclampsia • Placenta accreta • Postpartum psychosis 	<p>Such as Rhesus, Kell, Duffy, Kidd.</p>

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- Previous cervical tear
- Previous perinatal death
- Previous third and fourth degree perineal trauma
With no or poor function recovery, or has not been followed up in the gynaecology clinic post birth.
- Postpartum psychosis
- Fetal growth disturbance
Dependant on circumstances- early medical review and plan.
- Asphyxia (unless cleared for Family Birth Centre by a consultant obstetrician)
Defined as an Apgar score < 7 at 5 minutes

REFERENCE

Australian College of Midwives. 2008. **National Midwifery Guidelines for Consultation and Referral.** Canberra: Kimberly-Clark Australia Pty. Limited;.

Appendix 1: KEMH Birth Centre



WOMEN AND NEWBORN HEALTH SERVICE
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CLINICAL GUIDELINES
SECTION B: OBSTETRICS AND MIDWIFERY GUIDELINES

1 ANTEPARTUM CARE

1.1 ANTEPARTUM CLINIC VISITS

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1.1.2.5 Exclusion Criteria to Family Birth Centre
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1.1.2 MIDWIFERY CARE

1.1.2.5 EXCLUSION CRITERIA TO THE FAMILY BIRTH CENTRE

AIM

- To provide a guide to the health conditions ([medical](#), [gynaecological](#), [past obstetric](#) and [present pregnancy](#)) that exclude women from birthing in the Family Birth Centre.

BACKGROUND

The Family Birth Centre (FBC) at KEMH provides maternity care in a home-like setting for low risk women. If health conditions arise that place the antenatal woman or her fetus at increased obstetric risk, then consultation and referral for obstetric tertiary care is required.¹ Collaborative networks between maternity care providers enable access to safe efficient health care provision²⁻⁴.

KEY POINTS

- If a woman presents at the Family Birth Centre (FBC) with a condition on the exclusion list, a booking visit is done, and then her next antenatal visit is referred to the appropriate obstetric team antenatal clinic.
- Timing of the next appointment depends on the woman's medical/obstetric condition and gestation. This will be determined after consultation with the FBC obstetric team.
- Care should always be individualised based on each woman's health history and risks. Additional care and referral may be required. See also [clinical guideline section B: 1.1.2.2 Low risk midwives clinic with medical consultation](#).

In addition to the list on pages 2 -7 women are excluded from this option of care if:

- there is no evidence of antenatal care prior to 22 weeks gestation
- they decline antenatal testing and screening including an [anatomy scan](#) and [glucose tolerance test \(GTT\)](#).
- they are a refugee without evidence of a full medical screening
- they will not permit a doppler ultrasound to be used in labour for the purpose of listening to the fetal heart rate⁵
- Any pre-existing condition requiring a postnatal stay of >24hours



EXCLUSION CRITERIA	ADDITIONAL INFORMATION
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Indications at commencement of care

1. Medical History

- Autoimmune disease^{1,6}
- BMI <20⁶ or >35
- Cardiac disease^{1,6}
 - Arrhythmia/ palpitations/ murmurs recurrent or persistent
 - Valve diseases
 - Cardiomyopathy
 - Hypertension
 - Ischaemic heart disease
 - Pulmonary hypotension
- Diabetes^{1,6} - type I or II
- Drug or alcohol dependence/abuse⁶
- Endocrine disorders requiring treatment¹
 - Hyperthyroid on medication
- [Female genital mutilation \(FGM\)](#)⁸
- Gastric band

Active, major organ involvement, on medication for SLE/ connective tissue disorder. [Cat C.](#)

Low BMI is associated with increased pregnancy risks of preterm birth, SGA fetus & low birth weight.⁷

BMI >25 linked to pregnancy complications (stillbirth, congenital malformations, neural tube defects, preterm birth, low birthweight or macrosomia, gestational hypertension, pre-eclampsia, GDM, PPH & major depressive disorders) requiring medical obstetric practitioner care. BMI >30 also linked to increased rate of caesarean birth.⁷ [Cat C.](#)

[Cat C.](#)

A specialised Diabetes Clinic is available for women with pre existing diabetes. See [Guideline 3.1.2 Referrals](#). Women with gestational diabetes requiring insulin will be managed by one of the obstetric teams.

The woman is encouraged to attend the Women and Newborn Drug and Alcohol Service (WANDAS) clinic, see guideline [1.5.1 Referral to the Women and Newborn Drug and Alcohol Service](#). If she declines then book to an Obstetric Team clinic.

Addison's disease, Cushing's disease or other requiring treatment. [Cat C.](#)

Women who are hypothyroid on medication may attend the FBC provided they have an obstetric medical appointment at 24 weeks gestation. [Cat B.](#)

FGM associated with increased rates of caesarean birth, PPH, neonatal resuscitation and longer hospital stays.⁸

Women should be counselled on increased risk of band slip in pregnancy.⁹ Refer to

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Genetic/congenital- any condition¹ • Haematological^{1, 5} <ul style="list-style-type: none"> ➢ Anaemia- iron deficiency ➢ Declines/refuses blood products ➢ Coagulation disorders ➢ Haemoglobinopathies ➢ Haemolytic anaemia ➢ Rhesus & other antibodies ➢ Thalassemia ➢ Thrombo-embolic process ➢ Thrombocytopenia ➢ Thrombophilia & antiphospholipid syndrome • Infectious Diseases: <ul style="list-style-type: none"> ➢ Cytomegalovirus ➢ Genital herpes -primary or active ➢ Parvo virus infection ➢ Rubella ➢ Toxoplasmosis ➢ Tuberculosis- active or history of tuberculosis ➢ Syphilis ➢ Varicella/Zoster virus infection ➢ HIV infection^{1, 5, 7} • Malignant hyperthermia¹ • Neurological: <ul style="list-style-type: none"> ➢ Epilepsy – unstable^{1, 5} ➢ Brain abnormalities 	<p>obstetric teams for management.</p> <p>Discuss with the FBC medical team. Cat B. Cat C.</p> <p>Haemoglobin < 90gm/L not responding to treatment.⁵</p> <p>Due to increased risk of maternal mortality and serious morbidity from obstetric haemorrhage,^{10, 11} management needs to be in a facility where access to surgical PPH treatment is available. Cat B.</p> <p>Complete MR 295.99 "Refusal to Permit Blood Transfusion". Order FBP, Iron studies, B12, folate studies, Coagulation studies, U&E's. Arrange next appointment with medical obstetric team.</p> <p>Thrombosis, Haemophilia</p> <p>Platelets <100.</p> <p>On warfarin, previous obstetric complication or maternal thrombosis.¹</p> <p><i>Discuss with FBC medical team before accepting.</i> Cat B.</p> <p>Discuss with the FBC medical team before accepting. Arrange a FBC medical team antenatal visit at 34 weeks gestation to discuss prophylactic acyclovir and birth management. Cat B.</p> <p>Cat B.</p> <p>Cat B.</p> <p>Cat B.</p> <p>Cat B.</p> <p>Positive serology +/- treatment or primary infection. Cat B.</p> <p>Cat B.</p> <p>Acute or chronic, refer on to MFM.⁵ Cat C.</p> <p>Self or family history. The woman should be referred to obstetric teams for birth management plan. Cat C.</p> <p>Epilepsy medication/treatment or seizure in past 12 months. Cat B/C. If medical/obstetric risk factors are present, then not suitable for water birth or water therapy.¹²</p>

