Perceptions, constraints and labour relations:

Health delivery services to birthing women in rural and remote areas of North Queensland

Thesis submitted by

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Abstract

Although childbirth is a defining life event for most women, those in rural and remote areas of Queensland often lack choice and control over this significant experience. Childbirth is embedded in a myriad of complex and competing social, political and cultural discourses which affect both maternity practices and the quality of a woman's birthing experience. As the result of current health policies, centralised maternity facilities and the difficulty in recruiting suitable health professionals for rural practice, birth normally takes place in a large regional centre, under obstetric supervision. Relocation for birth separates women from family and support networks. Medical intervention in the birth process is common and cultural needs are difficult to accommodate. Despite the numerous Australian reviews of birthing, gaps in the literature indicate that there is a need for qualitative, sociological research that evaluates women's satisfaction with maternity care in rural and remote areas.

Thus, the purpose of this study was to explore the experiences and perceptions of childbearing women and maternity care providers in four selected rural and remote areas of North Queensland. The aim was to document these women's birthing choices and expectations as well as their assessments of the experience and the services provided. Their views are compared with those of the maternity care providers.

Recognising that the quality of women's birthing experiences is influenced by complex interpersonal, structural and ideological issues, this study synthesises postmodern insights with the political and moral imperatives of feminist emancipatory research. The theoretical approach reflects the cultural turn in sociology by being grounded in material reality while recognising the interplay between discursive social constructions and the complex specificity of real lives.

Contemporary feminist ethnography provided appropriate interpretive research techniques for this exploration of the sensitive topics of birth and the associated relationships between women and maternity care providers. Insights were gained through field notes, community profiles, participant observation and in-depth interviews with 48 participants, enabling identification of patterns of experiences and interpersonal dynamics.

The findings provide insights into the multiple macro and micro level influences on birthing experiences. Interwoven throughout the accounts are discourses around choice, risk and trust. Although participants' views on birthing covered a spectrum, the major themes which emerged were related to birthing options, quality of care, social and emotional support needs, socio-cultural background, and previous experiences. As well, as insights into effective models of maternity care for rural and remote settings

were identified. There was a tendency toward high satisfaction among women who birthed locally in the high support, low technology rural/remote setting. This was also reflected in many of the maternity care providers' accounts. Interactions between birthing women and maternity care providers and amongst the health professionals impacted significantly upon the quality of care and subsequent satisfaction across the birth experience. Of concern in the findings were the endemic interpersonal conflicts within families and workplaces, which can be related to gender relations and the culture of violence in wider social structures. This, along with the need to recruit and retain health professionals sensitive to the diverse needs of childbearing women and competent in advising and supporting them, was identified as a major challenge for the maternity services.

This study identifies factors which enable or constrain the effective delivery of rural/remote maternity services and the subsequent satisfaction of childbearing women with giving birth. It makes several unique contributions. First, it identifies the impact that interpersonal interactions have upon the satisfaction of birthing women, and the retention of rural/remote health professionals. Second, developing relational genograms creates a dynamic model of social organisation that has predictive possibilities, enabling identification of problems and intervention. Third, the evident success of a rural model of maternity care provides sound support for advocates of rural birthing. Fourth, it proposes practical ways to address the identified insider-outsider phenomenon and to enhance trusting, concordant relations. Finally, the qualitative data has provided detailed understandings of the strengths and limitations of maternity services not evident in official reports.

Contents

List of Tables and Figures

Abbreviations and Acronyms	
ABS	Australian Bureau of Statistics
ABSP	Alternative Birthing Services Program
ACMI	Australian College of Midwives Incorporated
ACRRM	Australian College of Rural and Remote Medicine
AHMAC	Australian Health Ministers' Advisory Council
AHWAC	Australian Health Workforce Advisory Committee
AHWOC	Australian Health Workforce Officials' Committee
AIHW	Australian Institute of Health and Welfare
ALSWH	Australian Longitudinal Study on Women's Health
AMA	Australian Medical Association
AMAP	Australian Midwifery Action Project
AMWAC	Australian Medical Workforce Advisory Committee
ARM	Artificial rupture of the membranes (to induce or hasten labour)
CALD	Culturally and linguistically diverse background (replacing NESB)
CN	Clinical nurse. A level 2 position in Queensland Health
C/ section	Caesarean section
CRANA	Council of Remote Area Nurses of Australian Inc.
CTG	Cardiotocograph
DEST	Commonwealth Department of Education, Science and Training
DEWR	Commonwealth Department of Employment and Workplace Relations
DoHA	Australian Government Department of Health and Aging
DoN	Director of Nursing
DVI	Domestic iolence Initiative, Queensland
EIP	Evaluation and Investigations Program
EN	Enrolled nurse
GP	General practitioner
MCH	Maternal, Child and Adolescent Health nurse
MSIPP	Medical superintendent in private practice
NICU	Neonatal intensive care unit
NMAP	National Maternity Action Plan
NPSU	National Perinatal Statistics Unit
NRHA	National Rural Health Alliance
NRWC	National Rural Women's Coalition
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PADV	Partnerships Against Domestic Violence
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RDAA	Rural Doctors Association of Australia
RM	Registered Midwife (endorsed in Queensland)
RN	Registered Nurse
RRMA	Rural, remote, metropolitan areas classification
SCARC	Senate Community Affairs References Committee
SVD	Spontaneous vaginal delivery
WHA	Women's Hospitals Australasia

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Chapter 1

Introduction: Why study the childbirth experiences of women in rural and remote areas?

1.1 Introduction to the study: question and aims and purpose

Birthing is a defining life event that is unique for every woman. How a childbearing woman perceives this profound transition in her life is closely related to both the social context in which she lives and her social relationships[1], including those with maternity care providers. While women can relate dramatic and emotional accounts of each birth experience, these reflexive narratives are seldom recorded and analysed. Official documents and medical sources only provide half the story. Through this project I sought to redress the scarcity of rural and remote birthing women's voices and to develop an understanding of the immediate relations and broader issues that shaped their passage[2] through this life phase. As the experience of pregnancy, labour and birth are shared with maternity care providers, the inclusion of their accounts provided an analytical counterpoint.

The narratives of women's (lived) experience of childbirth and those of maternity care providers are situated within the context of a complex network of converging social, political and cultural factors. Grounded in an exploration of the social relations surrounding childbirth in rural and remote Queensland, this thesis extends the boundaries of current sociological analyses of birthing. Through critically examining the social issues surrounding contemporary childbirth, together with findings from this ethnographic study, insights can be gained which will fulfil my feminist political imperative by identifying spaces for resistance and potentially enabling maternity care providers to offer a more responsive service.

It has been widely argued that the social context in which women give birth reveals a society's core cultural and political values (Zadoroznyj, 1999; Hirst, 2005; Kent, 2000; Fox & Worts, 1999; Reiger, 2001a, 2003, 2004; Davis-Floyd, 1994a, b; Papps & Olssen, 1997). According to current neo-liberal rhetoric, an individual childbearing woman should be able to select autonomously and rationally an optimal experience from a range of options. Contiguous with this assumption of available

[1] Here I draw upon Weber's (1949, p. 118) concept of a social relationship which includes "the behaviour of a plurality of actors" which may be mutual or asymmetrical depending upon the context, level, duration, and expectations of each party and the type of social (inter)actions which occur.

[2] Giddens perceives the life course as a "series of passages" though which an individual passes. These transitional phases are not institutionalised or accompanied by formalised rites (Giddens 1991, p. 78).

birthing choices are issues of risk and trust. Whilst endorsing the principle of informed choice, I argue that the neo-liberal ideal of a 'choice biography' is inherently problematic for birthing women, especially those living in rural and remote areas of Australia. Although I acknowledge the inspirational accounts of women whose empowerment is derived from a choice to 'own' their birth experience and who make active decisions about maternity care that enable the best possible event (Vernon, 2006), I also recognise the extrinsic influences which potentially constrain such satisfying outcomes. Women's expectations, preferences and subsequent experiences are profoundly shaped by factors beyond their control, including power relations, temporal and structural constraints, health policies, available models of care, diminishing services, and clinical practices. These not only influence decision-making but limit options. In addition, birth occupies a contested terrain characterised in part by conflict amongst maternity care providers and childbearing women. This too can have an unpredictable impact on specific birth experiences.

Childbirth is an experience which extends beyond the actual intrapartum act of giving birth to encompass the period from conception through pregnancy and into the postnatal period wherein women make the transition to motherhood. Satisfaction with this experience is difficult to define and measure in a meaningful way (Jacoby & Cartwright, 1990). Medical literature judges the quality of maternity care by perinatal mortality and morbidity rates, with some sources suggesting that a mother's foremost concern is safety and a healthy baby (RANZCOG, 2005; RCOG, 2001). As Michael Fine (2005) observes, evaluations of care tend be concerned with outcomes rather than inputs. This outcome focus can be contrasted to women-centred accounts which assess the quality of a birth experience in terms of social relationships and social contexts (Garcia, Kilpatrick & Richards, 1990; Oakley, 1993a, b, c; Brown, Lumley, Small & Astbury, 1994; Fox & Worts, 1999; Brown & Lumley, 1998; Bruinsma & Brown, 2001; Kildea & Leap, 2003; Brown, Davey & Bruinsma, 2005).

The place of birth has been shown to have important implications for the type of birth experience, the model of care, its outcomes and women's subsequent satisfaction (AIHW, 2005; Laws & Sullivan, 2004; Fourer & Hunter, 2006). The social support networks available to women throughout childbirth are also highly significant to perceptions and outcomes. Lack of support is shown to have adverse physical and psychological outcomes on both women and their children (Elsenbruch, Benson, Rücke, et al., 2007; Lumley, Watson, Small, et al., 2006; Senate Community Affairs References Committee [SCARC], 1999; Oakley, Hickey, Rajan & Rigby, 1996; Brown, Lumley, Small & Astbury, 1994; Oakley, 1993). Thus, some women are willing to take physical risks to ensure that their social and emotional needs are met (Roberts, Tracy

& Peat, 2000; Chamberlain & Barclay, 2000; Tracy, 2005a; Fox & Worts, 1999). For women residing in small rural and remote areas of Queensland, birth normally takes place in a regional or metropolitan hospital, under obstetric surveillance. To ensure the physical safety of the woman and foetus, relocation is required several weeks before birth thereby separating the expectant mother from the support of family and friends during this period (Croker 1994, 1995, 1996, 2002b). Of concern is the well-documented knowledge that relocation for birthing contributes to a higher incidence of obstetric interventions and perinatal morbidity (AIHW, 2005; Hirst 2005; Laws & Sullivan, 2004; Tracy, 2003; 2005a; Wagner, 2002; NPSU, 2001; Queensland Health, 2000).

Little is known at this time about how childbearing women and maternity care providers in rural and remote areas of North Queensland perceive birthing experiences. Although assumptions are commonly made about what women desire and expect from childbirth, and about the consequences of unmet expectations (Green, Coupland & Kitzinger, 1990), most information is derived from anecdotal accounts (Campion 2005b, c; NRWC, 2004). These are largely dominated by the voices of medical professionals rather than those of rural or remote childbearing women (RDAA, 2003; 2005c, 2005e; Kenny, 2004; ACRRM, 2004). Women's expectations of health services, preferred ways in which they negotiate birth, satisfaction with maternity care and perceived constraints on a 'good' birth experience need to be further identified and documented (Kildea, 2001; 2003; Fitzpatrick, 1995). Qualitative studies that explore these women's perceptions and representations of childbirth are lacking. Research into rural health and perinatal outcomes is dominated by quantitative, reductionist approaches which result in a lack of appreciation of the relational aspects of health interactions that are extraneous to the biomedical model (Bogossian, 1994; Oakley, 1980). Risk/technocratic discourses prevail (Leap & Kildea, 2003; Zadoroznyj, 2001; Lupton, 1999). While quantitative clinical and epidemiological sources provide calculable norms that are valuable for informing health policy, evidence-based practice and risk management strategies, they cannot reveal the complexity of the social context or provide knowledge about the experiential phenomenon of rural and remote birthing. This raises the question addressed in this thesis.

1.1.1 Question and aims

What can be learnt from the perceptions of rural and remote childbearing women and maternity care providers that will contribute to improving the quality of birthing experiences?

Given this question, my general aim is to explore the perceptions and experiences of childbearing women and maternity care providers in four rural and remote areas of North Queensland. The study has four specific aims:

1. to explore rural and remote women's birthing choices, expectations and satisfaction with their experience;
2. to examine women's perceptions of factors which enabled or constrained their satisfactory birth experience;
3. to identify and document perceived strengths and limitations in existing services;
4. to compare and contrast the views of birthing women with those of rural and remote maternity care providers.

The feminist ethnographic approach taken in this study is most appropriate for eliciting the intensely personal information related to the sensitive topics of birth and relationships between and amongst rural and remote maternity care providers and birthing women.

Behind the question and these aims is the story of the way in which this study evolved. An account of the development of this study and my position in relation to the research project follows in Section 1.2. Then, to situate the study, rurality and remoteness are defined and classified (1.3). In sections 1.4 and 1.5, the key themes of choice, risk and trust are conceptualised. In the final sections, 1.6 summarises this chapter and 1.7 provides a guide to navigating the thesis.

1.2 Personal voyage: Positioning myself as a researcher

Within social research there is a growing awareness of how the researcher's self is interwoven into the research encounter and research process. While Norman Denzin, for example, argues that the research process "must become political, personal and experiential" (1998, p. 315), this trend is most apparent in feminist writings where there is an emphasis on the lived experience of the researcher and the personal pronoun (Kleinmann & Copp, 1993; Seibold, 2001; Oakley, 1981; Reinharz, 1992; Smith, 1988; Ardovini-Brooker, 2001). Like Jane Haggis (1990), I have found that a brief account of my journey makes clear the concatenation between my lived experiences as a woman, mother, educator and nurse/midwife, together with my sociological development - a period where my theoretical perspectives became visible to me. These experiences inform my current thinking. Haggis points out that such "conjunctures, and the self-conscious awareness of their determining impact on the conduct of research, is a principal characteristic of feminist research" (1990, p. 68).

As a nurse/midwife and sociologist, I have been inculcated with the humanistic goals of the 'Enlightenment project'. These include a belief in human rights, integrity, equity, autonomy and social justice. My socialisation and life experiences in developing countries, along with work in rural and remote areas of Australia, have resulted in a strong commitment to social justice. Within the academy, my values accorded with feminist philosophy so that the feminist approach I adopt is the primary lens through which I interpret the world (Croker, 1994b). Consequently, I desire to redress inequities in life chances and gendered health outcomes, in particular through advocating for women's health rights (Croker, 2000; 2004a; Croker, O'Connor, Usher, Harvey, Wilson & Sellen, 2002).

In my work, the personal became political (Jaggar, 1983). The global value of collective feminist action towards social justice was reinforced for me when I participated in the 4th United Nations Conference and NGO Forum on Women in Beijing (1995). As such, feminisms provided an oppositional discourse to the global dominance of patriarchal exploitation and oppression. However, while valuing the united voice possible with politically active forms of feminism, which facilitated collective efforts to promote change in oppressive regimes and institutions, feminist scholars such as Dorothy Smith (1979, 1998, 1991), Caroline Ramazanoğlu (1989, 1993) and Iris Young (1995) alerted me to the limitations of feminisms within modernity and the tensions with postmodernism.

Although I was already influenced by Marxism and politicised by Gramsci's notions of hegemony and counter-hegemonic resistance, I also developed a growing appreciation of the important insights provided by postmodernist and poststructuralist feminists (Gore, 1992; Luke & Gore, 1992b, c; Lather 1990, 1992; McNay 1992, 1994; 2003; Sawicki, 1991, 1994; Grosz, 1994; Lupton 1994, 1996, 1999a; Bartky, 1990; Tapper, 1993). This opened a whole new world of explanations and awakened an understanding of my position within various discourses[3] (Croker, 1994). Through these feminist readings of the 'masters' of philosophy, such as Foucault and Nietzsche, I found an exhilarating reappraisal of the taken-for-granted constructs I had embraced from modernity. Nietzschean notions of "nay saying" and "yeah saying" offered a positive affirmation rather than the negative moralism of some forms of feminism (Tapper, 1993). Foucauldian concepts of the capillaries of power, its nexus with knowledge and implementation through regulatory mechanisms, advanced my understanding of the ways in which male power is legitimised and naturalised. I gained insights from postmodern and poststructural feminist critiques of the social construction

[3] For me, this was an epiphany.

of gender, the influence of various discourses on, for example, the body, biomedical science and motherhood. Deconstructing such discourses allowed for a re-evaluation of their aspirations and authority. However, I have retained my activism and preparedness to move beyond the text to include material and spiritual considerations within the frame of research on women's lives (Croker, 1997, 1999; 2001; 2004b). In my methodology (Chapter 5), I address the philosophical tension arising within this project when melding feminist emancipatory goals and postmodern explanations.

As a midwife, I adopted the philosophical mantle of 'guardian of normal birth' and supported the movement away from the medicalisation, surveillance and control of childbearing women's 'docile' bodies towards reclaiming a woman-centred approach to birth. However, as a reflective practitioner and activist, I was confounded by the way women's birthing experiences and ability to make choices were influenced by their socio-demographic background and structural constraints. Some women positioned themselves as reflexive and assertive consumers[4] while others seemed resigned to being passive patients. This raised questions about the nature of patriarchal institutions, hegemonic masculinity and the influence of medical hegemony on childbirth.

Before beginning this project, I worked as a midwife in both a small remote Aboriginal community and a tertiary referral hospital in a regional centre. During that time, I became aware of the social, emotional, economic and cultural problems women from rural and remote areas experienced when 'sent to town' to have their babies. Disadvantage was compounded for women with young children and those upon whose labour contribution the family relied. The antenatal waiting period was boring, expensive and lonely if family and friends were not able to accompany the expectant mother. Also, a lack of social and emotional support in labour is known to affect the birthing process, potentially leading to a cascade of obstetric interventions and postnatal consequences (Tracy, 2003; Wagner, 2002; Norbury, 1996; Odent, 1984; Haire, 1974). Once under the obstetric 'gaze', these women were subject to the surveillance, regulation and prudential management that accompany risk discourses (Rose, 2006; Lupton, 1999b). The medical imperative overrode other concerns. Some women showed resistance, either by absconding from hospital or not seeking medical attention until in well-established labour, thus preventing evacuation to, or delivery in, a regional hospital. These 'non-compliant' behaviours were considered irresponsibly risky and young and/or Aboriginal women were sometimes patronisingly treated as

[4] In Chapter 3, I differentiate between the terms patient, client, consumer and service user when discussing maternity services.

naughty girls (Litherland, 1994). However, anecdotal accounts suggested that their reasons for valuing psychological and social well-being over physical safety were neither frivolous nor irrational.

By contrast with the rural/remote women who attempted to resist obstetric surveillance and relocation, there were those who welcomed and requested medicalised births within the 'safety' of a hi-tech setting. These were usually 'white', privately insured patients receiving care from a consultant obstetrician. Regardless of the potentially adverse outcomes of cascading interventions, they would request either induction of labour or an operative delivery so that they could control the time and place of birth, plan care for their children, arrange for a support person and return home sooner.

Through such encounters in my midwifery practice, inchoate questions arose about what constituted a 'good' birth for women in rural and remote areas. What did rural/remote women want? I wished to explore their expectations, choices and constraints; their resistance and compliance with policies; and whether they were satisfied with existing maternity services. Further, I wondered how rural/remote birthing women's perceptions compared with those of their maternity care providers.

Many years of fieldwork in Northern and Western Queensland, including a women's health project in remote Mt Isa and participating in rural women's online discussion groups, have helped shape the research question and my current understanding.

Reflexivity and ongoing engagement with literature have been iterative components of this research process. Reflections on my experiences inform my perspective and are incorporated within the frame of this thesis. They also inform my practice. Through interviewing childbearing women and health professionals for this study, I came to appreciate their heterogeneity and realised that, if I truly believed in choice and enabling women to have an optimum experience, then I should not impose my birthing philosophy upon them. Now when I ask "What *do* rural women want?" the findings of this study inform my response. Although every woman and every birth is different, the findings of this thesis will show that the interrelated issues of choice and trust are core concerns.

1.3 Conceptualising rurality and remoteness

Conceptualising rurality and remoteness is not an inconsequential matter as it has a considerable impact upon policy and service planning decisions as well as subsequent eligibility for, and access to, resources and services. The Australian Bureau of Statistics (ABS) advises that it is "vitally important that anyone developing

policies, funding formulae or intervention strategies understands the alignment, or lack of alignment" between classifications of rurality and remoteness and their local objectives (AIHW 2004e, pp. 20-21). However, there is little consensus within the Australian literature on the definitions and delimitations of 'rural' and 'remote' (Humphreys, 1998; Jones, 1998; Smith, 2004; AIHW, 2004e; DoHA, 2005). This is partly due to the heterogeneity of rural Australia and to the differing uses of such definitions by organisations representing diverse interests such as health, education and farming or mining industries, which create challenges for rural health researchers (MacLeod, Browne & Leipert, 1998; Wainer, Bryant & Strasser, 2001; Wainer, Strasser & Bryant, 2005).

Awareness of how definitions differentiate between 'urban', 'regional', 'rural' and 'remote' is significant when viewing official statistics based on particular criteria and areas. Two conceptualisations predominate - descriptive and socio-cultural. The first concept focuses on geographic location and how the degree of distance restricts access to resources, delivery of goods and services. Diminished population size also limits possibilities for the social interaction available in urban centres. Disadvantage is shown to increase with the degree of remoteness and isolation from the convenience of urban amenities.

The second conceptualisation considers how socio-cultural factors such as socio-economic status, ethnicity, indigenousness, lifestyle, and the attitudinal and perceptual characteristics of a population influence its access to appropriate, affordable services (Jones, 1998; Smith, 2004; Institute for Regional and Rural Research, 2004) Regarding health services, the AIHW (2004e) adds that, although the social demographics and physical environment influence a town's ability to attract and retain health professionals, these characteristics are also overlooked in the geographic classifications.

Three classification systems for measuring the degree of rurality and remoteness in Australia currently predominate. In order of recency, these are the Rural, Remote and Metropolitan Area (RRMA) classification, the Accessibility/Remoteness Index of Australia (ARIA and ARIA+[5]) and the Australian Standard Geographic Classification (ASGC) Remoteness Area Structure (RAS). The strengths and limitations of each are compared and contrasted by the AIHW (2004), DoHA (2005) and RACGP (2005) and summarised in Appendix 1. In addition, Queensland Health has designated

[5] Aria+ adds a greater level of precision to measuring small remote centres. By comparison with the ARIA index values, its instability enables changing and actual levels of remoteness to be reflected; however it has the same limitations as outlined in Appendix 1 (AIHW 2004e, pp. 16-17).

zones which have been re-defined during this project. Of significance to this study is the way in which differing classification and zonal systems influence official data, in particular reports from the AIHW, ABS and DoHA, thus making comparisons problematic. This is evident in the following categorisations of the four towns and surrounding districts included in this study (and further described in Chapter 4). According to RRMA they are designated as (4) *Other rural* and (7) *Other remote.* With ARIA, one study site would be considered *moderately accessible*, one as *remote* and two categorised as *very remote*. The inability of the ASGC RAS to represent small local contexts is evident in the classification of these study sites as *outer regional*, *remote* and *very remote*. Variances across the classifications are found with key factors such as geographic distance, responsiveness to changes in population density, economic base, land usage, natural resources and the inclusion or exclusion of socio-cultural considerations, workforce supply, available health providers and health outcomes.

Both the AIHW and ABS caution that the gross population groupings used by all three classification systems, such as into statistical local areas (SLAs) and postcodes, cannot accurately reveal changing levels of disadvantage, inequities and specific areas of need. Therefore, these geographic systems are of limited practical use when researching accessibility of health professionals and maternity services at a local level. Furthermore, qualitative distances are also important when considering remoteness and isolation, for example, whether or not distance from a service centre is measured by road and in relation to car ownership, available public transport and seasonal road conditions[6] (AIHW, 2004e). Along with road conditions, these are major considerations affecting accessibility in rural and remote areas of North Queensland, especially during the 'wet' season.

Most documents reviewed during this study, with two notable exceptions, used the RRMA and ARIA systems despite their limitations. First, when defining 'rural', Hirst's (2005) review of Queensland's maternity services excludes the highly-populated south east corner, along with the six regional coastal centres. Second, when designing this study, Queensland Health's zoning system designated two of the centres classified as 'Other Remote' (7) by the RRMA as 'Rural', thus reducing their eligibility for certain incentives, services and resources.

As I am investigating health services at a local level, I have also designated two sites as small rural (Sugar Town and Mining Town) and two as remote (Pastoral Town

[6] The RRMA does not measure proximity to service centres by road. ARIA does but fails to consider transport and road conditions.

and Stockton) to be consistent with the initial Queensland zonal categories and available health services. However, cognisant of the complexity of these local areas, I have incorporated the social, cultural and environmental factors which, in dynamic ways, affect their levels of disadvantage. Furthermore, feedback from residents in these study sites has made it clear to me that a social definition is also important. 'Locals' did not consider themselves to be remote or 'in the bush'[7], while transient residents, notably newcomers from urban centres, feel isolated even in major rural areas. Recognising this social perspective, Jan Jones defines rural people as those who are born and /or brought up in a rural area, who perceive themselves to be rural and are recognised as such by members of the community to be rural (1998, p. 30). However, this restrictive delimitation excludes the transient 'blow-ins' who also experience the health disadvantages of rurality and remoteness.

For the purpose of this thesis, the comparative terms 'rural' and 'remote' are used when a contrast in degree of remoteness is intended, while the nexus 'rural/remote' is used when inclusively referring to both remote and rural areas of Australia having the characteristics of distance from a regional centre, reduced accessibility, limited infrastructure and services, relative isolation, and a small, largely dispersed population. As will be shown in Chapter 4, this study does not focus on advancing the conceptualisation of rurality and remoteness, but rather includes both rural and remote maternity contexts to demonstrate the diversity of experiences.

1.3.1 Rurality and remoteness as a women's health issue

In designating these project sites rural and/or remote I am combining both geographic and sociological notions. My construction of rurality and remoteness premises that, as distance from a metropolitan centre increases, women's health and well-being potentially worsen and life chances become more limited, for a range of reasons. When compared with urban areas, these disadvantages include higher fertility rates and more teenage pregnancies, accompanied by lower educational levels, poorer socio-economic status, fewer employment opportunities, and a less healthy lifestyle (Lumby, 2000; Queensland Health, 2000; AIHW, 2004a, b; Smith, 2004; NRHA, 2005) in a harsher, male-dominated environment where gender discrimination and violence are more prevalent (Poiner, 1990; Dempsey, 1992; Alston, 1997; Jones,

[7] This necessitated a change in project title from "Birth in the bush" as it did not reflect local, temporal perceptions. Remote area 'locals' did not consider themselves to be in the 'bush' or 'outback'. They applied these terms to extremely remote and isolated areas, such as NT pastoral properties and Aboriginal communities.

1998; WESNET, 2000). Access to affordable, acceptable, effective and appropriate services is limited by geographic distance, social isolation and the diminishing provision of rural women's health services. Continued closures of small maternity units restrict rural/remote women's choices of health provider, prevent continuity of care and inaccurately reflect their preferences about where to give birth. As well, women's attitudes to existing services, their perceptions of health and well-being, and concerns about confidentiality in small communities, all contribute to the disadvantage they may experience in small rural and remote communities (Bryson & Warner-Smith, 1998; George & Davis, 1998; Croker et al., 2002; NRWC, 2004; McMurray, 2006; Webster, 2006). The National Rural Health Alliance (NRHA, 1999; 2005) has identified a need for culturally and gender appropriate women's health services, including improved access to female practitioners. This is further supported by the Croker et al. (2002) study of women's health in remote Queensland which also identifies the importance of providing adequate, appropriate information for a heterogenous community along with the need for continuity of care from appropriately qualified (female) health professionals. What is clear is that rural/remote women would like a choice (Campbell, MacFarlane & Cavenagh, 1991; Tracy, 2005a, 2006), and at this time the trend towards limiting birth options is continuing (Hirst, 2005; Henderson, 2003).

Delimiting participants in the study

It is often assumed that, when researching rural and remote health in North Queensland, the focus will be on Aboriginal health issues. As described in Chapter 4, participants in this project were volunteers who came from a cross-section of the community and, as such, a minority of Aboriginal women is represented amongst both the 21 maternity care providers and 27 childbearing women. These women have not been positioned as 'other' to the ethnically diverse mainstream community found in the four research sites.[8]

1.4 Conceptualising choice, risk and trust

Choices which are made within a health context are not simply individual preferences but are informed by "wider social values and in the context of material factors of the situation" in which maternity carers and birthing women live and work

[8] Lenore Geia, an Aboriginal midwife, is specifically focussing on childbearing indigenous women in North Queensland with her PhD study, currently in progress.

(Hugman, 2005, p. 39). The backdrop is the "existential terrain" of late modernity[9] in which global trends are actualised in the localised events of everyday life (Giddens 1991, p. 80; 2002). Thus, these social values are not only expressed as health policies and practices but also as individual life plans and consumer expectations. General issues of 'ontological security[10]' (Giddens, 1991; 2002), confidence in abstract systems and interpersonal trust facilitate or hinder the social relations through which perceptions of available choices and attendant risks are formed. When applied to the social relations that are the focus of this study, it is evident that maternity care providers have a professional responsibility to be reflexive when exercising the social power and authority which potentially affect the perceptions and experiences of the women who draw upon their knowledge and skills.

The term 'choice' is commonly associated with a neo-liberal ideal of individual autonomy and the client/consumers' rights to make informed decisions that enhance their lives. Issues regarding an individual's freedom and ability to make reflexive, rational choices are found within both sociological and birthing literature. It is recognised that multiplicity of choice is not available to everyone (Giddens, 1991; Beck & Gernsheim-Beck, 1995). As shown in Figure 1, the notions of risk and trust which together with contextual factors make decision-making problematic, are closely interrelated with choice. This section will first explore the notion of choice from a health sociology perspective, then examine the contiguous issues of risk and trust in relation to childbearing women and maternity services. Further influences on birthing and the organisation of maternity are discussed in Chapters 2 and 3.

[9] With Giddens and Beck, the synonymous terms 'late modernity', 'high modernity' and 'second modernity' have varied across time and between authors.

[10] Ontological security provides a sense of order, continuity and stability in experiences at individual and global levels, as well as about the future. The resulting individual sense of wellbeing offsets anxiety about the uncertainties and risks of life in the late modern / postmodern era. However, negative life events can threaten an individual's ontological security.

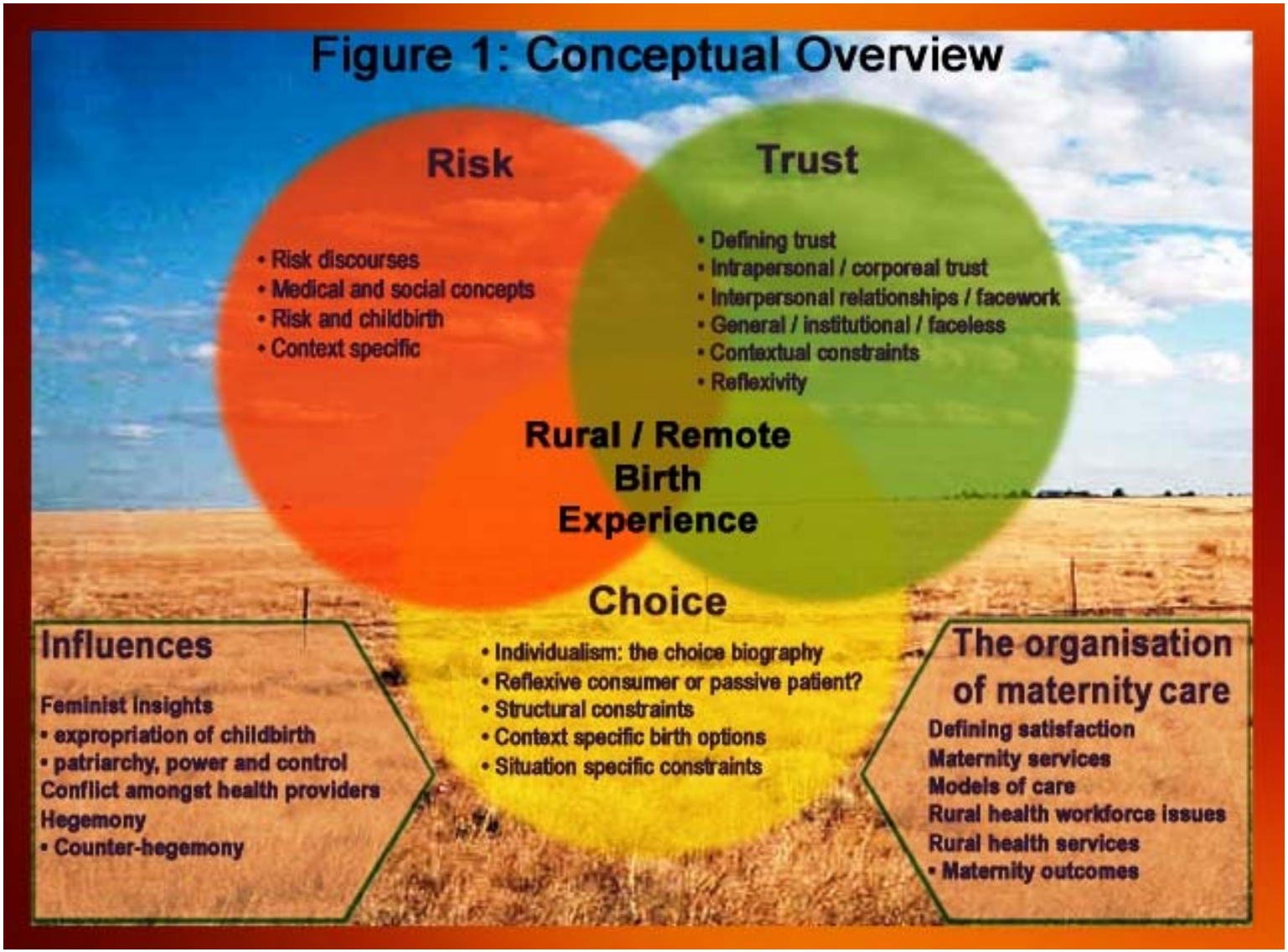

Figure 1 Conceptual overview

1.4.1 Birthing choices for whom?

Pregnancy and birth are commonly portrayed in parenting magazines, consumer websites and maternity client information leaflets as a life phase filled with choices. These include a wide range of options about care providers, place of birth, birthing positions, natural birth, technological interventions, infant care and many other related topics.

Conversely, the news media carry stories of women pejoratively labelled and criticised for their opposing choices of either elective caesarean ('too posh to push') or homebirthing ('earth mothers') (Horsburgh, 2005; Australian Associated Press [AAP] 2005; Fang, 2005; Pirani, 2003; Hickman, 1999); or censured for wanting a natural, undoctored birth (Grimm, 2005) and disallowed the option to refuse a caesarean section (AAP, 2005; Lupton, 1999b). Alarmist articles such as "Natural birth riskier than drink driving" are followed by letters providing evidence of the safety of natural birth and the dangers of obstetric interference in the process (Owens, 2001).

From these proliferating and often competing information sources, a birthing woman is supposed to make well-informed decisions when selecting from the range of options that lead to a safe, memorable and gratifying childbearing experience for herself (and her family). However, as Kent observes, "the very concept of choice is hotly contested for it is sometimes assumed that women choose, or make decisions about their lives, in a vacuum" (2000, p. 6).

1.4.2 Theoretical perspectives on choice

Within sociological literature, choice is inherent in the concept of agency and is a key notion within the widely accepted individualisation thesis (Beck, Giddens & Lash, 1994). Public, political and professional discourses have been extensively influenced by the belief that the everyday lives of people in late modernity have been freed from traditional ties, distinct life course phases, predictable ways of knowing and pre-determined structural restraints: social class for example, has been relegated to the 'zombie category' (Giddens, 1999; Bolam, Murphy & Gleeson, 2005; Brannen & Nilsen, 2005). The contemporary discourse of choice constructs the formation (and reformation) of individual identity through a plurality of possible lifestyles, life plans and potential experiences across the life course (Giddens, 1990; 1991; 2002). So, for individuals who actively make "decisions not only about how to act but about who they want to be", self-actualisation becomes a possible trajectory (Giddens, 1991, p. 81).

Therefore, in our globalised, consumerist society, the traditional biography has allegedly been replaced by a 'choice biography' wherein reflexive, autonomous

individuals are able to shape their own life courses freely from a range of possible options without reference to the lives of past generations, unrestricted by gender (Baker, 2005a, b; Walkerdine, Lucey & Melody, 2001) or the temporal constraints of space and place (Brannen & Nilsen, 2005; Beck, Giddens & Lash, 1994; Giddens, 1994, 2000; Warren, 1995). Giddens comments that, "Modernity confronts the individual with a complex diversity of choices, and because it is non-foundational, at the same time offers little help as to which options should be selected" (1991, p. 80). He cautions that various consequences tend to follow such choices.

According to Ulrich Beck's critique, individualisation involves "first, the disembedding and, second the re-embedding of industrial society ways of life by new ones, in which the individual must produce, stage and cobble together their biographies for themselves" (1994, p. 13). Beck (2000; Beck & Willms 2004) emphasises the constraining role of global market forces upon an individual's agency and ability to access employment, education and resources. Further, when exploring the consequences of the crumbling social framework in industrial societies, Beck and Elisabeth Gernsheim-Beck (1995) add a gender analysis to the critique of individualisation. They argue that a post-traditional society does not liberate women from gender roles in the labour market or the private sphere. Instead, interpersonal relations are destabilised and confused while gender inequalities continue to be evident both in employment options and the home. A new kind of social subjectivity emerges through which "private and public issues are intermingled and augmented" (Beck & Gernsheim-Beck 1995, p. 42). Individualisation becomes a hybrid of consumerism and confidence- seeking through self-achievement. Thus, Beck and Gernsheim-Beck (1995) conclude that, although people are ideally liberated to create individualised biographies, they do so in an increasingly unpredictable society in which choices and decisions are not only constrained by uncertainties in almost every aspect of life but also associated with a distribution of risk (Beck, 1999; Beck & Willms, 2004).

For social actors in high modernity[11] and postmodernity, reflexivity therefore becomes essential as uncertainty and the lack of foundational truths require individuals to be cognisant of potential risks and, following careful deliberation, to make rational decisions about their life trajectories (Giddens, 1990; Beck, 1999; Zadoroznyj 2001; Lupton, 1999a). Lane (1995, 2000, 2005), Lupton (1997) and Zadoroznyj (2001) describe a reflexive re-making of self that is evident in consumer behaviour, the provision of maternity services and consumer criticism of obstetric care. Furthermore, Zadoroznyj argues that:

[11] Beck and Willms (2004) use the term 'second modernity' to describe late or high modernity

> In giving birth, women can choose between different discursive constructions of childbirth, each with different conceptions of risk, different implications for how childbirth should be managed, as well as different implications for the extent of the involvement of birthing women themselves in the management of their births (2001, p. 119).

However, Zadoroznyj (2000) observes that this is particularly challenging for women pregnant for the first time (primigravidas).

Although the idealised, autonomous, self-regulating citizen is central to neo-liberalism, so too is governmentality. Deborah Lupton's study of Australian first-time mothers reveals how the apparatuses of 'biopolitics' regulate pregnant women and render them docile (1999b). Through governmentality by the state, health institutions and other agencies, women are subject to subtle forms of discipline and regulation embedded in dominant discursive constructions of pregnancy and accepted birthing practices. This results in accordance with taken-for-granted attitudes, acceptance of 'expert' advice and subsequent forms of self-monitoring. Thus, the freedom to seek out options that maximise their life opportunities and minimise risks is governed by 'expert' knowledge (Lupton, 1999b, pp. 61-62). The nexus between choice and trust is evident in Lupton's work (1997, 1999b). Like Giddens (1990, 2002), she recognises the ambivalence created when decision-making necessitates individuals placing their confidence in expert knowledge and relying upon abstract modern institutions. This is discussed further in section 1.5.

Several studies have explored the contention that a post-traditional biography overrides structural constraints such as class and gender. Beck and Gernsheim-Beck (1995), Beck, Giddens and Lash (1994) and Beck and Willms (2004) analyse the structuring character of the global labour market and its influence on individuals.

When considering the position of individual choice within the agency-structure dynamic, Brannen and Nilsen (2005) argue against the current sociological trend to place 'agency' and the choice biography centre-stage while rendering invisible 'structure' in the form of traditional biographies that include gender, class, life phases and contextual factors. They draw upon the work of C. Wright Mills to support their re-capturing of the structural aspects in the dynamic so that 'private troubles' are seen in terms of 'public issues'. Brannen and Nilsen's (2005) analysis is not only embedded in the social context of people's lives but is also sensitised to the influence of gender, class, time and space upon people's actions. These temporal constraints are apt in this project as well.

Bolam, Murphy and Gleeson (2004) explore class identity and health in the UK and find limited support for the individualisation thesis. While epidemiological evidence shows that class-based inequalities have persisted despite overall improvements in health, they assert that the simple reproduction of structural and material conditions does not adequately explain the disparities. Working class participants in Bolam, Murphy and Gleeson's study negotiate their identity as they shift between competing positions and juxtapose private and public realism in an attempt to make sense of their health. Ambivalence is apparent when participants attempt to reconcile the conflict between neo-liberal ideology and their health experiences.

Similarly, in his study of UK mothers, Simon Duncan (2005) argues that class continues to be culturally constructed whether through individualisation or rationality. Motherhood, he asserts, remains a classed activity. Class inequalities and a gendered division of labour constrain employment options and limit lifestyle choices for mothers. As with Beck's (2000; Beck & Willms, 2004) observations of labour market structures, Duncan (1995) asserts that, while class seldom features as a self-conscious social identity, it remains materially just as important as ever. Likewise, Joanne Baker (2005a) contends that individuals construct a social narrative that fits with the notion of neo-liberal subjectivity.

Joanne Baker extends the feminist analysis of neo-liberalism to conditions within a local setting by exploring entitlement and constraint amongst young women in North Queensland (2005a, b). Her findings reveal that the 'difficult freedoms' of neo-liberalism, such as choice, flexibility and social mobility, have been disavowed. Despite constraints such as low socio-economic status, racism, sexual abuse, domestic violence and single motherhood, Baker found that the young women in her study held an intense personal accountability to live up to 'girl power' expectations. As such, they framed their difficulties and successes in life inside individualised frameworks and were unlikely to mention social or external factors as impeding their progress. In accordance with neo-liberal public discourses, these young women constructed identities which they were self-reliant, made strong and resilient through adversity and enabled by choice and preference. Baker was puzzled by a dissonance between the optimism of some young women and the structural constraints on their lives (2005a).

Walkerdine, Lucey and Melody (2001) support Baker in arguing that class and gender constraints continue to affect the subjectivity and identity of young women within the unravelling social fabric of a post-industrial society. Their work examines the lives of girls and women striving for the neo-liberal promise that they can be self-creating, autonomous, upwardly mobile and can 'have everything' if they take responsibility for their life choices. However, only women who have certain resources

are able to achieve this state of self-creation. Walkerdine, Lucey and Melody (2001) reveal that young women of all social positions are subjected to profound social, cultural and psychological regulation. While they embrace the neo-liberal ideal of the 'choice biography', structural constraints (especially class) shape the invention of this identity, making it elusive and fragile (Walkerdine, Lucey & Melody, 2001).