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> ➢ Muscular dystrophy or Myotonic dystrophy^{1,5} ➢ Spinal cord abnormalities ➢ Subarachnoid/aneurysms, haemorrhage^{1,5} ➢ AV malformations^{1,5} ➢ Myasthenia gravis^{1,5} ➢ Spinal cord lesions (para or quadriplegic)^{1,5} • Neuromuscular disease¹ • Psychiatric disorders^{1,5,7,13} <ul style="list-style-type: none"> Including: <ul style="list-style-type: none"> ➢ Schizophrenia ➢ Bipolar ➢ Depression on medication ➢ Anxiety on medication ➢ History of puerperal psychosis • Renal function disorder¹ <ul style="list-style-type: none"> ➢ Acute or chronic renal failure^{1,5} ➢ Disorder in renal function¹ ➢ Glomerulonephritis⁵ ➢ Previous kidney surgery¹ ➢ Pyelonephritis⁵ ➢ Renal transplants¹ ➢ Pyelitis ➢ Urinary tract infections (UTIs)-recurrent • Organ transplants^{1,5} • Respiratory Disease¹ <ul style="list-style-type: none"> ➢ Moderate/ severe asthma⁵ ➢ Severe lung function disorder ➢ Current H1N1 ➢ Sarcoidosis • Sexual abuse 	<p>Self or family history. Cat C.</p> <p>Severe, unstable or extensive psychiatric disorders requiring medical supervision.</p> <p>Puerperal psychosis may occur with 25% of postnatal women with bipolar I disorder or schizoaffective disorder.¹⁴</p> <p>Planning by the medical team and the woman is required to assess treatment risks/benefits and reduce maternal morbidity.^{15,16}</p> <p>Cat C. Refer to Childbirth and Mental Illness (CAMI) Clinic.</p> <p>Renal impairment with or without dialysis¹. Cat C. Women with a past history of kidney / ureteric stones must be reviewed by a medical officer and the appropriateness of continuing care in the FBC documented in the medical notes.</p> <p>Cat B.</p> <p>Untreated asymptomatic bacteriuria can lead to UTIs (cystitis & pyelonephritis) with risk of low birth weight and preterm birth.¹⁷⁻¹⁹ Treatments include antibiotics,¹⁷ close monitoring,¹⁸ and non-pharmacological¹⁸ methods. May be suitable for FBC after medical review. Cat A/B.</p> <p>Cat C.</p> <p>Cat C.</p> <p>Oral steroids within past 12 months & maintenance therapy.¹</p> <p>Can worsen during pregnancy.¹</p> <p>Exclude any trauma that could affect mode of birth. Provide referral, risk assessment and increased psychological monitoring antenatally to minimise posttraumatic stress</p>

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Skeletal problems¹ <ul style="list-style-type: none"> ➢ Osteogenesis Imperfecta ➢ Scheuermann's disease ➢ Scoliosis⁵ ➢ Spondylolisthesis • System/Connective Tissue^{1, 6} <ul style="list-style-type: none"> ➢ Anti-phospholipid syndrome ➢ Marfan's syndrome ➢ Raynaud's disease ➢ Periarteritis nodosa ➢ Scleroderma, Rheumatoid Arthritis ➢ Systemic Lupus Erythematosus (SLE) 	<p>and retraumatisation during childbirth.²⁰</p> <p>May cause severe pain in labour¹ Cat B/C.</p> <p>Cat C.</p>
<p>2. Pre-Existing Gynaecological Conditions</p> <ul style="list-style-type: none"> • Cervical amputation¹ • Fibroids¹ • Myomectomy / hysterotomy¹ • Pelvic deformities • Pelvic floor reconstruction¹ • Bi / uni cornuate uterus or reproductive tract anomaly^{1, 6} 	<p>Cat C.</p> <p>Associated with increase in obstetric complications,²¹ such as malpresentation, caesarean birth, preterm birth, hysterectomy and PPH.²² FBC medical review for pregnancy management/ counselling. Cat B.</p> <p>Cat C.</p> <p>Such as trauma,⁵ symphysis rupture, rachitis.</p> <p>Colpo-suspension after prolapse; fistula/ previous rupture.¹ Cat B/C.</p> <p>Cat C.</p>
<p>3. Past Obstetric History</p> <ul style="list-style-type: none"> • ABO-incompatibility • Presence of clinically significant maternal antibodies¹ • Asphyxia, fetal (unless cleared for Family Birth Centre by a consultant obstetrician) • Autoimmune thrombocytopenia¹ • Cervical incompetence/ weakness^{1, 6} • Caesarean section⁵ 	<p>Cat B.</p> <p>Such as Rhesus, Kell, Duffy, Kidd. (Other maternal antibodies may be included as directed by the Transfusion Laboratory) Cat C¹.</p> <p>Defined as an Apgar score < 7 at 5 minutes.</p> <p>Cat C.</p> <p>Including cervical suturing / previous cervical tear. Caesarean to be offered. Cat C.</p> <p>Specialised midwifery led Next Birth After Caesarean (NBAC) clinic available if appropriate, with senior obstetric review at 24 & 36weeks.</p>