In the light of these critiques of the neo-liberal subject, it is questionable whether or not rural and remote birthing women are, or can be, autonomous health consumers. The former Office of Women's Policy (1999) recognised the particular challenges to self-actualisation experienced by young rural and remote women. Similarly, I contend that the expectation that they will be able to create a choice biography will be profoundly shaped and constrained by social structures and neo-liberal governmentality. Not only do these constraints need to be taken into account but current practices, that regulate women through encouraging 'informed compliance' (Kirkham, 2004) and dependence on 'experts' rather than freedom of choice, need to be further explored.

From a feminist sociological perspective, the work of four Australian scholars stands out as most relevant to this study. Deborah Lupton's work provides valuable poststructural insights into trust, risk and governmentality, especially in relation to mothers' encounters with medical experts (1994; 1996; 1997; 1999a, b). Furthermore, when exploring the construction of the patient qua consumer, Lupton (1997) suggests that consideration should be given to times when a person may wish to adopt a passive, dependent stance rather than that of a reflexive medical consumer. Kerreen Reiger's postmodern analyses contribute to an understanding of the complex macro and micro politics of birth, both historically and currently. Like Lupton, Reiger explores the discourses that regulate and discipline childbearing women, their relationship to the state and medical authority and their resistance as reflexive consumers (Reiger, 1999a, b; 2001a, b; 2003; 2004). Further, Reiger (2000) employs historical insights and consumer perspectives when examining the current politics underpinning jurisdictional disputes between Australian midwives and medical practitioners. She advocates for birthing women's entitlement to individualised midwifery care. Similarly, Karen Lane's poststructural analyses reveal the power and micro-politics inherent in medical and maternity consumer discourses, which influence decision-making (2000; 2002; 2005).

While recognising the significant contribution that Reiger and Lane make to a sociological understanding of childbirth issues, Ann Taylor (2002) argues against their dichotomous views of childbirth choices. However, Maria Zadoroznyj's studies of childbirth in Melbourne are the most applicable to this project (1996; 1999; 2000; 2001). From an eclectic perspective, she considers structural obstacles to maximising

choice in maternity services while adding as further barriers the inadequate dissemination of accurate information, the invisibility of midwives, and the dominance of medical experts who subscribe to risk discourses (Zadoroznyj, 2000). Although Zadoroznyj explores the urban experience rather than the rural, her findings not only reveal that birth is a critical reflexive moment in women's lives but that this is mediated by parity and socially structured differences such as social class[12] and social control, which create differential access to self-actualisation (Zadoroznyj, 1999; 2000; 2001). Furthermore, Zadoroznyj elucidates the intersection between parity and social class, revealing that the experience of childbearing can override some of the constraints of class when women make reflexive decisions about subsequent births (1999; 2001).

1.4.3 Choice and health politics

Although patient charters are based upon the ethico-legal assumption that choice is inherently beneficial and advocate autonomous, informed decision-making, within the health system "support for the concept of choice is neither universal nor unconditional" (Bate & Roberts, 2005, p. 1488). Many health professionals believe that evidence-based practice, not socio-political forces, should guide decisions. A recent debate on patient choice in the *British Medical Journal* highlights the disparate views, politics and paradox of choice. For some it is perceived as empowering patients, while others consider a plethora of choices debilitating leading to bewilderment and high levels of anxiety and stress. Bate and Roberts contend that "the amount of choice on offer … exceeds our ability to effectively exercise that choice, or even enjoy it" (2005, p. 1488). Given the propensity for litigation, choice could be perceived as advantageous for health services as it devolves onto patients the responsibility for selecting from a range of alternatives.

Health managers claim that they find choice highly disruptive to planning and assert that, in a collectivist health system, choice is neither cost-effective nor efficient and quality care cannot be assured (Dean, 2005). By contrast, Stephen Black comments that:

> The purpose of choice in health is to create a strong incentive for providers to improve how well they organise what they do. The incentive benefits everyone, even those who don't exercise choice; it may even be that only a few have to choose for everyone else to benefit. There is a lot of scope for improvement in the current system, but not much incentive to drive it (2005, para 4)

[12] 'Social class' describes the women's material, social and cultural capital (Zadoroznyj, 2001; 1999).

While plurality of provision may be an idealistic goal for childbearing women in rural/remote Queensland, improving local maternity services to a satisfactory level is not unachievable. Not only does the Australian College of Midwives (ACMI) support these women's right to choose the options of care and mode of birth for their babies (Owens, 2001) but current research reports support the safety and efficacy of birthing in small maternity units (Kildea, 2003; Tracy, 2005a; 2006; RDAA, 2003; 2005). Alternative models of women-centred care are possible within the public health system (Hirst, 2005) and these are discussed further in Chapter 3.

Bate and Roberts (2005) report that UK health 'consumers' want access to a good local health service and a greater choice of providers. They are concerned that choices may not only undermine an existing health system that works reasonably well but also create inequities amongst certain people or groups. Higher socio-economic patients are more likely to hold higher expectations, be better educated, have access to information and the ability to deal with the available choices than those from lower socio-economic groups. Bate and Roberts advocate "facilitated choice" using "patient advisors" (2005, p. 1489) without acknowledging the potential for biased information giving, reinforcing passivity or informed compliance.

'Informed choice' is an illusive concept (Mmono, 1999) as research into women's understandings of options and the factors which influence their preferences reveals. Concerns emerge about the type and quality of information and the manner in which it is disseminated to, or withheld from, maternity consumers. Biases in the information disclosed about risks, benefits, limitations and consequences are also reported (Kirkham, 2004; Gamble, 1999). For example, a significant number of Australian women studied by Gamble (1999) and Turnbull, Wilkinson, Yaser, Carty, Svigos and Robinson (1999), felt that they had not been involved in decision-making about their mode of giving birth and an appreciable proportion felt that they had insufficient information. This can lead to postnatal dissatisfaction with decision-making. As Naomi Wolf (2001) points out, misconceptions arise and, like her, women may be subjected to sheer contempt from the medical establishment when exercising their right to be informed before making decisions.

The politics of choice are exemplified by the debate over modes of delivery, especially whether or not elective caesarean sections should be available on request to birthing women experiencing an uncomplicated, 'low risk' pregnancy. The increase in primary caesareans[13] is most evident in healthy, private obstetric patients. The three

[13] Also know as caesarean on demand, caesarean by choice or, for a woman who has not had a previous operative delivery, elective primary caesarean section

most commonly cited non-medical causes for operative births are: demographics, physicians practice patterns and maternal choice. The rising demand has been largely attributed to the impact of a woman's right to autonomous choice in decisions over delivery mode (Young, 2004; Van Wagner, 2004; Pirani, 2003; Paterson-Brown, 1998; Amu, Rajendran & Bolaji, 1998). However, of the three 'stakeholders' in this debate, the dominant voices are those of professionals, in particular midwives and obstetricians, not those of birthing women (e.g. Van Wagner, 2004; Gamble & Creedy, 2001; De Costa, 1998). Furthermore, as Christine Nuttall notes, "the debate amongst medical professionals is often devoid of social content" (1999, p. 1). Input from social scientists is required to highlight demographic disparities, criticise defensive obstetric practices and enable considerations beyond financial cost-benefit and physiological risk assessment to be included (Béhague, Victora & Barros, 2002; Nuttall, 1999; Langer, 2002).

Maternity care providers' personal birth preferences have been shown to influence their discretionary practice (Kirkham, 2004; Dickson & Willett, 1999; Gamble, 1999). Since the controversial revelation by Al-Mufti, McCarthy and Fisk (1997) that female obstetricians in the UK experiencing a normal, singleton[14] pregnancy would choose a caesarean section, numerous international studies have further explored maternity care providers' preferences and reflected upon the interrelationship between personal beliefs and practice. Obstetricians are also usually gynaecologists and are exposed to traumatic births and postnatal complications; these influence their perceptions of natural birth as a risky process with morbid outcomes and their subsequent preference for clinical control. This finding is supported by Land, Parry, Rane and Wilson's (2001) study of Australian and New Zealand obstetricians' personal choices in relation to modes of delivery and long-term outcomes. In the absence of any clinical indication, the majority would choose an operative birth and were agreeable to patients' requesting an elective caesarean section (Land, et al., 2001).

By contrast, Dickson and Willet (1999) not surprisingly found that practising midwives who were pregnant for the first-time would prefer a vaginal delivery. Although midwives also attended traumatic deliveries, they managed the bulk of uncomplicated pregnancies and births. Consequently, they overwhelmingly supported vaginal birth. According to Dickson and Willet (1999), midwives are therefore the most suitable professionals to assist women to make informed choices about mode of delivery. This perspective is supported by the Australian Midwifery Action Project (Barclay & Brodie,

[14] 'Singleton' describes a single foetus and 'normal' pregnancy. Multiple babies increase the complexity and risks of childbirth.

2003). Growing international concerns over the medicalisation of birth and rising intervention rates are discussed further in 2.2.1 and Chapter 3.

The combination of factors influencing rural/remote women's decision-making is apparent in Judith Fitzpatrick's (1995) study of women in Far North Queensland for whom choice of birthplace was severely limited. As there were significant differences in perinatal morbidity and mortality amongst rural and urban Aboriginal, Torres Strait Islander and Caucasian women, evacuation for hospital birth was mandatory and potentially life-saving, but resistance was also possible. Fitzpatrick revealed that birthing women who had the "education and knowledge about how the system worked utilised options alternative to the regional public hospital" (1995, p. 580). To reduce the geographic, social and cultural barriers to appropriate clinical care, Fitzpatrick argued for the development of community-based perinatal services that would enable women to choose homeland birthing.

The politics surrounding women's choices and perceptions of risk have so far been discussed in relation to clinical debates such as those over place of birth, mode of delivery and choice of maternity care provider. The following section further conceptualises risk.

1.4.4 'Choice' within risk discourses

Closely intertwined with maternity practices and childbirth choices is the notion of concomitant risks. For the purpose of this thesis, it is useful to explore the concept of medical risk along with broader social definitions of risk.

Richard Smith describes medical risk as "a combination of a probability of something happening (where statisticians might be able to help you but often can't), a feeling of the dreadfulness of that event (which is very personal), and a context for the event" (2003, para 5). As doctor-patient relationships have changed, communicating risk has become a central medical role. Smith observes that many doctors are not proficient at this, whereas "good doctors" should also be "sensitive to the psychological and social factors affecting patients", as building a trusting relationship with the 'patient' is important for effectively communicating risk (2003). The Royal Australian College of Obstetricians and Gynaecologists concurs (RANZCOG, 2005).

In Western cultures of late modernity, risk discourses prevail (Beck, 1992; Lupton, 1999a, b; Lane, 1995): within the health industry, risk management, defensive practices and the growing "safety movement" predominate (Nisselle, 2004; Wilson & Symon, 2002; RCOG, 2001). Jonathan Gabe (1995) asserts that a "veritable industry" has been developed around risk assessment. He expresses concern over the

economic and personal costs which result from science and technology striving to define, manage and reduce perceived threats to health. Michael Fine also observes that notions of risk are increasingly applied to health care and as such are the central concept replacing need and equity as major factors shaping policy and performance targets (2005, p. 258). Care has become tied to accountability and reduced to technocratic work practices. Fine (2005) adds that the emphasis and responsibility have shifted from organisations to the "entrepreneurial self" who exercises "self care" to avoid risks when making choices.

By contrast, Dingwall comments on the irony that sociology's critique of medicine has led to "a celebration of alternative medicine theories" at the expense of lifesaving interventions (1992, p. 166). Others like Nisselle (2004) reject allegations that the biomedical emphasis on risk management and defensive practice has been at the expense of quality of care.

Risk management has had profound effects on maternity services. While advocates of risk management believe that it ensures diminution of risk and therefore improves quality of care, others like Walsh (2003), and Wilson and Symon (2002) reflect that dominant paradigms for birthing, socially constructed beliefs, biased values and political motivations that reinforce power relations, need to be exposed. Denis Walsh argues for a re-framing of risk discourses in maternity care with a paradigm shift that assesses the "likelihood of benefit" and endorses practices efficacious to both clinical outcomes and maternal satisfaction (2003, p. 474).

Most women-centred sources stress the need for an holistic approach that balances the essential concern for the physiological safety of the mother and infant with a consideration for the cultural, social, psychological and emotional needs of birthing women (Oakley 1993a; Brown, Lumley, Small & Astbury, 1994; Stanfield, 1996), especially for those from rural/remote areas (Myles & Tarrago, 1994; Chamberlain & Barclay, 2000; Kildea, 2003; Hirst, 2005).

Accompanying the redefinition of birth as a medical condition rather than a natural life event (Davis-Floyd, 1994a, b; Oakley, 1980, 1993b; Johanson & Newburn, 2001) is a vocabulary of risk and a culture of fear and blame (Skinner, 2002). Like Ann Oakley (1980; 1993a, b, c), Karen Lane asserts that risk has "monopolised debates about childbirth to the exclusion of other factors such as satisfaction and control" (1995, p. 56). It can be argued that the language of risk not only influences decision-making but provides a means for socially controlling childbearing women (Skinner, 2002; Lane, 1995). One way forward, Lane argues, is for medical practitioners to acknowledge that women, as birth consumers, have the expertise to define their own health priorities, understand the risks and reflect upon the consequences of their choices (2000, p. 43-

44). Similarly, other maternity 'consumers' argue for a restructuring of services to enable women to have informed choice and a sense of control (Nolan, 2002; Wilson & Symon, 2002). Mary Nolan (2002) advocates a preventative strategy to address risk management and improve well-being outcomes. Instead of focussing on adverse scenarios, Nolan suggests that best care practices and innovative strategies which reclaim 'normal' physiological birth from pathological risk labels need to be introduced.

'Normal' birth is medically constructed from epidemiological statistics and clinical cases (RCOG, 2001; Lupton, 1999b; Howlett-White, 1999). Although RANZCOG recognises childbirth as "a natural and personal process", the emphasis is on responsibility for the physiological safety of mother and baby (2005 para 3) and, arguably, medical indemnity. While stating a duty to communicate effectively "an appropriate level of information", RANZCOG advises women that "the right to informed choice" involves taking responsibility for "refusal of advice or treatment" (2005, para 4).

Globally, safe motherhood initiatives save lives (WHO, 1995, 2005; Rogo, 2005; UNESCO, 1997). However the 'dangers' of birth are inappropriately applied to healthy, Australian women experiencing an uncomplicated, "low risk" pregnancy (Maternity Coalition, 2002; Tracy, 2003). As further discussed in Chapter 3, the Senate Community Affairs Reference Committee describes an "inverse care law" whereby disproportionate resources are channelled to "women at no risk, especially those with private health insurance, rather than those with high need" (SCARC, 1999, p. 164; King, 2000).

While perceptions of risk compound, the definition of 'normal' birth narrows and birthing processes increasingly come under obstetric surveillance with prudential risk management resulting in an increasing reliance on scientific and technological interventions to solve perceived problems (Laws & Sullivan, 2004; Johansen & Newburn, 2001; RCOG, 2001). There is an expectation that rational and responsible women will be self-regulating and comply with expert medical advice (Lupton, 1999b; Davis-Floyd, 1994a).

As Ulrich Beck points out, herein lies the 'trap' for people in late modernity who desire personal control (1999). While people are become increasingly sceptical about the omniscience of scientific experts, they also become enmeshed within an atmosphere of "indomitable risks" which then makes them more reliant upon scientific and technological expertise to manage uncertainty and reduce anxiety (Beck 1999, p. 141; Skinner, 2002). Risk assessment, management and a safety culture exist alongside the iatrogenic outcomes of medical interventions. Skinner observes that, as a consequence of this contradiction, the reflexive maternity consumer demands "fully informed choice without knowing that this is no longer possible" and that maternity

providers can expect to be constantly questioned, challenged and blamed for adverse outcomes (2002, p. 71). This leads to further endeavours to control risk through managing the birthing body (Lane, 1995; Lupton, 1999b).

Janemaree Maher (2003) points out that obstetric knowledge is privileged in clinical encounters. It offers a certainty of physiological safety (as opposed to the psychical or affective aspects of giving birth), in exchange for entrusting the pregnant body to expert management. This privileging of the obstetric model as 'safe' is evident in the controversies over birth centres, stand-alone primary childbirth units and small rural maternity wards (Foureur & Hunter, 2006; Sommerfeld, 2005; Tracy 2005a, b; Grimm, 2005; Cresswell, 2005a; AMAQ, 2005; ACMI, 2005a, c). However, Howlett-White (1999) contends that the opposition to obstetric management of birth is problematic as a pregnant woman chooses a professional that she considers the most qualified, competent and appropriate for her 'illness'. By contrast, others argue that the ongoing closure of small maternity units restricts parents' choices about where to give birth and therefore inaccurately reflects a preference for obstetrical rather than general practitioner or midwifery-provided care.

Deborah Lupton comprehensively reviews the proliferating risk discourses which subject women to perinatal vigilance, surveillance and regulation. She observes that the childbearing body is constructed as being doubly at risk. The pregnant woman and foetus are represented as "highly vulnerable" and "susceptible to a multitude of threats" (Lupton, 1999b, p. 63). Having been designated a risk status based on statistical norms, self-surveillance and regulation are expected of the birthing woman. Lupton describes the high levels of fear and anxiety that permeate the birthing experiences of women across sociodemographic groups, but especially in primigravidas (1999b, pp. 71, 75). Society expects responsible pregnant women to seek close medical supervision and assistance if they are to be delivered of healthy babies. Women who do not comply, typically those from marginalised or disadvantaged groups, are seen as immoral, callous and unconcerned about the welfare of their babies (Lupton, 1999b, p. 66). Lupton's findings show varied responses from Australian birthing women ranging from ambivalence, a sense of powerlessness and induced passivity, to positive responses about their fears being assuaged by prenatal screening technologies and control over the birth (1999b).

This brief exploration makes apparent the impact that a culture of risk has on maternity services and medical encounters, as well as birthing women's perceptions of their options. In this study, neither the rural/remote childbearing women nor the maternity care providers were directly asked about risk. However, during the in-depth interviews about their experiences, risk-related issues were common themes. Similarly

and closely associated with choice and risk, trust arose as a significant concern for most participants.

1.5 Trust

During the research process, issues related to trust were identified as significant interdependent themes and sub-themes within the participants' stories. As will be shown in Chapters 7 and 8, their narratives were embedded in contextual factors and contained attributes of trust described in sociological and health literature. Although intrapersonal trust emerged as one sub-theme, this has not been incorporated. Given the constraints of this thesis, it was necessary to exclude my exploration of the corporeal aspects of intrapersonal trust such as women's experiences of maternal embodiment and female identity.

A review of the theoretical literature on trust in healthcare and social settings reveals that, while trust, distrust and mistrust are focal issues, conceptualisations differ across nursing/midwifery,[15] medicine and sociology. With risk and uncertainty permeating all aspects of everyday modern life, trust is widely viewed as an essential component in effective social relationships. There is common concern that trust at a general societal level has declined substantially in late modernity, accompanied by an increasing desire for trustworthy relationships at an interpersonal level. However, incongruence between notions of trust creates unintentional misunderstandings when applied to everyday life, therapeutic relationships, different models of care and when used across contexts and disciplines. Differing perceptions of what is implied and expected from a trusting relationship is problematic at both an interpersonal and organisational level.

Evidence suggests that declining trust, along with growing distrust and mistrust in the healthcare system, is of concern (Walton, 1998; Hall, Camacho, Dugan & Balkrishnan, 2002; Mechanic, 2004, Hugman, 2005). Public awareness of abuses of power and authority, breaches of trust, unethical behaviour and the commercialisation of health services, along with concerns about publicity regarding poor quality of care, iatrogenesis and adverse outcomes all contribute to a 'crisis' in trust (Walton, 1998; Moynihan & Smith, 2002; Mechanic, 2004; Hugman, 2005). This has a potential impact upon women's anticipated experiences, interactions with maternity carers and

[15] Nursing and Midwifery literature are combined here as most published references to trust are found within nursing literature. However, email discussions within midwifery and maternity interest groups (e.g. OzMid; Birthrites) emphasise mutual trust as an essential component of the relationship between a birthing woman and her midwife if an optimal outcome is to be achieved).

subsequent satisfaction with maternity services (Zadoroznyj, 2001; Reiger, 2000; Mozingo, Davis, Thomas & Droppleman, 2002).

Section 1.5 provides the conceptual background for my later analysis of rural/remote women's everyday views on trust and its influence on their birth experiences. Notions of trust found within general, health care and sociological literature will be compared and contrasted.

1.5.1 Concepts of trust

Definitions of trust are diverse and contested. As trust is employed as a noun, verb and adjective it may describe the quality of a relationship or be an entity of itself (*Shorter Oxford English Dictionary,* 1993). Trust is conceptualised as both a process and an outcome (Johns, 1996; Norcom, 2002), as well as a measurable attribute (Hall, Camacho, Dugan & Balkrishnan, 2002; Norcom, 2002). Often depicted as the 'touchstone' of effective health interactions, trust is therefore a desirable goal (Hugman, 2005; Hupcey, Penrod, Morse and Mitcham, 2001; 2002a; Walton, 1998; Mechanic, 1998). Notions of trust commonly contain elements of choice, vulnerability, risk-taking, fidelity, respect and expectations (Anderson, Anderson & Glanze, 2002; *Shorter Oxford English Dictionary*, 1993). In both everyday usage and allied health literature, trust in the form of trustworthy is used synonymously with dependable, reliable, someone or something you can have confidence or faith in, and has connotations of honour, ethical principles and a moral dimension. Trusting someone or something implies an obligation or commitment (Walton, 1998; Hugman, 2005). Antonymously, distrust describes a lack of confidence; while regarding someone or something with suspicion is mistrust (*Shorter Oxford English Dictionary*, 1993). Trust therefore involves a willingness to accept vulnerability based on an expectation of an action important to the trustor (Hall, Camacho, Dugan & Balkrishnan, 2002, p. 1420).

Following an interdisciplinary meta-analysis of conceptualisations of the term, Hupcey, Penrod, Morse and Mitcham concluded that:

> Trust emerges from the identification of a need that cannot be met without the assistance of another and some assessment of the risk involved in relying on the other to meet this need. Trust is a willing dependency on another's actions, but it is limited to the area of need and is subject to overt and covert testing. The outcome of trust is an evaluation of the congruence between expectations of the trusted [other] and actions (2001, p. 290).

This comprehensive definition will be readdressed in Chapter 8 when discussing notions of trust within my findings on 'Labour relations'.

Within the literature I reviewed, theorising on trust differentiated between types and attributes. There is a tendency to typologise trust into four levels ranging from the all encompassing global trust to the most specific intrapersonal trust[16]. I have found these groupings useful when seeking to understand trust relations with and within rural/remote maternity services. Most literature addresses the two middle levels and these are the principal focus in this study.

Trust of abstract, 'faceless' social organisations and collective entities (comparable to the ontological security which will be discussed in 1.5.2) is termed social, general, system and institutional trust, while interpersonal trust characterises relationships between specific individuals and generally involves 'facework'. A further distinction can be made between trust in a specific known institution (such as a local health service), and trust in a large, impersonal social or professional system (Hall, Camacho, Dugan & Balkrishnan, 2002).

Global trust is envisaged by Hupcey, Penrod et al. (2001; 2002a) and Hupcey (2002c) to be at an overall societal level. Arising from general trust, it is influenced by a person's evaluation of encounters with the healthcare system, interactions with healthcare providers and the satisfactory fulfilment or otherwise of their needs and expectations (Hupcey, Penrod et al., 2001, 2002; Hupcey, 2002). Pre-existing trust and contextual factors can inhibit or foster the development of global trust (Hupcey, 2002; Hupcey, Clark, Hutcheson & Thompson, 2002). By contrast, Hall, Zheng, Dugan, Camacho, Kidd, Mishra & Balkrishnan (2002) conceptualise patient trust in five domains: fidelity, competence, honesty, confidentiality, and global trust. In a related theoretical work, Hall, Camacho et al. describe global trust as the "irreducible 'soul' of trust" that combines elements from some or all of these five domains of trust (2002, p. 1421).

Social trust is considered to be a form of social capital that binds people together for common, mutually beneficial purposes. Social capital in rural Australia is "enhanced by networks of trust built at the community level" (Alston 2005a, p. 154). Anne Hampshire and Karen Healy contend that, although social capital is an ambiguous concept, it contributes to community well-being and the general enhancement of quality of life through the norms of trust, reciprocity, citizen participation and social belonging (2000, para 4). Social trust is considered a characteristic of traditional, collective contexts (such as rural society) and the

[16] Intrapersonal trust describes faith and confidence in oneself and one's abilities, for example, a childbearing woman's innate belief that she can birth without intervention, breastfeed and mother her baby.

implications of its erosion within the advanced capitalist societies of late modernity are widely analysed within sociological sources (Coleman, 1988; Giddens, 1990, 1994, 2000; Fukuyama, 1995; Cox, 1995; Nye, 1998; Cook, 2004). A crisis in social trust is frequently described, and in contemporary rural Australia can be associated with the depletion of social capital (Cocklin & Dibden, 2005).

When applied to encounters with the health care system, health[17] literature suggests that the mythical ideal of a social trust has been threatened for some time by the technical and economic imperatives and defensive practices which medicine has embraced. Therefore social trust is influenced by media exposure and general reputation rather than first-hand knowledge.

David Mechanic and Mark Schlesinger also depict social trust as being connected with broader forms of confidence in social institutions generally (1996, p. 1693). They use the term to describe the loss of social trust in collective institutions and the medico-legal consequences of public distrust. David Mechanic asserts that, in a well functioning society, social trust is the 'glue' that facilitates social cooperation, thus avoiding defensive medical practices and the diversion of health care dollars to costly and intrusive enforcement of rules and regulations (Mechanic, 2004, p. 1418; Mechanic & Schlesinger, 1996).

General trust is established through media portrayals, social interactions and health encounters, for example with professional groups such as health care providers. Exploration of health consumer's views and experiences reveals a high level of public trust in nurses and midwives; however this is often accompanied by a lack understanding of their scope of practice (Buresh & Gordon, 2000; Zadoroznyj, 2000; Stratigos, 2000d; Centre for Research into Nursing & Health Care Consumer Perspectives, 2002; Heath, 2002). By contrast, Hall, Camacho et al (2002) and Mechanic (2004) observe that general trust in the medical profession has diminished; however specific, interpersonal trust in a patient's own doctor is retained. While assimilating the negative media about unethical behaviour, breaches of trust and poor quality care, patients "typically believe their own doctor is different" (Mechanic, 2004, p. 1418). Therefore, although general trust and interpersonal trust differ significantly, a number of theorists see the potential to influence the formation of trust in health organisations and systems through positive interpersonal relationships with health professionals (Hupcey, Penrod et al., 2001, 2001; Hall, Camacho et al., 2002; Hall, Zheng et al., 2002; Mechanic, 2004).

[17] 'Health' in this context subsumes medicine, nursing, midwifery and allied health literature. However, because of its particular disciplinary perspective, clinical psychology is not included.

Interpersonal trust between people is the widely recognised in as an essential component of effective relationships. Risk is a critical attribute of interpersonal trust and the risk varies with the form and quality of the relationship (Norcom, 2002). At this level trust is both an iterative process and an outcome. Because trusting increases vulnerability, when people assess the risks and benefits of depending upon another person to act in their best interests, they then evaluate the outcome of that trust (Johns, 1996).

Trust is critical to a person's willingness to enter into a therapeutic relationship. Both Merrilyn Walton (1998) and Richard Hugman (2005) argue that expectations of a health professional's expert knowledge, competency, and beneficence enable people to seek care, divulge sensitive information, entrust responsibility for their well-being and follow recommendations. In turn, health professionals have a reciprocal obligation to provide proficient care while acting with appropriate motives and within ethical norms (Hugman, 2005; Walton, 1998). This reciprocal interpersonal trust is desirable but cannot be presumed. A review of sociological and health related literature reveals that, at both an organisational and interpersonal level, trust is problematic.[18]

1.5.2 Sociological perspectives on trust

Trust is currently a contentious and topical issue in social science theorising. Over the past decade, investigating notions of trust has become an imperative as concerns increase about the implications of declining trust and the trend towards individualism and consumerism. Erosion of trust and rising risk consciousness not only have an impact upon aspects of everyday social life but also on attitudes to medical science, the utilisation of health services, public health policy, and the nature of medical encounters and therapeutic relationships. When analysing trust within rural/remote maternity experiences, insights can be drawn from social theory as well as sociological critiques of healthcare encounters.

According to Niklas Luhmann (2000, p. 94), previously trust had "never been a topic of mainstream sociology"; consequently it had been poorly theorised and operationalised. Seeking to redress this deficit, Anthony Giddens (1994; 2002), Clarissa Cook (1997), Deborah Lupton (1997), Michael Thiede (2005), Jane Goudge and Lucy Gilsona (2005) are amongst those arguing the importance of examining notions of trust so that it has conceptual clarity and theoretical utility. Within Australian

[18] In separating the literature into social and health sources to facilitate review, I acknowledge that health professionals publish in social science journals and, likewise, sociologists are to be found in medical/health literature.

literature, exploration of trust within maternity experiences is advanced in the work of feminist scholars such as Deborah Lupton (1997; 1999b), Karen Lane (2005) and Maria Zadoroznyj (1999; 2001). Their concepts of trust will be outlined following a brief overview of trust as a theme within general sociological literature.

Sociologists have traditionally believed that a strong and healthy society requires trust. “Stable collective life must be based on more than mere calculations of self-interest … an element of trust is essential” (*The Concise Oxford Dictionary of Sociology* 1996, p. 539). The attributes and outcomes of trust and distrust are widely discussed, particularly in the context of a civil society founded on notions of human and social trust (Durkheim, 1964; Parsons, 1951; Luhmann, 1979; Gambetta, 1988; Coleman, 1988; Fukuyama, 1995; Cox, 1995; Cook, 2004). Francis Fukuyama asserts that, without trust, people will only interact cooperatively “under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated and enforced, sometimes by coercive means” (1995, p. 27). Advocating the need to redevelop social trust, Eva Cox comments on the ways in which concepts of competition and free market forces reduce faith in social institutions like the health system, leaving “individuals competing in an endless process of distrust” (1995, pp. 8, 9).

Some sociological literature tends towards structural-functionalism, seeing trust as essential to the functioning of society as a whole (Latham, 2002; Walton, 1998; Parsons, 1951). Turner (1995) and Kutchins (1991) describe the Parsonian approach. In this, the fiduciary relationship is an important component of professional ethics, values and norms. Furthermore, within doctor-patient relationships, patients are portrayed as ignorant and incapable of making medical decisions about their treatment; docility and compliance are necessary. Patients, according to Talcott Parsons, cannot be consumerist and evaluate medical care before it happens (i.e. experience surgery or childbirth) so must trust the doctor to act in their best interests (Latham, 2002; Turner, 1995; Parsons, 1951). Therefore, trust is considered essential to successful medical encounters. Eliot Freidson is notable for contesting the Parsonian view and advocating a consumerist approach (1970; 1993).

Echoing Parson’s concepts, Bernard Barber’s (1983) often-cited work explores differing expectations of trust within relationships and subsequent causes for disappointment when they fail. Barber differentiates between three dimensions: trust in the continuity of the natural and the moral order; the technically competent performance expected of persons in particular roles; and their fiduciary obligations and responsibilities (1983, p. 165). As Luhmann points out, this attempt at clarification “leaves unspecified … the social mechanisms which generate trust in spite of possible disappointments” (2000, p. 95).

Other sociologists discuss individual perspectives of trust from either a personal level (Lewis & Weigert, 1985 in Hupcey, Penrod et al., 2002; Luhmann, 1988) or at the level of an institution or system (Luhmann, 1979; Shapiro, 1987 & Zucker, 1986 in Hupcey, Penrod et al., 2002). Lupton (1996; 1997; 1999) works at both levels exploring "the macro effect of micro issues and the micro effect of macro issues" (James & Gabe, 1997, p. 8) from a poststructural perspective.

Giddens has been highly influential in advancing notions of trust and risk in late modernity at individual, societal and global levels. He examines the dialectical link between the globalising tendencies of late modernity and localised events in everyday life (1990, 2002). Eclectically building his theory of self-identity and intimate relations upon earlier sociological and social psychological notions, Giddens views trust as integral to the development of self (1991; 1992). Extending Erving Goffman's (1959; 1974) exploration of 'face work' in everyday interactions, Giddens differentiates between the face-to-face commitments, which were foundational to trusting relationships within traditional societies, and the development of ontological security in faceless, abstract systems within late modernity (1990; 1992; 1994; 1999a, b; 2002). As daily life in late modern society becomes increasingly fragmented, disembedded and globalised, people derive a great deal of ontological security from these abstract systems. Time-space distanciation necessitates faith and confidence in the reliability of impersonal principles (Giddens, 1994; 2002). Deep uncertainty and anxiety over risk is averted by basic trust. Consequently, this can be related to public trust in reliable transport, communication systems, the health system and childbearing women's confidence (or lack thereof) that maternity services will provide both safety and a certain standard of 'expert' care. With the shift in trust relations away from face-to-face involvement to dependence on abstract entities (such as the health system) and mediation from expert systems (such as bodies of reflexive knowledge like medicine), social relations can become detached from the local context.

As trust is regarded as a necessary part of life, detaching social relations from the local context has extensive repercussions if expert knowledges and systems fail. Lupton notes that:

> [people are] turning back to face-to-face relationships in the attempt to 're-embed' their trust in those they know personally. This involves different sorts of trust relations … and different sorts of risks (1999, p. 77).

Challenges to the infallibility of 'expert knowledges' erode public trust and invite consumerist risk appraisals. Critiques of biomedical science and the effects of medical technological imperatives on health services, can reduce public confidence in health

care. Rolf Lidskog (1996) examines the shift in public attitudes to scientific knowledge from a position of trust to a consciousness of the flaws and associated risks. Concerns about medical fraud, and news items such Pirani's critique of medical scientists "Doctoring the evidence" (2006), invite reflexive health consumers to weigh up the risks before trusting medical interventions. Kristin Rolin (2002) argues for a differentiation between the credibility of science and perceptions of its trustworthiness. At a community level, the conditions which influence perceptions of the trustworthiness of [medical] scientific testimonies require further analysis. In particular, Rolin criticises the gaps in theorising on the gender dimensions of trust in the validity of science (2002).

The nexus between knowledge and power has been well recognised and explicitly applied to situations involving risk and trust (Lupton, 1997; 1999; Cook & Easthope, 1996; Peterson, 1994; Giddens, 1990, 1992; Luhmann, 1988; Lewis & Weigert, 1985). Within the sociology of emotions, patients' notions of trust and risk in the medical encounter are further examined, as will be outlined.

Sociological literature largely focuses on the doctor-patient relationship within medical encounters. However, Cook (1997) acknowledges that trust is important for all health workers. Nurses and midwives are seldom mentioned, possibly because of their subordinate status in the patriarchal medical hierarchy, or because key figures like Max Weber (1949) and Talcott Parsons (1951) focus on doctors' specialised knowledge, authority, autonomy and status in society. In this literature, 'patients' are positioned as people in a vulnerable, dependent role. As such, choice is not a prerequisite of trust within the medical encounter.

This becomes problematic with childbearing women experiencing a normal life event. Unless women experience complications, they are not sick. None the less, childbirth has become highly medicalised and risk-laden. Once women enter the health system, various strategies are adopted that turn pregnant women into docile patients. Despite rhetoric to the contrary, they are expected to conform to the sick-role. Therefore, the following discussions about doctor-patient relationships can be applied to birthing women and their relationships with both doctors and nurses/midwives.

Deborah Lupton (1996) discusses the relationship between trust, risk and dependency in her study of the emotional aspects of patient-doctor/nurse encounters. Ambivalence, uncertainty, anxiety, faith and hope are emotions patients use to describe their relationships with health professionals. Lupton's interviewees see trust as synonymous with faith in the face of uncertainty and the potential marvels of medical knowledge and technology. This faith in medicine supplants religious belief. Drawing on patients' words, Lupton finds trust described as "your life in their hands" and "…they are a doctor…they know what they're doing you know…" (1996, p. 163). Being

vulnerable, sick people are forced to trust in medical knowledge and expertise as there is no alternative.

Hupcey, Penrod et al. (2001) comment on the way in which concepts of faith and confidence are often interchanged with trust without having its attributes. Faith, they argue, not only excludes choice and testing trustworthiness, but does not necessarily require prior evidence that the individual(s) will behave in a certain way. While confidence is an allied concept to trust, it does not involve placing oneself in a dependent situation (Hupcey, Penrod et al., 2001). Whether choice precludes faith and confidence, however, will be examined later in this thesis.

Trust allied with faith and confidence is also evident in international childbirth literature. Riewpaiboon, Chuengsatian, Gilson and Tangcharoensathien (2005) explore the 'mythical trust' women have in obstetricians. Birthing women, who could afford private obstetric care, even when delivered in a public hospital were found to believe that their choice created a basis for interpersonal trust and confidence that they would receive higher quality care. Potter, Berquó, Perpétuo, Leal, Hopkins, Souza and de Carvalho Formiga (2001) also support this finding. The access and affordability of this perceivedly more trustworthy and beneficent private obstetric care links choice and trust with social class (Riewpaiboon et al., 2005; Potter et al., 2001).

Trust involves respect for medical expertise and a belief in the promise of 'cure'. Lupton (1996) found patients' views consistent with Max Weber's notion of charismatic authority. That is, doctors are attributed their status and authority "by individuals or groups by virtue of certain qualities by which they are treated as extraordinary or exceptional" (Lupton, 1996, p. 164). Added to this, people may still hold the Parsonian notion that the professional standing, expertise and certification of doctors warrant social trust. Patients want to believe that they can have faith in doctors and trust them to act in their best interests. As such, trust in the therapeutic abilities of medicine allows patients to cope with uncertainty and anxiety (Giddens, 1990). Lupton asserts that this is "pivotal to the construction of 'doctor' and 'patient'; if patients do not invest their trust in doctors, then the role and function of doctors is altered" (1996, p. 164).

As social roles are re-defined in late modernity / post modernity, people move between the position of consumer, client and patient in a non-reflexive way. Each involves a different level of autonomy, self-reliance, dependency and trust within the relationship with the health professional. It is widely recognised that more consumerist behaviour, in which trust is given conditionally, is increased amongst middle class people (including birthing women) than those from lower socio-economic status groups (Lupton, 1996, 1997; Irvine, 1996; Howell-White, 1999; Zadoroznyj, 1999; 2001). As previously discussed, Zadoroznyj argues that parity is more influential than class in

transforming women into reflexive consumers. These phenomena are also evident in this study and will be discussed in Chapters 7 and 8.

Walton (1998) also recognises that trust is fundamental to the doctor-patient relationship. It enables people to place responsibility for their care in the hands of doctors. As already noted, this 'life in their hands' belief was also apparent in Lupton's study (1996, 1997). Like Lupton (1996), Walton (1998) is concerned about the imbalance of power between vulnerable, dependent patients and their doctors. Pellegrino, decrying the position of patients, believes that they are "condemned to a relationship of inequality with the professional healer, for the healer professes to possess what the patient lacks — the knowledge and power to heal" (cited in Walton, 1998, p. 17). Patients trust that their vulnerability "will not be exploited for power, profit, prestige or pleasure" (Walton, 1998, p. 17).

Walton (1998) stresses that doctors need to recognise the power imbalance and commit to putting the patients' interests first always. The underlying principle is that:

> Patients hand over trust to doctors who in return *promise* to help patients. This promise also entails the *understanding* that doctors will treat patients by using only those skills and knowledge of benefit to patients. This fulfils the professional part of the contract between patients and doctors. When doctors heal or care for patients by *applying* their knowledge and skills, the medical part of the contract is completed (Walton, 1998, p. 18).[19]

Dependency on medical expertise is an outcome for many people. In a vulnerable, childlike way, they prefer to hand over responsibility and decision-making to the health providers they trust. Others, however, take a consumerist position (Lupton, 1996; 1997; Irvine, 1996). Faith and hope have altered meanings here as consumers transfer trust from one health provider to another. There is a contradiction as people move between faith and rationality in deciding whom they will trust. As shown in Chapter 8, both of these positions were found in childbearing women.

Lupton (1996), like many of the medical authors, describes trust as a mutual responsibility. There is reciprocity and exchange in doctor-patient and nurse-patient relationships. Health providers have access to patients' intimate physical and emotional being. This gives them an imbalance of power over patients. Patients trust that they will not be hurt or exploited and that in return for dutiful care, money, "gratitude, docility and compliance" are expected (Lupton, 1996, p. 165). However, emotional reciprocity

[19] Author's emphasis

is seldom found in the relationship between doctors/nurses and a patient, yet unilateral disclosure is expected in such encounters (Lupton, 1996).

Hupcey, Penrod et al. (2001; 2002) explored mutuality and reciprocity of trust. They contrasted unilateral trust (affecting only one side or party) with bilateral trust (affecting both parties, but not necessarily reciprocal in nature) with the give and take of reciprocal trust. Reciprocity was found where there were mutual goals and equal status; thus, unlike Lupton (1996, 1997), they asserted that the relationship between health providers and patients/clients was not reciprocal, but rather unilateral or bilateral (Hupcey, Penrod et al., 2001; 2002). Although trust is generally discussed in unilateral terms, it may be based on exchange, but the trust is not necessarily returned.

Inequalities in power relations between health professionals and patients, along with concerns about the effects that impersonal interactions have on trust within medical encounters, have been addressed by several Australian scholars (Lupton, 1996; Grbich, 1999; Peterson & Waddell, 1998). Patients' notions of trust are consistent with the everyday concepts described earlier; however, their expectations of medical encounters are not always met (Lupton, 1996; Walton, 1998; Cook & Easthope, 1996; Irvine, 1996; Peterson & Waddell, 1998). In Lupton's (1996; 1997) study, while some patients had faith in doctors because of medical authority, lack of confidence and mistrust were described by others in some medical encounters. Differences in the way in which trust is defined can lead to misunderstandings. Poor communication skills (verbal and non-verbal) were factors found to affect trust and led patients to describe some doctors as 'good' and others as 'bad' (Lupton, 1996; Walton, 1998). Trust and disclosure were given or withheld accordingly.

Numerous studies have revealed how the ever-increasing use of medical technology alters the relationship between health professionals and patients and may contribute to a diminished trust in medicine Not only does the intervention of depersonalised technology reduce the 'face work' and emotion work that patients expect to accompany caring but dissatisfaction occurs also when faith in technology fails to meet curative expectations, (Bates & Lapsley, 1987; James & Gabe, 1996; George & Davis, 1998; Walton, 1998; Collyer, 2002; Moynihan, 1998; 2002). Women's ambivalence towards reproductive and birth technologies suggests that reliance on medical solutions is associated with mistrust of its efficacy (Klein, 1989; Rowland, 1992; Smith & Turner, 1990; Davis-Floyd, 1994b; Peterson, 2005).

Also considering shifting social and political relations, Judith Allsop (2006) assumes that patients mistrust medical competence. Linking to consumer perceptions

of risk, she considers how patients' relationship to doctors and the state have been influenced by global changes. As competence is no longer predictable, State and professional bodies are confronted by the need to regain patient confidence (Allsop, 2006).

From a different perspective, Jane Goudge and Lucy Gilsona (2005) identify the limited knowledge of the way in which trust functions across geographical locations and cultural differences. While low trust environments are recognised, there is a need to learn from past cross-cultural experiences and develop strategies to build trust in the health system.

Michael Thiede (2005) argues that the relationship between health care providers and patients/consumers is critical to whether or not an individual decides to utilise a health service. In a culturally diverse society, the role of trust within interactions becomes critical. As an iterative process, Thiede asserts that effective communication enhances trust and this in turn develops trust in the health provider. He shifts the focus from the availability and accessibility of health services to consumer demand. Thus, a low trust environment becomes a barrier to access.

Based on the sociological literature reviewed, it is possible to conclude that interrogating notions of trust is ongoing as sociologists endeavour to achieve conceptual clarity and theoretical utility. Although perspectives vary, there is consensus that, in post-traditional society, trust is necessary in everyday life but changes in character as individuals increasingly rely on abstract systems while desiring face-to face contact. The calculation of risk is significant in the decision to trust, so an individual may choose not to trust if the risk is too great. Trust develops over time and is influenced by social experiences. The theoretical utility of these sociological notions of trust will be considered in relation to the rural/remote maternity context in Chapter 8.

1.5.3 Conceptualisations of trust in Nursing and Medical literature

Incongruent conceptualisations of trust held amongst health professionals, patients and reflexive health consumers have implications for the relationship between birthing women and maternity care providers. Paradoxically, high levels of public trust in doctors, nurses and midwives reported in the popular media can be contrasted to the unease about patient trust found in the health journals (Godlee, 2006; Buresh & Gordon, 2000; Stratigos, 2000d; Centre for Research into Nursing and Health Care Consumer Perspectives, 2002). Highlighting potential areas of concern, Godlee (2006) cautions health professionals against complacency about public trust.

While trust is viewed in both Nursing (including Midwifery) and Medical literature as fundamental to effective health encounters, there is a general difference in emphasis. Within Nursing, the focus is largely on strategies to develop clients' trust while medicine tends to be responding to the 'crisis' in patient[20] trust. Distrust is a prevalent theme.

Nursing contains the largest body of literature on trust, most of which falls within two perspectives - clinical and organisational. Clinically, interpersonal trust is viewed as essential to nurse-client relationships. Organisational positions focus on the association between trust and various outcomes or levels of effectiveness. Jeanine Johns' (1996) seminal work found that nursing definitions of trust were vague, diverse and commonly borrowed from other disciplines, such as psychology. Conceptualising trust as both a context-specific process and an outcome, Johns attempts to operationalise and measure trust. She draws on Meize-Grochowski's definition of trust which states that it is a "willingness to place oneself in a relationship that establishes or increases vulnerability with reliance upon someone or something to perform as expected" (cited in Johns, 1996, p. 81). This vulnerability implies trust from a client perspective, so does not encompass reciprocity from care providers.

Trust is usually conceptualised as an entity which can be developed with, acquired or won from clients. It occurs at an interpersonal level and is linked to life experiences. A client is usually seen as developing confidence in and respect for an individual nurse over time. Trust is unilateral within this relationship.

Nursing, and more so Midwifery, literature tends to adopt psychological concepts of trust. So, for example, the relationship with a birthing woman is described in terms comparable to that applied to an intimate relationship, such as between partners, family members or friends (Flint, 1986; Leap, 1993; Hunt & Symonds, 1995; Johnstone, 1997; Coyle, Hauck, Percival & Kristjanson, 2001; Chan & Edmonstone, 2002; Staff, 2000; Tracy, 2005b; Toomey, 2007). This may assume a mutuality and reciprocity in trust which seldom occurs in therapeutic relationships (Brook, 1996; Smith, 1996; Stanfield, 1996; Howell-White, 1999; Hupcey, Penrod, et al., 2001; 2002; Norcom, 2002; Staff, 2000; Thompson, 2004; Robertson, 2003; Kirkham, 2004; Toomey, 2007), let alone with birthing women from diverse cultural backgrounds (Rice, 1998; McCourt & Pearce, 2000; Gibbins & Thomson, 2001; McLachlan, Waldenstrom & Short, 2003; Olds, London, Ladewig & Davidson, 2004). The positive aspect of this evident desire by midwives to develop reciprocal trust is that they are open to information sharing, eliciting birthing women's opinions and endeavouring to work with consumer choices (Flint, 1986; Johnstone, 1997; Robertson, 1998, 2003; Lavender,

[20] See Section 3.1 regarding the differentiation in descriptive terms.

Walkinshaw & Walton, 1999; Tracy, 2000; 2005a, b; Chan & Edmonstone, 2002; Kirkham, 2004; Fenwick, Hauck, Downie & Butt, 2005; Thompson, 2005; Vernon, 2006; Toomey, 2007).

By contrast with the Nursing/Midwifery literature, medical journals contain fewer references to trust. Although medical trust is linked to competence, integrity and truth, medical literature centres on *distrust* and *mistrust* with a focus on responding to threats and means of restoring trust. Defensive medical practices and 'risk management' policies are a consequence of this outlook.

Mechanic and Schlesinger's (1996) definition of interpersonal trust in individual doctors draws on the Hippocratic Oath and links to professional and fiduciary obligations. According to Mechanic and Schlesinger, within medicine:

> Trust refers to the expectations of the public that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and not inappropriately defer to others (control), and that they will make patients' welfare their highest priority (agency). Implicit in these criteria are the further expectations that responses will be sensitive and caring, that they will encourage honest and open communication, and that rules of privacy and confidentiality will be respected … (1996, p. 1693)

This encapsulates the views of other medical scholars, such as Clark (2005). This ideal notion of trust is one which supports the status quo of medical dominance, the sick role, and patient compliance. From this perspective, the success of medical care depends upon patients' believing in this ideal and not being reflexive consumers. Recently, however, there has been a significant shift from Parsonian notions of assumed trust in medical encounters.

Analyses of distrust and mistrust prevail in medical literature. The 'crisis' is epitomised by Mechanic's descriptions of an "environment of rampant distrust" (1996, p. 8) and the "climate of suspicion" (Mechanic & Schlesinger, 1996, p. 1693). Concerns encompass public distrust of medical authority, medical distrust of potentially non-compliant and litigious patients, and the need to cultivate and regain trust in doctors and the health care system. These themes are well supported by a decade of medical articles (for example Light, 1996, 2001; Leppert, Partner & Thompson, 1996; Finkelstein, Wu, Holztman & Smith, 1997; Levinsky, 1998; Hillman, 1998; McCarthy et al., 1999; Hall, Camacho et al., 2002; Hall, Zheng et al., 2002; Clark, 2002; Smith, 2003; Mechanic, 2004; Mello & Kelly, 2005). Multiple causes of this erosion of trust are described. These include changing health care delivery practices, the commercialisation of medical care, along with media attention to medical errors, rising

consumerism and for obstetricians especially, concerns about professional indemnity and litigation. Finkelstein, Wu, Holztman and Smith (1997), Thom and Campbell (1997), McCarthy, Finch, Cleary, et al. (1999) and Clark (2005) attribute the deteriorating relationship between patients and doctors to a complex situation involving interpersonal communication, patient expectations and health economics. They concur that patients are trusting until there is an event that breaches this trust. Trust, according to David Thom and Bruce Campbell, is highly correlated with the satisfaction found with individualised, patient-centred care (1997). Changing health delivery practices have made this type of care less common. Alan Hillman, who positions doctors as the "guardians of health", is "alarmed" that they can now only hope for the trust that was once "paramount" in relationships with many patients (1999, p. 1703). McCarthy et al. (1999) explore the validity and utility of scales that attempt to measure patient trust in the face of these challenges to medicine.

While Mechanic and Schlesinger acknowledge that public distrust also arises from conflicts of interest and "unscrupulous behaviour" by some institutions and professionals, they defensively assert that the medical community has made "extraordinary efforts to build confidence in physicians' competence and ethics through rigorous standards for education accreditation and through active public relations" and yet "confidence in medicine collectively has plummeted" (1996, p. 1693; Mechanic, 1998; 2004).

While Nursing/Midwifery literature generally seeks to build interpersonal trust, in the medical literature there is a tendency to attribute distrust to external causes at global, general and societal levels. However, Merrilyn Walton (1998) challenges doctors' attempts to blame patient distrust on external factors. She outlines situations brought before the Health Complaints Commission that undermine trust, concluding that: "We are constantly reminded of the importance of 'trust', not by doctors adhering to principles of beneficence, but by their failure to promote trust" (1998, p. 13). Similarly, Donald Light (1996) deplores doctors who have betrayed public trust by prioritising their private patients over the needs of their public ones. Further, Light and Hughes (2001),[21] reveal the ways in which some medical services exploit patients' trust for profit, and how particular models of managing health care contribute to loss of respect and trust.

Restoring general trust in health services has implications at an interpersonal level and vice versa. As Mechanic and Schlesinger point out, "Trust in one's physicians

[21] As a sociologist who focuses on medical and pharmaceutical practices and health policy, Donald Light publishes in both medical and social science journals.

and nurses can flow from confidence in the competence and commitment of the institutions with which they are affiliated" while "patients who trust in their physicians are less likely to worry about the trustworthiness of the hospitals" (1996, p. 1693).

Distrust has medico-legal and economic consequences. As discussed in section 1.4.4, regulatory enforcement to ensure compliance with risk management policies not only leads to medicine being practised in a defensive manner but also diverts the medical dollar away from patient care (Mechanic, 1998; 2004; Mello & Kelly, 2005).

Recognising that the vulnerability of patients has been exploited, Finkelstein et al. (1997) and Chalmers Clark (2005) advise the medical profession to deepen its commitment to developing empathetic attitudes and skills. Rather than practising defensively, medical practitioners can cultivate and sustain trust through developing mutually respectful relations (Finkelstein et al., 1997; Clark, 2005). This would address the doctors' ethical responsibilities rather than just managing risk and legal issues.

A small body of older medical literature considers the implications for trust relations when working with disadvantaged groups and across cultures. Although medicine is well recognised by social scholars as a powerful institution of social control, this is largely overlooked in the medical literature.[22] The asymmetrical relationships created by diverse cultural, linguistic (CALD) and socio-economic differences can hinder trust in therapeutic relationships. Patients from CALD backgrounds may feel ill at ease and trust is put under pressure because of asymmetrical relationships in staff-patient encounters (Kajubi, 1999; Thomas, 1999). As obstetricians who work with ethnic minorities and socially disadvantaged women, Leppert, Partner and Thompson (1996) highlight the importance of learning from the community ways to develop mutual trust through improved interpersonal communication, cultural awareness and sensitivity. They describe how historical experiences with punitive health and welfare authorities have created fear and suspicion and consequently obstruct effective maternity care delivery. "Losing one's children" and incarceration were amongst these fears (Leppert et al., 1996, p. 141). These perspectives on trust are applicable to the barriers perceived by Aboriginal women in this study.

A trend towards concordance is apparent in recent medical and midwifery articles. Accepting that social, structural and interpersonal factors have diminished 'instinctive' trust in experts, authors acknowledge that there is a need to re-define

[22] As a powerful institution of social control, Medicine is recognised as an alternative to, yet aligned with, the legal/judicial system (Illich, 1974; Foucault, 1975; Waitzkin, 1983; Conrad, 1992; Turner, 1995; Zadoroznyj, 1999).

relations between health professionals and patients (Stevenson & Scambler, 2005; Godlee, 2005a). Patients are becoming recognised as health consumers who are entitled to informed choices based upon unbiased information (Kirkham, 2004). Their perspectives need acknowledgement and they need to be involved in decision-making about their care. In relation to birthing women, the desire to gain their trust is evident in the debates over childbirth interventions, such as active management of labour and operative deliveries, as well as ethical concerns with clinical trials (Lavender, Kingdon, Hart, Gyte, Gabbay & Neilson, 2005; Godlee 2005a). While Fiona Stevenson and Graham Scambler (2005) advocate concordance, they believe that the same social influences which create distrust will make it difficult to accomplish. Further, they draw upon Habermas when claiming that "support for the notion of concordance could possibly result in a growth of hidden communication pathologies by means of … systematically distorted communication" (Stevenson & Scambler, 2005, p. 5). Recognising that successful communication and effective interpersonal relations underpin trust in health encounters, in this thesis it will be argued that concordance is the way forward.

From the available literature one surmises that trust is considered essential for successful therapeutic encounters. Being perceived as trustworthy is important for all health professionals. Trust is used synonymously with faith and confidence. It is perceived as integral to ethical, competent and caring practice. Nursing/Midwifery literature incorporates trust into psychosocial and cultural considerations when relating to clients. Within Midwifery sources, trust is aligned with reciprocity, mutual honesty, and a sense of intimacy between a birthing woman and her midwife. Shared decision-making is one outcome of this. While the principal focus of nursing literature is gaining unilateral interpersonal trust through effective communication, it is only recently that a handful of medical authors have recognised the need for doctors to develop their interpersonal skills. Although some medical authors consider trust to be a prerequisite to caring, others recognise that "trust building is an iterative process, requiring repeated evidence of competence, responsibility and caring" (Mechanic, 1996, p. 8). The sense of entitlement to fiduciary trust found in most medical sources is reminiscent of Parson's ideal of the doctor-patient relationship. Analyses of the 'crisis' in trust prevail in medical literature. Medical concern about diminished public trust predominantly focuses on threatening factors external to the therapeutic encounter including health systems, health economics, changing models of care, deprofessionalisation, risk management and rising consumerism.

1.6 Chapter summary

Chapter 1 has presented a rationale for studying women's perceptions of their childbirth experiences in rural and remote areas of North Queensland, contextualised within the global issues affecting social relations and health services in late modernity. As a reflective, feminist researcher, I have outlined my position and the way in which this study evolved in Section 1.2. Describing a study setting as rural or remote is problematic because the differing definitions have implications for access and available services, so in Section 1.3 the utility and limitations of the three most commonly used classification systems have been compared and contrasted. Then, the concepts of rural and remote, which will be employed in this study of women's health, were outlined and delimited.

The second half of the chapter explored the conjuncture between choice, risk and trust as key concepts for understanding health encounters and rural/remote birthing experiences. In Section 1.4 theoretical perspectives on choice and risk discourses were analysed. Gidden's notion of the 'existential terrain' of late modernity and Beck's concept of a 'risk society', where global trends are actualised in localised, everyday life events, were explored. A review of relevant sociological and health literature revealed how diverse notions of choice, risk and trust are expressed in social values, politics, health polices and practices, individual life plans and consumer expectations. Significant concepts outlined included ontological security, confidence in abstract systems and expert knowledge, and the importance of 'face work' for developing interpersonal relations and actualising the desire to 're-embed' at a local level. The limitations of the individualisation thesis and neo-liberal ideal of a choice biography were discussed. Issues of choice and reflexive consumerism for birthing women were presented from a feminist perspective and shown to be related to parity and social background.

The final section, 1.5 extended the literature review with a specific focus on differing conceptualisations of trust, mistrust and distrust in sociological and nursing, midwifery and medical literature. There was a general consensus that trust is essential for effective health encounters and that the erosion of trust is problematic. Typologies were common with trust grouped into global, social, general, interpersonal and intrapersonal levels. Of these, the reviewed literature largely concentrated on general and interpersonal trust. Causes and strategies to manage the 'crisis' in trust have been outlined from the various discipline perspectives. The notion of concordance is proposed as a way forward. This redefines relations within a medical encounter to enable shared decision-making and agreement about health care choices. This will be

revisited in Chapters 8 and 9 when addressing the implications between choice, risk and trust at the local level of maternity care provision. These key concepts will be advanced later in this thesis.

1.7 Outline of the thesis

This thesis is divided into five sections as visually depicted in Figure 1.1, *Navigating the thesis.* This first chapter constitutes section A and it has introduced the study. The second section, B, contains Chapters 2 and 3, which review the literature from two perspectives. As this is an interdisciplinary study, structuring the thesis in this way enables the reader to become familiar with the core body of literature in each field. Chapter 2 examines the socio-cultural, historical and political influences on birthing through a feminist lens. By contrast, Chapter 3 is specifically concerned with health delivery. Beginning with a general discussion of evaluating health services and quality care, the discussion then moves to reviewing the provision of maternity services in Australia, Queensland and rural/remote areas. The third section, C, contains three chapters. Of these, Chapter 4 flows from the review of rural/remote maternity services to describe the study sites where this project is situated. Chapters 5 and 6 discuss the methodology and methods. Section D contains two data chapters. Childbearing women and maternity care providers' perceptions of a good birth are discussed in Chapter 7. Chapter 8 presents the findings on relationships amongst and between maternity care providers and birthing women. The analysis encompasses occupational and family violence, along with issues related to choice risk and trust. Finally, section E contains the concluding chapter (9) with key findings and recommendations.

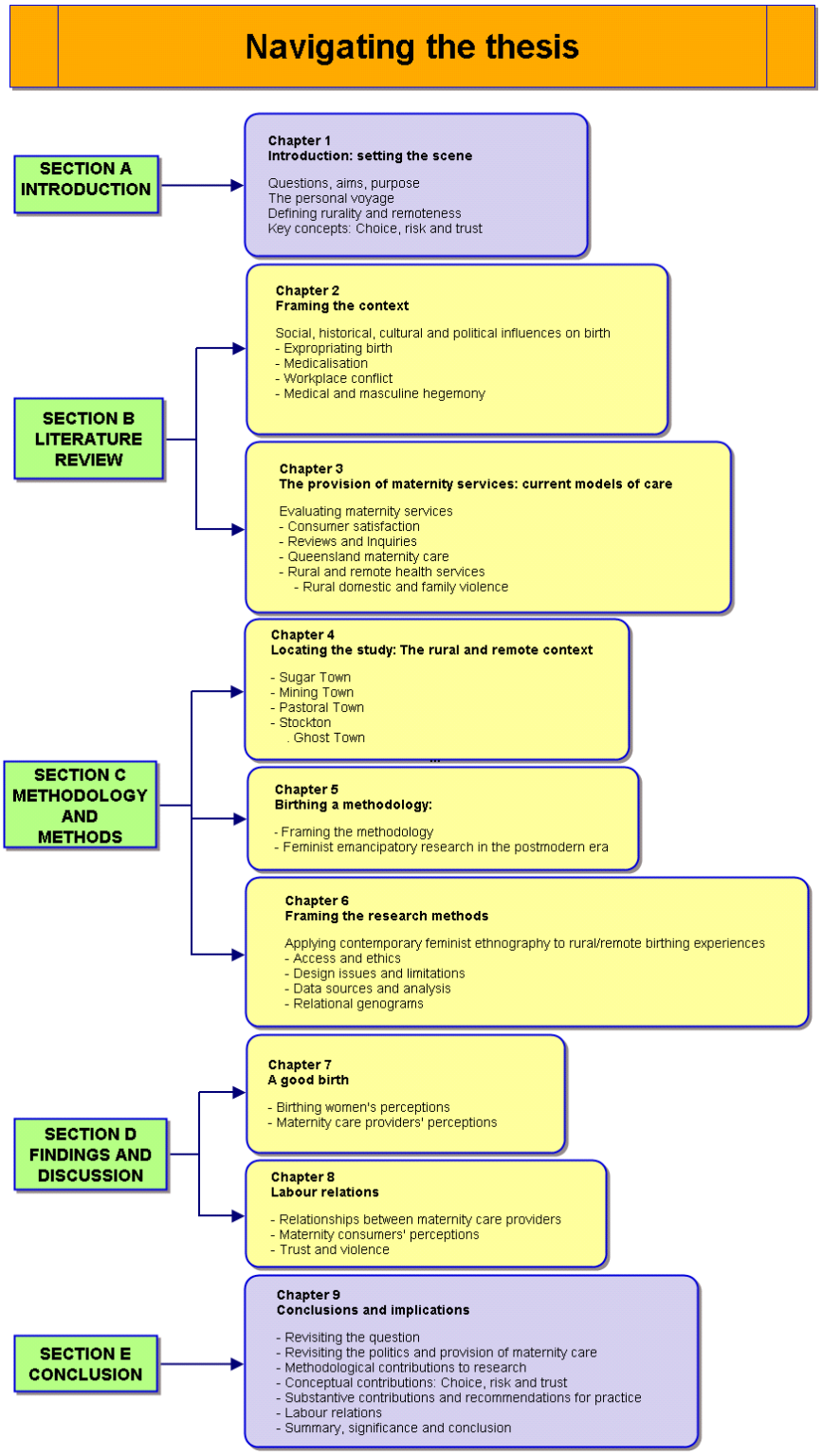

Figure 1.1 Navigating the thesis

Chapter 2

Framing the context: Reviewing social and political influences on birth

2.1 Influences on women's birthing experiences

Childbearing women's bodies can be perceived as contested "site[s] of human action in the social world" (Kent, 2000, p. 4). This statement locates childbirth, as an event and an issue, in a myriad of elaborate discourses which cross historical, socio-cultural and political boundaries. At the heart of these discourses is the regulation and control of childbirth. Pivotal actors are the providers of health services to birthing families who are also situated in complex and competing discourses which have led to social and cultural practices that affect maternity care. As noted in the Introduction, a key issue in the ongoing debate over models of care is that of women's informed choice and the extent to which they can or should have control over their own experience of pregnancy and birth (Kilpatrick & Richards, 1990; Kent, 2000; Senate Community Affairs References Committee [SCARC] 1999; Gamble & Creedy, 2001; Stapleton, Kirkham & Thomas, 2002; Kirkham, 2004; Australian Associated Press, 2005; Horsburgh, 2005). Lack of choice applying to access, expectations and preferences are significant to rural women's birth outcomes (NRHA, 2005a; Warner-Smith, 2005; Maternity Coalition, 2005; Lavelle, 2005; Ford, Nassar, Sullivan, Chambers and Lancaster, 2002; SCARC, 2005, Croker, 2002; Kildea, 2001; Tracy, 2005). Therefore, this chapter provides an overview of the background literature which addresses factors that in general influence women's ability to negotiate their 'ideal' birth experience, specifically within the rural and remote context of North Queensland.

The following review is not exhaustive, but aims to reveal the macro-structural influences upon birthing practices and examine the micro-interactive aspects of relationships between women and health providers. The body of the chapter is organised into three sections beginning with literature on the struggle for control of women's birthing bodies. This leads into a discussion of the jurisdictional disputes and tensions between and amongst health professionals followed by the impact of medical and masculine hegemony on birthing and rural women's lives.

There is extensive literature on the historical, socio-cultural and the political issues surrounding birth; however few studies have explored the experience of birthing in rural and remote areas of Queensland from the perspectives of the childbearing women and their health providers. Of the three studies located, Kathleen Fahy (1995a) explored the

marginalisation of teenage mothers and the attitudes of maternity providers in a rural town in South-east Queensland; Judith Fitzpatrick (1995) focussed on obstetric practices in Far North Queensland and identified issues for remote indigenous women, especially related to their lack of choice; and finally Gunhild Fisher (1999) studied the socio-medical representations of maternity and personal transformations of birthing women in rural North-east Queensland from an anthropological perspective. While each of these studies contributes useful insights on birthing in rural Queensland, they differ from this study in the demographics of participants, research sites and the research questions which they investigate.

2.2 Labour relations: The struggle for control of childbirth

Power relations amongst maternity care providers and with birthing women are deeply rooted in history and have an impact upon both the provision of care and the birthing experience. Therefore, a background understanding of the issues is significant to understanding current jurisdictional disputes, obstetric practices, cultural presumptions and social expectations within Australia.

An examination of the historical record illuminates issues that underpin the cultural transition of birthing from women's business, conducted within the private, female sphere, to the current medicalised birth conducted within a public institution controlled and regulated by the State. The long-contested history of childbirth involves interference by religious authorities, inter-professional rivalry and the privileging of medicine by the State and judiciary.

The most notable accounts of these processes come from second wave feminist scholars since the early 1970s, who took issue with the treatment of birthing women and the disempowerment of women as mothers and caregivers. Influential socialist feminists pioneered the sociology of reproduction; the ripple effect of their critiques still impacts today (Leap, 2005). Ann Oakley (1979; 1980; 1986; 1992) Barbara Ehrenreich and Deidre English (1973), Jean Donnison (1977; 1988), Lesley Doyal (1995) and Marjory Tew (1995) questioned how and why the (male) medical profession took control of childbirth and challenged the cultural presumptions and ideologies underpinning obstetric discourses. While acknowledging the impact of strong feminist perspectives on the conventional history of medicine, Deidre Wicks also considers the resulting harm to the current image of nurses (and midwives) as women who "capitulated" and are now "defeated" and "devalued" (1999, pp. 251-252). Wicks adds that "black and white" feminist accounts inadequately explain the "contradictions and reversals of power" or the dynamic complexities of contemporary practice (2002, p.

309). Similarly, Ann Saul warns against "overly polemical" analyses which "rest on unidimensional theories of history in which men conspire to deprive women of their natural power in the area of birth" (1994, p. 2). Like Mira Crouch and Lenore Manderson (1993), Saul (1994) argues for a more critical sociological approach to examining the politics of birth.

The following section provides a brief history of medicine and maternity care, largely from the viewpoint of renowned feminist scholarship on birth. Although the earlier feminist works can be criticised for a tendency towards essentialism and for being too homogenising of women's oppression, their exposure of the dominant ideologies is foundational to later analyses of childbirth, including those by male sociologists such as Evan Willis (1989) and Bryan Turner (1995). Feminist critiques of the influences of patriarchy and gender relations on the expropriation of birth are now common throughout the sociological, nursing and midwifery literature. While acknowledging the profound effects that patriarchy has had on childbirth and maternity care provision, as an inductive feminist researcher, I would caution readers of the following discussion against generalist assumptions that all contemporary medical men are self-serving, all midwives are essentially virtuous and women-centred or that all birthing women are docile bodies under an oppressive clinical-gaze.

2.2.1 Expropriating childbirth

Since antiquity childbirth has been a women's affair (Genesis 35:17; 38:28 *New International Version*; Abbott, 1988; Apunipima Cape York Health Council, 2000). Widespread literature across disciplines demonstrates the ubiquitous role of the "midwife"[23] in women's reproductive issues such as fertility, contraception and pregnancy as well as support in labour, attendance at birth and provision of maternal and infant care. This unique relationship and the positive impact it has on birth outcomes is well acknowledged by the World Health Organisation (Phumaphi, 2005; WHO, 2005). While the role and practices of midwives have varied across time and cultures, the social meaning of birth has remained closely aligned with the social meaning of midwifery (Hunt & Symonds, 1995; Lupton, 1994; Berg, Lundgren, Hermannson & Wahlberg, 1996; Kent 2000). Until modernity, midwifery was practised within a community setting by women and for women. Consequently, women's birthing

[23] From the Anglo-Saxon, *mit wif*, midwife literally means 'with woman'. The name and meaning varies across cultures and time. For example, the Norwegian for midwife, *jordm∅rdre* means 'earth mother', while the French *sage-femme* and German *weise frau* describe a wise woman. The internationally accepted WHO definition (1992) describes an educated, qualified and legally licensed practitioner in contrast to lay-midwives or traditional birth attendants.

practices have been deeply embedded and intertwined with the practice of midwifery and this cooperative relationship has been convincingly shown to impact upon a woman's authority over her birthing choices (Oakley, 1984, 1986, 1993; Wertz & Wertz, 1989; Leap & Hunter, 1993; Saul, 1994; O'Dent, 1996; Tew, 1995; Wagner, 1998; SCARC, 1999). Therefore, when considering the social construction of birthing, the personal narratives of mothers and midwives can be situated in the same 'critical plane' (Thomson, 2004) when they share assumptions, beliefs and values about the position of women within in patriarchal society, both past and present.

Historically, the social construction of gender roles both enabled the position of midwives to be respected within women's sphere of activity and also made them vulnerable to outside attack by male authority. Although a woman's reproductive processes were considered normal life events, their 'little secrets' were surrounded by mystery, rituals and taboos (Broomhall, 1999; Versluysen, 1981; Finkelstein, 1988). Europeans commonly held beliefs about 'original sin' with the pain of childbirth being viewed as the 'curse of Eve' (Fraser, 1984; Steinman, 1998, Woolcock, Thearle & Saunders, 1997). Midwives' knowledge of female reproduction and their skills in managing the mysteries of nature along with their role as guardians of women's business, contributed to their persecution (Donnison, 1977, 1988; Versluysen, 1981; Finkelstein, 1988; Turner, 1995; McClive, 2002).

Before the twentieth century, most women's social roles were subservient to those of men and confined to the private sphere. Shorter (1982), Doyle (1995), van Hall (1998), Annandale and Hunt (2000) assert that the inferior position, exploitation and victimisation of women threatened their health, resulting in a higher mortality rate than that of men. In addition, malnutrition, disease and medical ignorance meant that maternal and infant mortality rates were high (Doyle, 1995; George & Davis, 1998; Johanson, Newburn & Macfarlane, 2002); consequently childbirth was dreaded by many women. According to Shorter (1982), the precondition for a reversal in female mortality was an overall improvement in women's physical condition, along with advances in obstetrical and gynaecological care between 1900 and 1930. However, the adequacy of this explanation has been contested by Annandale and Hunt (2000) and van Hall (1998), who assert that the achievement of social equality and freedom are prerequisites for the enhancement of women's health. This view is endorsed by Safe Motherhood programs which contend with similar issues in developing countries today (WHO 1995, 2005; Phumaphi, 2005; Rogo, 2005).

In the past, hospital birth was uncommon outside of major cities (Johanson, Newburn & Macfarlane, 2002) with homebirthing continuing in rural areas of Australia

into the 1950s[24]. With the exception of the 'man midwives' who emerged in the seventeenth century, midwifery has always been a feminised profession. Traditionally, midwives were skilled women largely from the lower classes and as such, they were barred from formal learning and public practice. Although midwifery texts were printed and distributed, illiteracy reduced their impact (Oakley, 1984; Gelbart, 1998). In addition, the prevalent cultural view was that the publication and "open discussion of sexual matters was not appropriate for women" which, according to Broomhall (2002, p. 2) limited the content of female-authored texts.

Historical records dating from the Middle Ages through to the nineteenth century reveal that crafts like midwifery were learnt through an apprenticeship system combining an oral tradition with extensive practical experience. As Shorter (1982), Leap and Hunter (1993), Leap (2005) and Turner (1995) point out, distinctions need to be made between the urban midwives, who were more knowledgeable and competent with obstetric complications than their medical contemporaries, and the traditional or lay midwife in rural areas who needed to call upon trained medical services when intervention was required. Similarly, Allotey (2005) recounts the visionary English midwives who, confident in their knowledge and abilities, resisted the emerging medicalisation of birth.

Gelbart (1998), Marland (1993), Murphy Lawless (1998) and Broomhall (2002) describe how exceptional sixteenth and seventeenth century European midwives needed to be elite women, whose education and political astuteness enabled them to successfully challenge the jealous medical establishment, status seeking surgeons, finance ministers, legal and religious restrictions. The alliance of Church and State precipitated a change in authority over birthing practices. Defending the rights of women and their infants against power has been documented as a midwifery role for 4000 years (Exodus 1:15 – 22, *New International Version*) and continues today through peak bodies (Maternity Coalition; International Confederation of Midwives [ICM]; Australian College of Midwives [ACMI]). Although there are documented accounts of professional rivalry between physicians and midwives during the Middle Ages, from the seventeenth century the regulation and licensing of midwives intensified and was accompanied by the punishment of 'sinful', 'disobedient' women. Theodicy aligned their wisdom and craft with ignorance, superstition and Satanism (Ehrenreich & English, 1973; Donnison, 1988; Burch, 1994; Turner 1995). During the "burning years" when

[24] For example, older women in the farming towns of North Queensland fondly relate how the midwife would not only attend the birth but stay with them for their 'lying-in' period, assisting with domestic duties while they recovered. The midwife could also be of their ethnic background.

"witches" were eliminated, a wealth of folk knowledge about women's health was destroyed (Ehrenreich & English, 1973; Wertz & Wertz, 1989; Elworthy, 1996; Murphy-Lawless, 1998). As Evan Willis (1989) points out, medical dominance preceded modernity; however it is was strengthened by the emergence of technocratic medicine and the resiting of birth into male-run 'lying-in' hospitals (Versluysen, 1981; Donnison, 1977; 1988).

Nicky Leap (2005) examines the feminist tradition of exploring resistance to patriarchal, medical dominance in Europe from the middle ages to modernity. She provides evidence that the witch hunts "have been exploited in terms of 'inventing a holocaust' "as midwives seek inspiration and comfort "in rhetoric that resonates with our contemporary struggles" (Leap 2005, p. C1).[25] Whilst revisiting the passionate rhetoric of midwifery icons who resisted medical dominance and the medicalisation of childbirth, Leap explores the issues of gender politics, power and control and suggests that activism should be grounded on the evolving polemics of the changing discourses.

Modernity is a significant point in the social construction of birth for three reasons: birth becomes pathologised and medicalised during this period, the place of birth begins to shift to the hospital and the differentiation in jurisdictions for accoucheurs occurs. Turner (1995, p. 89) describes the professional strategies of male practitioners in modern Europe to confine the role of midwives to that of "mere attendants at the birth" while they equipped themselves with instruments and technologies for interventions into "abnormal" births.

With the introduction of charitable "lying-in" hospitals in eighteenth century European cities, the shift from homebirth to centralised institution placed lower class women under the supervision of male midwives, precursors of obstetric management. No antenatal care was provided and "poor labouring women" were considered to be malingering if they attended prior to "lying-in" (Versluysen, 1981; Oakley, 1984; Donnison, 1977; 1988).

Lying-in hospitals provided an ideal teaching environment for male practitioners. Notable exceptions to the exclusion of pregnant women were the university hospitals which provided shelter for expectant, largely unmarried women from the lower classes. These impoverished and 'immoral' birthing women became "living manikins" (Schlumbohm, 2001, p. 59) for the doctors and man-midwives being trained in new 'scientific' obstetric techniques, such as the use of forceps, enabling them to gain the skills needed to attend to wealthy patients.

[25] This is an example of the Nietzschean notions of nay saying and *ressentiment*, as discussed in Chapter 5 (Horstmann & Norman, 2002; Tapper, 1993).

De Costa (2002), an obstetrician, reflects upon the benefits and disadvantages of women birthing in nineteenth century lying-in hospitals. While these institutions gave women access to technological 'advances' such as the relief of obstructed labour and intrauterine manipulation, she notes that conversely, the contaminated instruments, frequent vaginal examinations and over-crowding resulted in high maternal mortality rates from epidemics of puerperal sepsis[26] (De Costa, 2002).

Odent (2002), a prominent obstetrician and critic of medicalised birth, explores a corollary between the industrialisation of agriculture and the emergence of modern obstetrics. Distrust in 'natural' processes has led to a reliance upon technology and obstetric practices involving high levels of intervention, with iatrogenic consequences.

From another perspective, Moscucci (1990, cited in Lupton, 1994), views the emergence of male medicine's concern with female reproduction as coinciding with concerns about the quality of the industrial labour force. The emergence of capitalist society necessitated industrialisation and urbanisation which created appalling social conditions, widespread disease and high mortality rates (George & Davis, 1998), with women and infants from the poor masses being at greatest risk (Doyle, 1995; Marland, 1993; Finkelstein, 1988). Impoverished birthing women could not afford the fees of a skilled professional and so relied upon cheap birth attendants (handywomen) or untrained neighbours who could be re-paid with a reciprocal service. As Tew (1995) explains, this led to an association between midwifery and poor birth outcomes which medicine exploited into the 20th century. Concerns about maternal and infant mortality led to scrutiny of midwifery practices and an assertion that the solution lay with the rationality of science (Lupton, 1995).

With the advent of a technocratic model of medicine, female midwifery practices came increasingly to be seen as being in direct competition with medical science's expansion into the business of 'obstetrics,'[27] a trend which deepened hostilities between male and female practitioners. Versluysen (1981) and Willis (1989) provide historical examples of polemical literature that shows the vigorous debates and battles for territory.[28] Professional rivalry led medical men to embark upon a well-documented, well-coordinated and well-financed campaign to deliberately and systematically assert authority over female midwives and childbirth. They used their privileged social position to

[26] The maternal mortality from puerperal sepsis was as high as 4:5 birthing women in 19th century Europe (Louden 1986, cited in De Costa, 2002, p. 668).

[27] British doctors practising midwifery debated possible titles for their profession. *Accoucheur* was considered too French whereas the Latin derived 'obstetrician', meaning 'to stand before' sounded honourable and in keeping with the scientific domination of nature (Wertz & Wertz, 1989).

[28] For example, the knighting of an English male midwife in 1780 was considered a political and professional victory.

influence the media, politicians, policy makers and the public. Midwives were denigrated, ridiculed and regulated to increase medical management and control of birth (Tew, 1995; Wertz & Wertz, 1989; Donnison, 1977, 1988; Oakley, 1980, 1984, 1993a; Garcia, Kilpatrick & Richards, 1990). As is evident in recent media exposure of the disputes between obstetricians and midwives over models of maternity care, “Battlefield birth” continues to this day (Cresswell, 2005; ACMI, 2005a; Hirst, 2005; Grimm, 2005).

It has been argued that the medicalisation of birth was spawned by the industrial revolution and is closely aligned with capitalism. Waitzkin (1983) and Doyal’s (1995) analyses of the political economy of health care reveal the mechanisms of power and control employed by the dominant (capitalist) class in society to achieve a medical monopoly and scientific technocracy, in the business of childbirth. According to Freidson (1970), Willis (1989) and Turner (1995), medicine derives its power from the state and strategic alliances with political and economic elites. The strategies used to assert medical dominance and destroy competing occupations include well-organised, concerted efforts to devalue, discourage, subordinate and exclude the opposition (Freidson, 1970; Willis, 1989). Hooyman and Gonyea add their examination of the inter-relationship between patriarchy and capitalism, stating that "Under capitalism, patriarchy expanded from the private sphere of the home into the public arena of the marketplace, with men dominating and oppressing women in both realms" (1995, p. 29). Miers (2000) attributes gender inequality, the sexual division of labour within the health sector and present doctor-nurse relations to the patriarchy-capitalism nexus. Not only does this have implications for women as professional carers (midwives) but, according to Hooyman and Gonyea, this has also particularly affected women's role in reproduction, that is, giving birth, rearing the next generation and nurturing those already in the workforce (1995, p. 27). Fahy (1995a, 1997) applies the combined effects of patriarchal and capitalist ideology to maternity services, especially focussing on the (mis)treatment of unwed, teenage mothers in Australia.

The authoritative accounts of British authors Donnison, (1977, 1988), Oakley (1980, 1984), Kitzinger, (1988), Leap and Hunter (1993) Tew (1995), Doyal (1995), Murphy-Lawless (1998) and Kent (2000) reveal how patriarchal biases, gendered assumptions and commodification of services within the context of capitalism enabled elite medical men to exclude female midwives from formal education and lucrative practices while achieving a privileged social status upheld by church support and state legislation. Not only did medicine colonise women’s bodies, expropriating birth, but also, as the dominant discourse, medical ideology was transmitted across the world, with colonisation of new lands being accompanied by replicated health care models. Consequently, similar themes also emerge in North American literature, notably the

work of Ehrenreich and English (1973), Rich (1976), De Vries (1985), Wertz and Wertz (1989) and Davis-Floyd (1994 a, b), as well as in New Zealand (Donley, 1986; McLauchlan, 1997; Papps & Olssen, 1997) and Australia (Finkelstein, 1988; Willis, 1989; Crouch & Manderson, 1993; Lupton, 1994; Lecky-Thompson, 1996; Reiger, 2001).

Tuchman (2005) argues alternatively that the displacement of midwives found in Britain and the colonies was not a universal experience. She contends that the portrayal of midwives as victims of a state-sanctioned medical hierarchy is only one interpretation; alternatively, European midwives could be seen as beneficiaries of a state's protectionist policies. Tuchman emphasises midwives' success in resisting elimination by obstetrics through trading their independent practice for state regulation and protection (2005, p. 23). While this partially explains the higher status of midwives in some countries and the greater reliance of birthing women on their expertise, Willis' theory is more suitable for the Australian situation.

Evan Willis (1989) uses midwifery as an exemplar of an archetypically subordinated profession. According to Willis, this process has gone through four stages in Australia. He describes the English antecedents, the pioneering era, the transitional era up to 1910, followed by the era of take-over in which birth was re-sited from home to hospital and the sexual and occupational division of labour was transformed (Willis, 1989). This is evident in current workforce and perinatal statistics (AHWAC, 2002; AIHW, 2004a, b).

Through the 20th century, birth, once seen as natural and the domain of women, became pathologised and medicalised culminating in the 'reign of technology' of the 1960s and 1970s (Wagner 1994b; Crouch & Manderson, 1993). The childbearing body was portrayed as frail, imperfect, incompetent and in need of expert medical intervention to assist with safe delivery. The introduction of operative obstetrics and analgesia, accompanied by the promise of a safe, painless birth, enticed women into hospitals and medically managed care (Tew, 1995). Medical knowledge became corporatised and the biomedical model of care became hegemonic (Willis, 1989, p. 219). Birthing women became a compliant, docile population of patients. The role of midwives as guardians of natural birth was dramatically changed (Garcia, Kilpatrick & Richards, 1990; Marland, 1993; Mahowald, 1993; Oakley, 1993a).

Despite some resistance, throughout the twentieth and into the 21st century, midwives have been legally de-limited and stringently regulated by various Acts of Parliament and State registration authorities, and thereby becoming successfully marginalised (Finkelstein, 1988; Saul, 1994; 1997; Lecky-Thompson, 1996; Leap, 2005). Thus, within Australia, obstetrics has achieved a high social status while

reducing professional competition and maintaining control of both normal and abnormal childbirth. This transformation has both a class and gender basis (Wicks, 1999; Wearing, 2004). Although Wicks (1999) challenges this over-simplification, Australian Midwifery is overwhelmingly comprised of women[29] (AHWAC, 2002; AIHW, 2004a, c) whose scope of practice ensures that they work mainly in institutionalised settings under obstetric supervision, for lower pay than medical practitioners (Willis, 1989; Barclay & Jones, 1996; Fahy, 1997; AHWAC, 2002). Some critics contend that midwives have lost their traditional skills with birthing women and instead have become obstetric nurses who extend the professional control and surveillance of childbirth (Donley, 1986; Barclay, Andre & Glover, 1989; Papps & Olssen, 1997; Lane, 2005).

As a consequence of this long, bitter struggle over the control of childbirth, 'labour relations' continue to be tense as professional boundaries are re-defined or reinforced (Garcia, Kilpatrick & Richards 1990; Kitzinger, Green, Coupland, 1990; Lecky-Thompson. 1996; Callaghan, 1996; Thompson, 1996; Wicks, 1999; 2002; Stewart, 2005). With the fall in fertility and birth rates in Australia (AIHW, 2004a; Bryson, Strazzari & Brown, 1999), competition amongst carers in the childbirth 'business' has increased. Jurisdictional disputes continually arise between maternity care providers, as is evident in media releases from the Australia College of Midwives, the Australian Medical Association and the Australian College of Obstetricians and Gynaecologists (Cresswell, 2005; ACMI, 2005a).

With the national shortage of midwives and obstetrically qualified medical professionals, two scenarios have emerged. From a consensus/pluralist perspective, the first can be seen as an attempt to provide collaborative, 'seamless' models of care to birthing women through midwife-run clinics, 'share care' with GPs, multi-disciplinary alliances and joint ventures in rural health. Weaver, Clarke and Vernon (2005) call for a *modus vivendi*[30] and an end to the 'turf wars'. As neither profession is able to survive without the other, they advocate a complementary practice that would benefit maternity care providers and birthing women. Current discussions explore the nature of collaborative relationships between health professionals (Brodie, 2005; Reiger, 2005), and with birthing women (Reiger, 2001a; 2005; Lane, 2005). However, from a conflict perspective, the uneasy alliance between maternity care protagonists could be compared to Latimer's (2004) notion of 'inclusion' to retain control and reduce the threat of competition from another occupation within a multi-disciplinary workforce.