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> Eclampsia/Pre-eclampsia^{1,6} 	Cat C.
<ul style="list-style-type: none"> Fetal growth disturbance⁵ <ul style="list-style-type: none"> > IUGR/ SGA > Macrosomia 	Dependent on circumstances- early FBC medical review and plan. IUGR has increased risk of perinatal morbidity & mortality. ^{23,24}
<ul style="list-style-type: none"> Placenta accreta^{1,6} 	Cat C.
<ul style="list-style-type: none"> Psychological disturbance^{1,6,13} <ul style="list-style-type: none"> > Postpartum depression¹ > Postpartum psychosis¹ 	<p>Previous serious disturbance.¹ Cat B/C.</p> <p>Individualised to patient. May be suitable for low risk midwifery care with medical review. Cat A/B/C.</p> <p>As risk of postnatal recurrence is 25-57%, preventative treatments could improve outcomes.²⁵ Refer, with the woman's consent, to Department of Psychological Medicine. Cat C</p>
<ul style="list-style-type: none"> Postpartum haemorrhage (PPH) >500ml^{1,5} 	<p>Requiring treatment / transfusion¹. Previous PPH increases risk of future PPH.²⁶⁻²⁸ Delay in transport/receiving appropriate treatment impacts on obstetric outcomes²⁹. Active third stage management can reduce the risk of PPH.³⁰</p> <p>May be suitable for FBC after medical review. Cat B/C.</p>
<ul style="list-style-type: none"> <i>Previous eclampsia or HELLP syndrome</i>^{1,6} <i>Previous pre-eclampsia</i>^{1,6} 	Cat C.
<ul style="list-style-type: none"> <i>Previous retained placenta</i> <i>Previous shoulder dystocia</i> 	
<ul style="list-style-type: none"> <i>Previous third and fourth degree perineal trauma</i>^{1,5} 	With no or poor function recovery, or has not been followed up in the gynaecology clinic post birth. Caesarean birth may be advised if previous major sphincter trauma. ^{31,32} If functional recovery, may be suitable after FBC medical review. Cat B/C.
<ul style="list-style-type: none"> Recurrent miscarriages⁷ >3 consecutive 	Offer investigation ²¹ and refer to medical team for further management.
<ul style="list-style-type: none"> Rhesus Isoimmunisation^{1,6} 	May be suitable with FBC medical review. Cat B/C.
<ul style="list-style-type: none"> Trophoblastic disease^{1,6} 	Hydatidiform mole or vesicular mole within previous 12 months. ¹ Cat C.
<ul style="list-style-type: none"> Other significant obstetric event¹ 	Dependent on individual circumstances. May be suitable after medical review. Cat A/B/C.

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
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Indications discovered at subsequent visits / developed during pregnancy

4. Present Pregnancy

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Adolescent pregnancy <16years • Antepartum haemorrhage (APH) • Blood group incompatibility¹ • Cervical weakness^{1, 6} • Cervical cytology abnormalities¹ • Cholestasis¹ • <i>Decline</i> antenatal screening tests <ul style="list-style-type: none"> > Anatomy scan > Glucose tolerance test (GTT) • Ectopic pregnancy¹ • Endocrine <ul style="list-style-type: none"> > Addison's/ Cushing's disease¹ > Gestational Diabetes Mellitus (GDM)¹ • Fetal anomaly suspected^{1, 6} | <p>Specialised Adolescent clinic available. >17years in consultation with FBC medical team.</p> <p>Refer to obstetric teams if after medical consultation is considered inappropriate to remain under FBC care.</p> <p>Cat C.</p> <p>Dilation <37 weeks & / or cervical procedure. Cat C.</p> <p>Assessment and follow up with medical team required.³³⁻³⁵ If no current management plan has been formulated discuss with FBC medical team immediately. May be suitable for FBC after medical review. Cat B/C.</p> <p>May be suitable with FBC medical review. Cat B/C.</p> <p>Anatomy scans screen for fetal anomalies^{36, 37} and wellbeing³⁷; with subsequent identification and referral to the medical obstetric clinics assisting the woman and fetus to receive best possible care.³⁸</p> <p>The GTT aims to identify Gestational Diabetes Mellitus which is associated with perinatal morbidities^{39, 40} (e.g. macrosomia and shoulder dystocia), with untreated GDM increasing the risk of perinatal mortality.^{41, 42} All women should be encouraged to have a GTT as risk factors alone are unreliable predictors.⁴³</p> <p>If the woman makes an informed decision to decline screening tests, document reason in patient notes and refer care to the medical team.⁴⁴</p> <p>Cat C.</p> <p>Or other endocrine disorder requiring treatment.¹ Cat C.</p> <p>Specialist Diabetes Clinic available; see Guideline 3.1.2 Referrals. Cat C.</p> <p>Congenital abnormality (structural or chromosomal).⁷ Dependent on anomaly. May be suitable after FBC medical review.</p> |
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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Fetal death in utero^{1, 5} 	<p>Cat A/B/C.</p>
<ul style="list-style-type: none"> • Fetal growth disturbance⁵ <ul style="list-style-type: none"> ➢ IUGR/ SGA ➢ Macrosomia 	<p>Cat C.</p> <p>Dependent on circumstances- early FBC medical review and plan.</p> <p>IUGR has increased risk of perinatal morbidity & mortality^{23, 24} & Apgar <7. ⁴⁵</p> <p>Macrosomia associated with increased rates of caesarean birth, shoulder dystocia, neonatal resuscitation, neonatal intensive care admission⁴⁵ and Apgar <7. ⁴⁵</p>
<ul style="list-style-type: none"> • Hypertension (HTN)^{1, 5} <ul style="list-style-type: none"> ➢ Any with Proteinuria ➢ Chronic HTN ➢ Pre-eclampsia or Eclampsia 	<p>Cat C.</p> <p>> 1+ Cat C.</p> <p>HTN present <20 /40. Cat C.</p> <p>BP >140/90 and/or rise of >30/15mmHg from booking BP, with any:</p> <ul style="list-style-type: none"> • Proteinuria • Platelets <150x10⁹/l • Abnormal renal or liver function • Imminent eclampsia
<ul style="list-style-type: none"> • Infectious disease^{1, 6} <ul style="list-style-type: none"> ➢ Genital Herpes ➢ HIV infection⁷ ➢ Tuberculosis- active ➢ Varicella/ Zoster virus 	<p>Late in pregnancy- active lesions. Cat C.</p> <p>Refer to MFM,⁶ where the woman can be counselled on interventions to reduce the risk of mother to child transmission.^{7, 47} Cat C.</p> <p>Cat C.</p> <p>Infection in pregnancy. Cat C.</p>
<ul style="list-style-type: none"> • In vitro fertilisation (IVF) 	<p>Increased rate of preterm birth and neonatal intensive care admission.⁴⁸ Risks associated with infertility (e.g. advanced age,⁴⁹ obesity, hormonal treatments⁵⁰) and psychological function⁵¹ need consideration. May be suitable after FBC medical review.</p>
<ul style="list-style-type: none"> • Malignant disease⁷ • Mal-presentation at term^{1, 5} 	<p>Non-cephalic presentation (breech/transverse/oblique/unstable lie). Breech - refer for medical review & ECV at 35/40 if suitable.^{1, 52} Cat C.</p>
<ul style="list-style-type: none"> • Multiple pregnancy^{1, 5} • Placental abnormalities^{1, 5} 	<p>Cat C.</p> <p>Placenta praevia/ abruption/ accreta/ vasapraevia. Cat C. Not suitable for FBC care. Low lying placenta that is >2cm from cervical os may be considered for vaginal birth in a hospital setting where emergency</p>