[29] 99% of midwives in Australian are women (AHWAC 2002; AIHW, 2006).

[30] According the *Dictionary of Cultural Literacy* (2002), a *modus vivendi* describes a temporary compromise between adversaries; an accommodation of a disagreement between parties pending a permanent settlement.

There is a notable resistance on the part of medicine to an autonomous Nurse Practitioner model and to stand alone midwifery units (Grimm, 2005; AMAQ, 2005; Cresswell, 2005b). The AMA endorses the ongoing exclusion of Independent Midwives from Commonwealth support for indemnity insurance or Medicare provider status (AMA, 1999; ACMI, 2002a, b; Maternity Coalition, 2002; 2004a, b). However, alternative models of maternity care are emerging and will be discussed in Chapter 3, "The organisation of maternity care*".*

2.3 Hostility: Unhealthy relationships amongst care providers

As negative workplace interactions emerged in this study as a significant barrier to the optimal care of childbearing women, this section will draw on four theoretical approaches in an effort to provide a background understanding of potential causes that underlie workplace aggression between care providers. Because there is no consensus on the most appropriate term to describe the antipathy between health professionals (Sinclair, 2005), workplace bullying, conflict, harassment, horizontal violence, hostility, 'hazing', mobbing and aggression are just some of the terms used synonymously to describe the phenomena.

2.3.1 Professionalisation

One explanation is that of professionalisation. Accepting Weber's contention that medicine is the profession *par excellence* (Latham, 2002)*,* tensions arise amongst other health professionals as they attempt to raise their occupational status, improve their professional capital, and encroach upon each other's professional boundaries in their efforts to expand their scope of practice and seek recognition as autonomous practitioners (Brodie, 2005; Palmer & Short, 2000; Williams, 2002). Turner (1995) and Wicks' (1999; 2002) interpretive critique of professionalisation explores the professional project to attain both a monopoly and autonomy over an area of practice along with the power and privilege to manipulate and control clients and markets. In particular, Turner (1995) highlights the need to consider occupational histories, and the social production of professional claims to knowledge and expertise as well as the cultural contexts in which professions have evolved. Where one professional body encroaches horizontally or vertically upon another's occupational territory (such as obstetricians attending to normal birth or midwives practising autonomously in birth centres and homes), conflicts occur. Consequently, as is seen in relations between medicine, nursing and midwifery, tensions arise when the professions struggle for expanded occupational control, seek autonomy, or defend their boundaries against perceived territorial threats.

Within Australia, midwives seek to challenge the status quo and regain a scope of practice that enables autonomous practitioners to provide woman-centred, seamless care between institutions and the community (ACMI, 2005b; AHWAC, 2002; Brodie, 2005). This has placed them in conflict with both nursing and medicine. Advocates for the professionalisation of midwifery aspire to the lead-carer status of midwives in the United Kingdom and New Zealand (Barclay & Jones, 1996; James & Willis, 2001; Maternity Coalition et al., 2002; AHWAC, 2002). As such, through both educational initiatives and political action, midwifery is challenging the occupational positions, status and professional ideology of medicine and nursing (Reiger, 2001b, James & Willis, 2001).

Australian midwives are firstly nurses[31] and as such their practice is governed by nursing councils in each state. However, rather than identifying with nurses, or seeking gender solidarity[32], midwives perceive disciplinary differences so have pursued their own professional project. Those who embrace the midwifery philosophy (ACMI, 2005b) resent being subsumed by nursing (Brodie, 2002; 2005). This struggle for professional recognition, self-regulation and self-determination is evident in Hancock's statement:

> [Midwives] consistently justify and defend our existence separate from nursing. Nursing has 'spoken for' and enshrouded midwifery in a cloak of anonymity. Midwifery's intention has always been to distinguish itself as a discipline in its own right, to strive for the rights and needs of women and to focus fundamentally on health, normality and wellness. Additionally, midwives themselves have moved to research and to implement innovative patterns of care that have further advanced their roles and autonomy and been recognised internationally for safety, economy and satisfaction for women (1999, p. 12).

Hancock advocates reviewing midwifery's alliance with nursing and directing energy towards an amicable and mutual relationship between midwifery and obstetrics so as to achieve "the best care we can provide for and with women" (1999, p. 13). This position presumes that midwives and birthing women are working in a harmonious partnership to achieve a mutual goal (Maternity Coalition, 2002; Lane, 2002, 2005; Thompson, 2004, 2005; Toomey, 2007), rather than that midwifes are using consumer support as a strategy to build professional capital and achieve disciplinary gains.

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[31] At the time of writing, the first direct entry, Bachelor of Midwifery students are completing their degrees in South Australia. Within Queensland, a midwife who is not a nurse cannot be registered with the Nursing Council, only endorsed, and consequently her scope of practice is restricted.

[32] National statistics tend to subsume midwifery within Nursing. However, while 8.7% of the Nursing workforce are men, only 1% of the midwives are male (AIHW, 2006).

Kerreen Reiger (2001b, 2005) revisits the notion of power as domination in her interpretative study of the conflictual relationship between midwifery and obstetrics. She asserts that, positioned as the 'other' by obstetrics, and seeking professional recognition, midwives participate in perpetuating a professional narrative that entrenches the cultural and psychological dynamics of the gendered power relations, thus contributing to the mutual disrespect and conflict (Reiger, 2005). If health professionals are to provide quality care to birthing women, Reiger contends that they need to respect professional differences, seek new ways of collaboratively working together and avoid 'turf wars' (2005, p. 2).

Mavis Kirkham's (2005) interpretation of oppositional thinking can also be applied to inter- and intra-professional differences. Through dichotomous thinking, paired opposites are created in which the 'other' is perceived as different and devalued (Thiele, 1986; Oakley, 1993; Croker, 1994). According to Kirkham (2005), this simplistic and limited way of viewing 'them and us' within practice is most likely when staff are "overstretched and vulnerable" as it "provides temporary relief"; however it causes isolation, ruins professional alliances and reinforces existing power relations. Kirkham asserts that "categorising some groups of colleagues and clients as the 'other' may account for some of the horrible ways in which midwives treat deviant groups" (2005, p. 1).

Contrary to the professional project, Lane (2005) finds that a significant number of midwives remain comfortable within the security of the current professional hierarchy and institutional model of care while a significant number of the obstetricians she interviewed challenge the stereotype of the intransigent doctor and expressed concern about the way some midwives teamed with women against them.

In summary, while professionalisation explains some of the fraught relations between professions, in particular midwifery and obstetrics, as Wicks (1999; 2002), Hamlin and Harrison (2003), Reiger (2005) and Kirkham (2005) point out, the professionalisation project alone does not explain the endemic horizontal violence between and amongst midwives and nurses.

2.3.2 Oppressed group behaviour

Inter-group hostility and bullying within both nursing and midwifery are also congruent with Paulo Freire's (1971) description of oppressed group behaviour (Crookes & Knight, 2001; Papps & Olssen 1997; Hastie 2002a, b; Muff, 1988; Hedin 1986). As evident in section 2.2, the dominant ideology in the health system is male, medical, technical and controlling; therefore relationships between health care providers are asymmetrical. According to Freire (1971), members of oppressed groups

aspire to resemble the oppressor. Instead of targeting their hostility towards the higher status group which controls their subordination, the oppressed group glorify and sympathise with the dominant group: viewing them as right, powerful, good, and the existing sexual power relations as 'natural'. Manifestations include overt and covert non-physical hostility such as undermining co-workers, infighting, 'back-biting', 'upmanship', 'bitchiness', jealousy, scapegoating, manipulative and subversive behaviours and denigration of other members of the group (Whitehouse, 1991; Clements, 1997; Crookes & Knight, 2001).

According to this theory, the effect of these behaviours is to fragment or 'divide and conquer' the subordinated group, which serves the dominant group's purpose. However, deconstructive approaches would argue against the hegemonic, decontextualised stance taken by the proponents of oppressed group behaviour. Multiple flaws in these constructs are revealed by Gore (1990a, b), Lather (1990), Luke (1991) and Papps and Olssen (1997) who question the validity of labelling groups as oppressors or victims. They problematise the inherent notions of 'empowerment' and power as a possession or desirable end-state. Wicks adds that, while it is important to consider the powerful social forces that direct and limit nurses [and midwives], they should not be viewed as "passive or misguided victims of these forces" or "misguided collaborators in a patriarchal system" (1999, pp. 3-4). Furthermore, there is little evidence that raising a 'critical consciousness' (Freire, 1971) of the effects of bullying amongst female health providers has empowered the oppressed group and reduced the problem (Glass, 2003; Shallcross, 2003).

Susan Clements (1997) and Nel Glass (2003) comment that horizontal violence has become part of women's everyday experiences and reality so that many nurses (and midwives) perceive it as accepted behaviour. These destructive behaviours have been mistakenly associated with women working together and therefore minimised. As Carloyn Hastie (1995; 2002b) points out, the consequences can be devastating when 'midwives eat their young'. As the tragic literary accounts show, not only are 'fledglings' affected by this workplace violence.

Linda Shallcross (2003) provides chilling descriptions of the behaviours and serious consequences of the 'mobbing syndrome' in Australian workplaces. These accounts can readily be applied to nursing and midwifery contexts. Malicious passive-aggressive and abusive behaviours occur when a staff member challenges the status quo or the dominant workplace culture, resulting in attrition of capable workers (Shallcross, 2003). As this phenomenon often occurs horizontally or from the 'bottom-up', it may be perceived as either hegemonic or as another challenge to the inherent power-relations which Freire (1971) describes within oppressed group behaviour.

Within midwifery, the philosophy underpinning practice ranges from that of obstetric nurses, who are comfortable with medicalised birth in an institutional setting, through to midwives who work in community-based teams and those who provide low-interventionist homebirthing. Different models of care attract midwives with particular characteristics and personal philosophies. Instead of achieving strength through diversity, and seeing this as a continuum of care, attitudes and beliefs are often placed in opposition. Conflicts arise, for example, between hospital-based and community-based midwives. In particular, homebirthing midwives and the women for whom they care are often treated with animosity and even victimised, by midwives who support a biomedical approach and see birth outside of a hospital as am inherently uncertain and risky practice (Saul, 1994; Lecky-Thompson, 1996; Callaghan, 1996; SCARC, 1999; Chan & Edmonstone, 2002; Lane, 2002). Furthermore, Carolyn Flint (1993, p. 138) describes the "blaming, bickering, backbiting and bitching" which prevents midwives from effectively providing collaborative care to birthing women.

Horizontal and vertical aggression barriers are such significant problems that childbirth websites dedicate space to strategies for their reduction (Hastie, 2002a, b; Sinclair, 2005) and the Australian College of Midwives is in the process of updating the position statements that define horizontal violence in midwifery (ACMI, 2002e) and provide strategies to avoid it.

2.3.3 The 'vocabulary of complaints'

Turner's (1986) 'vocabulary of complaints' provides an alternative insight which can be applied when analysing interactions within maternity settings. Using discourse analysis to frame the social interactions, Turner studied the formation of a system of complaints which developed in Australian nursing as a response to the social and cultural factors creating dissatisfaction. He identified the function of this system of complaints as an occupational sub-culture designed to unite nurses in opposition against both their hospital-based superiors and the demands of their patients. As Turner points out the doctor/nurse relationship is "a primary illustration of medical dominance" in which "the frustrations of nursing are over-determined by a range of structural and ideological features which conspire to limit the professional autonomy of the nurse" (Turner, 1986, p. 368). The vocabulary of complaint is a response to the lack of work-context autonomy and medical surveillance of nurses and patients. This concept can readily be applied to the relationships between health providers in maternity settings.

Based on C. Wright Mills (1940) sociology of motives, Turner's (1986) study evaluates the motives and accounts given as explanations for activities, with a focus on

deviant or untoward actions. Of particular interest were the reasons given for why actions were taken and the responses to evaluative inquiry. Accounts could be excuses that recognised untoward acts, or justifications which, while accepting responsibility for the behaviour, did not acknowledge the act as negative.

Turner recognises that all social actors enter social situations already equipped with individualised vocabularies which "structure and interpret everyday realities" (1986, p. 375). This notion is extended to occupational groups in which the vocabulary functions to delineate authority and official ideology. Turner states that:

> Vocabularies of complaint provide techniques or devices for handling situations which are inherently conflictual, especially where there are systematic conflicts between norms and actual practices (1986, p. 375).

Significant for this study is Turner's distinction between the formal, frontstage, "discourse of compliance" and the informal, backstage "discourse of complaint" (1986, p. 375). Croker's (1994) research, which explores the mismatch between formal interviews with nurses about clinical experiences and their complaints during informal interviews about dissatisfaction and disagreements with educators and hospital staff, gives credence to Turner's work. The formal, professional character of nursing and midwifery was found to be controlled through education and training, but sub-cultural ideology was powerfully transmitted through a socialisation process 'while on the job' (Croker, 1994; Turner, 1986).

Forsyth and Mackenzie (2003) apply Turner's notions to the problem of nursing retention in the contemporary Australian health workplaces. Although they find the discourse of discontent to be as described by Turner, the focus of the vocabulary of complaints has changed from issues related to lack of autonomy and subordination to medicine to concerns about the health system and frustration with deteriorating industrial conditions.

Mary Stewart (2005) considers the counter-productive outcomes of such subversive 'back-stage' discourses. To circumvent the dominant knowledge system and avoid unnecessary obstetric interventions, Stewart finds that midwives do not accurately document their vaginal examinations of labouring women in order to 'buy time.'[33] While this is a powerful way to undermine the authoritative, 'scientific'

[33] Obstetric management of labour includes normative times for each stage which are documented as partograms. Critics of partograms allege that they are based on flawed data as the definitive study included women who did not experience normal physiological labour. Midwives recognise an alternative perspective in which individual women have labours of variable duration. (Stewart, 2005; Olds et al., 2004; Wagner, 2002).

management of labour and values midwives' tacit knowledge, the practice is problematic as the lack of transparency means that no documentary evidence is produced to challenge medical ideology or to rewrite parameters of flawed instruments like partograms. In addition, the unethical practice leads to questions of integrity as it excluded disclosure to birthing women and involved inculcation of students, some of whom felt pressured to conform (Stewart, 2005). Given that perinatal records are employed for statistics and defining norms, the vocabulary of discontent could be employed more constructively for change.

The vocabulary of complaints serves several important functions. It teaches nurses/midwives to reject the principles of the official superstructure and how to survive the work conditions. It also creates an alternative, powerful sub-culture and ideology in which the individual benefits from the collective experience of other workers and then socially transmits this knowledge to the next generation. In this way complaints become normative in "recommending and legitimating attitudes of opposition" (Turner, 1986, p. 376).

Luke (1991), Holub (1992), Croker (1994), and Papps and Olssen (1997) claim that it is within these spaces of opposition within institutions of social and ideological control that opportunity arises to insert counter-hegemonic discourses and practices in an endeavour to develop a pedagogy of resistance. Covert opposition supposedly empowers individuals by valuing their experiences, but it can also act as a social 'leveller' to deflate idealism or ensure the conformity of peers. It provides an outlet for negative emotions, such as anger, tension and anxiety, created by nurses/midwives' subservient position and lack of autonomy. Thus, according to Turner (1986), it allows nurses/midwives to reassure themselves of their status by asserting themselves in a limited way while establishing the solidarity of the workforce against the intrusion and dominance of the bureaucracy and its superiors. However, despite this apparent solidarity, the space appears to support a culture of silence[34] that is counter-productive to oppositional politics. Turner states that the routine "diversity and density" of complaints by nurses/midwives delegitimises authority within the medical hierarchy and demonstrates a "pragmatic acceptance" rather than a "normative commitment" to this authority (1986, p. 380). The complaints do not challenge existing structures or the prevailing ideology and, as such, what resistance there is remains contained, tolerated and accepted by the dominant group. This space in discourse is one with great potential for women, nurses and midwives. While it must be recognised that the

[34] Patricia Staunton, then a union official, was frustrated with the unproductive nature of tea room 'whingeing' and 'bitching' (Croker, 1994).

experience of contemporary nurses/midwives will differ from those in Turner's research, the oppositional space still exists and will be explored further in Chapter 8 which looks at perceptions of labour relations in rural maternity settings.

2.3.4 Conflicting cultures of care

Conflicts that characterise maternity care environments can also be attributed to competing paradigms. Contrasts between biomedical, social and biopsychosocial approaches to health delivery have been extensively discussed in sociological literature, with a particular focus on issues surrounding the medicalisation of normal life events like birth (e.g. George & Davis, 1998; Short, Sharman & Speedy, 1998; Grbich, 1999; Samson, 1999; Germov, 2002; White, 2002; Zadoroznyj, 1999, 2000). The polarity of views on maternity care has been raised as a cause for concern by the Senate Community Affairs References Committee inquiry into childbirth procedures (SCARC, 1999) and the recent Review of Maternity Services in Queensland (Hirst, 2005). Within childbirth literature, these paradigms are generally presented as binary oppositions (Oakley, 1993; Davis-Floyd, 1994a; Callaghan, 1996; Murphy-Lawless, 1998, 2000) although others consider this dichotomy to be too simplistic (Crouch & Manderson, 1993; Reiger, 2001a, b; Kirkham, 2005).

Cheryl Hirst (2005) describes two predominant cultures in Queensland's maternity care environments: each is underpinned by distinct ethical commitments, each has a different knowledge and skills base, each upholds an oppositional framework for risk and safety and both vie for prominence. She describes these two conflicting cultures of care as either 'Mechanic' or 'Organic'. Proponents of the Mechanistic model "stress the need for access to the best facilities, equipment and carers modern medicine can provide in order to deal with the unforeseeable risks of pregnancy and childbirth" (Hirst, 2005, p. 15). Advocates of the mechanic or technical culture include obstetricians and other medical specialists who cite a successful track record of safety and objective outcomes based on a medicalised, objectivist and interventionist culture of care. By contrast the 'Organic' model of care "stresses normality and espouses care that respects and involves a woman as the person in control of care" (Hirst, 2005, p. 15). This aligns with a social model and can be considered a 'productivist' approach, as it assumes the construction of knowledge or reality through social interactions (Lane, 2002). Proponents of this culture of care include international organisations like WHO, UNICEF, the International Congress of Midwives (ICM), and several renowned obstetricians and neonatologists (such as Marsden Wagner and Michel Odent) who advocate humanising birth.

Hirst's (2005) framework of maternity care in Queensland, and the site of her recommended strategies for change, is included as a graphic representation (Figure 2). This model will be employed in Chapter 8 where *Labour Relations* are analysed. As conflict is detrimental to carers, birthing families and the quality of care provided, the overlapping section in which a cooperative, interdisciplinary model of care is possible is significant for this thesis (Hirst, 2005, p. 16).

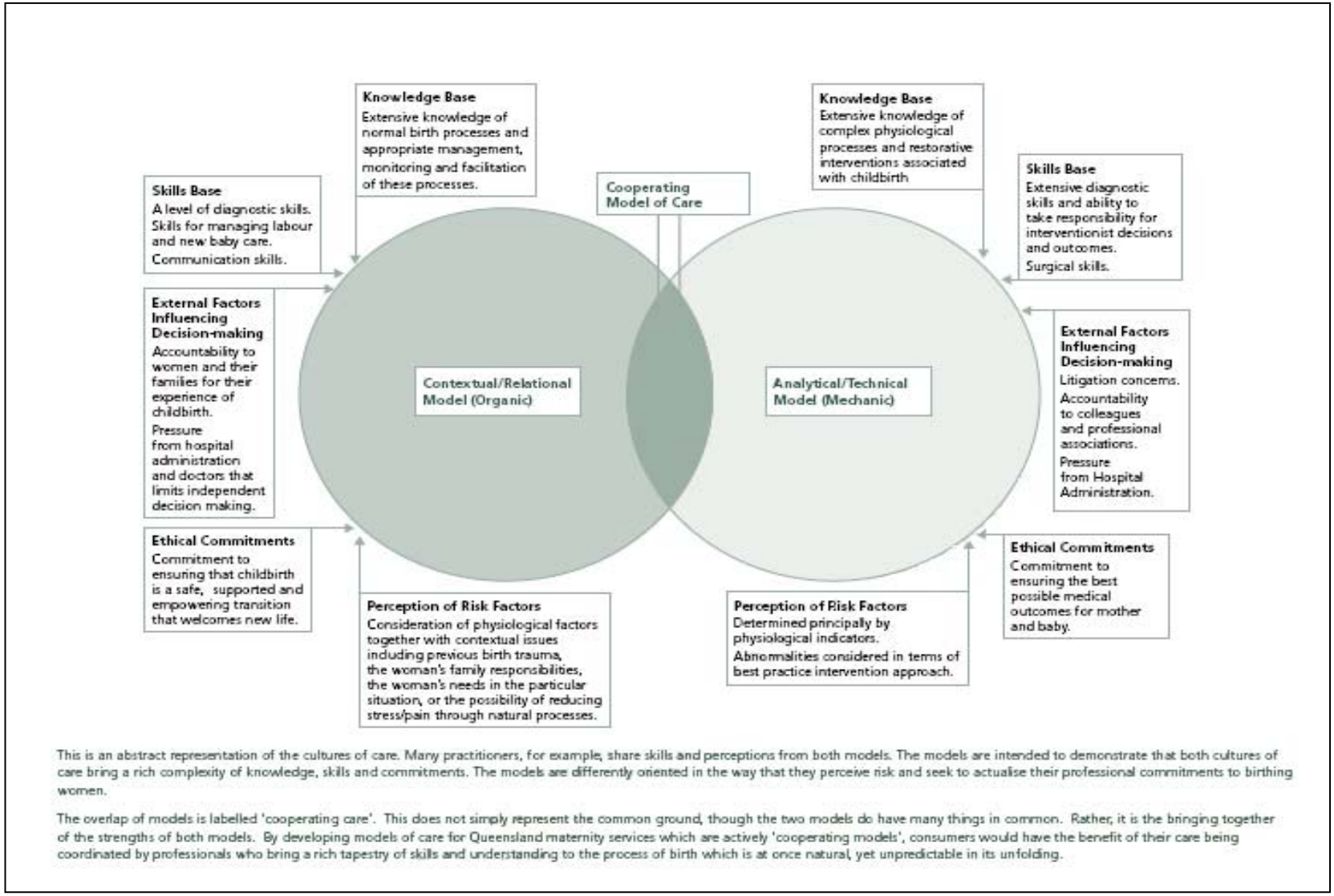
Similarly, Karen Lane (2002) considers the overlap between the competing models of maternity care, and classifies midwives who fall between the medical (obstetric assistant) model and the (professional, independent) midwifery model as 'hybrids' as their practice draws "variously on each of the major discourses according to contextual factors" (2002, p. 26). Lane is critical of their pre-reflective views on the relationship between the body and society and their slippage between contradictory models of knowledge about the body. She considers that education may resolve this problem by raising midwives' awareness about the realistic and social constructivist theories of knowledge (Lane, 2002, p. 30).

Contrary to Lane's view that a philosophical overlap between models is a deficit, I support Hirst's perspective that, despite differences, this space offers the potential for trusting and respectful relationships between health professionals. Accordingly, Kirkham (2005) advocates avoiding polarised positions and thinking in absolutes; developing instead broader, more inclusive concepts. Rather than being Lane's derogatory 'hybrid', carers who occupy this space could be considered socially oriented healers who minimise conflict and establish a positive, cooperative and caring environment for everyone involved in maternity care. They would be able to provide flexible maternity care that meets the range of birthing women's needs within a given context.

Conflict impacts upon both the provision and experience of maternity care. Four theoretical explanations for antipathy within health settings have been outlined. In the following section women's position in maternity care will be tied to the concept of hegemony while examining sociological literature on the nexus between scientific medicine and patriarchal ideology. Then, the issue of masculine hegemony is presented as a further influence upon childbearing women's lives in the rural context.

Figure 2.0 Cultures of Maternity Care

Source: Hirst, C. (2005). *Rebirthing.* p. 16.



This is an abstract representation of the cultures of care. Many practitioners, for example, share skills and perceptions from both models. The models are intended to demonstrate that both cultures of care bring a rich complexity of knowledge, skills and commitments. The models are differently oriented in the way that they perceive risk and seek to actualise their professional commitments to birthing women.

The overlap of models is labelled 'cooperating care'. This does not simply represent the common ground, though the two models do have many things in common. Rather, it is the bringing together of the strengths of both models. By developing models of care for Queensland maternity services which are actively 'cooperating models', consumers would have the benefit of their care being coordinated by professionals who bring a rich tapestry of skills and understanding to the process of birth which is at once natural, yet unpredictable in its unfolding.

2.4 Hegemony

Hegemony is a concept which helps to explain the perpetuation of medical dominance and the subordinate position of women, especially in rural society. As this study explores perceptions of birth, hegemony is integral to an analysis of the themes of power, control, choice and trust. If medical hegemony is total, then choice becomes a redundant notion. Similarly, hegemonic masculinity in rural society impacts upon women's decision-making and subsequent childbearing experiences. Therefore, counter-hegemonic factors which undermine the dominant ideology are also pertinent to this discussion. Gramsci's notion of ideological or cultural hegemony refers to a social group's distinctive set of ideas, assumptions, theories, doctrines as well as "the practical activities through which dominant groups exert their dominance and through which they subjugate and marginalise other viewpoints and practices" (Papps & Olssen, 1997, p. 22; Waitzkin, 1983; Gottlieb, 1989; Holub, 1992). Baer, Susser and Singer add that hegemony describes a process:

> by which one class exerts control of the cognitive and intellectual life of society by structural means as opposed to coercive ones …[This is] achieved through the diffusion and reinforcement of certain values, attitudes, beliefs, social norms and legal precepts that … come to permeate civil society (1997, p. 14).

Therefore, hegemony as an active, formal system is evident in the "cultural leadership" of a particular class (Williams, 1977, p. 110). As such, medicine has the cultural authority to dominate the health system, subordinate midwifery and expect compliance from birthing women. Raymond Williams argues that hegemonic relations saturate the whole process of living to such a depth that they even constitute the substance and limits of simple experience and common sense (Williams, 1977, p. 110). Within sociology, it is widely recognised that institutions such as schools, churches, mass media and family inculcate the values and beliefs which support the dominant ideology, thus achieving acquiescence, muting resistance and maintaining the established order (Waitzkin, 1983; Giroux, 1983; Gottlieb, 1989; Holub, 1993).

2.4.1 Medical Hegemony

One explanation for the perpetuation of obstetric dominance within maternity care is the concept of medical hegemony. A number of scholars have considered the relationship between scientific ideology and hegemony. Following Habermas' (1970) views on the ways in which scientific ideology pervades society and legitimates current patterns of domination within a capitalist society, Waitzkin (1983) and Kent (2000)

apply these to medical science. Waitzken (1983, p. 140) supports Habermas' (1970) assertion that this creates a 'technocratic consciousness' which makes a fetish of science so that people become reliant on scientific technology and so are no longer able to reason for themselves. As there is a trend towards increasing the range of problems amenable to technical solutions, issues arise with the positivism of science and the way in which it de-politicises medical interventions, thus inhibiting self-reflection and political emancipation.

Julie Kent (2000), when researching pregnancy and childbirth in Britain, raises concerns about the hegemonic effects of scientific rationality and objectivity. She critically observes the influence of medical hegemony on medical claims about the neutrality of reproductive technologies and to expert knowledge of childbirth.

While applying hegemony to the "doctoring of childbirth and regulation of midwifery in New Zealand", Papps and Olssen add a cautionary note:

> If the concept of 'science' in relation to 'gender' needs careful handling, so too does the concept of 'medicine' in relation to 'science'. [Both concepts] denote a plurality of objects and processes. That is, they refer not just to thought systems but to solid groupings, institutions, as well as codes of behaviour (1997, p. 22).

Further, Papps and Olssen differentiate between the traditional healing practice of medicine and the more recent construction of medicine as a scientific and commercial entity. They note that it is the "special epistemological status" and cultural leadership claimed by medicine which is controversial and warrants further examination (1997, p. 22).

Waitzkin (1983) and Baer, Susser and Singer (1997) analyse the hegemonic relations between doctors and patients. As advocates of social medicine, they criticise the maintenance of power and social control through medical ideology and assert that existing hierarchical class structures are reinforced during medical encounters. Contrary to Talcott Parson's (1951) view of consensus within doctor-patient relations, most sociologists now challenge the social expectation that patients consider medical practitioners as their social superiors and abide by their expert judgements (Waitzkin 1983; Baer, Susser & Singer, 1997; George & Davis, 1998; White, 2002; Cook, 2004). However, the dominant medical ideology prevails. Even Habermas recognises that it is impossible to have symmetrical relations of power but urges people to strive for this democratic ideal (Warren, 1995).

From a North American perspective, Robbie Davis-Floyd (1994a, b) considers hegemonic obstetric rituals within hospitals. Her critique particularly focuses upon the medicalisation of birth and the dominance of a technocratic model which not only

positions birthing women under obstetric surveillance, but is also highly interventionist in applying a technical 'solution' to the 'problem' of birth. Davis-Floyd is concerned that this dominant technocratic model of birth has come to be seen as 'normal' and legitimised as routine maternity care.

Following Williams (1977), Deidre Wicks (1999) builds upon Gramsci's belief that hegemony was never total or complete; counter-hegemonic resistance was possible. While Gramsci differentiates between the thoughts and actions of dominated groups (Gottlieb, 1989; Holub, 1993), Wicks (1999) argues against this structuralism. She maintains that it is possible to retain Gramsci's insights into the ways individuals and 'masses' respond to domination "while avoiding his conceptual dualism" (Wicks 1999, p. 24). Instead, to understand how the status quo is maintained, Wicks suggests employing Foucauldian notions of knowledge and power as they are constructed through dominant discourses. Exploring the discourses and discursive practices of subjugated groups reveals the extent to which hegemony is partial or complete. Wicks adds that: "Discourses represent political interests, but they are not just a structuring principle; they are also a medium for the constitution or for resistance and challenge to these structures" (1999, p. 25). Building upon Gidden's (1990) notion of 'duality of structure', Wicks adds that analysing discourses within social institutions, such as health care services, enables an exploration of the structuring of agency, modes of thought/knowledge and individual subjectivity (1999, p. 25).

Wick's (1999) gendered notions of hegemony go beyond the Marxist concept. Applying the concept of hegemony, she analyses the contested professional boundaries between doctors and nurses in Australia. In her exploration of the pervasiveness of medical dominance Wicks considers the effects of patriarchy on the sexual division of labour within the health setting. Patriarchy and hegemony in relation to rural culture are explored in Section 2.4.3.

Significant to this study are analyses which extend Gramsci's interest in counter-hegemonic practices, with several scholars commenting on the possibility of resistance through purposive politicisation and cultural changes to material social processes (Williams, 1977; Waitzkin, 1983; Gottlieb, 1989; Holub, 1992; Baer, Susser & Singer, 1997). For Williams, the concept of hegemonic cultural domination is based upon selective systems of inclusion and exclusion, thus providing for both social reproduction and resistance. Williams contends that: "A lived hegemony is always a process... It does not just passively exist as a form of dominance, it has continually to be renewed, recreated, defended and modified (1977, p. 112). Papps and Olssen, applying this to obstetric control of childbirth, comment that is has the "character of a battle in that the [dominant group's position] has constantly to be remade and rewon"

(1997, p. 21). This resonates within current discussions over the expansion of midwifery models of care for low risk women in urban and rural centres (Maternity Coalition et al., 2002; Rural & Regional Health Services Branch, 2003; Cresswell, 2005; ACMI 2005a; RDAA et al., 2005).

As a hegemonic entity, medicine is recognised as having successfully displaced religion and at times the judiciary as an institution of social control (Roach Anleu, 1999; Samson, 1999; Foucault, 1977). Through the process of medicalisation, childbirth has become a disorder, and birthing women's bodies have been pathologised into hazardous biophysical processes, therefore needing therapeutic intervention from obstetric and medical specialists (Johansen, Newburn & Macfarlane, 2002; Tew, 1995). However, despite the modes of hegemonic control described so far, Medicine has never completely dominated health care and its authority is increasingly under challenge from diverse sources.

2.4.2 Counter hegemony and medicine

In similar ways to the growing general disenchantment with science, the authority of medical science and its application through social practices have been eroded by counter-hegemonic forces (Harding, 1993; Van Wijk, Kolk, Van Den Bosch, Van Den Hoogan, 1995; Lupton, 1997; Walton, 1998; Wilson, Harrison, Gibberd & Hamilton, 1999; Moynihan & Smith, 2002; Germov, 2002; White, 2002). Some of these forces specifically undermine the practices and mechanisms through which obstetric medicine controls maternity care. However, in battling hegemony, counter-hegemonic successes also constantly need to be remade and rewon (Williams, 1977; Papps & Olssen, 1997).

The ambivalent nature of the relationship between medicine and patients has been examined from a variety of perspectives notably those of feminism, consumerism, post-structuralism, de-professionalisation. Earlier challengers to the Parsonian notion of patients' consensual subjugation to medical authority not only include proponents of the Women's Health Movement (Broom, 1991; Saltman, 1997) but also Willis (1989), Freidson, (1970, 1993), Foucault (1975, 1977), Haug (cited in Gray, 2002; Irvine, 1999; Freidson, 1993) and Illich (1974, 1977).

Reflecting upon the Women's Health Movement, Saltman contends that feminist health issues and medical consumerism share four similarities: both have issues with the lack of client-centred care, inappropriate health service delivery, the reinforcement of stereotypical gender roles, and the medicalisation of women's lives (Saltman, 1997, p. 229). The Women's Health Movement has been subsumed by health consumer groups, which are largely comprised of women. Current examples

include the Maternity Coalition, the homebirth movement and the many birth information and support groups who confront the dominant model of maternity care.

When exploring medical dominance, Willis (1989, 2002) and Freidson (1970, 1993) debate the mechanisms of power employed by corporate medicine and its struggle to maintain dominance in response to globalisation, bio-technological advances and changing health management practices. Foucault (1975, 1977) contributes to an understanding of the knowledge/power nexus, creating an opportunity to reevaluate deviance and resist the clinical gaze, while Illich (1974, 1977) provides insights into the concepts of cultural and clinical iatrogenesis. These notions have been readily applied to birthing practices (Lupton, 1994; Moynihan, 1998, 2002; Johansen, Newburn & Macfarlane, 2002).

While the professionalisation projects of nursing, midwifery and allied health (as discussed in 2.3.1) challenge the status quo, so too does deprofessionalisation. Haug's (1973, 1988) deprofessionalisation hypothesis argues that social changes, such as the emergence of educated consumers aware of their rights, challenge the lay-person's belief in medical status, authority and omniscience (Gray, 2002; Irvine, 1999; Walton, 1998). This erosion of medical supremacy and its underpinning hegemonic ideology is compounded by the increasing bureaucratisation, deregulation, and rationalisation of health services (Freidson, 1993; Collyer & White, 1997). 'Proletarianisation', with a decline in medical power, occurs as a result of deskilling and salaried, fee-for-service employment of doctors; resulting in loss of economic independence and loss of control because of managerial authority and bureaucratic regulations. The State's role in finance, regulation and intervention reduces medical autonomy (Freidson, 1993; Irvine, 1999). Loss of medical authority is also an outcome of diminishing public trust, negative media coverage, concerns about profit motives, rising consumerism with altered client expectations (Walton, 1998; Irvine, 1999) and rising cynicism about practices like 'daylight obstetrics' and public patient charters (Queensland Health, 2002). Furthermore, deprofessionalisation is occurring through consumer access to extensive internet information (Broom, 2005; Cruess, Cruess & Johnston, 2000).

As an educated public becomes well informed about the possibilities, issues and flaws within the current health system, instability is created in the traditional power dynamic between patients and health professionals. Mindful of the inter-relatedness of power and knowledge, Lupton applies the concept of the reflexive self to health consumers, commenting that they may opt either to adopt a passive role or to act "in a calculated manner" when "skeptical about expert knowledge" (1997, p. 373). Similarly, Zadoroznyj's (2001) exploration of reflexivity in maternity consumers in Melbourne, found that "clear, socially patterned variations" influenced whether birthing women took

a passive or highly reflexive role in obstetric encounters. Working class women and those experiencing their first birth were less likely to critically question the authoritative truth of obstetric discourses (Zadoroznyj, 1999, 2001; Lupton, 1997). Conversely, it can been argued that consumer desire for assistive reproductive and obstetric technologies has undermined the 'proletarianisation' of medicine so that gains towards de-medicalising conception and birth have been eroded (Rowland, 1992; Irvine, 1999; Collyer, 1999; Gamble & Creedy, 2001; Peterson, 2005).

Resistance to medical authority has been activated and supported by other health workers. Nursing, midwifery and allied health workers have an ambivalent relationship with medicine within the professional hierarchy and examples of resistance to medicine as the 'ruling class' are common. In particular, midwifery has challenged the perpetuation of medical dominance and ideological control over maternity care with some success in New Zealand (Guilliland, 1994; Papps & Olssen, 1997) and the United Kingdom (Garcia, Kilpatrick & Richards, 1990; Kent, 2000, Kirkham, 2004).

Counter-hegemonic resistance also comes in several subversive forms. These include oppositional models, such as the Vocabulary of Complaints (presented in section 2.3.4) along with consumer's active avoidance of obstetric care and passive aggressive responses to biomedical models of care. These responses are most evident in literature on Aboriginal women who seek an alternate birth experience that incorporates their belief systems. In particular, 'non-compliance' becomes an issue when the model of care does not provide appropriate cultural practices or consider the place of birth, and when maternity providers value only women's physiological safety not their psychosocial and emotional well-being (Muhlen-Schulte, 1989; Fitzpatrick, 1995; Croker 1995, 2002b; Rawlings, 1998; Chamberlain & Barclay 2000; Chamberlain, Barclay, Kariminia & Moyer, 2001; Callaghan, 2001; Campbell, 2003). Unfortunately, non-compliance and avoidance as counter-hegemonic practices are problematic as the ideological status quo does not change and detrimental perinatal outcomes can result from the lack of maternity care.

In summary, medical hegemony is not total; counter-hegemonic forces are evident in the rising scepticism about the omniscience of scientific medicine and in particular, of obstetrics as a social practice. Opposing discourses include feminism, consumerism, post-structuralism and de-professionalisation with resistance coming from both health consumers and other health professionals. In the following section, the concept of hegemony is integrated into the discussion about gender in rural society.

2.4.3 Hegemonic masculinity and the rural context

Hegemonic masculinity discursively constructs and shapes gender experiences; therefore, it has the potential to influence women's perceptions of childbearing and mothering in rural areas. Gender is "defined collectively in culture …sustained by institutions" and "enacted in the [everyday] lives of individuals" (Connell, 1998, p. 4). As previously outlined, women are widely regarded as occupying a subordinate position in most societies, including Australia, and this impacts upon their health and well-being (Annandale & Hunt, 2000; Kent, 2000; Germov, 2002; Turner, 2002). Ongoing concerns about the detrimental effects of gender inequity are evidenced by the role of the Australian Human Rights and Equal Opportunity Commission (HREOC), the Federal Sex Discrimination Commission, and the mainstreaming of the Office of the Status of Women within the Department of Family and Community Services (Goward, 2004). Neo-Marxist and feminist scholars argue that masculinist discourses and patriarchal ideology are hegemonic in Australian society (Connell, 1987, 2002; Dempsey, 1990; Poiner, 1990; Wearing, 1996; Thorpe & Irwin, 1996; Pritchard Hughes, 1997; White, 2002; Walsh, 2003). According to Connell, inequitable gender relations are actively reconstituted in everyday life through social and cultural institutions to maintain the status quo and create a 'patriarchal dividend' (2002, p. 142). Therefore, hegemonic masculinity is an intransigent, defining characteristic of power relations between men and women in the workplace (Probert, 1997; Wicks 1999, 2002; Wearing, 2004), recreational settings (Gough & Edwards, 1998) and the home (Gilding, 1997; Baxter, 1998, 2000; McMahon, 1999; Bryson, McPhillips & Robinson, 2001; Dempsey, 2002).

While it is increasingly evident that contrasts between urban and rural have been stereotyped and generalised, the underlying causes for the differences in gender experiences are found within the social fabric of rural and remote communities (Grace & Lennie, 1998; Bramston, Rogers-Clark, Hegney & Bishop, 2000). It is arguable that hegemonic masculinity is particularly entrenched in rural society (Poiner, 1990; Alston, 1998a, 1998b, 2000, 2005a, 2005b; Dempsey, 1990, 1991; National Rural Women's Coalition [NRWC], 2005).

Like Dempsey (1990, 1992), Poiner (1990), Pini (2004a, b) and the NRWC (2005), Margaret Alston (2005a, p. 139) finds that "gender is a critical determinant of the lived experience of small-town rural Australians" and the expectations and constraints experienced by rural women are "shaped by macro-level gender order and the discursive practices that affect an individual's response" (2005a, p. 141). Building upon earlier rural studies, Alston notes the many ways in which masculine power and

privilege are discursively created and recreated within small country towns (2005a, b, Alston & Kent, 2004). To illustrate hegemonic masculinity in rural communities, Alston effectively uses the framework of the 'five capitals' - economic, institutional, human, social and environmental – all of which impact upon rural and remote women's health. Similarly, Barbara Pini's (2004a, b) research into management of the sugar industry and local government in rural North Queensland adds support to the argument that, despite social re-structuring and re-negotiation of gender roles, masculine authority continues to be normalised, legitimised and endorsed within Queensland's rural communities.

By contrast, some rural scholars contest the simplistic portrayal of rural women as passive victims of patriarchy. Grace and Lennox (1998), for example, discuss the politics of change, diversity and identity with the greater participation of women in rural industry, and the accompanying development of rural women's networks and organisations in Australia. As Grace and Lennox point out, rural women's organisations are problematic as they tend to have a narrow focus on farm women's concerns and recreate gender identity through typically incorporating "issues such as health, education and access to reliable telecommunications" (1998, p. 354). Alston (2000) suggests that is gradually changing despite hegemonic gender relations.

By comparison, Rothwell lends credence to a counter-hegemonic position when arguing that Queensland "women are increasingly taking up front-line positions in the rural rebellion", in particular through the political efforts of the Regional Women's Alliance (1999, p. 2). He reports on the rural leadership of dynamic women's groups. These women are adding rural politics to their existing workload and are moving into a gap vacated by men. As one of Rothwell's interviewees commented: "Our husbands simply don't have time. I think we have to take control" (1999, p. 29). Therefore, although it can be argued that country and farming women's associations tend to reinforce gender, they also make a valuable contribution to the well-being of rural/remote communities by lobbying on issues such as health. As such, they effectively take concerns from within the private sphere into the public domain through both gender specific groups (National Rural Women's Coalition [NRWC], 2004, 2005) and collaborative endeavours (Doctors Association of Australia, Australian Local Government Association, Country Women's Association, National Farmers' Federation, & Health Consumers of Rural and Remote Australia, 2004).

Alston (2005a) notes that patrilineal inheritance and control of farms and business ownership, along with the sexual division of labour, reinforce the traditional gender order. Although farming women, through their contribution to income and management, have attempted to re-negotiate gender relations in the workforce and

domestic spheres, social traditions and institutions are resistant to change. Alston's (1998b, 2000, 2005a, b) findings reflect wider Australian and international trends (Martin, Roach Anleu & Zadoroznyj, 2002, p. 325; Shortall & Kelly, 2002; Contzen, 2004). Martin et al. observe that rural "family life has not become the new realm of freedom and flexibility" but that women "continue to be bound by strong gender norms" (2002, p. 325). Consequently, the triple burden of farming work, domestic and caring obligations combined with a subordinate social status, have been identified as risks to rural women's health (NRWC, 2004, 2005).

The intransigence of masculine hegemony not only influences women's general health but is also implicated in domestic violence, especially in rural and remote areas (Bryson, 1994; Thorpe & Irwin, 1996; Alston, 1997; Office of the Status of Women, 1997; Women's Services Network [WESNET], 2000; Bagshaw, Chung & Partnerships Against Domestic Violence Taskforce [PADV], 2000; Walsh, 2003; Wendt & Cheers, 2004; AIHW, 2005). While it is simplistic to assert that male supremacy manifests as domestic violence, across cultures and settings the prevalence increases when there is an unequal distribution of power between the genders and where patriarchy is systemic, such as in mining and farming communities (Seddon, 1993; Thorpe & Irwin, 1996; Smallwood, 1996; PADV, 2000a, b; Bagshaw & Chung, 2000; Croker et al., 2002; Wendt, 2004). As such, the extent of violence is associated with the well-documented male ethos and the complex interplay of patriarchal values and attitudes found in rural and remote communities (Coorey, 1988; Smallwood, 1996; Alston, 1997; WESTNET, 2000; Croker, 2000; Wendt, 2004). This is compounded by context-specific issues which are discussed further in Chapter 3.8.

Rural masculine hegemony is threatened by globalisation, networking, improved media access, neo-liberal rationalism and the need to retain and attract young people in order to be sustainable (Herbert-Cheshire, 2003; Alston, 2005b; Cocklin & Dibden, 2005). Resistance to the problems created by patriarchy and hegemonic masculinity can be read into the social mobility of young people with out-migration from farming areas. Rural studies show that young rural women are reluctant to marry farmers; many leave for better education and employment opportunities (Herbert-Cheshire, 2003; Alston, 2002, 2005a). Meanwhile, the women who migrate into the communities experience uncertain employment in the rural labour market, the precarious position of daughters-in-law (Alston, 2004, 2005a, b), social isolation and loss of gender-appropriate services (Croker et al., 2002; Warner-Smith, Bryson & Byles, 2004; Warner Smith, 2005).

This review has demonstrated the well-documented association between medical and masculine hegemony and women's well-being in rural Australia. Although

counter-hegemonic forces undermine the status quo of power relations, hegemony is re-created at both structural and interpersonal levels through everyday discursive practices. Therefore, this study will explore the impact this has on the perceptions and experiences of birthing in four small rural and remote communities.

2.5 Chapter summary

Through a review of theoretical literature and news media, Chapter 2 has framed the macro-structural historical, cultural, social and political influences on childbirth practices. Given the contested and conflicting perspectives on childbirth, it has provided a background to the key issues and debates. Seminal feminist critiques of the expropriation and medicalisation of childbirth have been outlined. Gender, class and patriarchy are revealed as dominant issues. As the interactive aspects of relationships between and amongst birthing women and maternity care providers are significant to this study, the literature review has encompassed explanations for the jurisdictional disputes that perpetuate 'battlefield birth' and create tensions with birth consumers. The impact of hegemonic medical and masculine discourses on shaping childbirth practices and rural women's lives have been discussed along with significant possibilities for counter-hegemonic resistance.

Chapter 3

The provision of maternity services: Current models of care

3.1 Introducing the maternity scene

Maternity services are a social product; therefore options and availability are determined by social, cultural and political processes. Exploring the care provided by maternity services to birthing women and babies reveals "a great deal about the kind of society we are and wish to be" (Hirst, 2005, p. 1). Childbirth is the most common reason for the hospitalisation of women and the Australian health care system provides safe care within a medicalised environment with resulting low mortality (AIHW, 2004a, b). Public health measures have also greatly contributed to the overall improvement in maternal and infant health in the past 50 years (AIHW, 2004a; SCARC, 1999; Wagner, 1998). However, consideration also needs to be given to women's satisfaction with maternity care, gaps in the system, diminishing services, rising obstetric intervention rates and ensuing morbidity (Hirst, 2005; SCARC, 1999). When evaluating the quality of maternity services as textually represented in the following reports, particular emphasis is placed upon whether these are 'women-centred' as advocated by the major reviews in childbirth. Indicators of quality care and influences which shape maternity services are also discussed.

Overall, the organisation of health care in Australia "reflects the way financial and human resources have been selected, allocated and arranged to meet society's recognised needs" (George & Davis, 1998, p. 80). However, Ann Oakley observes that "institutional structures and systems can often be subversive of the goals they were set up to meet" (1992, p. 186). As an organisation, the health system is composed of many interdependent institutions and professional groups, each with specific roles and tasks (Hardcastle, 2004) founded on dissimilar paradigms and with distinctive cultures. Consequently, Stephen Duckett views it as a "contested terrain characterised by conflict over values and policy issues" (2004, xxi). Helen Belcher adds that health policies "are products of a clash between the ideologies of compulsion and freedom of choice" (2002, p. 257). Common to these and other similar analyses of the health institutions, policies and processes (e.g. Palmer & Short, 2000; Gardner & Barraclough, 2002), is the recognition that there is an emphasis on the structure and functioning of health care institutions and the organisation of the health workforce, rather than on the experiences of health service clients, who in this study are birthing women.

There are limitations to the following review of the health policy literature

relevant to this topic. At the time of writing, Queensland Health is re-structuring the state health system. The rapid expansion of knowledge and the constraints of this thesis limit the scope of the ensuing discussion. In addition to the continuous changes in political priorities and health policies, the discussion in this thesis relates to the situation in the health settings at the time of data collection. Thus the policies and practices are located within that period. Although the impending indemnity crisis is foreshadowed in some sources, my data collection pre-dated its impact on services and is not a focus of this study.

When reviewing literature on the value and quality of a maternity service, three groups of 'stakeholders' emerge – consumers/users, health providers and wider society. This study is an exploration of the views of two groups - birthing women (clients/consumers) and rural/remote maternity service providers (doctors, midwives, child health nurses and Aboriginal health workers). Although health policies may describe maternity care as 'women-centred', whether or not this is achieved can only be assessed by seeking the opinions of the clients who use the service. In addition, it is also important to seek the views of the maternity service providers as it is now well recognised that "systems of care will only work well if those providing the care are happy and feel their professional skills are being put to good use" (Campbell & Garcia, 1997, p. 8).

Although the terms consumer, user, patient and client are used interchangeably within health literature, each represents a different discourse. A 'consumer' or 'user' is often juxtaposed with health service provider, yet the concept of a consumer can be problematic as it is also related to consumption of medicine as a commodity within a market economy (Lupton, 1996) in response to "inducement of an almost limitless variety of wants, as opposed to needs" (Eastwood, 2002, p. 225). The construction of a health consumer as a politicised social actor is a term found in neo-liberal and advocacy discourses (Gardner & Barraclough, 2002; Palmer & Short, 2000; Queensland Department of Family and Community Services, 1995) and in some feminist literature on birth (Lane, 1995, 2005; Lupton, 1997; Zadoroznyj, 2001). Unlike the ideology underpinning the neo-liberal concept of an autonomous individual, the feminist notion of a politicised maternity consumer has arisen from the women's health movement. It describes a woman who is educated about her body and birthing alternatives and is aware of her rights; she is thus 'empowered' to actively seek an optimal birth experience (Vickerstaff, 1996; Stanfield, 1996; Howell-White, 1999). Conversely, 'patient' is synonymous with an illness model, passivity and the sick role, so is not suitable for describing healthy birthing women. By contrast, 'client' is preferred in midwifery texts as it indicates an active role in choosing "assistance from

professionals who have special skills and knowledge that the client does not" and making "responsible" decisions about that care (Olds, London, Ladewig & Davidson, 2004, p. 5). However, submissions to the recent review of maternity services in Queensland indicate that birthing women do not feel that they are active participants in their own care (Hirst, 2005, p. 2). Therefore, although consumer and client are the preferred terms used in this thesis, I recognise both the asymmetrical power dynamic and that the implied reflexivity and choice of health care may not be possible or desired by all birthing women.

Lupton (1997) and Zadoroznyj (2001) observe that birthing women fulfil the roles of both reflexive consumers and passive patients in their interactions with maternity services. In particular, Lupton notes the therapeutic value of being a patient, while Zadoroznyj further explores the intricacies of the encounters between birthing women, obstetricians and midwives and the factors, such as class, education and parity, which influence the roles women adopt.

Interactions between health providers and clients are complex. Duckett observes that, "They are essentially relations of power, but are presented paternalistically as being entirely about 'caring' for the patient's [sic] interest" as health professionals make their own judgments about what the patient needs rather than allowing patients to make their own decisions (2004, p. xxii). This imbalance is compounded when there are differences such as gender, class and ethnicity between the health professional and client that affect their experiences with the health institution and may have negative consequences on health outcomes. Furthermore, Eileen Willis (2002) argues that the conflict and contest over policy and funding between the state, health professionals, clients and the private-for-profit sector, has been to the detriment of social models of health and women's health interests.

The following sections first outline a means of evaluating health services (3.2) and then significant reports regarding maternity care are overviewed (3.3 -3.5). Next, Australian models of maternity care are outlined, together with the options available to women in rural and remote areas in Queensland (3.6). The Australian maternity services discussed here are the private and public care available to women, with a particular focus on the public system which provides the bulk of the services. In the final two sections, the issues related to place of birth (3.7) and domestic violence services for rural and remote childbearing women (3.8) are considered.

3.2 Evaluating health services

Although there are a number of proposed frameworks for evaluating a health

care system, I have employed Duckett's (2004) contemporary Australian model combined with Campbell and Garcia's (1997) focus on the organisation of maternity care provision. Duckett (2004), and Campbell and Garcia (1997) suggest that to achieve client satisfaction and quality outcomes, a service should aim for the following five key principles:[35]

1. *Efficiency* relates firstly to the allocation of human and financial resources to achieve an optimal ratio of outputs to outcomes, efficacy and effectiveness. Second, *dynamic efficiency* describes the ability of the health service to be innovative, responsive and able to change. In Australia, inefficiency is evident in the relations between the Commonwealth and states, cost shifting between sectors, policy makers' attention to powerful lobby groups, long bitter struggles against reforms and various policies that result in unnecessary hospitalisation and procedures (Duckett, 2004, pp. 274-275). Consideration also needs to be given to practical points such as priority setting, good communication, clinic waiting times and local implementation of maternity policies and procedures as well as observing any gaps in specific local resources (Campbell & Garcia, 1997). Allocative and dynamic efficiency are closely related to the next four principles.

2. *Effectiveness*. For women and babies who use a maternity service, and for the staff who provide it, attention also needs to be given to whether it is effective and safe (Campbell and Garcia 1997, pp.14, 16). As Enkin, Keirse, Neilson, Crowther, Duley, Hodnett and Hofmeyr note "women who receive care, professionals who provide care, and those who pay for care all want it to be effective" (2000, p. 3). While everyone agrees with this principle, they disagree upon what constitutes effective care. Priorities vary from forgoing absolute safety for a satisfying personal experience to reducing physical morbidity and mortality while disregarding the comfort and desires of the birthing woman (Enkin et al., 2000). Consequently, different maternity practices affect outcomes. Some have demonstrated positive effects, especially in low-resource settings, such as the continuous presence of a doula[36] or known carer on reducing the barriers that impede the progress of labour, easing pain and

[35] These key principles are not described here in order of priority. There are ideological disagreements between and amongst health policy makers and maternity service providers as to how these evaluative principles should be prioritised.

improving breastfeeding success (Pascali-Bonaro & Kroeger, 2004) while others persist despite a lack of supportive research evidence, such as fragmented care and rising obstetric interventions. Therefore, effectiveness is also affected by dynamic efficiency.

3. *Acceptability* to clients and service providers. Acceptability to clients is usually assessed through individual consumer complaints, issues raised by consumer or community lobby groups and patient satisfaction surveys. Measuring and reporting patient satisfaction is contentious and subject to political overlays (Duckett, 2004). Some reports show that dissatisfaction is highest amongst vulnerable individuals from the most socially disadvantaged groups (Walton, 1998; Yelland, Small, Lumley, Rice, Cotronei & Warren, 1998), while others suggest that assertive, well-educated, middle class clients are more likely to be critical of care (Green, Coupland & Kitzinger, 1990; Zadoroznyj, 1999).

   A maternity service should be acceptable to birthing women and their families, and sensitive to their needs. Campbell and Garcia (1997) add that it is important to elicit their views and consider their experiences with criteria such as helpfulness, conflicting advice and preferences for the lead maternity carer, as well as for the type, location or time of a service. Cultural acceptability is also significant for client satisfaction (Rice, 1998; Small, Rice, Yelland & Lumley, 1999; McCourt & Pearce, 2000; Campbell & Brown, 2003).

   Acceptability to staff influences job satisfaction and retention. However, Duckett notes that "the interests of providers are not always coincident with the interests of consumers [yet] provider acceptability affects the system, and to a large degree, affects the extent to which it is able to achieve dynamic efficiency" (2004, p. 279).

4. *Accessible* to all and provided on an equitable basis. From a social justice perspective, equity of access and the ability to accommodate women's diverse needs overlap with acceptability as a further dimension of quality (Kelahar, Manderson & Potts, 2003). Responsive planning to achieve equitable access and acceptability may justify additional funding to optimise outcomes in specific groups with special needs (Duckett, 2004; Campbell & Garcia, 1997; Kelahar, Manderson & Potts, 2003). Therefore, improving equity and accessibility

[36] A 'doula' is an older experienced woman who provides skilled support to a woman in labour. It has been shown to reduce pain and improve outcomes.

requires being sensitive to the views, values, location and needs of minority groups such as women who are socially or geographically isolated and those from culturally and linguistically different backgrounds. These should be considered when planning where and when maternity services are offered and whether they provide cultural safety.

5. *Sustainable.* The long-term human and financial implications of a model of care need to be considered along with whether improved outcomes and staff retention justify the expenses (Campbell & Garcia, 1997). When assessing sustainability based on efficient outcomes, Duckett observes that professional opposition and rational economic imperatives tend to override "patient's expectations of dignity, compassion, information, provision and involvement" (2004, p. xxiii). Instead, allocative and dynamic efficiencies need to be balanced to achieve sustainability.

These principles provide a useful foundation in this project for later analysing Queensland's maternity services and exploring notions of "a good birth" for participants.

3.3 Consumer acceptability: Selected studies with birthing women

Consumer satisfaction studies tend to emanate from doctoral studies and research centres. The most commonly cited review is *Having a baby in Victoria* (Brown & Lumley, 1990); its findings are re-iterated in later studies and reviews. Based upon postnatal satisfaction surveys, it reveals that, although most women were satisfied with their maternity care provision, there was also a desire in the community for new options for the provision of maternity services in Australia. The subsequent, rigorous research with birthing women by the Centre for Mothers and Babies in Victoria is notable for revealing consumer perspectives through both large scale surveys of recent experiences and smaller multi-method studies. Notably, *Missing Voices* (Brown, Lumley, Small & Astbury, 1994) became a seminal work on mothers' experiences, especially through challenging the dominant obstetric paradigm as the most efficacious model by highlighting fragmented care, the morbid effects of birth interventions and the significant lack of social support, especially in the postnatal period. Brown and Lumley (1998) recommended changes to childbirth practices in Victoria which could also be adopted by other states. To contemporise the findings of these earlier studies, in 2000, Bruinsma, Brown and Darcy (2001) surveyed all recent mothers in Victoria to capture their views and experiences of different models of maternity care.

A growing number of small selective studies offers insightful evaluations of acceptability for specific populations. These range from birth services to rural and remote Aboriginal women (Myles & Tarrago, 1993; Perkins, 1997; Campbell & Brown, 2003; Carter, Lumley, Wilson & Bell, 2004), to immigrant Asian women birthing in Melbourne (Rice & Naksook, 1998; Yelland, Small, Lumley, Rice, Cotrioni & Warren, 1998; Small, Rice, Yelland & Lumley, 1999; McLachlan, Waldenstrom & Short, 2003), East Timorese refugees in Sydney (Myors, 2003) and Filipinas in remote areas of Queensland (Kelahar, Potts & Manderson, 2001; Kelahar, Manderson & Potts, 2003). Such studies make a valuable contribution to providers' ability to offer acceptable, accessible and equitable services which meet diverse, local needs.

West Australian research in progress seeks to compare women's expectations of labour and birth with an evaluation of their recent experience. Fenwick, Hauck, Downie and Butt (2005) have identified five main themes. Of these, three reflect a positive outlook on birth. Fenwick et al. labelled these 'owning and believing in birth as a natural event', 'satisfaction with the birth process and outcomes' and 'involvement and participation in the birthing experience' (2005, p. 23). Sub-themes relevant to this study include achievement, fulfilment and expectations of control and choice. The remaining two themes encapsulate women's negative and unaffirming experiences of birth as a negative and medical event (Fenwick et al., 2005). Women's expectations were influenced by public, professional and private childbirth discourses "especially those related to books and magazines, and the stories of mothers and sisters" (2005, p. 24). Notably, Fenwick et al's (2005) findings challenge the belief that many women willingly and knowingly choose or expect birth to be a medicalised event and argue that maternity care providers are implicated in perpetuating a technical rather than humanistic approach to birth.

Several studies have focussed on postnatal care, especially the quality of hospital care (Gilmour & Twining, 2002), outcomes of early discharge (Brown, Bruinsma, Darcy, Small & Lumley, 2004), and comparing midwife led interventions for managing postnatal depression (Small, Lumley, Donohue, Potter & Waldenstrom, 2000; Bland, Lumley & Small, 2000; Lumley, 2005). Croker and McDonald (2000) report on the void in care for women in rural and remote areas of Queensland during the intermediate postpartum period.

A leading hub for related research is the Centre for Family Health and Midwifery at the University of Technology Sydney (UTS). Researchers have produced insightful work on parenting experiences, in particular fatherhood (Lupton & Barclay, 1997) and mothering (Rogan, Schmied, Barclay, Everitt & Wyllie, 1997; Barclay, Everitt, Rogan, Schmied & Wyllie, 1997).

Midwifery scholars associated with the UTS Centre have been committed to improving maternity care and developing service models that provide continuity of care within a community setting (e.g. Homer, Davis, Cooke & Barclay, 2002) and enable 'normal' birth for healthy women. Their projects are evidence of a commitment to women-centred models of care through which all women have the right to a service that more closely aligns with their socio-cultural and geographic needs.

The UTS Centres' most influential work is the Australian Midwifery Action Project (AMAP) which identified barriers to the utilisation of midwifery models of care for healthy ('low risk') women. With consumer participation and through extensive inter-disciplinary negotiation, AMAP achieved an efficient, effective and acceptable community-based model of midwifery care within a culturally diverse urban setting (Brodie, 2002; Barclay, Brodie, Lane, Leap, Reiger & Tracy, 2003; Leap, Barclay & Sheehan, 2003a, b).

Maternity services that meet the needs of rural, remote and Aboriginal women have also been explored through the "Birth in the Bush" project (Barclay & Kildea, 2004). Using a participatory action approach, initiatives have been trialled in rural NSW and the NT (Kildea, 2001, 2003; Kennedy & Leap, 2001; Tracy, 2003).

Consumer-initiated projects and collaborative research between birthing women and health professionals provide essential insights into the acceptability of maternity services for women. Kerreen Reiger (1999b, 2001b, 2003) and Karen Lane (1995, 2002) bring sociological insights to childbirth as they engage as consumers and scholars on maternity initiatives like AMAP, NMAP and projects with the Australian College of Midwives (ACMI) and the Maternity Coalition. As Australia's peak national maternity consumer advocacy organisation, the Maternity Coalition keeps birthing women's issues, including those of rural women, in the popular media (e.g. 2004a, 2004b) whilst also providing current information and activism through electronic newsletters and collaboration with professional organisations.

Findings from these woman-centred sources reveal the increasing desire for birthing women and midwives to have a greater input into the structure and modes of maternity services.

National maternity action plan (NMAP) for the introduction of community midwifery services in urban and regional/rural Australia

NMAP is designed to promote "rigorous debate" and the reform of maternity services nationally (2002, p. 37). Developed collaboratively by consumer advocates, the Maternity Coalition, the Association for the Improvement of Maternity Services (AIMS, Australia), Australian Society for Independent Midwives and Community

Midwifery WA Inc. in consultation with birthing women and their families, this plan comprehensively details evidence-based reforms of Australia's maternity services. It is the most widely disseminated and influential national document to date. NMAP advocates a woman-centred service similar to primary care models available in the UK, Canada and NZ. Demonstrating strong consumer demand in urban, regional and rural areas, the authors urgently call upon "both Federal and State/Territory governments to facilitate substantial change to the way in which maternity services are provided, by making available to all women the choice of having a community midwife provide continuous maternity care through the publicly funded health system" (2002, p. 5). Based upon effective and efficient pilot programs within Australia and successful models overseas, the NMAP authors conclude that:

> There is real potential for significant improvements in maternity services – as measured by consumer satisfaction and the health and wellbeing of women and babies immediately following birth and in the first year afterwards – without the need for increased outlays in maternity services. Governments should be called upon to support access to one–to-one continuity of care from a community midwife as a mainstream and cost effective option in maternity services (2002, p. 39)

Although this plan has been broadly endorsed by birth support groups, consumer organisations, NGOS like the Women's Electoral Lobby, Schools of Nursing, Colleges of Midwives, individual health professionals and politicians, and high profile, global childbirth authorities, its recommendations have not been adopted by state health authorities or maternity agencies.

3.3.1 A government perspective on women's health: The background from 1990 to the present

The 1990s were a significant decade for women globally, with nations reviewing the status of women in the lead up the United Nations Fourth World Conference and NGO Forum on Women in 1995 and the WHO goal of Health for all by 2000. The WHO (1995, 1997), Family Care International (1994, 1995), Family and Work Institute (1995) and UNICEF were associated with reproductive health and *Safe Motherhood* initiatives intended to tackle the root causes of detrimental influences on maternal and infant health, including social injustice, gender inequality and poverty. 'Too young, too many, and too close' were identified as significant contributors to maternal mortality and morbidity in developing countries (WHO, 1995; 1997; Thompson, 1996; Koblinsky, Campbell & Heichelheim, 1999).

Of particular ongoing significance are several WHO documents. First, *Care in normal birth* contains universal guidelines for the routine care of women during uncomplicated labour. Notably, it states that "In normal birth there should be a valid reason to interfere with the natural process" (1.6) and challenges the "uncritical adoption of a range of unhelpful, untimely, inappropriate and/or unnecessary interventions [that are] all too frequently poorly evaluated" (WHO, 1997, 1.1). In addition, the unjustified technological spiral is unaffordable. The global "epidemic of operative obstetrics" is criticised (4.5). This consensus document also reinforces the WHO declaration[37] on *Appropriate technology for birth* that recommends against routine procedures like electronic foetal monitoring, states that the induced labour rate should not exceed 10% and a reasonable caesarean section rate should range between 5-15% in developed nations. *Care in normal birth* also confronts the risk approach to maternity care and disproportionate number of women receiving care that follows standardised protocols which can only be justified for complicated births. It also defines the various levels of involvement by caregivers; trained midwives[38] are described as the most appropriate carers for normal birth (WHO, 1997, 1.5, 1.6). WHO advocates collaborative care to well-informed women in decentralised services. This document also outlines "Procedures that are frequently used inappropriately" (WHO, 1997, 6.4) but which are often still routine care in some Queensland maternity settings.

The second, widely influential source on perinatal care was *Effective care in pregnancy and childbirth* by Enkin, Keirse, Renfrew and Neilsen (1995). Based on evidence from systematic reviews, these psychosocially sensitive recommendations have since been revised by Enkin et al. (2000) and widely distributed by WHO.

Also popularising WHO policies was Marsden Wagner's (1994a) commonly cited critique *Pursuing the birth machine: The search for appropriate birth technology* followed by his ongoing global awareness-raising, amongst both professionals and consumer groups, about unnecessary and ineffective obstetric interventions in normal birth (Wagner 1994b; 1998; 2000a, b; 2002).

Within Australia, the Commonwealth Government released women-centred documents such as the *National strategy on violence against women* (1990), *National women's health programme* (1992), and *Birthing issues* (1993). The Office of the Status of Women (1992) reported on Australia's commitment to the United Nations

[37] The WHO 'Fortesla declaration' (1985) on the *Appropriate Technology for Birth* forms the basis of international policies on perinatal care. Updated by Chalmers (1992) and AbouZahr & Wardlaw (2001), it is considered by some critics to be "unachievable and arbitrary" (SCARC, 1999, p. 106).

[38] Based on the international definition of the midwife and contrasted to the care-giving roles of obstetricians and traditional birth attendants.

'Convention on the elimination of all forms of discrimination against women'.

Under a Labour government, Queensland's health policies mirrored the social justice frameworks of national documents with the *Health and social justice strategy statement* (1991), *Rural health policy* (1991), *Primary health care policy* (1992), *Stop violence against women* (1992) culminating in the *Women's health policy* (1993). The women's health policy notably focussed on equity, access, participation and rights for women from diverse backgrounds and pledged to make the state health system more appropriate for its major users and health providers more responsive to women's health needs. Furthermore, the Queensland health minister undertook to involve "consumer and community participation … to ensure flexibility, integration and variety in policy and program development" (1993, p. 1). However, the *Women's health policy* (1993) and policy recommendations within the subsequent *Survey of Queensland women* (Renfrew & Office of Women's Affairs, 1998) were thwarted by political changes.

3.4 Maternity service reviews and inquiries

Alongside these broader policies on women's health, federal and state health bodies have regularly reviewed maternity services over the past fifteen years. They have released significant findings, and widely disseminated reports containing evidence-based recommendations. The Australian Health Workforce Advisory Committee believes that the impact of these reports "should not be underestimated … [they] described current practice in maternity services, consolidated consumer reviews, and provided a platform from which further planning and research could be conducted" (AHWAC, 2002, p. 22). However, although the Australian national reviews share a historical space with the United Kingdom's *Changing childbirth* (1993) and New Zealand's *Cartwright report* (1988), they have not had the same enduring impact as catalysts for change in women's health services (Kent, 2000; Papps & Olssen, 1997). Recommendations need to be actualised as policies and legislation; these it turn are dependent upon politics, shifts in ideology, funding and the will to implement changes. In 1999, the Senate Community Affairs Committee (SCARC) inquiry into childbirth procedures opened their report with an admonitory statement that their findings were very timely because:

> It follows a series of state and national reports which have reviewed childbirth services: in New South Wales (Shearman Report, 1989), in Victoria (Having a baby in Victoria, 1990), in Western Australia (Select Committee on Intervention in Childbirth, the Turnbull Report 1995) and the National Health and Medical Research Council (Options for Effective Care in Childbirth, 1996). *All of these*

> *made recommendations, almost none of which have been acted upon. It is time for National leadership!*[39] (1999, p. 1).

The deficits highlighted by the National Health and Medical Research Council (NHMRC, 1996) and the Senate Committee (SCARC, 1999) remain a concern and many are re-iterated in later reviews of Queensland's maternity services. The principal issues and recommendations of the major national and Queensland reviews will now be outlined.

Options for effective care in childbirth

Rising concerns among Australian women about the "culture of obstetrics care" and concomitant high rates of obstetric intervention led to the commissioning of the NHMRC review of *Options for effective care in childbirth* by the Women's Health Committee. Reports from Victoria, New South Wales and West Australia had revealed "an increasing desire for midwives to provide a greater input into maternity services" (NHMRC, 1996, 1). At the time of the review, Australia had one of the highest rates of caesarean section in the developed world - this indicator is commonly viewed as the culmination of a cascade of birth interventions.[40] While recognising the "generally excellent" perinatal outcomes in Australia, the expert panel responded to the consumers' attitudes and desires for alternatives (NHMRC, 1996).

In both the public and private sectors, the "traditional model of obstetric care [involved] women entering hospital and being cared for by a team headed by a general practitioner or specialist obstetrician" (NHMRC, 1996, pp. 1-2). There was an increasing demand for the non-interventionist approaches found in a few birthing centres and midwifery units.

Amongst the problematic issues identified, culturally appropriate and accessible care for minority groups was significantly deficient. The notable exception to this was the Alukra Aboriginal birthing centre which temporarily served as the model for the third recommendation regarding regional care for indigenous women (Central Australian Aboriginal Congress, 2004; Carter, Lumley, Wilson & Bell, 2004). Lack of continuity of care and the need for care by a known health professional were also identified as problems, especially for women in the public system (NHMRC, 1996).

Of particular note for this study is the NHMRC's concern for rural /remote

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[39] Emphasis added

[40] WHO recommends 15% yet 21.9% Australian births were by caesarean section. Rates were lowest in the ACT (19%) and highest in SA (24.9%) with the private sector averaging 29.5% (up to 56.3%) (NPSU, 2001).

birthing women, especially those from minority groups, who are required to deliver their babies in large city hospitals. The panel noted that, "The separation from family, friends and community, the dependence upon strangers in the hospital atmosphere, and the uncertainty of what is expected of them all determine the length of stay and the level of satisfaction and compliance" (NHMRC, 1996, p. 17). The need to improve the training of rural GPs in obstetrics, paediatrics and anaesthetics relevant to maternity services was recommended, and improved coordination was required when women were transferred to a regional centre (NHMRC, 1996, p. xiii).

In the fifteen recommendations made, the two overriding concerns were with maternal and infant safety, and women being able to make informed choices from a range of birthing options. The report is highly supportive of the care provided by birthing centres and recommends that their philosophy and practice be adopted by all major maternity units (NHRMC, 1996, p. xii). Integrated and shared care models were proposed to provide continuity of care across the birthing experience, with a focus on the postnatal needs of women following discharge (NHMRC, 1996; Vickerstaff, 1996).

Following draft recommendations of the NHMRC's comprehensive report, the Commonwealth's *National women's health programme* allocated limited funding for the *Alternative birthing services programme*. This resulted in Queensland Health's *Birthing services program*[41] (1995). For a limited time, funding was available for innovative models of care like the Ngua Gundi program in Rockhampton (Perkins, 1997). Home birthing, access to independent midwives and several birth centres became available throughout Queensland. Now the only surviving birth centres are in Mackay and at the Royal Women's Hospital in Brisbane. Although recommended by the NHMRC, the woman-centred philosophy has only been applied to varying extents in hospitals around the state, with implementation of policies changing with senior staff. Conservative medical resistance to alternative models was, and still is, strong (SCARC, 1999; Cresswell, 2005; ACMI, 2005a). However, inspirational midwifery models have been applied at Selangor, a rural private hospital (Staff, 2000) and Mareeba, a rural public hospital[42] (Smith, 1996; Staff, 2000). As will be discussed later, availability of options is still diminishing.

The NHMRC's *Review of services offered by midwives* advised on "measures that should be implemented to authorise midwives to order and interpret a limited range of tests, and to prescribe drugs as part of their care of healthy women during

[41] Spelling of programme and program is inconsistent in government documents.

[42] Mareeba shire had its maternity service withdrawn in 2005. Following community activism, a midwifery service has been restored for low risk birthing women.

uncomplicated pregnancy and childbirth" (1998, pp. 1, 9). The report called for the formal recognition of an expanded role for midwives but found considerable variations in scope of practice, policies and legislation between states. The scope of the report was limited to "midwives working in and employed by public maternity services" including hospitals, outreach and community settings (NHMRC, 1998, p. 1). It acknowledged that the implications for service delivery in rural and remote areas was under review at the time of writing.

Rocking the cradle

It is significant that the Senate Community Affairs References Committee (SCARC) *Rocking the cradle* report into childbirth procedures opens with a comment that almost none of the recommendations from the state and national reviews of childbirth services between 1990 and 1996 had been implemented (SCARC, 1999, p. 1). The Committee endorsed the recommendations from the earlier NHMRC reviews and recommended that Commonwealth and state governments work together to ensure development and implementation of guidelines. Although the Senate inquiry was broad-ranging, a significant and ongoing concern was with the escalating costs and morbidity associated with obstetric interventions.[43] While safety was found to be valued by birthing women above all other considerations, the extent of medicalisation and associated disempowerment of women was unacceptable (SCARC, 1999, p. 2). The Senate Committee drew attention to the 'inverse care law' whereby:

> A disproportionate amount of funding for antenatal, birth and postnatal care is channelled to the 80% of women at no risk, especially those with private health insurance, rather than those with high needs … Many healthy women receive specialist obstetrical care when there is no medical indication for it and where midwifery care would be equally appropriate and less expensive. At the same time, many women at high risk receive inadequate general health care (1999, p. 164).

Citing the submission from the Queensland Council on Obstetrical and Paediatric Morbidity and Mortality, the Committee noted that "In no other 'condition' are well people expected to visit medical specialists for primary health care. Yet this is the main option for women with private health insurance, and for many rural women regardless of health insurance status, for care during pregnancy" (King, p. 513 cited in

[43] The Australian caesarean section rate exceeded that of the USA and was contrasted to Holland at 6%, Sweden 10% and the UK with 12 %. 'Modern' women in Brazil and Thailand had a 75% rate (SCARC, 1999, p. 81).

SCARC 1999, p. 164). The exceptional rate of intervention, especially antenatal screening practices and elective caesarean sections amongst privately insured women, was considered "a huge waste of resources" and contrasted to the lack of funding for improving perinatal outcomes in indigenous women and infants. Although reasons for escalating antenatal and intrapartum intervention rates were explored, such as fear of litigation, maternal requests, older nulliparae and previous caesarean section, the committee concluded that the significant variations in rates between different states and hospitals, and between the private and public sector, were unacceptable and medically unjustified. Drawing on national perinatal data sources, the inconsistencies were attributed to practices determined by individual institutions, individual practitioners and the health of individual patients. Observing that "far too many practices are based on custom and fashion rather than on evidence and evaluation" (1999, p. 4), the Senate Committee called for the development of best practice guidelines that would "improve the quality of care, reduce the use of unnecessary, ineffective services or harmful interventions and ensure that care is cost effective" (1999, pp. 2-3).

When addressing the issues of litigation, indemnity and defensive medicine, the Committee sought the guidance of Fiona Tito, who reported that fear of litigation for negligence far exceeded the risk. As very few successful claims had been lodged against obstetricians (Tito, 1993, 1996, 1999)[44] there was no 'litigation crisis' in obstetrics. However, the significant rise in MDO indemnity insurance premiums impacted on practice and provision and so required further attention by the Commonwealth Government (SCARC, 1999, p. 184).

When considering the delivery of maternity services, the Committee reiterated the need to address the adverse effects on quality caused by fragmented services exacerbated by cost-shifting across funding sectors. Women commonly received segmented antenatal, intrapartum and postnatal care from multiple carers. A void in postnatal care following the trend towards early discharge was a concern. The Committee recommended that the Commonwealth government work with state governments to provide seamless episodes of care from the beginning of pregnancy through birth into the postnatal period. Continuity of carer, with team and shared care models were recommended (SCARC, 1999).

The continuing option of homebirth was supported by the committee. One NSW obstetrician commented that, while a minority of women chose this option, the philosophy of the homebirth movement had "civilised hospital births" as it had become

[44] By contrast, gynaecological procedures such as complications of hysterectomy, sterilisation and laparoscopic procedures far exceeded obstetric claims (Tito, 1996, 1999).

apparent to obstetricians that they were practising in a way “which was not necessarily either beneficial to mothers or making them happy” (SCARC, 1999, p. 70). The impact of homebirth proponents was to make hospital birth more humanised, holistic and women-centred.

Birth centres were seen by SCARC as an ideal “intermediate position” but the shortage was “disappointing”. Not only were birth centres more cost-effective than expensive interventions, but they also fulfilled women’s desire for a less medicalised approach to birth while still having access to specialised obstetric care if required (1999, p. 3).

As the findings of this study will relate to perceptions and constraints within ‘labour relations’, it is significant that the Senate Committee was concerned about the polarisation of views on childbirth both in the community and amongst professionals. Views within the community varied from a belief that interventions like elective caesareans should be available on request, regardless of medical indication, while others argued for birth as a natural life event where the aim was to be intervention free. Amongst the maternity providers were doctors who felt that a birth without medical supervision was irresponsible and risky; conversely, many midwives deplored the medicalisation of birth, escalating interventions and concomitant morbidity (SCARC, 1999, p. 3). Such polarised opinions are an enduring theme throughout the international literature as well as being evident in the daily politics of birth within maternity settings.

Reviewing the adequacy of information provided to birthing women about available safe choices was one of the SCARC terms of reference (1999, p. 9). The desire for impartial, evidence-based information was an unmet need. Using funding from the Public Health Outcome Agreements, governments were to ensure that both birthing women and principal carers received current, comprehensive, accurate and objective information on antenatal and birth options, and services available in their area (SCARC, 1999, p. 5).

Birthing in rural and remote locations was also considered by the Senate Committee who investigated the “adequacy of access, choice, models of care and clinical outcomes” for women, especially those who were also Aborigines or Torres Strait Islanders (1999, p. 9). The Committee acknowledged the limited available options and problems with distance and time when a woman was transferred to an urban centre. No rural and remote consumers made submissions to the inquiry. However, submissions from RACOGP and staff from tertiary hospitals in NSW and SA, made a strong case for continuing obstetrics in small rural hospitals. Evidence presented showed that “Although access to obstetric facilities for rural and remote

women is often limited, health outcomes for women choosing to deliver in [these] locations are not necessarily worse than for metropolitan teaching hospitals" (SCARC, 1999, p. 71). Conversely, perinatal mortality and morbidity statistics from GP obstetric units in rural areas in NSW were identified as being amongst the best in the world. The low level of interventions in country areas was attributed to the limited locally available options (such as no access to epidural anaesthetics and limited induction labour), the skilled application of non-interventionist forms of pain relief, and maternity care providers being skilled at identifying potential problems and transferring 'at risk' women to regional centres. However, there was concern that staff of small units with fewer than 100 births a year would be unable to maintain the required skill levels (SCARC, 1999).

Like the NHMRC (1996), the Committee recognised that birthing in country hospitals was a more satisfying experience for healthy women than being forced to travel to a major urban centre far away from home and the support of their families. However, the RACOGP submission contended that this was being threatened by the rationalisation and centralisation of hospital services, a trend which "should be resisted unless unequivocal advantages can be demonstrated" (SCARC, 1999, p. 72). When obstetric units closed because of the low number of deliveries, rural hospitals effectively turned into nursing homes yet unanticipated births still continued. Women who presented for unbooked births were often in preterm labour or experiencing a complication which required obstetric expertise, consequently perinatal outcomes were suboptimal in such circumstances (SCARC, 1999, p. 73). Therefore, the Committee highlighted "the need to keep small rural obstetric units open and to staff them adequately [as] rural women will continue to want care closer to home and have every right to expect a safe, accessible service" (RACOGP submission cited in SCARC 1999, p. 73). Figure 3.0 starkly shows how this need and 'right' has been ignored in Queensland.

The Senate Inquiry has been the most thorough and authoritative review of birthing issues and maternity services in Australia. As such it was welcomed by progressive health professionals, birthing women and rural communities. Selected issues which emerged from the inquiry have been the focus of further research. All five evaluation principles were addressed in the inquiry and ensuing recommendations, yet I would argue that these have not been fully implemented, especially in Queensland. With diminishing options, many maternity clients/consumers continue to have unmet needs and expectations. This will be further considered when discussing of the Hirst review in Queensland in Section 3.6.1.1. The following section continues with reports at a national level with a focus on rural/remote workforce issues.

3.5 Reports on maternity service provision – the midwifery and medical workforce

Most subsequent reviews have focussed on allocative efficiency and acceptability to service providers; these in turn impact upon sustainability, especially in non-urban areas. Rising intervention rates, polarised views on models of care and jurisdictional disputes capture attention but the foremost concerns found in these documents are workforce issues (Innes & Strasser, 1997; Wells, 2000; ACMI, 2002a, b; AHWAC, 2002; AIHW, 2004c, d; AMA, 1999; NHMRC, 1998; Nisselle, 2004; RDAA, 2005a,b,c,d,e). These tend to be medico-centric, highlighting indemnity issues for medical practitioners and strategies to reduce the shortage of rural doctors and obstetricians, especially when this is associated with the loss of a maternity service (Tito, 2003; AMA, 1999, 2001; O'Dwyer, 2002; Wells, 2002; Humphreys, Jones, Jones & Mara, 2002; AIHW, 2004d; ACRRM, 2004; QRMSA, 2004; AMWAC, 2004a; RDAA, 2004, 2005d; Lavelle, 2005; Campion, 2005; Mello & Kelly, 2005; Kershaw & Starky, 2005). Less evident in the spotlight, but equally significant for service provision, are the workforce issues for midwives. Of concern is their lack of indemnity cover (and consequent loss of independent practitioners), the education and skills maintenance required for an extended scope of practice, government support for midwifery models of care, the ageing workforce, recognition, recruitment, retention and remuneration (ACIL, 1996; Lamb, 1999; O'Dwyer, 2002; ACMI, 2002a, b, c; AHWAC, 2002; Barclay et al., 2003; Maternity Coalition, 2004a, b; AIHW, 2004c; RDAA, 2005c, e; Hirst, 2005).

Reports of the Australian Medical Workforce Advisory Committee (AMWAC), which is responsible for medical workforce planning, and the Australian Health Workforce Advisory Committee (AHWAC), covering the nursing, midwifery and allied health workforces, provide insights into the current status of health provision. Medical workforce trends evident in the 1996 AMWAC report and 2003 Rural Doctor's Association (RDAA) report persisted in the 2004 Health Workforce Queensland (HWQ) and AMWAC surveys. Well documented is the maldistribution of the medical workforce with a significant shortfall of GPs and specialists in rural and remote areas. Although more women had entered medicine, in Queensland only 12% female medical practitioners chose to work in non-urban areas[45] (AMWAC, 2004b; HWQ, 2004).

Noting this gender imbalance, the Australian College of Rural and Remote Medicine (ACRRM) suggests it could be redressed with more flexible professional and practice structures which would allow female GPs to be women as well as doctors

[45] Queensland had only 14 female GPs in other rural areas and 12 in remote centres (AMWAC, 2004b).

(Wainer, Strasser, Bryant, 2005, p. 9). The RDAA adds that all rural and remote practioners have family and education concerns (2003).

The ACRRM identifies the shortage of female doctors in rural and remote areas as an important issue for meeting community needs. Following evidence from the Australian Longitudinal Study of Women's Health (Lee, 2001), the ACRRM notes that female rural doctors spend 30% of their consulting time managing women's health issues, in response to patient demand (2004, p. 53). Women report increased comfort with a female GP and are therefore more likely to seek professional assistance. Thus, the relative absence of doctor choice in rural areas makes access to female practitioners particularly important, especially for younger women and those who have sensitive medical concerns such as sexual health, rape, unwanted pregnancy, domestic violence and postnatal depression. This unmet need may therefore have negative health consequences (ACCRM, 2004, p. 52). Outreach services are provided by female GPs and Mobile Women's Health services but these provide neither acute care nor continuity of care (ACCRM, 2004, p. 54).

AMWAC reports that the maldistribution of the obstetric and gynaecological workforce has increased with greater reliance upon specialists from larger centres to provide outreach services to rural and remote areas (2004a, b). Queensland has a significant need for more trainees, therefore AMWAC recommends obstetric education programs for rural GPs along with alternative models of maternity care for areas with low birth rates (2004a).