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EXCLUSION CRITERIA	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> • Preterm labour (threatened) or birth^{1, 6} • Preterm rupture of membranes^{1, 6} • Psychological health issue⁷ <ul style="list-style-type: none"> > EPDS >12¹ > Positive to Q10 self harm¹ > H/o attempted suicide or self harm > Or longer postnatal stay is recommended. • Recurrent UTI's in pregnancy • Renal function disorder- Pyelitis¹ • Surgery during pregnancy¹ • Thrombosis¹ • Physical, psychological or behavioural circumstances that present, where the midwife, providing antenatal care, believes that the FBC is not a suitable environment for the woman to birth. 	<p>transfusion is available.^{53, 54} If placenta <4cm from os, then at increased risk of PPH regardless of birth method.⁵⁵</p> <p>Cat C.</p> <p>May only be suitable for FBC with medical review. Cat B/C.</p> <p>May be suitable for FBC after medical review. Cat B/C. Obstetric and psychiatric teams should work collaboratively with the woman to manage the woman's physical and mental health.⁵⁶</p> <p>Increased risk of suicide after self harm attempts.⁵⁷ When risk of suicide present, refer with the woman's consent to Department of Psychological Medicine.⁷</p> <p>Treatment includes antibiotics and close monitoring with follow up urine culture. May be suitable for FBC after medical review. Cat A/B.</p> <p>Cat C.</p> <p>Cat C.</p> <p>Cat C.</p> <p>In this case, a decision will be made about the woman's suitability in conjunction with the Midwifery Manager and the FBC medical team.</p>
<p><i>Category A: Responsibility for care = Midwife; discuss as needed with medical practitioner.</i></p> <p><i>Category B: Responsibility for care = Medical practitioner or midwife within scope of practice, after consultation with a medical practitioner. (After medical approval, may be included in low risk midwifery care).</i></p> <p><i>Category C: Responsibility for care = Medical practitioner (Not appropriate for low risk midwifery care).</i></p>	

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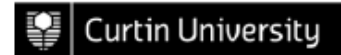
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Appendix 2: Letter for Participants for Study



Participant Information Letter

Western Australian women's experience of private midwifery care: A grounded theory study

Introduction

My name is Clare Davison and I am a midwife. I am also studying at the School of Nursing and Midwifery at Curtin University for a Masters Degree by research. I would like to invite you to take part in a study to find out why women choose a private midwife as their lead maternity caregiver. I am interested in knowing what your experience of private midwifery care. Understanding the reasons for this choice may provide maternity health care providers with strategies to improve care and choices for women accessing maternity care in all settings

Childbirth is a life changing experience and is now known to be more than just a biological process. The majority of research focuses on the physiological aspects of labour and birth, such as length of labour and type of birth. What is often not considered is women's decision-making process and overall experience.

Depending on a number of criteria, women in Western Australia may be able to choose from a range of maternity care options. These include private and public hospitals wherein obstetricians and midwives provide care; a midwife-led Family Birth Centre, a midwife-led Community Midwifery Program, and privately practicing midwives. A small but stable number of women in Western Australia choose a privately practicing midwife as their primary maternity care provider.

Why am I doing this study?

I want to find out why women choose to use a privately practising midwife as their primary caregiver, what led you to make this choice and how do you feel about the experience.

What is involved in taking part in the study?

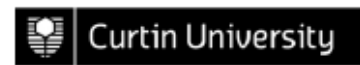
If you decide to take part in the study you will be asked to participate in an interview lasting approximately 60 minutes. This would preferably be face to face but if you are unable to do this it can take place over the telephone. During the interview you will be asked general information about yourself such as your age, when you left school, your work. You will then be asked to talk about your experience of choosing a privately practising midwife. You may be asked some specific questions about your experience during the interview. With your permission, the interview will be recorded using a digital voice recorder. Following analysis of the interview you may be telephoned to clarify any points you may have made during the interview. The interviews will be done at a time that is suitable for you and in a place where you feel comfortable.

What are the potential risks to taking part in the study?

A potential risk is that recalling a difficult or upsetting experience may cause distress. If this happens, the audio recorder will be switched off at your request and should you wish you can withdraw from the study. Contact details for counsellors will be provided should you wish to utilise these.

What are the potential benefits to taking part in the study?

A potential personal benefit you may experience is the opportunity to reflect on and explore your experience of birth with a private midwife. Your experience will also contribute to the development of knowledge, which can aid maternity care providers in all areas to improve care and the services they provide.



Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part or wish to withdraw at anytime you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you withdraw.

Privacy

All the information provided by you will remain private and confidential. Only myself and my primary academic supervisor will have access to your personal details. Any information that may identify you will be removed during transcripts of the interview and I will give you a false name and/or code number. Results of the study may be published in professional journals and presented at conferences however the material will contain no identifiable information about you.

Storage of information

All of the collected material will be stored in a locked filing cabinet for 5 years and then destroyed. The master computer containing personal details will be kept in a separate location to the interview transcripts. All files will be password protected. All data will be managed in accordance with the Australian National Health and Medical Research Council (NHMRC) guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at Curtin University.

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this study. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

Clare Davison (Masters candidate)	0403 968409 or email clare.l.davison@student.curtin.edu.au
Professor Yvonne Hauck	9266 2076 or email y.hauck@curtin.edu.au
Jennifer Wood	9266 2088 or email j.wood@curtin.edu.au

Who to contact if you have any problems about the organisation or running of the study?