The 'crisis' in obstetrics, as presented by the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), emphasises the effect that indemnity insurance costs have on practising obstetricians, and suggests that this reduces women's choices (Hughes, 2002; Duke, 2002; Lavelle, 2005). However, once again they overlook the under-utilisation of midwives and possibilities for alternative models of care.

Midwifery workforce issues are addressed in the 2002 AHWAC report. The committee experienced difficulties determining future midwifery needs as this was dependent upon a number of factors such as trends in fertility and birth rates, perceptions of risk, and the individual clinical needs and personal choices of birthing women, along with the availability and utilisation of a range of models of care and health services. Inconsistent regulatory requirements between state jurisdictions were noted as barriers to competent practice. AHWAC recommends re-entry programs and, following the preliminary findings of the Australian Midwifery Action Project (Barclay et al., 2003), recognises the educational and professional development requirements of the expanded midwifery scope of practice. Based upon an assumption that there are

"unlikely to be fundamental changes in the current provision of maternity services" (AHWAC 2002, p. 2), the committee reinforces the NHMRC (1996, 1998) and SCARC (1999) recommendations that states and territories should not only provide women with the option of access to safe and reliable midwifery models of care that accommodate their diverse needs but also to provide quality information on available options for maternity care (AHWAC 2002, pp. 3, 26).

Through access to specialist GPs and midwives, local services in rural and remote areas can provide both safety of care and quality with outcomes that are as good if not better than urban centres (Cameron, 1998; ACCRM, 2004; RDAA, 2005; NRHA, 2005). Based on perinatal outcomes, the ACCRM reports fewer premature births, hypoxic infants and low birth weight babies when maternity care is provided locally (2004, p.53) whereas lack of local maternity care is associated with increased infant mortality (ACCRM, 2004, p. 52). However, the acute shortage in rural and remote areas of suitable health professionals, such as obstetrically qualified GPs, female doctors and midwives, necessitates reconsidering alternative service models. Sustaining services requires initiatives to develop and maintain maternity care providers' competencies, along with professional development opportunities and incentives that retain them in the local area (CRANA, 2004; NRHA, 2005; RDAA, 2005).

3.6 Available models of maternity care

National reviews have repeatedly made recommendations about types of maternity services and models of care. Based upon reports from the professional colleges and the reviews of workforce requirements, it is possible to map the services which are available to women in Australia. However, not all those options are available to birthing women in Queensland, let alone those in rural and remote areas. While Table 4.0 in Chapter 4 compares the possible models of care with those available and accessible to birthing women within in this study, Table 3.0 depicts the key areas addressed in major maternity service reviews, with the national reviews shaded. Section 3.6.1 then outlines reviews of Queensland's maternity services.

Table 3.0 Key maternity service reviews

REVIEWS AND REPORTS / KEY ISSUES / RECOMMENDATIONS	Options for effective care in childbirth (NHMRC, 1996)	Review of midwifery services (NHMRC, 1998)	Rocking the cradle (SCARC, 1999)	National maternity action plan (Maternity Coalition et al., 2002)	Aboriginal birthing on homelands (QLD Health, 1995)	Alternative birthing services program, (ACIL, 1996)	Mothers & babies (QLD Health, 1998)	Rebirthing (Hirst, 2005)
Consumer concerns								
o Safety	*	*	*	*	*	*	*	*
o Control over birth process	*		*	*	*	*	*	*
o Continuity of care / known carer	*		*	*	*	*	*	*
o Information and choice	*		*	*	*	*	*	*
o Improved communication	*		*	*	*	*	*	*
o Need for focus on women, not on aspirations of service providers	*		*	*	*	*	*	*
o Family–centred care	*		*	*	*	*	*	*
o Deficit language in perinatal care	*							
Access to alternative care models	*		*	*	*	*	*	*
o Increasing options for childbirth	*	*	*	*	*	*	*	*
o Expansion of philosophy and practice of birth centres	*	*	*	*	*	*	*	*
o Homebirth / Homeland		*	*	*	*	*	*	*
o Community-based midwifery care		*	*	*	*	*	*	*
Informed decision-making and access to objective information Choices – comprehensive, accurate, current information on available antenatal and birth options and services	*		*	*	*	*	*	*
			*	*	*	*		*
Barriers to effective care								
o Fragmented care: Coordination, collaboration & integration needed	*		*	*	*		*	*
o Professional territorial issues	*	*	*			*	*	*
o Polarised views amongst community and professionals			*			*	*	*
o Need for client-held maternity and infant records	*		*				*	

Women with additional needs o Aborigines & Torres Strait Islanders o Migrant women o Cultural safety o Adolescent women o Rural /remote women	* * * * *		* * * * *	* * * * *	* * * *	* * * * *	* * * * *	* * * * *
Education needs o Childbirth education o Medical education – including rural o Midwifery education for expanded scope and sphere of practice	* * *	 *		* *		*	* * *	* * *
Postnatal care – ensure maternal & infant welfare services o community follow up o Breastfeeding support o Postnatal depression	* * * *	*	* * * *	* * * *	*	* * *	* * * *	* * * *
Rising obstetric intervention rates	*		*	*			*	*
Efficacy & cost of diagnostics /screening	*	*	*				*	*
Over-servicing for Medicare rebates Publish birth interventions for each hospital & insurance status of women	*		* *					
Evidence based research into effective care – monitor best practice	*		*	*	*		*	*
Emergency & retrieval procedures	*		*			*	*	*
Funding recommended: Cost-shifting limitation	*	*	* *	*	*	* *	*	* *
Indemnity & litigation concerns	*	*	*	*		*	*	*

3.6.1 Queensland – a decade of reviews

Within Queensland, the organisation of maternity services is a product of historical processes that reflect national and international politics, policies and trends, which, according to the recent independent review are "without the benefit of a strategic framework for relating care to consumer needs or contemporary knowledge and ideas in any systematic way" (Hirst, 2005, p. 1).

In the search for background literature on Queensland's maternity services, 55 relevant reports were located. Because of their extent, these reviews are listed in a bibliography as Appendix 1. Others were not accessible outside of Queensland Health or were restricted to private maternity services, so those reports were not included. A selection of the reports most significant to this study is profiled in Table 3.0. As a comparator for the Queensland content, the first four columns contain the four national reviews previously outlined. Of the 55 maternity reviews in Queensland, this shows only four. First is the report on the four stage project trialling an incremental approach to culturally appropriate birthing for indigenous women on homelands (including outer Torres Straits). Second is the independent review of Commonwealth funded alternative birthing services; 54 recommendations were made to all levels of government, health services and professional groups (ACIL, 1996). The third, 'Mothers and Babies' (1998) was informed by previous reviews and Queensland Health endorsed documents. It concluded that there was considerable unmet consumer demand for options in maternity care. Finally, the Hirst (2005) review *Rebirthing* is described in further detail.

3.6.2 *Rebirthing*: Report of the review of maternity services in Queensland (Hirst, 2005)

This report is the culmination of a decade of maternity reviews in Queensland. Commissioned by the Queensland Government, Cherrell Hirst, Chancellor of QUT, undertook an independent review of the state's maternity services. Recognising that reforming maternity care requires a whole-of-government approach, Hirst comprehensively examined Queensland's public and private services from conception throughout pregnancy, birth, post-birth care and parenting support. As my institution participated in the review, a number of findings on rural and remote birthing experiences from this PhD project are reflected in the report. As well, several recommendations in *Rebirthing* pre-empt this thesis.

Birthing women across Queensland took advantage of the opportunity to express their concerns and raise issues. Of the 447 submissions received by the

Review, 229 were from maternity service consumers and a further 18 submissions were from community organisations representing memberships of over 500 consumers.[46] In addition, 44 of the submissions from health professionals reported on both carer and client experiences (Hirst, 2005, p. 121).

According to Hirst, "For many women, lack of choice is the primary reason for making a submission … They report having little choice and /or having been unable to access the kind of care that they wanted"[47] (2005, pp. 121-122). Consequently, women felt "uncomfortable" about the approaches available and had to "make a choice they feel is the best they can in the circumstances" (Hirst, 2005, p. 122). Consistent themes which emerged in these submissions related to choice, access, participation and respect. Key themes were:

- Safety;
- Continuity of care and carer;
- Choice and related access to services;
- The level of information about pregnancy, health care, approaches to care, providers and facilities, options;
- The quality of information, such as dissatisfaction with receiving biased information and antenatal classes which focussed only on birth often within an particular institution;
- Deficiency in access to antenatal education;
- Lack of preparation for parenthood;
- Inconsistent and/or incorrect information about breastfeeding and infant care;
- Perceptions of care in labour included questions about intervention levels and their necessity, as well as concerns about having these forced upon them. Many women reported negative labour experiences; some felt dehumanised, abused or victimised. Hospital protocols were perceived as unsupportive of women. During labour, women reported having their movement restricted and not being supported in their choices about pain relief or birth positions.
- Perceptions of care following birth – dissatisfaction with early discharge from hospital with inadequate preparation for parenthood; lack of access to assistance with postnatal depression;

[46] For example, Maternity Coalition (QLD), Friends of the Birth Centre, Homebirth Support Group, Consumers for Choice, Women in Agriculture, along with groups representing ethnic, Aboriginal, and disabled women.

[47] Of these submissions, homebirth was referred to in ¼ and $^1/_3$ to birth centre care. Care with a known midwife and care in local communities were other major choices.

- Women with additional /special needs felt marginalised and alienated, experienced negative stereotyping and reported receiving inappropriate advice and care.
- Participation and respect – women who experienced birth centre or homebirth reported positive experiences of involvement in decision-making. Many women who experienced hospital births reported relinquishing control, then feeling helpless and overwhelmed (Hirst, 2005, pp. 122-129). An endemic professional culture was reported to lack respect and patience. Women experienced a culture of 'care' from both doctors and midwives that was "both patronising and disparaging towards women; a culture which purports to know best but which often coerces women to conform to procedures which are mainly for the convenience of the system rather than for the safety and satisfaction of the women concerned" (Hirst, 2005, p. 125).

Choice and access for women in rural and remote communities

Unlike the previous National and Queensland reviews, rural and remote birthing women's views were powerfully expressed through their attendance at forums and in submissions. Their concerns were further advocated by support organisations and rural/remote health professionals. The issues raised foreshadow findings from this study, such as a lack of antenatal education and birthing places in local communities, the financial and personal costs of relocation to give birth in a major centre, disruption to families, and the risks attached to travelling for ultrasound scans and when in labour. Both maternity care providers and birthing women "called for greater effort to be put into providing birthing services for rural and remote women closer to home" (Hirst, 2005, p. 123). Women who birthed in small communities reported more personalised experiences with initial postnatal care; however many women also commented on being unable to have access to community child health clinics or to find local assistance with postnatal depression (Hirst, 2005).

Based upon available choices, birthing women's views about existing services and information on known outcomes, Hirst recommends a sustainable strategy which both implements evidence-based approaches to maternity care and enhances women's options (2005, ii). For rural and remote women, *Rebirthing* recommends additional funding to assist with relocation; that extended hospital stay be provided for women who require more hospital-based support, and that community post-birth care be strengthened. In particular, Hirst conceives of 'bub-hubs' of appropriately prepared and trained care teams to provide community-based, primary care models (2005, p. 5).

Queensland Health's response to 'Rebirthing'

Despite anecdotal accounts to the contrary within the Northern Zone,[48] the Queensland Premier and Minister for Health made a joint commitment to support the recommendations of Hirst's *Rebirthing* report. In a joint statement, they have promised to take action on Hirst's proposed strategies, to address the issues of concern and improve Queensland's maternity services. According to the Health Minister "The *Maternity 2010: Co-operative Centre for Mothers and Families* will be designed to improve practice, inform choice and build maternity services' capacity. The centre would ensure best practice changes to care by monitoring appropriateness, effectiveness, quality, safety and evidence of maternity services." (Queensland Cabinet, October 2005, para 18-19). A steering committee has been formed.

3.7 Place of birth

Issues around place of birth are implicit in the previous discussions on choice, risk, consumer satisfaction and the health workforce. This section outlines the trends in where Queensland women gave birth and briefly discusses why geographic place matters.

Poland, Lehoux, Holmes and Andrews (2005) argue that discourses of 'evidence based' and 'best practice' (and I would add economic rationalism), have resulted in flawed 'one-size-fits-all' health interventions and care settings. The significance of place, they assert, is overlooked. Detaching practices from the places in which care is received discounts the impact of "interactions between key personalities, circumstances, coincidences (timely opportunities, changes in leadership, ideas 'whose time is right', organisational constraints, available resources, history of management relations, etc…)" (Poland et al., 2005, p. 171). In addition to factors such as the physical, social and cultural characteristics of the setting and macro and micro level health policies, Poland et al. (2005) contend that the most significant and pervasive dimensions of place concern the emplacement of power relations in and across settings, and the influence of technology. Therefore, to achieve efficiency and the desired outcomes in service delivery, power is exercised as part of the political anatomy of places through the regulation of institutional practices, care providers and birthing women within maternity settings. This is evident in the location of birth within hospitals and the trend away from rural and remote communities to hi-tech tertiary

[48] Personal communications from maternity staff engaged in the reviewing the provision of services to rural and remote areas in the Northern Zone, September – October 2005; July, 2006.

settings under obstetric surveillance. Table 3.1 shows that during my data collection period 98.4% of Queensland births took place in a hospital setting. Of note is the significant rise in the number of women giving birth while trying to reach the hospital.

Place of birth is widely identified as being significant to women and their families. The political dimensions of power related to place of birth are evident both in the international literature, such as Davis Floyd (1994) and Howell-White (1999) in North America, and the United Kingdom's *Changing Childbirth* (Campbell, 1990; Campbell & Garcia, 1997) and in the ongoing Australian controversies about professional jurisdictions and safety (previously discussed). Globally (e.g. Epoo , 2005) and locally, Indigenous women associate empowerment and identity with birth sites and are prepared to sacrifice physiological safety for the psychological, emotional and spiritual importance of place (Myles & Tarrago, 1994; Croker, 1995; Fitzpatrick, 1995; Apunipima Cape York Health Council, 2000; Chamberlain, Barclay, Kariminia & Moyer, 2000; Kennedy & Leap, 2001; Carter, Lumley, Wilson & Bell, 2004). For Australia's rural and remote women, birthplace is a potential concern.

Table 3.1 Places of birth: Queensland 1995-1999

PLACE OF BIRTH	1995	1998	1999	% of births 1999	*Annual % change 1995-1999*
Hospital	47,259	46773	47,256	98.4	*0.0*
Birth Centre	190	281	387	0.8*	*19.5*
Home	242	171	164	0.3	*- 9.3*
Born before arrival	173	225	234	0.5†	*7.8*
Other			1	0.0	-
All births	47,864	47, 450	48,042	100.0	*0.1*

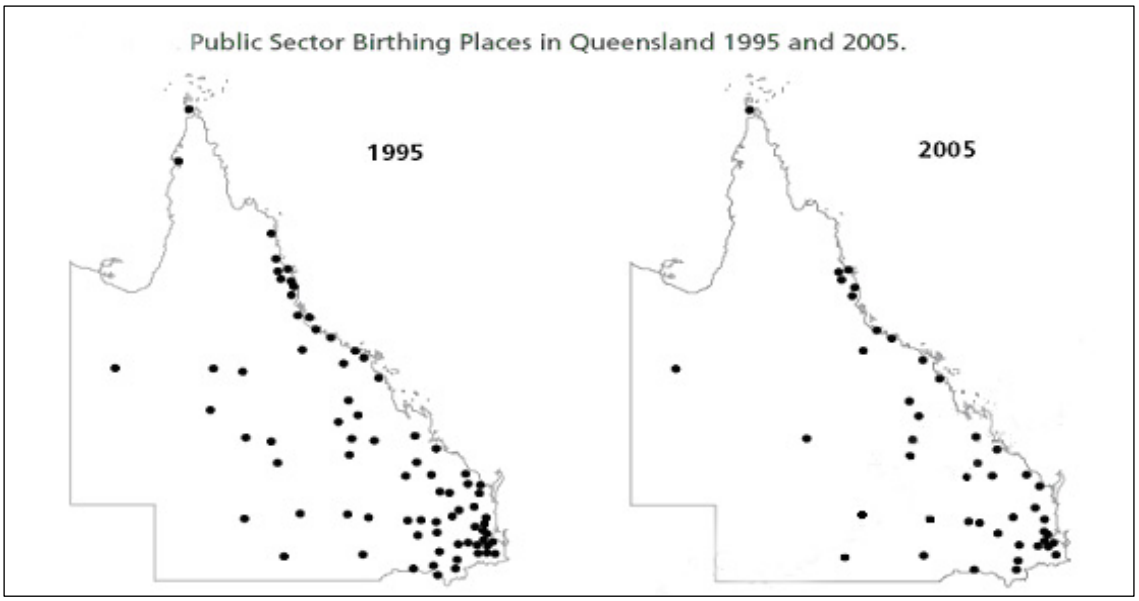
* Queensland had the lowest number of birth centre confinements in Australia, by contrast with ACT 7.5%; SA 5.1%; NSW 2.6%; WA 1.6%; VIC and TAS 1.4%; NT 1.3%

† Second highest in Australia after Tasmania.

Sources: Queensland Health (2000), AHWAC (2002, p. 148), AIHW National Perinatal Statistics Unit (Laws & Sullivan, 2004).

The limited choice of place of birth for women in rural and remote areas is evident in the NHMRC and Senate reviews of birthing and reinforced by Queensland reports on maternity services (Appendix 2). Hirst's (2005) *Rebirthing* review revealed that not only have maternity facilities diminished over the past decade (Figure 3.0), but of the hospitals described in this study, none are listed in 2005 as still offering a local birthing service (Hirst, 2005, p. 42). Birthing has shifted from rural and remote communities to tertiary centres.

Figure: 3.0 Public sector birthing places in Queensland



Source: Hirst C. (2005). *Rebirthing*, p. 20

This relocation of birth place is justified by the 'volume threshold theory' which maintains that birth is safest in large tertiary referral hospitals (Tracy, 2005b). Public maternity hospitals with more than 2000 births per annum can provide 24 hour resident obstetric, emergency, anaesthetic, operative and neonatal services as well as a level of expertise not available in small units. Women having their first baby (primiparas) are routinely sent to a major centre. However, Sally Tracy's (2005a) large population-based study of the 1,0003,657 Australian women who gave birth between 1997-2000 revealed that low risk women, including primiparas, who birthed in the smallest units (> 100 birth per annum) had remarkably more natural births and better perinatal outcomes than those who delivered in large hospitals. With fewer birth interventions, neonatal outcomes were also better in the smaller units.[49]

Place of birth is also implicated in the outcomes for women who choose private obstetric care. Roberts, Tracy and Peat (2000), King (2000) and Laws and Sullivan (2004) convincingly show that private maternity care results in a significantly higher incidence of interventions, especially caesarean sections, even for women categorised as 'low risk'.

Based on Queensland Health Information Centre's (2000) data on place of birth

[49] Tracy's (2005) comparative statistics show positive outcomes for primiparous women in small units (< 100 births pa) e.g. spontaneous onset of labour 81.7% v 71.3%; fewer inductions of labour 15.9% v 25.6%; fewer caesarean sections 11% v 25.9%, instrumental births 20.1% v 23.6%, episiotomies 25.7% v 29.3% and major tears 0.4% v 0.7%. This pattern persisted with multiparous women. Neonatal outcomes were better with fewer babies requiring intensive or specialist care (9.7% v 16.8%)

by the usual residence of the mother, in 1998-1999 most rural (77.7%) and remote (81.3%) births took place in a public hospital[50]. Private maternity care was preferred by 20.9% of rural women and 17.8% of remote women travelled to birth in a private hospital. Rural homebirth figures were lower than those for urban women however rural women had comparable access to a birth centres in Mackay and Bundaberg (urban 0.6%; rural 0.6%). Home and birth centres were not an option for remote women (0.1%). More remote than rural or urban women went into labour spontaneously and birthed before arrival at hospital. They also had longer hospital stays (Queensland Health, 2000). Using the usual residence of the mother, Appendix 2 contains further perinatal variables that profile comparative birth experiences in Queensland.

By comparison, the AIHW 2002 perinatal figures show a decrease in the number of confinements overall with 98.5% still occurring in hospital. Birth centre figures remain stable at 0.8% but with the loss of indemnity insurance for independent midwives, homebirths fell to 0.1%. The 2002 figures subsume 'born before arrival' under 'other' and this remains at 0.5% of births (Laws & Sullivan, 2004, p. 10). Although some private facilities are also contracted to take a small number of public patients, the majority of Queensland women still gave birth as public patients in a public hospital (67.9%). The remainder (32.1%) were either private patients within a public hospital or chose a private facility (Laws & Sullivan, 2004, p. 20).

Based on the Queensland perinatal data collection, Hirst (2005, p. 19-20) states that it is difficult to estimate accurately the number of women who travelled away from home ahead of their birth. However, in 2003, of birthing women residing in rural and remote areas, 62% relocated for birth. This included women who chose private care (25%) as well as those who relocated to gain access to public maternity care. Hirst notes that there were two groups of women accessing public hospitals: those with a maternity service and those without. Most women who birthed locally (83%) were low-risk pregnancies. For 82% of women who went away to birth, there was no local option. Of these, 57% relocated to birth in a public hospital outside their local government area and 46% were retrospectively considered 'low risk' (Hirst, 2005, p. 20).

Whether women are informed about the implications of birth place on perinatal experiences and outcomes is not addressed in the literature. Participants' views on place of birth and the consequences are discussed later in the findings of this study.

The final section outlines the response of health services to childbearing women experiencing domestic violence. In order, for health providers to respond satisfactorily, they require an understanding of the background issues and policies.

[50] 'Rural' included large centres like Cairns and Mackay while 'remote' included the city of Mt Isa.

3.8 Rural/remote childbearing women and domestic violence services

Although domestic and family violence were not originally anticipated to be themes in this study, the underlying cultural, structural and systemic issues which emerged in the findings (as shown in Chapters 7 and 8) necessitated reconsideration and inclusion of the relevant literature. Masculine hegemony and patriarchy have been presented as contributing factors in the previous chapter. At the time of data collection, domestic violence (DV) was finally being recognised as a significant public issue needing to be addressed at international, federal and state levels. Since the 1980s, DV had been acknowledged as a criminal offence and a public health concern in Australia (O'Shane, 1981; Queensland Domestic Violence Task Force, 1988); however the response by health services had often been unsatisfactory (Taft, 2002; Laing, 2000). Ongoing lobbying by women's health reformers, supported by the Australian Bureau of Statistics' benchmarking of the incidence of violence with the *Women's Safety Survey* (ABS, 1996, 2003) and *Personal Safety Survey* (ABS, 2005), provide further stimuli for action. Intersectoral collaboration eventuated through the national Partnerships Against Domestic Violence (PADV) and in Queensland, the Domestic Violence Initiative (Queensland Health 1999, 2001).

Violence is recognised as having implications for the interactions between health professionals and their female clients, as well as placing an enormous burden on individuals, families, communities and the health care system (Queensland Health 1999; Stratigos, 2000a; Taft, 2002; NHMRC, 2002a, b; AIHW, 2005). The Queensland Domestic Violence Initiative (DVI) piloted the use of DV screening tools in selected antenatal and gynaecology clinics and emergency settings with concomitant training of health providers. During fieldwork, these had yet to be implemented in the small health services being studied. Gaps between policy and responsive practices were evident (Queensland Health 1999). However, recognition of women who were experiencing abuse, so as to be able to offer them appropriate, effective, non-judgemental assistance, was becoming part of the expanded role of the health care provider (Queensland Health 1999, 2001). The International Council of Nurses (2001) and Australian College of Midwives (ACMI, 2002d) now consider responding appropriately to violence to be a core competency. In collaboration with rural and remote health practitioners, the NHMRC (2002b) has developed specific strategies and practical suggestions to assist health providers to effectively prevent, reduce and respond to various forms of violence at a community level.

The impact of family and/or domestic violence has increasingly been accepted as a significant health issue affecting childbearing women (Queensland Health, 1999,

2001; Stratigos, 2000a; Quinlivan & Evans, 1999; Webster, 1999, 2000), particularly those socially and geographically isolated in rural in remote areas (Women's Services Network [WESNET], 2000; Bagshaw, Chung, Couch, Lilburn & Wadham, 2000; PADV, 2000; Warner Smith & Lee, 2003; Warner-Smith & Bryson, 2004). Current and previous partners are a significant threat to women's safety and well-being (ABS, 2005). After outlining definitions and forms of violence, the following review will briefly overview research on the significance of violence for this group of women.

3.8.1 Conceptualising violence against women

While the broader term 'family violence' is preferred by Aboriginal and Torres Strait Islander communities (WESNET, 2000), most literature refers to the less inclusive term 'domestic violence' (DV). Family violence is a more encompassing concept that "includes all forms of violence in intimate relationships and also covers a broad range of family relationships including those with extended family members (Partnerships Against Domestic Violence Taskforce [PADV] 2000a). Within indigenous communities, 'family' also incorporates "a diverse range of reciprocal ties of obligation and mutual support" (PADV 2000a, p. 5). Baghsaw, Chung, Couch, Lilburn and Wadham add that family violence does not assume that the violence is carried out only by men against women and can involve a wide range of abusive behaviours (2000). Acknowledging the differences between these concepts of violence, I consider 'family violence' to be more applicable for the extended interpersonal relationships within close knit rural and remote communities. However, in recognition of differing nuances to these concepts, in this thesis I will distinguish between the terms 'domestic' and 'family' violence when analysing the women's stories.

Domestic violence is overwhelmingly perpetrated by men against women (Bagshaw, Chung & PADV, 2000). Although domestic violence is often equated with images of the 'battered' woman with the emphasis on openly violent forms of sexual or physical abuse (Hunt & Martin, 2001; Walsh, 2003; Abs, 2005), it actually takes many forms, some of which are subtle and poorly recognized. The definition agreed upon at the *National Domestic Violence Summit* in 1997 was employed by the PADV Taskforce. It states that :

> Domestic violence is the abuse of power perpetrated (but not only) by men against women in a relationship or after separation. Domestic violence takes a number of forms both physical and psychological. The commonly acknowledged forms of domestic violence are: physical and sexual violence; emotional and social abuse; and economic deprivation (WESNET, 2000 p. 2).

The Domestic Violence Resource Services, the Office of the Status of Women and Department of the Prime Minister and Cabinet (OSW, 1997) and Bagshaw, Chung et al. (2000) expand these categories further to include verbal and spiritual abuse (Appendix 3). Of these forms of violence, it is significant for this study that the Queensland Domestic Violence Initiative (DVI) found emotional abuse was most commonly reported, followed by physical and then threatened abuse with only a few women reporting that they lived in fear (Queensland Health DVI, 2001). This finding contrasts with the earlier generic observation that the perpetrators' controlling behaviours leave the victims living in fear (OSW, 1997).

Accordingly, Deborah Walsh's (2003) Victorian study of violence in pregnancy revealed that is necessary to distinguish clearly between the extent, level, and type of violence. She addresses the controversy of whether the broad category of psychological abuse should be perceived as violence through exploring behaviours of concern to pregnant women. Walsh contends that measuring only physical abuse reinforces the notion that "violence is only about physical assault [and] contributes to silencing and ignoring all other experiences" (2003, p. 224). Likewise, the NHMRC (2002a) states that non-physical forms of violence should be acknowledged and dealt with. I also believe this is key issue that requires further exploration if rural and remote women's perceptions of abuse and experiences with current services are to be identified.

As discussed in Chapter 2, within the public sphere, patriarchy and hegemonically gendered practices have ensured that social and cultural general norms are perpetuated and that institutionalised forms of violence are overlooked in order to maintain the status quo (Connell 1987; National Committee on Violence Against Women, 1992; Thorpe & Irwin 1996; Saltman, 1998; Alston, 1997, 2005; Wendt, 2004). Formerly, DV was relegated to the private sphere where it was perceived as a personal and moral issue. However, barriers continue within the legal system (Stubbs 1994) and health systems (Saltman 1998; Stratigos 2000a, c, d; Taft, Watson & Lee, 2004). Although an abused 'wife' is often pitied, persistent 'victim blaming' means that she is also frequently held responsible for the violence as it is thought that her behaviour has in some way provoked the abuse (PADV, 2000a; OSW, 1988, 1995; Hunt & Martin, 2001). Officially, the current focus on domestic violence shifts away from the moral dimension to the consider the lifelong health effects of abuse on women and children as well as the burden on the health system and the social consequences of such dysfunctional behaviours (Domestic Violence & Incest Resource Centre, 1997; Roberts, Lawrence, Williams & Raphael, 1998; Queensland Health, 1999; Stratigos, 2000 a,c; Bagshaw, Chung et al., 2000b; Warner Smith & Lee, 2003).

Systemic or structural violence against women is well documented globally; within Australia it is addressed by Rosamund Thorpe and Jude Irwin (1996). They draw upon Pinthus' broad definition of violence as:

> … any action or structure that diminishes another human being; and in accepting this definition we must see that basic structures of our society are often violent in concept. We must recognise the violence built into many of our institutions such as schools and places of work in that they are competitive, hierarchical, non-democratic and at times unjust (Pinthus 1982 cited in Thorpe & Irwin 1996, p. 2).

As is implied by this definition, Thorpe and Irwin (1996) argue that within Australia there exists a culture of violence. Historically derived, it is enacted against indigenous peoples and across class and gender, with a continuum existing between public practices and the entrenchment of violence within the private sphere. Gendered power imbalances result in discrimination and systemic violence within all major institutions. Despite attempts by feminists to raise awareness of the problem, popular culture and socialisation reinforce racist, classist and gendered behaviours that either promote or passively fail to acknowledge the roots of violence and oppression. The interpersonal violence that women experience in their everyday lives, Thorpe and Irwin contend, "could not continue to the extent it does without societal support" (1996, p. 2). However, as violence is insidious, and has the multiple and subtle forms, it is not readily recognised and challenged, especially when hegemonic discourses are perpetrated by major institutions and professionals, or as part of everyday gender relations within a rural community (Coorey 1988, 1990; Poiner, 1990; Alston, 1998, 2005; WESNET, 2000; PADV, 2000; Croker, 2000, 2004a).

3.8.2 Depicting the problem

According to the NHMRC, "There is no real knowledge about the incidence of domestic violence in rural Australia" (2002b, p. 27), let alone for childbearing women in particular. Reporting of physical harm is patchy and the incidence of other forms of violence is difficult to measure (AIHW, 2005; NHMRC, 2002b) as women are reluctant to disclose them (Queensland Health, 1999; WESNET, 2000). Anecdotal accounts from rural/remote health professionals and community groups (Australian College of Rural & Remote Medicine, 2004), supported by research such as Coorey (1988; 1990), Alston (1997), Baghsaw, Chung, Couch et al. (2000), Croker et al. (2002), Warner-Smith & Lee (2003), Wendt (2004) and Croker (2004a), provide insights into the extent of the problem and the contextual constraints that women experience.

Commonly identified risk factors for violence that are relevant to this study

include women who are socially isolated, living in a rural or remote area, young, indigenous, and from ethnically and linguistically different backgrounds, particularly those within mining communities or living on farms and stations (Wendt, 2004; Warner-Smith & Lee, 2003; NHMRCa, b; WESNET, 2000; PADV, 2000; Quinlivan & Evans, 1999; OSW, 1997; Parker, McFarlane, Soeken, Torres & Campbell, 1994).[51] However, the true extent of the problem for these women is difficult to assess as shame and fear have been found to be major barriers to disclosure, regardless of cultural background (Wendt, 2004; NHMRC, 2000b; PADV, 2000a).

A growing body of literature suggests that violence is a hidden phenomenon that impacts significantly on pregnancy, birth and the postnatal period (e.g. Parker, McFarlane et al., 1994; Fahy, 1995; Webster, Chandler et al., 1996; Domestic Violence & Incest Resource Centre (DVIRC), 1997; Cokkinides & Coker, 1998; Colburn, 1999; McFarlane & Soeken, 1999; Foy, Nelson et al., 2000; Webster, 2000; Stratigos, 2000a; b, c) . Because reports on the prevalence and patterns of violence during pregnancy and following birth differ in methodology, estimates vary on the extent of the problem (Taft, 2002; Laing, 2000; Gazmararian, Lazorick, Spitz, Ballard, Saltzman & Marks, 1996). The ABS report *Women's Safety Australia* found that over a 12 month period 292,100 women experienced violence from their partners while pregnant. Of these, 140,300 experienced violence for the first time while pregnant (ABS, 1996). Joan Webster's Brisbane study found a third of antenatal patients experienced intimate partner violence, with many women being abused for the first time during pregnancy (1999; Webster, Sweett & Stolz, 1994). Taft estimates that 4-9% of pregnant women experience violence from either a partner or someone close to them (2002, p. 6).

Some studies have identified that an escalation in violence during pregnancy and notably after birth (Taft, 2002; Stratigos, 2000a, b; Foy, Nelson, Penney & McIlwaine, 2000; Colburn, 1999; Cokkinides & Coker, 1998). The majority of women who are abused in the first trimester of pregnancy are also abused in the three month period following birth (Bewley & Gibbs, 1991; Mezey & Bewley, 1997; Fulton, 2000).The Canadian Society of Obstetricians and Gynaecologists found that 21% of women abused by marital partners were assaulted during pregnancy. Schuumans (2000) reports that of these women, 40% were abused for the first time during pregnancy. Serious, severe violence was four times more likely to occur during pregnancy, resulting in a high incidence of miscarriage (Schuumans, 2000). Consequently, for childbearing women, the well-known effects of violence such as

[51] Adolescents, older women and those with disabilities are also specifically identified as at risk but these characteristics are not found amongst the participants in this study.

depression, substance abuse and medical disorders are compounded by a higher risk of miscarriage, termination and low birth weight (Ballard, Saltzman et al., 1998; Curry, 1998; Dejin-Karlsson, Hanson, Ostegren, Lindgren & Marsal, 2000).

Findings differ in other studies. Walsh reports that violence principally stayed the same or decreased during pregnancy (2003, pp.173-174). Similarly, several international studies found that violence decreased during pregnancy but escalated after birth. The postnatal period, when the new baby is demanding a woman's care and attention, has been widely identified as a time of high risk (Mezey & Bewley, 1997; Webster, Chandler et al., 1996; Webster, 1999; Webster, 2000; Schuumans, 2000).

For abused women, labour can trigger memories of violence. Distrust of authority figures may also be a problem along with fear of abandonment during labour (Pascali-Bonaro & Kroeger, 2004; Shuumans, 2000). Therefore the continuous, nurturing presence of a known woman has been demonstrated to enhance the experience and improve birth outcomes. Physical and emotional support by known female carers is particularly effective in low resource settings, such as the minimal technology available in rural/remote maternity settings (Pascali-Bonaro & Kroeger, 2004; Croker, 2000).

In reducing the immediate and long-term impact of violence on birthing women, their children, and the health care system, antenatal care has been identified as a safe point of entry into interventions towards harm minimisation and safety (Stratigos, 2000b, c). Midwives have been identified by Queensland women as the preferred health care providers to identify and assist women who are being abused (Stratigos 2000a; b, c). However, Stratigos (2000a) reports that 69% of midwives surveyed felt uncomfortable asking women about domestic violence.

The South Australian study *Reshaping Responses to Domestic Violence (Queensland Health Domestic Violence Initiative 2000)* confirmed findings of the *Women's Safety Survey* (ABS, 1996). "Women are more likely to disclose violence to friends and informal networks than to specialised or generic professional services" (DVI, 2000, p. 4). Queensland Health has acknowledged this finding and recognises the importance of supporting 'these informal networks through community information and appropriate resources (DVI, 2000, p. 4). However, studies in Australia (Webster, 1999; Stratigos, 2000c), the USA (Gazmararian, Lazorick et al. 1996) and UK (Mezey & Bewley, 1997; Fulton, 2000) have found that women are more likely to reveal to a midwife that they were abused than to a family member, friend or another health professional. Therefore, it is also important that maternity care providers, such as midwives, are able to respond effectively when a woman does disclose. Women participants in the South Australian survey and focus groups clearly stated that one of

the *least* helpful responses to their situation was the suggestion that they should leave their partners. Instead, they wanted to be able to make informed choices and stressed the importance of receiving unconditional support whatever their choice or situation (DVI, 2000). This enabling approach, in which women are given options and freely make their own choices, is supported by Queensland Health, in contrast to the interventionist model found in places such as the USA.

It is evident in this review of the literature that childbearing women in violent relationships who live in rural and remote areas have few available choices of health care providers or services from which to seek assistance. Within rural/remote communities, cultural and structural issues compound the problem and health services are having difficulty in responding appropriately to women experiencing violence.

3.9 Chapter Summary

Chapter 3 has provided an overview of maternity services in Australia with a particular focus on models of care available within Queensland. This has encompassed the plethora of reviews and inquiries into birthing services at national, state and regional levels. Recurring themes in the literature are, notably, health workforce issues, the role of women as birth consumers, the lack of choice in available models of care and of places to birth, the dominance of an obstetric approach, the rising rate of medical interventions and the particular problems experienced by rural/remote women. The final section highlights the need for rural/remote health services to address the issue of violence against women.

Chapter 4

Locating the study: The rural and remote context

4.1 Introduction

Located in North Queensland, this study is set within two rural and two remote townships together with their surrounding districts. Each community is a reflection of its history, economic base, and demographic profile. To protect the identity of the townsfolk and participants, the rural townships are referred to as Mining Town and Sugar Town, while the remote ones are titled Pastoral Town and Stockton. In addition, to further ensure privacy, personal communication sources and Shire Council names have been omitted. These townships were selected for their degree of remoteness, economic base and for the cultural and ethnic mix of their populations. Within each community, the research participants included birthing women and key participants amongst maternity care providers. In this way, issues that arose could be viewed from a number of perspectives.

In consistency with the contemporary feminist ethnographic approach discussed in Chapter 6, this chapter profiles the four communities. This study context is constructed from general literature, statistical data, field observations, documents from regional and community development groups and discussions with local industry and municipal spokespersons. As part of the fieldwork, photographic images that visually depict the economic base, social-cultural context and maternity facilities have been collected. A selection of these is presented in Appendix 12[52].

4.2 The rural townships

4.2.1 Sugar Town

As the name suggests, Sugar Town is a coastal agricultural community whose economy depends upon the sugar cane industry with farming and seasonal work at the two sugar mills being the principal employment. According to the Shire Council, the town's population is 5000 while approximately 13,500 people live within the Shire. However, although the Shire Council maintained that the population was stable, local professionals claimed otherwise, stating that it had been declining with the rural

[52] To preserve anonymity and confidentiality, photographic images will be restricted. Appendix 12 will not be available to the Digital Theses network.

economic downturn. Local people involved with social support services and youth activities asserted that there were limited job opportunities, especially for young people. The Shire Council, Development Bureau and Chamber of Commerce were working towards expanding the tourist potential of the area. They hoped to attract more labour-intensive industries to the region, in particular those that would create jobs and promote tourist activities.[53]

Sugar Town is a thriving country town that celebrates its Italian heritage, respects Catholic values and bemoans its recent loss of affluence. Although the majority of settlers came to Sugar Town from the United Kingdom (11.8%), the Italian population (7.8%) has the highest profile. Various Italian dialects are still spoken within the community and Italian is encouraged as a second language in the local schools. While virtually all of Europe is represented in migrants to the district over the past sixty years, descendents of Spanish, Finnish and Danish immigrants are prominent. Sugar Town's Chinese population is now in its fifth generation. At the time of data collection, the Shire Council estimated the number of Aborigines to be only 3.4% of the town's population; however the Aboriginal and Torres Strait Islander Health Service claimed that there were significant Aboriginal communities within small rural and seaside villages in their district. Historically, the Aboriginal population was largely removed to 'missions' in the late nineteenth century when the land was developed using Kanaka labour. South Sea Islanders descended from Kanaka labourers are more evident in the surrounding district than in the township. Many South Sea Islanders have now intermarried with Australian indigenous people. More recently, migrants have come from New Zealand (0.9%), the Netherlands and Germany (0.3% each), the Philippines and other South-East Asian countries (0.4%). Other ethnic groups constitute 11.2% of the population.[54] As described by Elder (1996), racial and ethnocentric ideologies of difference have been influential in forging the multicultural social structure of this district.

Within the Sugar Town community, 'traditional' patriarchal values are evident. As only 7% of jobs at the mill (including seasonal work) are filled by female employees[55], paid employment opportunities for women are largely limited to retail and service industries in the town. The gendering of work in Sugar Town's industries exemplifies the observations of hegemonic managerial masculinities and paternalistic processes described by Barbara Pini (2004a).

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[53] Personal communication, Spokesperson, Shire Council.

[54] These figures are based on Australian Bureau of Statistics (2001, 2006) and local Shire Council estimates available at the time of data collection.

[55] Personal communication, Spokesperson, Human Resources, CSR Sugar Mills 7/6/97

Social patterns indicate that women are expected to marry as young adults, become homemakers and mother an average of three children, however larger families are not uncommon. Extended family networks are significant for people in Sugar Town. Young mothers rely upon these family networks for childminding with the limited places available in the childcare centre being seen as desirable or necessary only for those 'unfortunate' mothers who do not have extended family support. One negative aspect of the close family networks was described by local social support service workers who revealed how families concealed problems with domestic violence to avoid shame. Pregnant teenagers and unmarried mothers are still stigmatised by the mainstream community in Sugar Town.

Health and community services experienced a period of restructuring in the late 1990s in Sugar Town. The Aboriginal and Torres Strait Islander Health Service lost the Aboriginal registered nurse (RN) who was qualified to perform pap smears, immunise children, perform on-site assessments and monitor health programs. Her position was relocated to a central city location and replaced by an RN who travelled to Sugar Town district three times a week. The local health workers were most dissatisfied with the need to refer clients to the local hospital for less culturally appropriate care.

By contrast, Maternal, Child and Adolescent Health (MCH) was expanding its programs and the increasing scope of the service created a challenging role for the single nurse providing that service. She elicited support from city-based organisations like Family Planning, the Nursing Mothers Association and the visiting School Based Youth Health Nurses in an attempt to cater for the diverse expectations and needs of the community.

Residents of Sugar Town expected to be able to give birth locally and so stay within their community and family support networks. This had always been possible with a history of visiting homebirth midwives until the 1950s, combined with the option of confinement at a local hospital. Local GPs provided routine obstetric care.

During initial ethnographic fieldwork in the mid-nineties, Sugar Town district had 198 births; however this figure subsequently fell, reflecting national trends. The local public hospital was well serviced by medical and midwifery staff at that time. Operative obstetrics and anaesthesia were available if required, enabling women to have emergency and elective obstetric procedures as well as epidural pain relief during labour, if required. Local general practitioners were qualified to relieve the public hospital's doctors on a rostered basis. However, this changed during the period of the study with the shortage of appropriately qualified doctors prepared to be on call 24 hours each day resulting in an increase in transfers of low risk birthing women from Sugar Town to the tertiary centre 120 km distant. As Sugar Town was adequately

staffed by skilled midwives, dissatisfaction with this arrangement became evident in the interview data.

At one time, Sugar Town also had a private Italian hospital but this had closed. Shared maternity care and private facilities were available at the local public hospital; however those women who desired private care from an obstetrician opted to travel to the city throughout their pregnancy and for the birth. About 40% of women elected to give birth in the nearest city rather than Sugar Town.

4.2.2 Mining Town

By contrast with Sugar Town, Mining Town is a much smaller inland community located in a semi-arid zone 270 km from the nearest coastal city. First developed as a pastoral area in the 1860s, the main economic activity since the 1880s has been the mining of gold, silver, lead, bismuth and coal, with cattle grazing, and recently horticulture, continuing farming traditions in the surrounding district. As a consequence of the changing economic conditions, Mining Town's population has fluctuated.