This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR52/2011). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hred@curtin.edu.au

What do I do if I would like to take part in this study?

If you would like to take part in this research study please read and complete the consent form provided with information sheet and return it in the envelope provided and I will contact you to make an appointment for interview.

THANK YOU



Partner and Health Professional Information Letter

Western Australian women's experience of private midwifery care: A grounded theory study

Introduction

My name is Clare Davison and I am a midwife. I am also studying at the School of Nursing and Midwifery at Curtin University for a Masters Degree by research. I would like to invite you to take part in a study to find out why women choose a private midwife as their lead maternity caregiver. I am also interested to know what their experience of this is. Understanding the reasons for this choice may provide maternity health care providers with strategies to improve care and choices for women accessing maternity care in all settings.

Childbirth is a life changing experience and is now known to be more than just a biological process. The majority of research focuses on the physiological aspects of labour and birth, such as length of labour and type of birth. What is often not considered is women's decision-making and satisfaction with their experience.

Depending on a number of criteria, women in Western Australia may be able to choose from a range of maternity care options. These include private and public hospitals wherein obstetricians and midwives provide care; a midwife-led Family Birth Centre, a midwife-led Community Midwifery Program, and privately practicing midwives. A small but stable number of women in Western Australia choose a privately practicing midwife as their primary maternity care provider.

Why am I doing this study?

I want to find out why women choose to use a privately practising midwife as their primary caregiver, what led them to make this choice and how did they feel about the experience.

What is involved in taking part in the study?

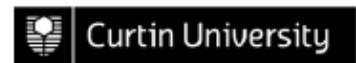
The primary population of interest for this study are women who have chosen a privately practising midwife as their lead maternity carer. To contextualise the information I obtain from women, however, I am also interested in hearing about others, such as doctors, midwives and women's partners, perceptions in relation to why women choose to birth with a privately practising midwife. If you decide to take part in the study you will be asked to participate in an interview lasting approximately 30 minutes. During the interview you will be asked some general information about yourself such as your age and your occupation. You will then be asked to talk on the subject of women's choice of a privately practising midwife; you may be asked some questions to prompt you during the interview. With your permission, the interview will be recorded using a digital voice recorder. Following analysis of the interview you may be telephoned to clarify any points you may have made during the interview. The interviews will be done at a time that is suitable for you and in a place where you feel comfortable.

What are the potential risks to taking part in the study?

A potential risk is that recalling a difficult or upsetting experience may cause distress. If this happens, the audio recorder will be switched off at your request and should you wish you can withdraw from the study at any time.

What are the potential benefits to taking part in the study?

A potential personal benefit you may experience is the opportunity to reflect on and explore your experience of birth with a private midwife. Your experience will also contribute to the development of knowledge, which can aid maternity care providers in all areas to improve care and the services they provide.



Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part or wish to withdraw at anytime you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you withdraw.

Privacy

All the information provided by you will remain private and confidential. Only myself and my primary academic supervisor will have access to your personal details. Any information that may identify you will be removed during transcripts of the interview and I will give you a false name and/or code number. Results of the study may be published in professional journals and presented at conferences however the material will contain no identifiable information about you.

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What do I do if I would like to take part in this study?

If you would like to take part in this research study please read and complete the consent form provided with information sheet and return it in the envelope provided and I will contact you to make an appointment for interview.

THANK YOU

Appendix 3: Consent Form for Study



Consent Form for Research Participants

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND PARTICIPANTS CAN WITHDRAW AT ANY TIME.

I
Given Names Surname

have read the information explaining the study entitled

***Western Australian women's experience of private midwifery care:
A grounded theory study***

- I have read and understood the information given to me.
- I have given the opportunity to ask questions and any questions I have asked have been answered to my satisfaction.
- I understand that the interviews will be audio recorded and transcribed
- I understand I may withdraw myself, and any information I may have provided during my participation in the study, at any stage, without any detriment to myself. All audio recordings and transcripts will be destroyed at the time of withdrawal.
- I agree that research data gathered from the results of this study may be published, provided that names are not used.
- I agree to participate in this study

Signature Date.....

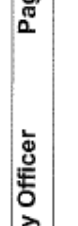
Address.....

Phone Number (H)..... (W).....

Mobile

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Appendix 4: The Community Midwifery Program (CMP)

 <p>Department of Health North Metropolitan Health Service Public Health and Ambulatory Care</p> <p>Code: Allocated by Policy Officer Page 1 of 3</p> <p>Category: Clinical</p> <p>Keywords: PHAC, Community Midwifery Program, Inclusion Criteria,</p>	<p>Policy Title: 5.1 INCLUSION CRITERIA</p> <p>The Community Midwifery Program (CMP) provides qualified community midwives for low risk pregnant woman planning to birth at home, in hospital or a birthing centre.</p>
<p>Procedures</p> <p>Application Process: The step by step application process involves;</p> <ul style="list-style-type: none"> ▪ Applications arrive (via fax, mail, email or in person) to TheBumpWA – CMP admin, all are dated on receipt. ▪ All applicants are sent an acknowledgement email and letter to confirm receipt of their application along with an information pack which includes the CMP 'What are my options if I wish to have a home birth?' pamphlet, information regarding CCE Midwifery Student, information regarding prenatal screening and diagnostics tests and TheBumpWA workshop flyers. ▪ The applicant's information is entered into the CMP database and the monthly birth log by administration. ▪ The application forms are placed into a folder ready to be assessed and allocated by CMM/CMC/CMS on a monthly basis. ▪ The CMM/CMC/CMS will review application forms (clients who are due in approx 6 months) and triage them to ensure the client meets the inclusion criteria (based on the information supplied on the application form). Should further details be required the CMM/CMC/CMS will contact the client or consult with an obstetrician to clarify suitability for home birth. ▪ Once the CMM/CMC/CMS has deemed the client suitable for 	<p>Policy</p> <p>Midwives provide comprehensive midwifery care throughout the antenatal, intrapartum and postnatal period. Acceptance of clients onto the CMP for a home birth is multifactorial and must involve a collaborative approach between the team of midwives, midwifery managers and obstetric professionals (if required).</p> <p>The level of risk is based on the <i>Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2013)</i> and the <i>Policy for Publicly Funded Home Births including Guidance for Consumers, Health Professionals and Health Services 2013</i></p> <p>This policy is to be read in conjunction with the:</p> <ul style="list-style-type: none"> • 'Policy for Publicly Funded Home Births including Guidance for Consumers, Health Professionals and Health Services 2013'.¹ • ACM – 'National Guidelines for Consultation and Referral 2013'.² • CMP POLICIES AND GUIDELINES.³ <p>This policy applies to All Midwives working for the Community Midwifery Program</p>