Mining Town exemplifies a number of the features described by Sturmey (1989), Butcher (1995) and Rhodes (2005). A local authority working closely with the mining industry administers the township. The community has been strongly influenced by industrial relations with the mining company, and has until recently been very reliant upon large mining companies to provide employment, housing, and community facilities. In conditions similar to those described by Sturmey (1989), Butcher (1995) and Rhodes (2005), women in Mining Town experience extreme climatic conditions, little respite from child rearing, potential marital conflict and domestic violence and there are limited opportunities for women seeking employment or education. Rhodes (2005) observes that the role of 'good' mining wives to be invisible, self-sacrificing and loyal supporters of mining men. Both Butcher (1995) and Sturmey (1989) found women were particularly vulnerable at times of industrial unrest and industry re-structuring. These features were evident during fieldwork in Mining Town.

Although categorised as rural rather than remote, Mining Town has a sense of isolation. It is three hours' drive from the centralised services found in the major coastal centres. In the late 1990s, several commercial institutions and two banks closed, leaving only a credit union. This resulted in an increasingly difficult economic climate for the business community and inconvenienced local residents. Although the town is linked to the coast by an all-weather road and a railway line, there is limited public transport. The rail-motor to the coast ceased operating in 1997 and regular bus services were reduced. The level of road maintenance is an ongoing safety concern

for residents. Private transport is the main option and this needs to be reliable as the nearest town is 87km along the road, thus disadvantaging low-income residents. Surrounding mountain ranges obstruct mobile phone transmission, consequently reducing outside communication and increasing isolation.

At the time of initial data collection, the population was estimated to have fallen to 2200[56] for several reasons. According the Regional Development Bureau and Shire Council, the district had experienced a rural population drain since 1986 which, combined with a trend towards retirees moving into the town because of cheap housing, meant that the birth rate was very low. In addition, since 1994 there had been a significant downturn in the coal industry, which resulted in approximately 60% reduction in employment.[57]

In 1997, the large mining company, which had been the major employer, contracted another company to run the mine sites, resulting in massive retrenchments and loss of benefits. This had a huge impact on the town, as the majority of the population was dependent upon mining for work, housing and health insurance. Underground mining work was well paid and so had created a comfortable income for those miners and their families. As well, the mining company had provided funding for social, recreational and emergency services and the former expectation that this would continue was replaced by ongoing uncertainty. While some families left the district, the trend was for the men to seek employment in other mines within the region, leaving their families in Mining Town and only returning home for rostered time off. Marital strife was noted to increase amongst the mining families and there was a need for confidential counselling services.[58,59]

Between 1997 and 1998 a large itinerant male workforce came to Mining Town as contractors and subcontractors to build a new power station. Once completed, the new power station was largely automated so the town's population and commercial income again decreased. In 1999 a new open-cast mine closer to Mining Town had initially provided hope that local men would find employment closer to their families, but this did fulfil local expectations as the majority of employees were mobile, temporary workers.[60] As the members of this largely male workforce would return to their home towns on their rostered days off, their presence created a short-term economic boost to

[56] Personal Communication, Spokespersons, Regional Development Bureau and Shire Council 20/2/97
[57] Personal Communication, Spokesperson, Development Bureau 20/2/97; 15/11/99
[58] Personal Communications, Community Welfare Officer (ongoing).
[59] This is consistent with Lazarus et al. (1986) and Croker et al. (2002) findings on women's mental health needs for remote mining towns.
[60] While 'fly in - fly out' rosters became normal at many mine sites, this was not an option in Mining Town.

the town but provided little ongoing commercial benefit for the district. In addition, they placed a strain on health and community services. With most local family men working away, these itinerant single men destabilised the community as they did not settle and so were not accepted as 'locals'. They were also perceived to be taking local jobs.

Many of the long-term residents were proud descendents of the original settlers and as such had extensive family networks. Acceptance into their community required time and commitment.[61] With an estimated 99% of the population descended from British migrants Mining Town is not an ethnically diverse community. The only significant ethnic migrant group are the Filipino women married to retired miners. Many of those women were observed to be fulfilling the challenging dual roles of aged carer and young mother in a social environment that treated them as outsiders. Consequently, they formed a close-knit, mutually supportive group. Originally two tribes of the Burra Communities, the Wagganpella and the Weebaringa people, had occupied the area; however few Aboriginal people are found in Mining Town today.

A social feature of Mining Town is the pattern of women raising children alone, yet within a family structure. Women enter relationships and become mothers as young adults but, because their menfolk are mostly miners, husbands/fathers have a minimal role in child rearing. As miners, men work long shifts for rostered, rotated blocks of time. Their time at home is reportedly spent in sleeping and recreational drinking. Those men who work as farmhands on surrounding properties are away all week, returning home on weekends when possible. Personal relationships tend to suffer as a consequence, creating an unmet demand for social support services. Mining Town does not have a day care centre and women are dependent upon female friends and family networks for support and guidance.

In response to this demand, the Community Support Centre initiated a Women's Support Group but this was largely attended by older women, not young mothers. The need for a domestic violence service was also being discussed at the Community Support Centre.

Health services in the town include the private Medical Centre and a small public hospital, both being serviced by the same general practitioner(s). The town has positions for two GPs, one of whom is the Medical Superintendent in Private Practice. During the study period, the medical staff varied from one male GP who was also the Medical Superintendent in Private Practice (MSIPP), to being staffed by both a male and a female GP, followed by a female doctor alone. The Medical Centre provides the

[61] Personal Communication, Spokesperson, Community Support Centre / Community Development Association 21/2/97 and 15/11/99.

outpatient services while emergencies are encouraged to go directly to the hospital. The town has a pharmacy but limited supplies of commonly prescribed drugs are available at the hospital. Although the hospital has a 35 bed capacity, its funded occupancy was to only seven from 1997, causing ongoing concern. Patient numbers regularly exceeded this funded allocation, such as on days when elective surgery was conducted or when there was a rise in acute illness in the aged population. Staff reported having up to 28 elderly patients at times. Patient care was then unfunded, placing a strain on human and financial resources.

Visiting health services include regular visits from a child health nurse who holds a clinic at the hospital, a social worker, speech pathologist and radiographer. When there is no female GP in town, visits by a mobile women's health nurse can be arranged. Because of a particular demand at the time of this study, a visiting paediatrician also held clinics several times a year. Monthly visits from the Royal Flying Doctor Service (RFDS) provided surgical, obstetric and gynaecological clinics as required. RFDS surgeons periodically conducted elective surgery.

While Mining Town had difficulty recruiting and retaining two doctors (preferably one of each gender), the nursing and midwifery staff were stable; many had been there for over 10 years. This is unusual for rural health centres. The exception was the Director of Nursing (DoN). This position had several short-term incumbents, and an industrial dispute accompanied the departure of the DoN who was initially in charge during this study. A local midwife who was well accepted by medical and nursing staff temporarily replaced her.

Although people in Mining Town are three hours' drive from the nearest major hospital and specialist medical care, referrals are routine. There is an expectation that patients will travel to one of the coastal towns or cities for care when necessary. This applies to all primiparous women and multiparas who experienced any complications with their first birth. Shared maternity care is available but all pregnant women are encouraged to give birth in a major centre, as anaesthesia and operative obstetrics are not available should an emergency arise. Consequently, this involves birthing women planning accommodation and childcare to allow for a waiting period of up to two weeks to avoid the risks of travelling while in labour. However, following birth, women often transferred back to the local hospital for their postnatal care.

Mining Town hospital had 12 births in the year under study with 28 births recorded for the district[62]. Two of these local births were by women with no previous

[62] Figures for small districts like this are not available from Health Wiz or the ABS so were obtained from the Maternal and Child Health Nurse who receives the birth notifications.

antenatal care who had adverse outcomes, while another required emergency evacuation when a complication arose. The remaining nine planned, local births had outcomes that were satisfactory for both the women and midwives. The local midwives, three of whom also had child health certificates, would like to have had more local births to maintain their skills. Of the 16 women who birthed outside of Mining Town, some had private health insurance provided by the mining company and elected to go to one of the private hospitals in the city. Although preference was given to the tertiary hospital, the remainder of the birthing women chose to give birth in one of the four coastal centres within three hours of Mining Town.

4.3 The remote townships

Pastoral Town and Stockton are both located in remote areas of Western Queensland. Although they are in two separate shires, these towns fall within the same health district and so some figures and services are shared. Consequently, these will be discussed together. A third location is also described here – the tiny village of Ghost Town. Ghost Town exists between the two remote towns and is also subsumed within this health district.

4.3.1 Pastoral Town

Pastoral Town is the centre of a Shire that covers an area of 26,936 square kilometres.[63] The district has been grazed since the 1860s with more intensive sheep farming occurring when land was allocated to soldier settlers in the 1920s.[64] A nearby river and the artesian basin ensure a permanent water supply. Of the overall population of 1250 people, 750 live within the township with an estimated 500 people on surrounding stations[65]. The population has fluctuated with the availability of work. The demand for station hands depends upon drought, agistment requirements, the shift from sheep to cattle farming reducing the need for shearing gangs, and the amalgamation of smaller properties to make larger stations that are more viable. Within the township, the railways are the major employer followed by the Shire Council. Many men are occupied with highway and railway line maintenance. Being a hub for rail and vehicle transport between the coast and major inland centres provides Pastoral Town with an income from travellers. In addition, the town has developed local tourist

[63] This is equivalent to the size of Belgium.
[64] This refers to a 1995 history of the district which has not been cited to maintain confidentiality of this community's identity.
[65] Personal Communication, Spokesperson, Shire Council.

attractions and now derives an income from these as well. In the mid 1990s the Shire also had funding for a successful rural adjustment scheme that temporarily created work for younger people. Although some local pastoral businesses have closed with the rural economic downturn, new services catering for travellers have opened. Pastoral Town has managed to retain a bank and the QIDC credit union.

Little is recorded about the sparse Aboriginal population of the Wunumara and Mbara tribes who occupied the district prior to European settlement. The majority of people in Pastoral Town are of Anglo-Celtic origin. Descendents of a few Chinese families have been in the area for six generations.[66] Only an estimated 5% of residents are Aboriginal (60 people), some of whom are descendents of intermarriages with Afghan camel drivers. New Aboriginal families were expected in the district as an Aboriginal development corporation had bought a nearby station.[67]

Health services in Pastoral Town centre on a private medical clinic attached to the doctor's house and a small ten-bed hospital. The doctor is a Medical Superintendent in Private Practice (MSIPP) and so patients attend the private clinic where they are bulk-billed. The private clinic also provides the pharmacy. Hospital inpatients mostly include elderly people and transfers from major hospitals for convalescence or postnatal care. Emergency treatment and acute care can be provided as required but serious conditions are normally transferred to a major centre after stabilisation. There is no commercial air service, so the RFDS evacuates emergencies while less urgent conditions travel by bus. This is about a six hour journey to a major centre, depending on road conditions. As the single ambulance is kept at the hospital and operated by nursing staff, it can seldom be sent to transport non-urgent patients for long distances.

In the mid-1990s, Pastoral Town became notorious for its suicide rate, especially affecting young men. Mental health issues came to the fore and series of workshops were conducted with health professionals and community groups to raise awareness and to design prevention strategies[68]. The Rural Health Training Unit also initiated farm safety workshops to reduce the incidence of preventable accidents.

Regular visiting health services to Pastoral Town included specialists from the RFDS, such as the Flying Obstetrician and Gynaecologist who would come every two months if required. However, if only one case was to be seen, that woman would be required to travel to attend a clinic at the hospital in another town. A dentist visited each month and, when there was no female GP, the mobile women's health nurse

[66] Reference omitted to maintain confidentiality of this community's identity.
[67] Personal Communication, Spokesperson, Shire Council.
[68] 'Pastoral Town' was also included in Jan Jones (1998) study of rural men's health.

would visit twice a year.

The health staff in Pastoral Town is largely itinerant and retention poor; consequently the skills mix is constantly changing. There is a regular turnover of agency nurses, many from the U.K., seeking rural experiences. Nurses with specialist skills and midwives with current practice are hard to recruit and retain. At the time of this study, only two of the nursing staff were long term residents with one being a highly valued community member. Barriers to the retention of health professionals included factionalism and horizontal violence amongst the nursing staff, and the low standard of available accommodation.

When the hospital was built, it was assumed that nurses were single women with few possessions. Accommodation for the Director of Nursing was a tiny self-contained, spinster's cottage next to the morgue. The nurses' quarters provided single bedrooms with shared bathroom, kitchen and living space; this inadequate accommodation was a barrier to staff retention. For example, during fieldwork for this project, a married couple with two young children were both on staff as nurses, but were unable to find rental housing for a family so they were attempting to live as a family unit in the quarters amongst other nurses working shifts.

Continuity of medical personnel has been an ongoing problem despite an attractive incentive package for the position as Medical Superintendent in Private Practice. Unlike considerations for nursing staff, the accommodation provided is based upon the assumption that a doctor will have a family. Therefore, doctors are not only allocated a house and clinic, but also receive the financial benefits of combining public and private practice, a four wheel drive vehicle and a computer package. After a two-year period with a popular, skilled, female MSIPP, Pastoral Town experienced many months where locum doctors provided medical care of variable quality. Since then, a succession of male, overseas trained doctors on short-term contracts has temporarily filled the position.

Permanent nursing staff compared their conditions to the incentive package offered to doctors and felt that there were few inducements for remote area nurses. In particular, there was a rapid turnover of DoNs who found that their salaries did not compensate for cramped living in the hospital grounds, access to the hospital car only for working purposes, being constantly on call without overtime and having to manage the perpetual staffing shortages. Clinical Nurses were reluctant to take on the role and responsibilities of a DoN because they could earn more with shiftwork and penalty rates. This problem was (and still is) evident in most rural and remote hospitals.

The combined health services of Pastoral Town and Stockton district will be discussed later in this section.

4.3.2 Stockton

Stockton is the most sparsely populated district in this study with a town population that has shrunk to 500 along with an estimated 350 people living on stations within the vast 40,818 square kilometres of the Shire. The nearest major centre, Mine City, is three hours' drive away and the coastal cities seven to eight hours distant by car, depending on weather conditions. It is a small cattle, sheep and rail township in the centre of a potentially rich pastoral area. Waterholes and an artesian bore provide the town's recreational areas and water supply. This flat, almost treeless savannah area is prone to extremes of drought and floods, especially in the south of the Shire, making farming a constant cycle of challenges.

Employment within the town is largely with the local Shire Council, which employs about 50 people, while the railways employ up to ten men for railway line maintenance. People on unemployment benefits pick up seasonal work or work on government projects when available. However, with the opening of several mines around Stockton, employment opportunities have increased in the region. Some men go away to these mines, returning to Stockton for their rostered time off. With the rural economic downturn, the bank in Stockton closed, along with one of the stock agencies and a coffee shop. Unlike Pastoral Town, Stockton does not have the ability to attract tourists but travellers do often break their journey in this small town, creating some work. In the surrounding district, landholdings have increased in size as they are bought by international pastoral companies. Northern Territory cattle companies have also bought up properties which they use for fattening stock raised across the border before it is sent to market. The professional population in Stockton, including nurses, doctor, teachers, police, financial consultant, Department of Primary Industries' staff and other government personnel is almost all transient.

With the shrinking population, the local school was reduced to offering education to Year 9 only, so young people with potential go away to boarding school to complete their schooling and then tend to stay on the coast. However, Stockton has a significant population of younger couples having families. Three to four children was the perceived as the family norm.[69] A 'baby boom' was experienced in 1997-1998 creating a demand thereafter for services that supported mothers and met the needs of young children, such as a child health clinic, playgroup and early childhood education.

Stockton is notable for its lively, well-attended social and sporting events. There is a strong sense of community commitment and participation in recreational and social

[69] This is consistent with national figures which show that rural /remote family sizes tend to be larger (ABS, 1995, 2006; AIHW 2004a, 2005).

events that residents say provides a good quality of life. Originally the land of the Wunumara and Ngawun people, Stockton today has little ethnic diversity with only five Aboriginal families and a couple of Filipino wives. Most of the European settlers came from the UK, especially Scotland,[70] and this ethnic composition is also reflected in the transient nursing staff.

Like Pastoral Town, Stockton has both a private clinic attached to the doctor's house, and a ten-bed hospital. It also has difficulty recruiting and retaining staff. For a year, the town had no MSIPP, just a series of locum doctors who came at six-week intervals. A male, overseas trained doctor eventually filled the position. He had been in the town for two years during this study but was considering leaving for family related reasons[71]. This doctor did not have obstetric experience so worked closely with an experienced rural midwife. For fear of litigation, he did not permit women to plan for a local birth, even as low risk public patients.[72]

Stockton hospital received the same visiting health services as Pastoral Town, with the addition of occasional services from a physiotherapist (who was married to a local grazier) and a podiatrist who attended to elderly residents. Because Stockton had a male GP, the mobile women's health nurse provided a wellness screening service twice a year.

4.3.3. Health experiences in Pastoral town and Stockton districts

Within the period of study, 35 births occurred in the combined Pastoral Town and Stockton district. Eight of these took place in Pastoral Town hospital and four in Stockton with the remainder being in either Mine City or a coastal centre where the women had friends or relatives. Most women entered a share care arrangement, seeing the local doctor as a bulk-billed private patient throughout the pregnancy and birthing within a public hospital. All women were required to travel to a major centre for routine ultrasound studies and obstetric monitoring. Women were expected and encouraged to leave the district four weeks before the due date to await birth in a major centre which could provide emergency obstetric care should it be required. If the pregnancy went post-dates, this could entail being away from home for up to six weeks. Transfers back to the local hospital for postnatal care were possible within twenty-four hours of giving birth; however transport could be a problem. Elective caesarean sections within the local hospital could be arranged with the Flying Obstetrician but he was unpopular with the birthing women and midwives. A few

[70] Personal communication, Spokesperson, Shire Council
[71] Personal Communication, Hospital Administration Officer

women with private health insurance preferred to seek private obstetric care in a major centre throughout their pregnancy and for the birth.

Women were not given the option of birthing in Stockton. While the only planned local birth in Stockton was an elective caesarean section, four women did experience unplanned, spontaneous, vaginal births. By comparison, the female GP at Pastoral Town had previous obstetric experience in remote communities and was confident to have low risk women birthing locally. Consequently, eight multiparous women in her care were able to safely birth without incident. With this doctor's departure, birthing once again became uncommon and unexpected in Pastoral Town.

In both towns, health services attempt to have two and preferably three midwives on staff. Even though local birthing is discouraged, midwifery skills are essential for managing women in pre-term labour, recognising and responding to complications of pregnancy, providing routine antenatal and postnatal care, lactation advice and other maternal and infant health services. For a time, Stockton had only one midwife and even while home on holidays she was called to attend a birth. When, for several months, Stockton attracted two experienced midwives, the limited opportunity to practice in this specialty area created concerns for them about deskilling, so they too left. Pastoral Town by comparison managed to maintain at least two midwifery qualified staff; however deskilling and lack of current practice are a recognised problem. Particular midwives in both towns provided extended, unpaid hours when new mothers were experiencing problems and needed counselling. They also provided an outreach service beyond the town limits in their own time.

The district encompassing Stockton and Pastoral town has a nurse filling the dual roles of community and aged care nursing, as well as maternal, child and adolescent health. Not only does she have a vast area to service but she also holds clinics in both towns twice a week as well as making home visits for assessment and monitoring purposes, along with initiating community health programs that reflect identified priority areas. Retention of a nurse in this position has been difficult, not only because of the challenging role but also because of professional isolation and marginalisation by the medical and hospital-based nursing staff.

Like the rural towns already discussed, neither Pastoral Town or Stockton has a child care centre and, within the town, paid employment for women is limited to a few positions in the local shops, clerical positions within the bank or credit union and branches of government agencies or professional roles within the school or hospital. It is unusual for married women with children to work but socially acceptable if they need

[72] Personal Communication, Hospital Administration Officer

to for financial reasons. However, on the surrounding properties, young women are employed in a variety of roles such as nannies, governesses, and jillaroos or in shearing gangs as rouseabouts, shed-handlers and wool classers (qualified stencil). Married women also are expected to participate in arduous unpaid work during seasonal activities like mustering, feeding and washing clothes for fencing or shearing gangs, while often also trying to teach their children through correspondence with the School of the Air.

Several notable social features are evident in these two remote towns. Firstly, there is a town – country divide; however attempts are made to reduce this with clubs and community groups endeavouring to cross the social barriers. The cause of the division is largely class and values. A squattocracy persists whereby the old pastoral (country) families who have inherited property have a privileged, almost genteel social position (even when economically destitute). In general they are better educated. After primary school through School of the Air, they choose to send their children to boarding schools for secondary schooling and many continue on to tertiary qualifications. In particular, while the sons tend to come home to work on the farm, daughters continue on to further education. Graziers also tend to choose to marry professional women who become competent partners in managing the property and staff. During fieldwork in Western Queensland I met women living on stations who had been (and some who continued to be) nurses, teachers, a pharmacist, physiotherapist, psychologist, veterinarian, journalist and a geologist. These grazing families tend to be conservative in their political beliefs, value traditional family structures and form a mutually supportive social network. Selected townsfolk are invited into that social group.

However, the pastoral properties also have a three tier social strata that reflects changing economic conditions. With young people leaving the farm, the 'country' squattocracy is crumbling - older station owners are selling their properties. These are either bought by aspiring working class families or by pastoral companies, largely owned by offshore investors[73], who place managers and a skeleton staff on the land. The managers and their families form the second tier and with their stable income, they look down upon the incoming families who are struggling to pay off farms. Seriously affected by drought and flood, the new farmers struggle with debts and some families have menfolk away working as contractors to bring in a reliable income, leaving the women to manage as best they can. This social hierarchy is most evident at gatherings like musters, horse races and when children studying through the School of the Air gather for arts or sports days.

[73] Stockton farmers informed me that the Sultan of Brunei owns the grazing company in their district.

By comparison, the majority of town people tend to be working class. They attend the local schools, which do not provide secondary schooling to a senior level. With limited job opportunities, few young people go on complete senior school by correspondence. Senior Shire council staff, business people, health and educational professionals tend to socialise together and with the established graziers, thus reinforcing class differences while partially crossing the town-country divide. The influence of this social hierarchy is apparent in the interview data.

4.3.3.1 Ghost Town

One participant came from a tiny, dwindling village between Pastoral Town and Stockton. Because of its nominal population and the necessity for residents to access services and facilities in either Pastoral Town or Stockton, it is not seen as a separate entity, but is largely subsumed in the discussion of the other towns.

Ghost Town had been a railway siding and a minor centre for surrounding graziers but in recent years the highway bypassed this community, freight trains seldom stopped, and it had lost all its services; even the pub, general store and single-teacher school had closed. A few elderly long-term residents remained. As the town now provided very cheap, affordable housing, it had recently attracted large, low income families. Racial disharmony and discontent were notable in this town as the older residents resented incoming Aboriginal people finding affordable homes in 'their' town.

Residents of Ghost Town were socially and geographically isolated. Ghost Town had a permanent water supply from artesian bores but frequently lost electricity during summer storms. Electronic communication was limited to telephones and radio. The daily coach service from Mine City to the coast could be boarded from the highway (roadside) for travel to Pastoral Town and Stockton. To have access to shops, social support, health services or community activities, Ghost Town residents needed to travel to one of the larger towns. Because their menfolk worked away as farmhands and shearers, some women were left without reliable private transport for significant periods of time. Lack of transport presented a major problem in situations such as when children were sick, when women experienced domestic violence or even simply when basic food supplies were unexpectedly needed. The problems experienced by women in remote Western towns were compounded for isolated childbearing women living in Ghost Town.

4.4 Available models of maternity care

While the previous section outlines possible health experiences in the rural and remote districts included in the study, the Table 4.0 depicts the range of possible models of maternity care found at a national, state, regional and local level during the time of the study. Table 4.0 summarises the limited options available and accessible to birthing women in rural and remote areas of Queensland. These continue to diminish with planned births no longer available in any of the four rural and remote districts discussed in the thesis.

4.5 Chapter summary

This chapter profiles the general characteristics of each of the towns and districts in which field work was undertaken, as well as focusing on available maternity services. Based on field observations, discussions with local spokespersons and available background literature, it sets the scene for the ethnographic fieldwork to be outlined in Chapter 6 and locates the findings, which are presented in Chapters 7–9, in the rural and remote context.

Table 4.0 AVAILABLE MODELS OF MATERNITY CARE

	Available in Australia	Available in Queensland	Accessible in nearest major town	Local rural/remote area during study			
				Sugar Town	**Mining Town**	**Stockton**	**Pastoral Town**
Public hospital outpatient - standard care	Y	Y	Y	Y	N	N	N
Public hospital outpatient - midwifery care	Y	Y	Y – coastal cities N – Mt Isa	N	N	Y	Y
Public hospital – team midwifery	Y	Y	N	N	N	N	N
Community midwifery	Y	N	N	N	N	N	N
Public hospital high risk care (requiring specialist obstetrician)	Y	Y	N	N	N	N	N
Shared care – public hospital with GP	Y	Y	Y	Y	Y	Y	Y
Shared care – public hospital with Midwife in Private Practice	N	N	N	N	N	N	N
Shared care – GP with Midwife in Private Practice	Y	Y	N	N	N	N	N
Shared care – Public hospital with community health centre	N	N	N	N	N	N	N
Shared care – GP, public obstetrician & public patient	Y	Y	Y – coastal cities Y – Mt Isa (Local and Flying O&G)	2 GPs with current obstetric quals	1 GP with outdated obstetric quals	Flying O&G	Flying O&G 1 GP with current obstetric quals
Private specialist obstetrician & GP with obstetric qualifications	Y	Y	Y – coastal cities N – Mt Isa	2 GPs with current obstetric quals	1 GP with outdated obstetric quals	Flying O&G	Flying O&G 1 GP with current obstetric quals
GP private	Y	Y	Y	Y	Y	Y	Y
Obstetrician private	Y	Y	Y – coastal cities N – Mt Isa	N	N	N	N
Midwife in private practice (Homebirth)	Y	Y	Y (limited access)	N	N	N	N
Hospital birth centre	Y	Y	Y – limited (Mackay) N – Mt Isa, Cairns, Townsville	N	N	N	N
Other models of care	Y	Y	N	N	N	N	N

Chapter 5

Birthing a Methodology

5.1 Framing the methodology

Methodology is defined by Sandra Harding (1987, p. 3) as "a theory and analysis of how research should and does proceed". Although qualitative researchers commonly develop methodology while the study progresses, this is usually presented as though it were a linear and sequential process rather than the result of an encounter between the researcher and the research process (Kleinmann & Copp, 1993; Seibold, 2001; Reinharz, 1992). Recognising this dynamic process, Caroline Ramazanoğlu simply describes methodology within social research as "concerned with procedures for making knowledge valid and authoritative" with variations in methodological approaches affected by philosophical differences over connections between ideas, experience and material or social realities (2002, p. 9). Thus, this chapter primarily focuses on the philosophical development of a methodological approach suited to this feminist, sociological project. Dorothy Smith argues that the starting point should be women's everyday lives (1988; 1990) while Jane Ollenburger and Helen Moore (1992) consider that a feminist sociological methodology should be informed by both the activism of women's studies and the empiricism of sociology. However, they add that a feminist approach should utilise new empirical and theoretical resources to enable framing the full range of women's experiences within the research (Ollenburger & Moore, 1992).

Developing an appropriate methodology for this qualitative research project, which explores sensitive issues about women's lived experiences and relationships amongst health providers, was an evolving process. While this qualitative research project could broadly be described as an interpretive inquiry that employs a feminist sociological approach and takes a deconstructivist position (DeVault 1996, 2004; Crotty, 1998; Game, 1991; Lather, 1990), the methodological approach could not be completely determined at the outset because of the fluid nature of the topic under investigation.

For the purpose of this study, an innovative methodology has been developed. It is situated within the interpretivist paradigm and, as social justice objectives underpin my practices, draws upon a feminist, realist epistemology that contrasts to positivist research practices (Ramazanoğlu 2002). While also incorporating postmodern processes of inquiry, I recognise critiques of postmodern, sociological perspectives (Rojek & Turner, 2000; Beck & Willms, 2004; Giddens, 1994; 2002; Smith, 1993). This methodological approach reflects the complexity, and the socio-cultural and historical

specificity, of real lives. Aspects of various interpretive approaches are applied to the sensitive topic of relations between health providers and childbearing women and the relationships that health providers have with each other. A critique of relations between power/knowledge and social institutions/participants is an integral part of this process. Reflexivity is also essential when analysing participants' contextualised experiences and the intersubjectivity between them and myself, as researcher (Glesne, 1992; Ezzy, 2002; Stanley & Wise, 1991; Game, 1991). This approach provides a contrasting discourse to the dominant quantitative paradigm in health research, which derives from the assumptions underpinning scientific biomedicine. Thus, it will be possible to examine the congruency between medical and social definitions of 'a good birth experience' for rural women and identify factors that influence any disparity in views. This has the potential to generate new understandings and signify alternative ways of connecting with others within the complexity and dynamism of social settings. Recommendations can then be made which may contribute to quality assurance and policy decisions affecting maternity provision in rural and remote areas.

In accordance with feminist research principles, this methodology chapter situates the researcher within the context of the project. It outlines the conjuncture of the researcher and the epistemological and methodological approaches adopted for this project. The methodological approach introduced in Chapter 1 is further discussed and issues that emerged are explored. Section 5.2 overviews the philosophical underpinnings of a hybrid feminist methodology that seeks pragmatically to meld an emancipatory intent with useful postmodern insights. Subsection 5.2.1 outlines the feminist principles, practices and assumptions applied to this study followed by a discussion of the ontology and epistemology in 5.2.2. Finally, section 5.2.3 explores the contradictions between emancipatory and postmodern approaches to feminist research, before providing an overview of the principal critiques of social research by feminist theorists. A way forward through the theoretical impasse is proposed.

5.2 Feminist emancipatory research in the postmodern era.

Researching the perceptions of rural/remote childbearing women and the health professionals who provide their care is a feminist, emancipatory, sociological project located within discourses that are derived from postmodern and late modern[74]

[74] I acknowledge that conceptualisations of postmodernity and late modernity both have merits. Within feminist literature, postmodernism is now the most common approach. By contrast, notable theorists like Giddens reject postmodernity; instead, his notion of late modernity proposes continuity. Similarly Rojek and Turner (2002), Beck and Willms (2004) reveal the limitations of postmodern sociology.

philosophical perspectives. Maternity services provide care for the universal category 'women', whose pregnant and parturient bodies are "irreducibly sexually specific" (Grosz, 1994, p. 19) and usually docile under the disciplinary gaze of patriarchal obstetric medicine.

As discussed in Chapters 2 and 3, despite the dominance of medical discourses, maternity care provision remains highly feminised and childbirth is still considered 'women's business'. In the nurturing and caring roles of mothers, health workers, midwives, nurses and occasionally doctors, women make a significant contribution to social wellbeing of small communities. While valorising an ethics of care which is important to the identity of women in this study, I will also avoid the pitfalls of essentialism of viewing 'caring' as an essential feminine trait. The subjective, lived experience of maternity care is the principal focus of this woman-centred project. The second area of investigation focuses on relationships amongst maternity care providers and the subsequent impact this has on maternity services for birthing women. Thus, this study aims not only to analyse critically the micro-politics of maternity encounters but also to identify ways in which these could be improved to meet appropriately the identified needs and desires of women in rural and remote localities.

Kathleen Fahy (1997, p. 27) asks the question, "Postmodern, feminist, emancipatory research: Is it an oxymoron?" Over the past decade, a number of feminist social researchers have attempted to address this question. Feminist scholars are endeavouring to outline alternative models of intellectual inquiry and to define practices that support feminist ideals of social relations and yet still allow for autonomous actions by individuals (Hesse-Bibar & Yaiser, 2004; Maynard & Purvis, 1994). Like Australian nurse scholars Kathleen Fahy (1995b, 1997), Nel Glass and Kierrynn Davis (1998), and Carmel Seibold (2001), I also faced a philosophical dilemma - how to reconcile my emancipatory values, beliefs and principles with the antihumanism, decentred subject and relativism of postmodern discourses. While valuing the united voice possible with politically active, collective forms of feminism, that have the potential to make a difference in women's lives, I was also alerted to their limitations and the tensions with postmodernity.

Jacqueline Stevens alleges that, "Feminist theory seems dead" (1998, p. 765). Recognising that that there can no longer be a unitary feminist agenda that suits all needs, Stevens comments: "One seeks some sense of common ground, if not for the purpose of self-edification, then at least as a reason not to criticise one's sister

feminists in public.[75] But it has vanished" (1998, p. 725). While I disagree with both Steven's bleak observation and Rojek and Turner's (2000) assertion that feminism has intellectually ossified, I acknowledge that there has been a theoretical impasse mired in the literary analysis of texts and accompanied by circular arguments amongst feminists which have disabled political activism. A way forward will be proposed later in this chapter.

In Chapter 1, my personal journey through these theoretical challenges to arrive at a position that reflects the particularity of women's lived experiences within a specific social context, is briefly outlined. As attempting to merge an emancipatory feminist agenda with postmodernism is contentious, a selection of theories from the extensive literature on debates will next be reviewed. In this review, the variant perspectives of standpoint epistemologists through to critiques of feminist postmodernism are considered. To conclude this section, I argue for a theoretical position similar to 'oppositional postmodernism' (Kincheloe, 1994; Fahy, 1997), which also endorses Rojek and Turner's (2000) appeal for a methodological shift back to the emplacement of social actors into 'real' social contexts. Following the example of several renowned feminist scholars, I have adopted a theoretical position that eclectically synthesises the strengths in the opposing discourses into a form akin to the latter work of Dorothy Smith (1988; 1990a, b; 1991;1993), Lois McNay (2003), Nancy Fraser and Linda Nicholson (1990) and Australian nursing scholars like Glass and Davis (1998). This woman-centred position valorises the political and moral imperatives of feminist research, and selectively incorporates aspects of postmodernism while being grounded in a material reality overlooked when text is privileged by 'armchair' postmodern theorists. Taking into account the politics of representation and difference, I consciously avoid a single category of 'women' and, as such, the findings of this study delineate each participant's specific identity, context and perspective. Section 5.1.1 first outlines the feminist principles and assumptions that underpin my methodology; then I discuss the philosophical tension arising when melding feminist emancipatory goals with postmodern explanations.

5.2.1 Feminist methodology: Principles, practices and assumptions.

As Carol Grbich (1999, p. 53) points out, there is "considerable diversity of interpretation among the many feminisms and different version of feminist thought" over

[75] Feminist scholars' philosophical disputes are the antithesis of univocal, which is confronting for novice feminists. Postmodern relativism enables such differences in opinion.

what constitutes feminist research. While theorists like Reinharz (1992) encourage diversity, asserting that there is no single methodological approach, others insist that feminist research is by women, for women and requires a distinct feminist consciousness (Stanley & Wise, 1990; 1993). In developing this methodology, I am cognisant of the extensive methodological and epistemological 'turf wars' which paved the way for newer hybridised paradigms. In retaining an emancipatory intent within a postmodern paradigm, my eclectic feminist position is concerned with the everyday world, and through incorporating reflexivity, I am mindful of power dynamics, difference and the politics of representation.

Drawing on the definitions and extensive debates over what constitutes feminist research, the following broad principles can be identified:

- The social identity of the researcher and her interaction with participants is recognised as relevant to the quality of the research results.
- The knowledge produced is highly contextual and subjective from a feminist perspective. This rejects the notion that all women share the same experiences and refutes the universality of knowledge and truth. No pretence is made to be objective, neutral and impartial.
- To avoid subject/object separation, participants are not made objects of research but will share the information and knowledge gathered.
- Qualitative open-ended methods are used as they allow the voices of participants to be heard, and they make visible the needs and experiences of individual women. While qualitative methods are not inherently feminist they are appropriate for providing contextualised information about women's experiences as distinct from decontextualised, universalised, quantified numerical accounts with fixed choice items.
- Feminist researchers are critically aware of their inquiry methods. Open and honest self-scrutiny is part of the self-reflective process of inquiry.
- Research evidence is used to politicise women by identifying transformative opportunities, and by enabling them to exercise power and to resist subjugation.

These principles provide a feminist methodology that places women centre-stage by valuing their perspectives, needs and attributes. Consequently, the contemporary feminist ethnographic methods employed in this study, and described in the next chapter, enable me to situate my inquiry within the ordinary lives of rural/remote people and the everyday problems they encounter.

As common epistemological themes expounded in feminist scholarship,[76] the principles outlined encompass all phases of the research process and influence methodological techniques, practices and approaches (Fonow & Cook, 1991). Underpinned by a feminist epistemology, which examines "assumptions about how to know the social and apprehend its meaning", the research process can be viewed within a sociology-of-knowledge" (Oakley, 1993, p. 83). However, just as there are many feminisms, there is no single feminist approach. The next section outlines some of the common themes and debates in the feminist research process as they relate to the interpretive methods I have selected.

Feminist researchers are critically aware of their inquiry methods and reflexivity is integral to the process. Such openness and honesty are unusual in standard, 'impartial' scientific methods. Innovative methodologies have evolved as feminist researchers, exasperated with the inflexible, restrictive, decontextualised, narrow range of possible responses offered by standard research designs, seek new approaches to intellectual inquiry. As such, feminist methodologies support feminist ideals of social relations and, as feminist principles underpin research practices, they also influence the creation of new knowledge.

5.2.2 A feminist epistemology

For several decades, feminist researchers have challenged the masculine bias and invisibility of women in knowledge produced through social and scientific research. Revealing that methodology is gendered has led to ideological debates over the most appropriate methods for understanding the social and material world. Based on feminist epistemology and ontology, feminist methods texts have "celebrated qualitative methods as best suited to the project of hearing women's accounts of their experiences" (Oakley, 1998, p. 707). This has led to a reappraisal of the phallocentric representations of the social within mainstream social science and endeavours to reconcile the postmodern with Sociology's structuralist, functionalist and positivist origins. While avoiding a spirit of *ressentiment,* the following discussion will review various feminist concerns with mainstream social research to develop a rationale for a distinct feminist methodology and methods.

[76] Sources of these methodological principles are inclusive of, but not exclusive to, the scholarship of Roberts (1981), Harding (1987), Grosz (1988), Nielson (1990), Cook and Fonow (1990), Stanley and Wise (1990), Acker, Barry and Essenveld (1991), Finch (1991), Smith (1991), Reinharz (1992), Maynard and Purvis, (1994), Kelly, Burton and Regan (1994), Grbich, (1999), Jackson, Clare and Mannix, (2003), and DeVault (2004).

Epistemology is "the study of assumptions about how to know the social and apprehend its meaning" (Fonow & Cook, 1991, p. 1) while ontology specifies the underpinning beliefs within theoretical positions about the nature of reality and the object of research (Ramazanoğlu, 2002). Understanding the social is significant to the methodology adopted for research as the assumptions shape the goals, methods of inquiry and resulting interpretations. Paradigm debates have resulted from the feminist project to construct methodological guides that theorise and analyse how research should proceed (Harding, 1987, p. 3). Cook and Fonow (1991, pp. 1, 2), for example, have applied methodology to include "the study of actual techniques and practices used in the research process".

Second wave feminist scholars have cogently argued that women are alienated from Western cultural discourses, even the revolutionary ones. These accusations range across disciplines with claims that these discourses are univocally masculinist, patriarchal, and that their phallocentricism excludes women's voices and lives. In addition, the neutrality of scientific methods has been contested by feminists who have identified an androcentric bias in the supposedly 'objective' definition of problems and interpretation of observations (Grosz, 1994; Fox Keller, 1990; Whelan, 2001). Integral to the mainstream ideology is a hierarchy of binary oppositions in which the masculine attributes are afforded value and feminine traits devalued. Women are surreptitiously excluded from its practices through "its usual implicit coding of femininity with the unreason associated with the body" (Grosz, 1994, p. 4).

Feminist critiques of scientific[77] methodology have led to reappraisals of scientific epistemology and practices. Positivist approaches to inquiry and subject/object relations are at the centre of these theoretical concerns. They reveal that the purportedly neutral, 'objective', 'value-free' processes of scientific research have an androcentric bias, which prejudices definitions of problems and interpretations of research findings (Grosz, 1994; Whelan, 2001). Of particular concern to feminists has been the employment of 'truths' and 'facts' to perpetuate existing sexual, power and political relations (Gilligan, 1982; Harding, 1987; Fahy, 1994; Papps & Olssen, 1997; Kent, 2000; Oakley, 1998; Walby, 2001).[78] The feminist critique of mainstream discourses has established that the voices of women and marginalised groups have been silenced. Therefore, one of the goals of feminist research is to redress this by "uncovering and removing the blinders

[77] The term 'scientific' subsumes the social, natural and health sciences.

[78] Amongst those feminist scholars are Roberts (1981), Gilligan (1982), Fox Keller (1987), Oakley (1993), Fraser and Nicholson (1990), Harding, (1991; 1993; 1987), Oakley (1993a), Harstock (1990), Lather (1990), Luke and Gore,(1992), Smith (1987; 1990; 1991), Sawicki (1994; 1991), McNay (2003; 1994; 1992), Grieve and Burns (1994), Maynard (1994) and Walby (2001).

that obscure knowledge and observations concerning human experiences and behaviours that have traditionally been silenced by mainstream research" (Ardovini-Brooker, 2001, p. 2). Numerous feminist studies have contested science's claims to universal relevance by providing alternative explanations that are more complete and more comprehensive (Harding, 1986; Gilligan, 1987; Westcott, 1990; Whelan, 2001; Brown, Lumley, Small & Astbury, 1994).

Although feminist disenchantment with the epistemological, methodological and ethical assumptions of social science has led to the extensive feminist critiques, there is considerable disagreement over what constitutes a feminist alternative to the prevailing research paradigm. As will be described in the next section, the disagreements lie largely between feminists with emancipatory intents and those who favour postmodern approaches to inquiry. Feminist scholarship is advancing innovative qualitative models of intellectual inquiry to define practices that support feminist ideals of social relations and yet still allow for autonomous actions by individuals (Maynard & Purvis, 1994; DeVault, 1996, 2004; Hesse-Bibar & Yasser, 2004). .

Feminist researchers within the postmodern create new knowledge, which reveals opportunities for political change. Kipnis (1988; 1992) considers feminism to be the paradigmatic political voice of postmodernism; Fahy adds that postmodernism "rather than undermining emancipatory feminism ... helps to sharpen the critical edge of research" (Fahy, 1995, p. 46). Patti Lather (1990) envisages a postmodernism of resistance, through the creation of a cultural and adversarial postmodernism. Others, like Weedon (1987), believe it is a way out of the mire of dogmatism, positivism, reductionism and single cause analyses of late modernity. In contrast, Dorothy Smith (1991; 1993) and Sandra Harding (1987) are critical of the way postmodernism reveres textual constructions over lived experiences. However, despite the fears of epistemological feminists like Smith (1987; 1990a, b), Harstock (1990) and Harding (1987; 1991), postmodernism has not enervated or destroyed women's social progress. Rather than postmodern critiques being "just stories" (Harding, 1987, p.188), they provide explanations for the discursive processes by which people gain understanding of their common world (Hekman, 1990).