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<p>Inclusion criteria and pre-requisites for home birth and low risk domino with the CMP</p> <p>Women requesting a home birth with the CMP must be considered to be at low risk of pregnancy and birth complications and meet the following criteria:</p> <ul style="list-style-type: none"> • is over the age of 18 at term (≥37 weeks gestation) • is ≤a para 5 • has the capacity to give informed consent • lives within a geographical boundary no further than 30 minutes from a maternity service • resides within the CMP geographical boundary by 35 weeks gestation • has received regular antenatal care, with a health professional beginning in the first trimester, in line with NICE guidelines • has applied to the CMP by 35 weeks of pregnancy • has a singleton pregnancy • at the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks • is free from pre-existing medical or pregnancy complications (as stated in the exclusion criteria in Section 3.2 of the <i>Policy for Publicly Funded Home Births 2013</i>) • remains free from any condition affecting either mother or baby that develops during pregnancy or labour and increases the level of risk whereby home birthing is no longer considered to be a safe option according to the <i>ACM National Guidelines for Consultation and Referral 2013</i> and the <i>Policy for Publicly Funded Home Births 2013</i> • weighs ≤10kg prior to the onset of labour (refer to CMP clinical guideline 1.1.2 for guidance). • has not had a child with a significant neonatal history as 	<p>care on the CMP (based on the available information) the client will be allocated a midwife/midwives.</p> <ul style="list-style-type: none"> ▪ Information on the application forms is then updated by Admin, client labels are generated and "Assessment of Risk Factors" and "Screening and Referral for Family and Domestic Violence" forms are attached ▪ Late applicants (>16 weeks) are given directly to the CMM/CMC/CMS for immediate triage and allocation. ▪ Every effort will be made to allocate women to midwives who live within 40 minutes of their home address. Under no circumstances will a midwife be allocated a woman who lives more than one hour drive from her home. ▪ Allocations are based on midwife workload, geographical considerations and client requests. ▪ All successful applicants are emailed/mailed and informed of acceptance onto the program. ▪ Unsuccessful applicants as determined by the CMC/CMM/CMS are notified by mail and if required, are phoned by the CMC/CMM/CMS to discuss the reasoning behind this decision. ▪ A letter is then sent to the successful applicants GP. ▪ All paperwork pertaining to the newly allocated client is then photocopied, scanned and emailed to the relevant midwife and a hard copy is also put in the midwives box for collection. ▪ The client is then contacted by their midwife <i>within two weeks</i> and a convenient time for both client & midwife is arranged to carry out a booking interview in the clients' home. ▪ The midwife undertakes the booking interview and establishes suitability for home birth. ▪ The client may then be accepted onto the program or declined (see booking interview below). If declined, a letter is sent to the client and her GP outlining reasons for this. ▪ Should a client be declined a place on the program, she may
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<p>determined by a consultant obstetrician and/or paediatrician</p> <ul style="list-style-type: none"> • has a suitable home environment including but not limited to clean running water, good mobile phone coverage or working land line and electricity • has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted) • general home cleanliness with ability to provide hygienic sanitation 	<p>wish to discuss this decision with the CMP management team. She will be advised to contact the CMP - CMM or CMC and may be required to seek obstetric review as per <i>ACM National Guidelines for Consultation and Referral</i>. Pending the outcome of this referral, the decision to decline may be reversed.</p> <ul style="list-style-type: none"> • The client is added to the allocation sheet which is updated daily by CMP admin and is colour coded to reflect place of birth and level of risk. (i.e. 'MED' indicates these clients are not suitable for home birth and are a Medical Domino –see below)
<p>Geographical Boundaries</p> <p>Women must reside within the geographical boundaries set by the CMP and live no further than 30 minutes from a maternity service. This includes 50kms North, 50km South of the CBD and 40kms East. The north, south and eastern boundary is determined in the north by the Great Northern Highway and in the south by the South Western Highway.</p> <p>Terms of Care Document</p> <p>If all medical, obstetric and neonatal history is unremarkable at the booking visit, the client will be asked to read and sign the Terms of Care document.</p> <p>This document must also be signed again at 28 weeks gestation and 36 weeks gestation.</p> <p>A client who declines to sign the Terms of Care document either at booking, 28 or 36 week periods, will be excluded from entering onto the program or continuing with the CMP. In this latter scenario, case management requires extensive involvement of the CMC and CMM.</p> <p>It must be made clear to clients that in a circumstance where best practice recommends birth in hospital, the CMP midwife will support them in hospital and NOT attend them in their home environment during the intrapartum period.</p>	<p>Booking Interview (refer to CMP clinical guideline 1.1.1)</p> <p>The booking interview must occur at or before 35+0 weeks gestation with evidence of sufficient prior antenatal care appropriate to booking gestation - in line with NICE guidelines on schedule of antenatal care and CMP Guideline 1.1 Antepartum Schedule of Care. At 35 weeks for low risk women, the minimum number of antenatal visits for a nulliparous woman is 7 and a multiparous is 5.</p> <p>A thorough history must be taken at the booking interview and any pre existing medical, gynaecological, neonatal and obstetric disorders must be detailed.</p> <p>After identifying any variance from the norm, the midwife must refer to this <i>Inclusion Criteria Policy</i>, the <i>Policy for Publically Funded Homebirths 2013</i> and the <i>ACM National Midwifery Guidelines for Consultation and Referral 2013</i>, to determine if the client is appropriate for a home birth.</p> <p>If the level of risk is unclear the midwife must ensure early obstetric opinion is sought in order to gain clarification (see referral process below). The midwife must also advise her CMC or CMM</p> <p>The midwife must ensure contemporaneous record keeping is maintained of all discussions and/or consultations.</p> <p>The midwife must also deem the home to be a safe and secure working</p>

<p>Supporting maternity hospital (back up hospital)</p> <p>All Clients on the CMP must book with their local supporting maternity hospital in case medical support is required during their pregnancy, birth or post partum period. Clients who do not wish to book at a hospital will be declined placement on the CMP. See CMP Policy and Procedure Manual 2014 for referral processes to supporting maternity hospitals (back up hospital).</p> <p>Low risk Domino Births</p> <p>Low risk clients requesting to join the CMP and birth in hospital or a birth centre setting may do so at one of CMP's supporting hospitals. Clients will be accepted as per availability of places and geographical restrictions set by supporting hospitals. These clients must meet the criteria set out for home birth (as above) and must not have any risk factors that would deem them unsuitable for a home birth with the CMP. Should these clients change their mind in labour and request a home birth, they may do so.</p>	<p>environment (refer to OSH policy on 'Home and Community Working').</p> <p>Should the client be deemed unsuitable for a home birth with the CMP at booking due to identified risk factors she will be declined a place on the program. The midwife must clearly explain the reasons for non-acceptance to the client and the antenatal assessment documentation must be completed. A letter confirming non-acceptance is to be sent to the client and referral to appropriate health care providers must be initiated. The CMP - CMC or CMM must be notified.</p> <p><u>Policy for Publically Funded Homebirths 2013 and the ACM National Guidelines for Consultation and Referral 2013</u></p> <p>All midwives have access to the Policy for Publically Funded Homebirths 2013 and the National Guidelines for Consultation and Referral.</p> <p>As per the National Midwifery Guidelines there are three levels of consultation and referral:</p> <p>Category A: the midwife must discuss the situation with a colleague (midwifery manager, backup midwife, medical colleague or other health care provider) and document this discussion in the client's notes.</p> <p>Category B: the midwife must consult with a medical practitioner or other health care provider.</p> <p>Category C: the woman/ neonate must be referred to secondary or tertiary care.</p> <p><u>Referral Process</u></p> <p>At Booking</p> <p>If a client has any indications at the booking interview which require consultation or referral (either category B or C of the <i>National Midwifery Guidelines for Consultation and Referral</i>), the midwife must organise an early appointment with the obstetrician at the clients supporting maternity unit (within 2 - 4 weeks of the booking) to discuss a plan of care and address whether this client remains suitable for home birth.</p>
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<p>Consider if a breach of this Policy constitutes misconduct. <u>WA Health Misconduct and Discipline policy.</u></p>	<p>This appointment would be most effective if client, midwife and doctor were all present.</p> <p>Should the obstetrician concur that a home birth is appropriate, written confirmation of this recommendation is to be obtained.</p> <p>Should the obstetrician and/or a specialist physician deem home as an unsuitable place of birth based upon medical/obstetric/neonatal risk factors identified at booking, the women is withdrawn from the CMP. The woman's care will be appropriately transferred to that of the obstetrician/specialist unless written agreement is obtained to confirm that the client can remain on the CMP as a 'medical domino'. In this case the antenatal care will be shared between the CMP and supporting maternity unit obstetrician.</p> <p>The CMC/CMM/CMS must be informed of the above change in plan of care and alter the allocation list to reflect this.</p> <p>Throughout Pregnancy</p> <p>Referral throughout pregnancy is required should deviations from the norm develop.</p> <p>Clients planning to birth at home - who develop a condition/complication during their pregnancy whereby home birth is no longer considered to be a safe option may remain on the CMP as a 'medical domino' if approved by the obstetrician. For these clients the obstetrician becomes the primary carer and the midwife works in collaboration with the obstetrician and supporting maternity unit in planning and implementing care. The midwife will continue to provide support and/or care throughout the continuum of the pregnancy, birth and the post partum period.</p> <p>Alternatively the client may choose to withdraw from the CMP and seek alternative maternity care.</p>
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RESPONSIBILITY		REFERENCES (STANDARDS)
Policy Sponsor	Principal Nursing and Midwifery Director	<p>EQIP- 1.1, 1.2, 3.2.1</p> <p>Legislation-</p> <p>Standards- ANMC Code of Conduct for Midwives in Australia, ANMC Code of Ethics Midwives in Australia</p> <p>Related Policies- OD 0492/13 Women's and Newborns' Health Network, Policy for Publicly Funded Home Births including Guidance for Consumers, Health Professionals and Health Services, 2013</p> <p>ACMI, Consultation and referral guideline, 2013</p> <p>CMP electronic policies and guidelines</p> <p>WA Health Substantive Equality Policy</p> <p>CMP Midwifery Guidelines for Midwifery Care , Community Midwifery Program Guideline 1.1 Antenatal Schedule of Care, Community Midwifery Program</p> <p>CMP Midwifery Policy '6.1 Documentation'</p> <p>Policy and Procedure Manual 2012</p> <p>Other related documents-</p> <p>Community Midwifery Program Sentinel event and Clinical advisory Group Recommendations, 2010</p> <p>CMP client pamphlet "What are my options if I wish to have a home birth?"</p>
Initial Endorsement	Dec 2009	
Last Reviewed	Jan 2014	
Last Amended	Jan 2014	
Review Date	Jan 2017	

Document Version Control			
Date	Version	Author	Notes
Jan 2014	4	Dawn Hudd (CPC)	New template, general amendments to wording. Amendments made in relation to re-release of Policy for Publicly Home Births 2013. Additional inclusion criteria regarding parity also added.
Aug 2012	3	Dawn Hudd (CPC)	Amendments made
July 2010	2 (V2.1)	Corrie Andrew, Tarryn Sharp	Amendments made
Dec 2009	1	Corrie Andrew	New policy

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Terms of Care 1



Government of Western Australia
 Department of Health
 North Metropolitan Health Service
 Public Health and Ambulatory Care

SURNAME	UMRN	SEX
FORENAMES	BIRTHDATE	
PATIENT'S ADDRESS		

Agreement regarding the provision of community based midwifery care (Booking Visit)

The Community Midwifery Program (CMP) will provide comprehensive midwifery services to me as a low risk pregnant woman, throughout the continuum of my pregnancy, childbirth and postnatal period.

I have agreed to participate in the program and have been made aware of the risks associated with having a home birth and the potential to be transferred from the CMP to hospital based obstetric services either during my pregnancy, labour/birth or during the postnatal period should complications arise.

The level of risk is determined in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2013), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2013.

For example home birthing is not available to women who:

- live outside the CMP geographical boundary and/or further than 30 minutes from a maternity service
- have a significant pre-existing medical and/or obstetric history which would result in home birth being an unsafe option as referred to in the Policy for Publicly Funded Homebirths 2012
- have a baby in the breech position at term
- are pregnant with twins
- have had a child with a significant neonatal history
- have any condition affecting either mother or baby that develops during pregnancy and increases the level of risk such that home birthing is no longer considered to be a safe option according to the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2013), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2013.

DECLARATION

- I acknowledge that in the interests of my own and my baby's wellbeing, my midwife will consult with my doctor or the medical staff at my supporting maternity hospital, should the need arise.
- I acknowledge that I must undertake the CMP's minimum standard of tests, which include an anatomy scan at 20 weeks gestation and a Full Blood Picture/Blood Group blood test between 28-34 weeks gestation.
- If the level of risk, as determined by the midwife in accordance with the CMP guidelines, policies and protocols, the ACM National Midwifery Guidelines for Consultation and Referral (2013) and the Policy for Publicly Funded Homebirths 2013, is such that either my own or my baby's wellbeing is compromised, I agree to being referred for and attending a medical consultation.
- I am aware that should I choose to decline the medical advice given at this consultation then I may be required to birth in hospital as a condition of remaining on the CMP, or withdraw from the CMP depending upon the circumstances.
- I acknowledge that my maternity care will be transferred to my nominated doctor or hospital if the level of risk is determined as unsafe for a home birth.
- I have read and understood the CMP "What are my options if I wish to have a home birth?" pamphlet and have had the opportunity to discuss its contents with my doctor or midwife and understand the risks as they have been explained to me.

Full name: _____

Signed: _____ Booking visit date _____

Witness name: _____

Signed: _____ Date _____

January 2014

This is a duplicate for tear out to be placed in medical records



Government of Western Australia
Department of Health
North Metropolitan Area Health Service
Public Health and Ambulatory Care

Terms of Care 2

Agreement regarding the provision of community based midwifery care (28 weeks)

The Community Midwifery Program (CMP) will provide comprehensive midwifery services to me as a low risk pregnant woman, throughout the continuum of my pregnancy, childbirth and postnatal period.

I have agreed to participate in the program and have been made aware of the risks associated with having a home birth and the potential to be transferred from the CMP to hospital based obstetric services either during my pregnancy, labour/birth or during the postnatal period should complications arise.

The level of risk is determined in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2008), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2012.

For example home birthing is not available to women who:

- live outside the CMP geographical boundary and/or further than 30 minutes from a maternity service
- have a significant pre-existing medical and/or obstetric history which would result in home birth being an unsafe option as referred to in the Policy for Publicly Funded Homebirths 2012
- have a baby in the breech position at term
- are pregnant with twins
- have had a child with a significant neonatal history
- have any condition affecting either mother or baby that develops during pregnancy and increases the level of risk such that home birthing is no longer considered to be a safe option according to the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2008), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2012.

DECLARATION

- I acknowledge that in the interests of my own and my baby's wellbeing, my midwife will consult with my doctor or the medical staff at my supporting maternity hospital, should the need arise.
- If the level of risk, as determined by the midwife in accordance with the CMP guidelines, policies and protocols, the ACM National Midwifery Guidelines for Consultation and Referral (2008) and the Policy for Publicly Funded Homebirths 2012, is such that either my own or my baby's wellbeing is compromised, I agree to being referred for and attending a medical consultation.
- I am aware that should I choose to decline the medical advice given at this consultation then I may be required to birth in hospital as a condition of remaining on the CMP, or withdraw from the CMP depending upon the circumstances.
- I acknowledge that my maternity care will be transferred to my nominated doctor or hospital if the level of risk is determined as unsafe for a home birth.
- I have read and understood the CMP "What are my options if I wish to have a home birth?" pamphlet and have had the opportunity to discuss its contents with my doctor or midwife and understand the risks as they have been explained to me.
- I confirm that I continue to meet the CMP Policy "Inclusion criteria for the Community Midwifery Program" and that there has been no change to my pregnancy birth plan.

Full name: _____

Signed: _____ Booking visit date _____

Witness name: _____

Signed: _____ Date _____

Terms of Care 3



Government of Western Australia
Department of Health
North Metropolitan Area Health Service
Public Health and Ambulatory Care

Agreement regarding the provision of community based midwifery care (36 Weeks)

The Community Midwifery Program (CMP) will provide comprehensive midwifery services to me as a low risk pregnant woman, throughout the continuum of my pregnancy, childbirth and postnatal period.

I have agreed to participate in the program and have been made aware of the risks associated with having a home birth and the potential to be transferred from the CMP to hospital based obstetric services either during my pregnancy, labour/birth or during the postnatal period should complications arise.

The level of risk is determined in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2008), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2012.

For example home birthing is not available to women who:

- live outside the CMP geographical boundary and/or further than 30 minutes from a maternity service
- have a significant pre-existing medical and/or obstetric history which would result in home birth being an unsafe option as referred to in the Policy for Publicly Funded Homebirths 2012
- have a baby in the breech position at term
- are pregnant with twins
- have had a child with a significant neonatal history
- have any condition affecting either mother or baby that develops during pregnancy and increases the level of risk such that home birthing is no longer considered to be a safe option according to the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2008), the Community Midwifery Program protocol on "Inclusion criteria for the Community Midwifery Program" and the Policy for Publicly Funded Homebirths 2012.

DECLARATION

- I acknowledge that in the interests of my own and my baby's wellbeing, my midwife will consult with my doctor or the medical staff at my supporting maternity hospital, should the need arise.
- If the level of risk, as determined by the midwife in accordance with the CMP guidelines, policies and protocols, the ACM National Midwifery Guidelines for Consultation and Referral (2008) and the Policy for Publicly Funded Homebirths 2012, is such that either my own or my baby's wellbeing is compromised, I agree to being referred for and attending a medical consultation.
- I am aware that should I choose to decline the medical advice given at this consultation then I may be required to birth in hospital as a condition of remaining on the CMP, or withdraw from the CMP depending upon the circumstances.
- I acknowledge that my maternity care will be transferred to my nominated doctor or hospital if the level of risk is determined as unsafe for a home birth.
- I have read and understood the CMP "What are my options if I wish to have a home birth?" pamphlet and have had the opportunity to discuss its contents with my doctor or midwife and understand the risks as they have been explained to me.
- I confirm that I continue to meet the CMP Policy "Inclusion criteria for the Community Midwifery Program" and that there has been no change to my pregnancy birth plan.

Full name: _____

Signed: _____ Booking visit date _____

Witness name: _____

Signed: _____ Date _____