As a standpoint epistemologist, Dorothy Smith has endeavoured to create a sociology of knowledge for women grounded in the everyday world. She believes that Sociology has failed to describe accurately or understand the 'problematics' women with diverse backgrounds experience the everyday world and has focused instead on producing ideology rather than knowledge (Smith, 1991). Rather than relying upon textually mediated discourses and extensive reinterpretations of highly esoteric male theorists to make her points, Smith advocates working from within women's lived

experiences as “to create a social science that discloses society as we know it” (Smith, 1991, p. 155). Like Smith, I too believe that the sociological knower should begin inquiry outside and prior to text, grounding new knowledge in experiences that are situated in actual practices and specific local settings.

While postmodernism has decentred the subject, power, knowledge and realism, Smith has maintained an image of social reality in her extensive writing on the social life of women. In particular, she has focussed on relations of power and conceptual practices of power within the everyday world and within the social sciences (Smith, 1988; 1990a; Layder, 1994). The scope of her eclectic scholarship extends from building on the radical aspects of the Enlightenment when exploring power relations in capitalist society, to analysing textual realities, agency and suppression of women's voices (1979; 1988; 1990a, b). Using reflexive critical inquiry, Smith is able to offer an "insider's materialistic" perspective on social practices, the actualities of women’s lives and women’s ways of knowing (Smith, 1990a). Adopting Smith’s concept of feminist sociological theorising, this research focuses on the relations between micro and macro features of the everyday social life of childbearing women and considers their concrete embodiments and locations in discursive power relations (Smith, 1993; 1991; 1990a, b; 1988). I agree with Seibold, that Smith’s later work is particularly helpful when exploring feminist approaches to discourse analysis as she deals with “the tensions inherent in grounding language, while also trying to do justice to embodied experience” (Seibold 2002, p. 12).

Luke and Gore (1992) concur that using everyday experiences as a starting point provides a vehicle that links personal and global issues to a person’s concrete embodiment and their discursive position in power relations. In their view:

> Women's asymmetrical yet numerically equal participation in the public remains confined to the extension of their domestic labour...For many women, substantive political problems often are private and not the same as those deemed as public, common interest (Luke & Gore, 1992b, p. 14)

Sue Stanley and Liz Wise (1993) share Smith’s (1991; 1990a, b) view that the social sciences not only justify and rationalise the power relationships which oppress women, they also provide the concepts, models and methods by which experience can be translated and transformed. Theoretical terms take over experience and reformulate it. Smith argues that Sociology is centrally involved in providing this conceptual language so is the main means by which this process occurs (1993; 1991; 1990a, b; 1988; 1979). Stanley and Wise add that, by transforming people's actual words and actions into this “abstract mode”, “the social sciences contribute to the systematic process by which what

are examined are social science problems, not the issues and concerns of everyday life experiences" (1993, p. 162). They argue that the separation of theory and experience is a condition resulting from the androcentricism within the discipline as men prefer a theoretical world and divorce themselves, where possible, from the mundane everyday world. Stanley and Wise comment that:

> Men, as men, tend to be alienated from the physical facts of their existence, from the world of concrete practical activities, including domestic labour and childrearing. For many, perhaps most women, these are inescapable social and physical facts; but they aren't features of most men's experience at all (1993, pp. 162-3).

According to Reinharz (1992), the misogyny and gynopia of a culture are mirrored in its social science. Therefore, Stanley and Wise suggest feminist researchers use the basics of feminist theory "to produce a critique of the social science theory, research methods and techniques, and descriptions of the research process itself" (1993, p. 159). They criticise the tendency of feminist researchers to seize existing models and methods of research without considering the importance of 'grounding' research in consciousness. Like Smith, Stanley and Wise argue that

> we [cannot] separate ourselves from what we experience as people (and researchers) involved in a situation. There is no way we can avoid deriving theoretical constructs from experience, because we necessarily attempt to understand what is going on *as* we experience it (1993, p. 160).

As advocated by feminist scholars (Smith 1979, 1991; Reinharz, 1992; Luke 1991; Stanley & Wise, 1993; Oakley 1993, 1998), my first concern with this study was not with the discipline of Sociology but the strategy of starting with ones' own experience now commonly employed by feminist researchers. In order to be motivated about research, I believe the topic under investigation should relate to one's own personal experiences. This is what makes it interesting while also providing both an emic and etic perspective. Through reading the work of feminist scholars such as Smith, I realised that it was not necessary to adopt a fixed ideology and attempt to perceive the world objectively and rationally. She legitimates my views, which had previously seemed unorthodox and unscientific.

Some poststructural scholars contend this epistemological position. Patricia Clough (1994), for example, opposes the focus on an active subject whose experience is the starting point for sociological inquiry. For Clough, a feminist psychoanalytics is a preferable approach because it promises deep and profound change for the individual

and of relations of power/knowledge through understanding the complexities of unconscious desire, which shapes the female subject (Clough, 1994). For her there is no subject other than that as constituted in discourse. Refuting this, Smith asserts that the poststructural view leaves no site from which "subjects can speak back as such" as "the beyond-discourse must be object or other" (1993, p. 183). This, Smith says, prevents women speaking for themselves. She argues that her years of experience with the women's movement have shown that

> there is indeed a site beyond and inclusive of the text-mediated, text-based discourses of professional sociology and academia. Or of the media, popular culture or high culture. You might describe it as where we live. As particular individuals, embodied, in particular actual spaces with particular others, at the time it is right now. Basic stuff … (Smith, 1993, p. 183).

The debate between the antithetic views of Clough's (1994) and Smith (1993) are but one example of such discussions between feminists who find their opposing positions irreconcilable.

5.2.3 Exploring the textual pathway from an impasse to a personal feminist position

There are inherent conflicts between my emancipatory feminist ideals, situated within Enlightenment discourses, and the adoption of postmodernist perspectives, which I also find insightful and useful. Each paradigm represents a particular worldview or *weltanschaung* that includes a belief system that defines the relationship between the knower and the known. Guba and Lincoln describe paradigms as "basic belief systems based on ontological, epistemological, and methodological assumptions" (1994, p. 107). Thus, each paradigm contributes to a form of understanding, to *verstehen*. The tension between these two opposing discourses, while initially considered irreconcilable, has led resulted in reappraisals and advances in social theory. Through selectively drawing upon the work of various feminist theorists, in this section I will reconcile the contradictions between oppositional or emancipatory discourses and the knowledges derived from postmodern critiques. Thus, a workable meld between these positions will be constructed. Through pragmatically merging useful constructs from oppositional or emancipatory discourses and the insights derived from postmodern/poststructural[79] critiques, I have developed my personal 'hybrid' philosophy and for feminist practice.

[79] Although postmodernism and poststructuralism have different origins, they both represent a disruptive, paradigmatic shift in thinking. The differences and similarities continue to be debated. While they are not synonymous, it is acceptable to conflate the terms as postmodernism/poststructuralism.

The opposition between modernism and postmodernism, structuralism and post structuralism has created a disruptive 'crisis' in Western thought. Nietzsche ignited the dispute by challenging the Enlightenment legacy and Foucault's poststructuralism fuelled the fire (Hekman, 1990; 1997). This paradigmatic shift led to heated debates between social theorists, including feminists and nursing scholars. The divisive contentions amongst feminists[80] confronted me with a philosophical dilemma. I wished to avoid subjugating women's (private) sphere of activity, retain feminist values that advance women's emancipation, whilst also adopting selected postmodern perspectives and analytical techniques. However, privileging feminist values created a contradiction as postmodernism decentres the subject and rejects the oppositional dualisms of modernity.

As Ramazanoğlu (2002) points out, emancipatory feminists have assumed that they represent the universal category 'women' who, as unified subject, are collectively oppressed. This brings to the forefront the problem with the politics of representation and highlights the risk of replacing one form of oppression with another when imposing a version of emancipation upon women as a universal category. Although well intentioned, there is a risk of constructing disadvantaged women as the 'other', and as an object of social regulation (Everingham, 1994; Gore, 1992). This has led to extensive criticism of Western emancipists' lack of insight into the diversity and differences between individuals. The proposed way forward avoids this essentialist/pluralist dilemma through employing a sensitive differentiated understanding that values diversity and allows for flexibility. While being non-prescriptive, highly subjective and contextualised, the deconstructive approach adopted here also enables consideration of how birthing women and health providers are inserted into particular discourses. In this way, the limitations of emancipatory feminism are addressed.

Like other radical Enlightenment movements, emancipatory feminism was founded in the liberal/humanism and Marxism of modernity. Although definitions of feminism are dynamic, diverse, positional and contested, some of the common features include an appeal to Enlightenment values of progress through social justice, rights, equality and freedom from oppression for a supposedly autonomous, universal subject. Emancipating and empowering women have been primary goals. Feminist critiques based on liberalism and Marxism have been shown to be inadequate and contradictory. They have attempted to work within the 'malestream' Enlightenment epistemology while

[80] Notably, Seyla Behabid (1995) published the disputed theoretical and political commitments of Judith Butler, Drucilla Cornell and Nancy Fraser.

also challenging its defining characteristics (Hekman, 1992; Ramazanoğlu, 2002). However, as Luke and Gore (1992) point out, these foundations delimit the possibility for theorising the emancipatory interests feminism claims to promote, particularly in relation to women and domination within gender relations. For example, Enlightenment dualisms which privilege the male and devalue feminine attributes are reversed so that the 'female nature' and virtues are exalted (Thiele, 1986; Hekman, 1990; Caine, 1988; Tronto, 1989). While revealing and deconstructing these dualisms has been popular within postmodern and poststructural critiques (Whelan, 2001), an essentialist gender identity has been fundamental in providing some unity to feminism. Ramazanoğlu suggests that, while the "specific goals of social transformation can be actively contested", injustices in gender relations enable common interests amongst women to be found despite social differences (2002, p. 7). McNay points to the tendency amongst radical feminists to construct women "as a global sisterhood linked by invariant, universal feminine characteristics" (1992, p. 1). Liberal feminists have worked within existing structures and institutions to bring about changes that largely benefit white, middle class women. Post-colonial and black feminists have challenged Western feminists' ability and right to represent their experiences of gendered subjectivity (Burgmann, 1984; hooks, 1989; Huggins, 1994). However, in destroying the humanist subject of Western philosophy, postmodernism also denies these and other marginalised women voice and presence (Ramazanoğlu, 2002). They assert that the individual woman with her contextualised needs and aspirations is decentred, doubly displaced and lost within the postmodern framework.

Contesting this view, McNay (1992) argues that the universal rationality of the Enlightenment is a regulative ideal that denies difference and the reality of a person's embodied experience. This, she believes, makes it unacceptable to feminists. In an attempt to accommodate these diverse views, the feminist project has been to rediscover and revalorise women's experiences both throughout history and across race and class differences. However, McNay is not clear on how this avoids essentialism and universalism. Acknowledging this problematic contradiction and the criticism, resistance and ridicule it invites, Ramazanoğlu (2002) comments that this feminist project to 'speak out' about women's lives has none the less led to considerable social change. Although this is not acknowledged by postmodern or poststructural feminists, the consequence of exposing gender politics and reducing the inequality between sexes is consistent with the Enlightenment goal of progress.

Jana Sawicki has observed that Foucauldian ideas about subjectivity and identity influence feminist intellectuals, not women en masse. Because of the opacity and complexity of his discourse, Foucault's work requires interpretation and mediation in order to contextualise it and make his ideas accessible (Sawicki, 1994, 1991). Foucault is

unable to *directly* influence the grass roots of feminism, the majority of women including, for example, women in developing countries, those experiencing domestic violence, women active within Farming Women's movements, the Maternity Coalition, birth rights groups and so forth. These women still seek the equality, emancipation, rights, and recognition offered by Enlightenment ideals. My intent is not to follow the postmodernist fashion of condemning rationality, the ideal of a universal humanity and the project of liberation without careful consideration. Instead, I propose a synthesis that merges the strengths of both paradigms.

Despite modifications, modernist feminism continues to have its limitations. In Hekman's view, it is “ultimately self-destructive because it reifies the Enlightenment epistemology that it seeks to overcome” (1992, pp. 5, 6). McNay (1992) considers Enlightenment values problematic because they implicitly rely on and legitimise a privileged male position. In Grosz's view, “Feminism has uncritically adopted many philosophical assumptions regarding the role of the body in social, political, cultural, psychical, and sexual life...[which are] complicit with the misogyny that characterises Western reason” (1994, p. 1). Enlightenment thinking is founded upon universalism which, according to McNay (1992, p. 128) is defined “surreptitiously” by identifying the experiences of a specific group of subjects as the “paradigmatic case of the human as such...These subjects are invariably white, [middle class] male adults”. Despite 'femininity' itself being a masculine construction, a 'liberatory subject' based on 'women's experience' remains a starting point for emancipatory theory (Sawicki, 1994, p. 289). Women are commonly portrayed as powerless victims within patriarchy. Power is perceived as being pejorative. Consequently, modernist feminism is based upon male narratives of gender and these “persistently tend to reproduce themselves in feminist theory” (Sawicki 1991, p. 1). Feminist critiques of the limits of liberalism and Marxism created a receptive environment for a radical new social and political theory.

The metanarratives criticised by postmodernists have been androcentric and have perpetuated patriarchy. Poststructural and postmodern critiques (such as those of Cheek, 1999, 1997 and Lather, 1990), created for me an awareness that has enabled me to move towards a more sensitive, differentiated understanding of women’s diverse experiences and led to a reappraisal of my approaches to the clinical setting. At this point, I began to question how the politics of need could be reconciled with posthumanism and relativism. A prescriptive position that assumed a privileged possession of knowledge would have been in accordance with hegemonic theories which have been shown to be masculinist and to revalorise patriarchal metanarratives (Lather, 1992; Luke, 1992; Croker, 1994). As Jennifer Gore aptly queries in her critique of empowerment discourses “What can we do for you? What *can* ‘we’ do for ‘you’?”

(1992, p. 54). In response, Gore explains that the assumption of what "we can do for you" shows

> an overly optimistic view of agency, a tendency to overlook context, an overly simplistic conception of power as property, the theoretic pronouncement of discourses as liberatory, [and] a lack of reflexivity… (Gore 1992, p. 15)

Like Gore (1992), Everingham (1994) also addresses the arrogant assumption that an enlightened intellectual who knows what is best for the subjects has the ability to empower or transform them. She suggests that within modernity such assumptions have at times become regulatory tools that perpetuate [motherhood] ideologies, which oppress women (Everingham, 1994). Similarly, Lather (1990) considers that deconstructing authoritarian power relations, even ones intended to be liberatory, reveals that collusion and conformity with a dominant discourse is expected often resulting in passivity, victimisation and a perpetuation of hegemonic societal relations[81]. This challenge to emancipatory action has led to claims that deconstructivism has led to debunking theories of hope and replacing these with a politics of despair.

Australian nurse theorists Speedy (1990b), Fahy (1995), Glass and Davis (1998) and Seibold (2001) acknowledge that, while feminist and nursing ethics founded on Enlightenment ideals may be threatened by the antihumanism of postmodernism, there are also inadequacies in an uncritical adoption of an emancipatory agenda. The efficacy of the postmodern critique to reveal the dark side of humanism and to elucidate the power-knowledge nexus within social relationships and institutions cannot be overlooked. Incorporating postmodernism provides new ways of perceiving power-knowledge, gender, race and sexuality. Adopting a lens that attempts to view knowledge from opposing paradigms creates a fundamental problem, which needs to be resolved in order to be able to present coherently and consistently a valid argument.

In the following sections, I map out a path through the pitfalls inherent in combining a form of emancipatory feminism, which recognises the rights and needs of the subject, with a postmodernist perspective favouring deconstruction and a decentring of the subject. I will consider the influential views of selected poststructuralist and postmodernist feminists and well as interpretations by a wider community of feminist scholars who support emancipatory ideals and human rights.

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[81] I was mindful of this caution when undertaking fieldwork with women whose understanding of childbirth and satisfaction with process differed from my midwifery philosophy. Although tempted to engage in 'awareness-raising', I was conscious that this emancipatory intent might reinforce existing power relations.

Moving beyond the theoretical impasse: Adding feminist perspectives to cautionary tales

This project views maternity services from an emic perspective, "the complex world of lived experience from the point of view of those who live in it" (Schwandt, 1994, p. 118) as well as critically deconstructing the gendered power/knowledge relationship within the texts from the etic (outside) viewpoint. The childbearing women and health care providers are all social actors, embedded within particular contexts, and construct their version of reality. I, as researcher, interpret their stories from my position. I also locate their stories within discourses of childbirth, patriarchal obstetric medicine, health politics and rural culture.

The reading of texts (literature and interviews) is affected by the 'lens' used. A researcher's theoretical perspective, as Denzin and Lincoln (1994) point out, will always be historically, socially and culturally mediated. Consequently, they observe that poststructuralists and postmodernists have contributed to the understanding that there is no clear window into the inner life of a person; it is always filtered (Denzin, 1994). Because postmodernism operates within the present moment, it has at its core a sensibility which Laurel Richardson asserts is "a doubt that any discourse has a privileged place, any method or theory a universal and general claim of authoritative language" (1991, cited in Denzin, 1998, p. 2). Therefore, reflexivity and deconstruction are paths through this plurality of views.

Einstadter and Henry suggest that a way out of the postmodernist-realist dilemma is by maintaining a connection and tension between the "demands of theoretical scepticism as articulated by postmodernist deconstructionism and the realists' construction of concrete policy" (1995, p. 299). In this way, a commitment can be maintained at the level of policy and politics using intellectual scepticism as a guide.

Although feminist appraisals of postmodern and poststructural discourses have produced some cautionary notes about the unintentional, negative consequences of emancipatory intents, they also introduce beacons that, in a contradictory way, either illuminate or obscure the way forward. While postmodern and poststructural critiques are not intended as guides for feminist activism, through deconstructing and revealing the mechanisms of power/knowledge within institutions, they offers valuable insights into social relations within a given context. Prescriptive approaches and the universalising effects of metanarratives and essentialist notions are thus avoided by postmodernism. A flexible, subjective and contextualised approach, suitable for this project, then becomes possible.

Poststructural analyses within postmodernism denounce the belief that there is a unitary female identity. Gender is not privileged over class, age, sexuality, race or

ethnicity as these are all seen to be normalising, political, and universalistic. There is no 'essential' nature to these concepts and they do not have fixed meanings; instead, they can indicate multiple, conflicting and changing identities. However, a number of feminist scholars have seen a parallel between postmodernism and feminism as both challenge the basic epistemological and ontological assumptions that have predominated in social theory. Holmwood asserts that a feminist postmodernism avoids the universalising grand narratives of mainstream approaches and the "debilitating relativism" of postmodernism yet retains a focus on the particularity of women's experiences (1995, p. 419). At present, many feminists (such as myself) desire to maintain an emancipatory agenda within a postmodern frame. However, postmodernism challenges the authority of feminist knowledge grounded in the experiences of women (Ramazanoğlu, 2002). Fraser and Nicholson (1990, p. 34) consider the commonly asked question: "How can we combine a postmodern incredulity toward metanarratives with the socio-critical power of feminism?" The conceptual framework they suggest supports my methodological approach:

> Postmodern critique need forswear neither large historical narratives nor analyses of societal macrostructures. This point is important for feminists, since sexism has a long history and is deeply and pervasively embedded in contemporary societies … However, if postmodern critique must remain theoretical, not just any kind of theory will do. Rather theory should be explicitly historical, attuned to the cultural specificity of different societies…and to that of different groups within societies (Fraser & Nicholson, 1990, p. 34).

This form of postmodernism allows for generalisations about social dynamics (using concepts such as gender and sexism), and reconciles them with specific temporal, historical and situational analyses. Fraser and Nicholson argue that "unitary notions of woman and feminine gender identity" be replaced by a "plural and complexly structured" conception of social identity in which gender is just one strand amongst race, ethnicity, class, age and sexual orientation (1990, pp. 34-35). Similarly, Luke (1992) suggests that, rather than engendering identity, affinities that connect women's experiences provide explanations that are more appropriate. By avoiding a universal identity and acknowledging differences, alliances around interests become possible. So, instead of being apolitical or politically paralysed, these authors optimistically see postmodernism as politically useful for feminists.

Through a selective reading of Nietzsche and Foucault, feminists writing from within a poststructuralist position have adopted constructs which, when applied discerningly, are useful when examining emancipatory practices (Patton, 1993; Tapper,

1993), motherhood and the politics of representation (Everingham, 1994), medical discourses (Lupton, 1994; Cheek & Porter, 1997), the processes of power and domination (Sawicki, 1991; Gore, 1992; McNay, 1992, 1994), and the discipline and surveillance of [birthing] women's bodies (Bordo, 1989; Grosz, 1994; Fahy, 1995b; Lane, 1995; Papps & Olssen, 1997; Lupton, 1999b).

Marion Tapper (1993), for example, productively employs Nietzsche's concept of *ressentiment* when reflecting upon some feminist emancipatory agendas. She is concerned with both discursive and non-discursive practices within institutions where feminists have achieved a measure of success and examines their power strategies and the conception of power under which they operate. There is a tendency to portray women as powerless victims of patriarchy while claiming that women relate in a non-authoritarian, non-competitive, non-hierarchical way that re-values essentialist feminine traits like nurturing and caring (Croker, 1994). By contrast, Tapper (1993) observes that the way feminists operate within institutions seldom actualises these ideals. Tapper found that "some feminist practices, rather than resisting power, might be complicit with it" (1993, p. 131). In this spirit of *ressentiment*, they have become preoccupied with power as control which, as described by Nietzsche and Foucault, is a double-edged sword. Positive expressions of power such as self-formation and autonomy can be overlooked when seeking power. Nietzsche asserts that the weak seek power in the form of 'justice' or equal power, and this may be followed by a desire to overpower (Patton, 1993). This, Tapper (1993) believes, carries the risk of submitting to the modern mechanisms of power in its negative forms of surveillance, normalisation and control. This form of power is evident in the maternity care providers' relationships discussed in Chapters 7 and 8. Deleuze describes it as the lowest form of the will to power, "the guise it assumes when reactive forces prevail in the state of things" (1983, p. xi cited in Tapper, 1993, p. 136).

Tapper has also raised my awareness that emancipatory feminist ideals do not always achieve their desired aims. For example, Nietzsche's concept of *nay-saying* can have either positive or negative applications. Tapper commends women for *nay-saying* as is evident in their desire to extirpate sexist language, and redress sexual harassment and economic exploitation, and for *yea saying* in the form of control of our bodies, affirmative action, the addressing of safety issues, equal opportunity (especially in decision-making positions) and legal changes. These positive, liberal feminist actions to include women are all based upon the principles of freedom, equality, rights and justice. However, with the desire to redress injustices through critically examining practices and discourses, there is a risk of finding 'evil' everywhere in text, individuals, culture and institutions. Feminist scholarship has catalogued the implicit and explicit sexual bias in texts authored by males and established these as a means by which male authority is socially

constructed, legitimised and normalised. In denouncing and rejecting all canons considered phallocentric, feminists may be excluding a philosophical heritage that could enrich feminist scholarship. Motivated by a backward looking spirit of *ressentiment,* past injustices are constantly revisited and new injustices sought everywhere. According to Tapper (1993, p. 134), the spirit of *ressentiment* seeks to "recriminate and distribute blame, to impute wrongs, distribute responsibilities and to find sinners". Consequently, differences are denied when "monolithic, univocal explanations" are made about male power and patriarchy, and women are portrayed as helpless victims. (Tapper, 1993, p. 134). The particular worth of individuals can be overlooked. Thus, *ressentiment* and *nay saying* aptly describe deficit models of feminism as well as occupational relations amongst maternity care providers.

While Tapper is one of the few feminist scholars to look to Nietzsche for insights, I have found useful cautions within her selective employment of his ideas. I favour feminist scholarship where possible, yet note that care must be taken not to exclude valuable constructs from male theorists. In addition, I am aware, when deconstructing texts, that there is a risk of reconstructing deficit models of power that can have the negative consequence of reiterating and thus reinforcing their position. When, for example, the history of midwifery is examined, or the way in which childbearing women have been manipulated over time is considered, injustices are found to be prevalent. The lesson here is to move forward with positive forms of action that are enabling rather than to attempt to redress injustices by becoming complicit with, and extending the strategies of control which already exist. When motivated by *ressentiment*, pre-reflective attempts by midwives to gain power through a contest with obstetrics could lead to birthing women becoming the 'spoils of war'. A positive resolution would allow for a *yea saying* which redefines the boundaries of midwifery practice, develops professional respect and enables birthing women to make informed choices. Therefore, reflection is needed when interpreting needs to evaluate whose agenda is being promoted and to avoid complicity with negative mechanisms of modern power and control such as surveillance, regulation and governmentality. This is in accordance with the notion of 'concordance', which is proposed as a way forward in Chapter 8.

Like Nietzsche, Foucault is noted for his critique of the Enlightenment ideals (1977, 1981, 1984) and analysis of the relationship between knowledge and power. Despite many limitations,[82] his ideas have had a significant impact on feminist theorising.

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[82] Not only is Foucault's work perceived as misogynistic, phallocentric and Eurocentric, but he also has been criticised for his poorly developed notion of resistance and the exigencies of feminist practice (Harstock, 1990; Sawicki, 1991; McNay, 1992; Grosz, 1994).

Therefore, his work cannot be dismissed when attempting to delineate a position that draws upon postmodernism/poststructuralism and attempts to integrate the opposing discourses of emancipatory feminism. The positive reconceptualisation of power in Foucault's later work (1981; 1987) is both 'freeing' and useful for feminist research (Gore, 1992; Lather, 1990, 1992; Luke, 1992).

While many of Foucault's methods and insights have been adopted by feminist scholars and have subsequently affected feminist practices, of importance is his critique of the politics of representation (Grosz, 1994) and the question of power as a central issue in the debate over difference. Through feminist readings of Foucault, I have come to realise that I could not 'empower' women but could only enable them. In particular, I became aware that my former zeal to convert women to feminism through consciousness-raising assumed that I possessed an authoritative 'truth' that devalued their perceptions and diversity (Foucault, 1981, 1984). In effect, I was silencing them.[83]

In his later works, Foucault constitution of identity is useful where white, middle class feminism had "constructed universal categories which erased or occluded differences among women" (Sawicki, 1994; Foucault …). McNay agrees that it is important to consider the intersection between power and difference (1994, 1992). She values this "complex and layered notion of difference" as captured in Foucault's notion of practices of the self (McNay, 1992, p. 64).

Sawicki's (1991) Foucauldian model selectively centres on his later analysis of power and subjectivity (Foucault, 1981; 1987). She claims that it can be utilised to support feminist insights about the need to analyse the politics of personal relations and everyday life, as well as revealing ways in which women participate in reproducing systems of domination despite our conscious protests against specific forms of it. Her Sawicki contends that her radical pluralist Foucauldian model of contributes to feminism in three ways. First, it "operates with a relational and dynamic model of identity" which is "constantly in formation in a hierarchal context of power relations at the micro level of society" (Sawicki, 1991, p. 9). Second, it challenges hegemonic power structures .While recognising domination. Sawicki's model also "represents the social field as a dynamic, multidimensional set of relationships containing possibilities for liberation as well as domination" (1991, p. 9). Finally, it "operates with an expanded sense of the political", which includes politicising personal and social relationships as well as theories, as these may act as instruments of domination or liberation (Sawicki, 1991, p. 9).

[83] Such a prescriptive approach was in accordance with the hegemonic theories which emancipatory feminists have identified as masculinist and which revalorise patriarchal metanarratives.

Although this is a useful theoretical model to apply to interactions within a maternity context, it overlooks the macrostructures of power and wider social influences, which cannot be neglected when studying maternity services for rural/remote women. Recognising the limitations of her approach, Sawicki advocates "a political strategy that is attentive to differences, to using and bridging them, [this] is vital if we are to build the global networks of resistance necessary for resisting global forms of domination" (1991, pp. 9,10).

In a similar amalgam of notions, Luke and Gore advocate an anti-foundational epistemology when adopting aspects of postmodernism that they find helpful with their feminist political projects (1992, p. 5). They reject the universal subject and essentialist notions and argue against totalising labels. While favouring postmodern deconstructive approaches, they wish to maintain engendered thinking and situate knowledge within an historical context. They recognise that there can be no finite answer, no certainties in any one theoretical position.

Modernist and postmodernist feminist positions are commonly depicted as opposing paradigms so that a researcher is forced to choose one or the other. However, according to Ramazanoğlu (2002), they should just be seen as having different theoretical concerns. Even so, there are inherent contradictions that feminist researchers cannot escape. Enlightenment assumptions are integral to feminist methodology, and as Ramazanoğlu points out, feminism is unable to entirely "abandon notions of progress and emancipation" (2002, p. 36). None the less, postmodernism opens up possibilities of freedom from the constraints of modern, humanist thought by offering new ways of viewing relationships between knowledge and reality. Through challenging previously accepted forms of authority, notions of truth and gender relations, postmodernism enables feminists to reconsider how power is transmitted through language and knowledge production, thus potentially creating a space for previously subjugated voices. According to Ramazanoğlu (2002, p. 86), the political conservatism of postmodernism, combined with intellectual radicalism and a feminist engagement with liberal and Marxist thought, has productive outcomes. Recognising the advantages of postmodern critiques, Ramazanoğlu (2002) considers that they provide a positive challenge to the defects in modern, humanist methodology. However, she asserts, feminism should "retain some of its distinctive elements in its approaches to social investigation as much else is swept away" (Ramazanoğlu, 2002, p. 86).

Susan Hekman (1990; 1997) is highly critical of feminists who challenge 'malestream' thinking across disciplines, calling for a revaluing of the feminine while also attempting to remain within the boundaries of the modernist discourse they decry.

Hekman's feminist critique “extends the postmodern critique of rationalism by revealing its gendered character” (1990, p. 5). However, for Hekman (1990; 1997), there is no space for dualisms within postmodernism, and so privileging the feminine would mean the inclusion of modernist baggage. She rigidly maintains the separate philosophical paradigms and argues that “feminists cannot simply choose the elements of modernism they like [for example, emancipation]...and discard those they do not like, such as sexism” (1992, p. 7). Quoting Finn (1982), Hekman adds:

> You cannot "doctor" these theories with respect to women and at the same time save the theory. The philosophical system does not survive doctoring. The exclusion or denigration of women is integral to the system and to give equal recognition to women destroys the system (1992, p. 7).

In contrast to Hekman’s inflexibility, Luke and Gore point out that postmodern/poststructural feminism acknowledges the contradictions of its own position in discourse and therefore remains critical and reflexive of “its own complicity in writing gender and writings others” (1992, p. 7). They argue that postmodern feminists do not have to abandon their theoretical foundations and can “stand firm on a politics of location and identity” in line with the feminist standpoint project (Luke & Gore, 1992, p. 7). Further, Luke proposes retaining scepticism of the kinds of certainties promised by modernist discourses, while adopting from postmodernism the irreducible fluidity and complexity of multiple identities, differences, knowledges and views (1992c). She suggests that, to avoid slipping into the relativism of endless difference, the key to stand firm on contextual and theoretical limits. Delimiting difference, uncertainty, partiality and context are commitments to locating perspective, experience, and knowledge in historical, political and social contexts (Luke, 1992c).

As evident in the discussion so far, feminist scholars, like Fraser and Nicholson, Luke and Gore, Sawicki, and Ramazanoğlu, have developed constructs of feminisms within postmodernism which I find appealing and productive, but which are contentious as these are seen to preserve elements of modernism that allow for political action. According to Seidman (1994), they retain “a commitment to generalising theories of gender, critical theoretical knowledge, and synthesising stories of male dominance”.

Standpoint theorists like Nancy Harstock (1990) defend emancipatory epistemologies, does not share their optimism about the usefulness of a feminist poststructural critique. She expresses suspicion towards poststructuralist critiques and asserts that by decentring the subject, feminist voices, authorities and identities are overlooked. Further, Harstock (1990) argues that adopting Foucauldian notions of

power, as it is exercised and experienced does not allow the systematic domination of the many by the few to be revealed. Focusing on the micro politics of power relations, means that the macro, structural causes of oppression are disregarded. If there is no 'subject' and the sources of inequality cannot be located then transformative political action is problematic for marginalised groups. Harstock adds, "For those of us who want to understand the world systematically in order to change it, postmodern theories at their best give little guidance" (1990, p. 159). The bleak view that, without an activist agenda, feminism is caught in a theoretical impasse contributes to the Steven's (1998) and Rojek and Turner's (2000) criticism that feminist theory is stagnating. Since Harstock took her stand against postmodernism, hybrid positions have become possible and these enable feminist critiques of power and knowledge at both micro and macro levels (such as McNay, 1994, 1992; Lupton, 1996).

For many scholars, the debate centres on the concepts and politics of power. While, in my estimation, power is recognised as a critical political issue that must be addressed by nurses/midwives and feminists with emancipatory intents, it is not possible to explore in depth poststructural notions of power within the constraints of this thesis. Consequently, analyses of power are only touched upon in this chapter.

As previously stated, emancipatory forms of feminism (and women in general) have had a negative view of power.[84] Their principal aims have been to gain the power to transform relations, and to empower women. There is a common conceptualisation of power as a fixed commodity within a given situation or institution (Foucault, 1981). This is a "zero sum theory" of power which views it as a product that can be won or lost (Gore, 1992; Croker, 1994). Foucault, while offering a possibility of resistance, undermines the agency of the empowerers. He argues that power is "exercised, and … only exists in action" (Foucault, 1980, p. 89). Individuals cannot give power to (empower) another, but can only be vehicles of power as it is exercised or circulated. This view is given credence in "resistance" works such as nurses' resistance against medical authority (Croker, 1994; Turner, 1986, 1995).

Feminist politics have been based on value judgements, concepts of social justice, rights, freedom, truth and rationality. These underpin projects that aim to overcome women's oppression and subordination, and which are actively carried out by transformative agents. These assumptions are seriously challenged by poststructural critiques within the postmodern. The many strands currently found in feminism reflect both the adoption of, and dissociation from, poststructuralist ideas that confront orthodox

[84] I realise this is a universal assertion but it is made on the basis of widespread literature and my previous research.

notions of rationality, a unified subject and interiority thus influencing the values or certainties on which an individual or group can set goals. Many feminists are torn between the wish to retain certain Enlightenment ideals like social progress while leaving behind the rationality and masculinist constructs.

Patti Lather questions the relationship between feminism and postmodernism when wondering how "our very efforts to liberate perpetuate the relations of dominance" (1990, p. 16). Lather reflects my position when commenting that:

> Postmodernism both imposes a severe re-examination on the thought of the Enlightenment and is being inscribed by those who want to critically preserve the emancipatory impulse within a framework sympathetic to postmodernism's resituating that impulse (1990, p. 48)

Lather (1990), Kipnis (1988; 1992) and Fahy (1997), see feminism as providing both the platform for political action and the political conscience that postmodernism needs. In what also reads as a merged position that recognises the strengths and weaknesses of both paradigms, Fraser (1991) and Glass (1998) share the opinion that the feminist struggle is in need of deconstruction, destabilisation of meaning, and reconstruction as well as the projection of utopian hope.

Developing an integrated feminist solution

While for some social theorists, feminism and postmodernism are binary opposites, for others the complexity of shifting philosophical approaches create the uncertainty, disorder and fragmentation makes intellectual and political change possible (Flax, 1990; 1992). However, while acknowledging that the disintegration of the modernist world has its benefits, others feel that the theoretical confusion and the lack of conceptual coherence undermine the feminist project (Harding, 1986; Holmwood, 1995). Luke and Gore (1992) do not believe that postmodern feminists "float uncommitted on a sea of postmodernist theoretical indeterminacy" but, like Flax, optimistically see the lack of certainty as providing openings for new knowledges that are provisional, open-ended and relational. This is a rejection of the totalising certainty of modernity with its finite and unitary truths. As Glass and Davis (1998) point out, the difficulty in resolving the problem is compounded by the ways in which both feminist and postmodernist discourses are constantly evolving. However, they argue that:

> rather than the meeting of binary opposites, there is a degree of shared epistemological and ontological ground where the boundaries over lap … It is a place where new intellectual and political terrain has come into being (Glass, 1998, p. 45).

It is on this terrain that many of these philosophical 'turf wars' were fought and it can be argued that oppositional spaces have become apparent. Feminism has been redefined within the postmodern regardless of the incongruency of attempts to integrate political agendas intended to redress women's oppression along with critiques of the unified subject, power, and knowledge. For example, Glass and Davis (1998, p. 47) believe that it is possible to validate women's' individual differences "while simultaneously recognising the importance of unity concerning transforming oppressive states". However, like Glass and Davis (1998), I too acknowledge that there are limitations to the possibilities of empowering and transforming women and that there is a need to acknowledge and value differences. Through deconstruction of the major debates, there is a way to reconcile emancipatory and postmodernist constructs as an "integrated solution" (Glass, 1998, p.50). When applied to nursing and midwifery, this involves recognising that there are multiple forms of postmodernism, some of which see fragmentation as potentially liberating and others which possess "the fundamental concepts capable of producing a general social theory" (Glass, 1998, p. 50).

To find an integrated solution, Fahy (1997), Glass and Davis (1998) and Seibold (2001) have, like me, taken an interdisciplinary approach and looked outside of nursing to feminist postmodernism and postmodern sociology. Drawing on the work of significant theorists such as Fraser and Nicholson (1990), Lather (1990), Stanley (1990) and Lemert (1996) they employ the postmodern notions of power and subjectivity to identify the "strategies of medical dominance, nursing submission and resistance, and [to] assist with the emancipatory intention to destabilise organisations and structures" (Glass 1998, p. 50). Refuting Hekman's warning, that feminists cannot selectively choose what they want to take from postmodernism, enables a selective embrace of theoretical constructs compatible with feminist purposes from the many 'flavours' of postmodernism.

Postmodernism is dynamic and evolving and has increasingly become an interdisciplinary pastiche of ideas. This pluralism and plasticity of forms create postmodernism*s* that provide opportunities for new theorising. Paradigmatic purists who argue that feminisms and postmodernism continue to be binary opposites maintain boundaries that are intellectually restrictive and inhibit political potential. It could be argued that the restrictive power they exercise sets limitations on theorising that deny the plethora of voices and differences they purport to enable. Theirs is a negative, inflexible form of postmodernism that paralyses action and has limited application for feminist research. I argue for a postmodernism that "resituates the emancipatory impulse" (Lather, 1990), is critically attuned to feminist political agendas, acknowledges the complexity, diversity and particularity of women's experiences, and is inclusive of marginalised voices.

While acknowledging the inherent philosophical contradictions, I believe that a number of feminist scholars have now effectively demonstrated that postmodernism can be constructively revisioned so that it retains its main tenets while becoming compatible with feminist purposes.

This section has explored the dilemma of attempting to merge emancipatory action with the useful insights postmodernism offers. It draws upon significant theorists have explored this impasse. While some continue to maintain that emancipatory feminism and postmodernism are binary opposites, others take a more optimistic view and I have adopted the possibilities for integration that they outline. These acknowledge the foundations of feminism through providing a political platform and political conscience to the postmodern critique. Although there is a focus on the micro politics of relations, structural causes of oppression and possibilities for resistance are not overlooked. However, to translate this theoretical perspective into research action that can be applied to this project, a feminist epistemology is required. In the following section, the development of a feminist epistemology and sociology of knowledge for women will be explored, as these will inform the conduct of this inquiry.

5.3 Chapter summary

Chapter 5 outlines the contribution selected feminists have made to the development of a feminist sociology of knowledge that informs this study. From the extensive theorising around the sociology of women, I have included excerpts from scholars who advocate beginning with the everyday world not within textually mediated discourses. These scholars challenge the relationship of women with the concepts and methods of existing disciplines and intellectual traditions and move towards making sociology accountable for the lived experiences of people. This is evident in their attempts to make visible the social relations and organisation of social practices that shape people's lives. Using the work of feminist sociologists, I have outlined the key features of a feminist epistemology and ontology. In particular, this includes using women's experiences as the starting point of sociological inquiry.

This study, which is based within rural and remote communities, presents the voices of real people with real needs. It focuses on the subjective reality of women’s existence while considering the impact of patriarchal and masculinist discourses on their lives. One of the outcomes of this research is to identify the gaps between consumer goals (what women require and desire to meet their needs) and existing maternity services. Thus, this research has a social justice framework and political goals while also taking a deconstructivist stance. Discursive analysis provides a critique of the key

concepts in this study of choice, risk and trust.

The theoretical position taken in this study incorporates the opposing positions of critical enlightenment thinking and postmodernist discourse. It offers valuable insights into social relations within a given context and avoids the universalising effects of essentialism. Although postmodernism/poststructuralism has brought new perspectives to sociology with its radical rejection of the epistemological foundations of Western thought, I see inherent problems in rejecting all the principles of the Enlightenment-humanist legacy. While rejecting essentialist notions, I advocate a postmodernist paradigm that incorporates a political program and avoids 'ossifying' feminism (Rojek &Turner, 2000; Stevens, 1998). Thus, the interpretive methodology adopted for this study respects difference, enables investigation of both micro to the macro social processes, while remaining grounded in the everyday lives of rural/remote women. I have pragmatically merged useful constructs from oppositional discourses and the new knowledges derived from postmodern critiques into my personal 'hybrid' philosophy and feminist practice. The application of this interpretive methodology to appropriate processes for inquiry is evident in the next chapter where contemporary feminist ethnographic methods are discussed.

Chapter 6

Framing the research methods

6.1 Applying feminist methods to researching rural birth experiences

The research techniques and processes used in this project demonstrate the application of feminist interpretive methods. These techniques are derived from the feminist methodology discussed in the previous chapter and designed for exploring the sensitive topic of rural and remote birthing experiences. This feminist interpretive inquiry grounds emerging knowledge in women's voices and experiences. When exploring interpersonal relationships, I have been mindful of the gender and power differentials around confidentiality and trust (Cook & Fonow, 1991; Jansen & Davis, 1998; Ramazanoğlu, 2002). A retrospective, reflexive approach is taken when discussing the interrelationships between the research design and methods employed to generate data, and the practicalities, contradictions and dilemmas I encountered in the field. The specific strategies, processes and data sources used when implementing the project are outlined along with critical reflections on my assumptions and relationships with research participants.

The approach employed in this study is derived from contemporary feminist ethnography. This was applied to the question of what could be learnt from the perceptions of rural and remote childbearing women and maternity care providers that would contribute to improving the quality of birthing experiences. Given this question, my general aim was to explore the perceptions and experiences of childbirth in four rural and remote areas of North Queensland. To achieve this aim, I interviewed 27 childbearing women and 21 maternity care providers so as to develop an understanding of their expectations and available choices, and to reveal factors which they perceived as enabling or constraining a 'good' birth experience. A feminist ethnographic approach was considered most appropriate for eliciting the intensely personal information related to the sensitive topics of birth and relationships between and amongst rural and remote maternity care providers and birthing women.

This chapter begins by outlining contemporary feminist ethnographic methods and discussing the data collection tools used in this study. Then, in sections 6.3 and 6.4, ethical concerns about conducting sensitive research, design issues and limitations follow. Section 6.5 then outlines the childbearing women, maternity care providers and the medical records as data sources. Finally, the methods of data analysis are explained

(6.6) along with a description of the relational diagrams (6.7) that will be used to display the data on labour relations.

In conformity with a contemporary ethnographic approach, a contextual background to the study has been detailed earlier in Chapter 4 with descriptions of the rural and remote locations and the available models of maternity care.

6.2 Multi-sited, contemporary feminist ethnography

Contemporary feminist ethnography is a loose frame which incorporates a dynamic revisioning of the classical/critical ethnography (Stacey, 1991; Reinharz, 1992; Glass, 2003). Stacey asserts that the ethnographic methods of "intensive participant-observation" yield a "synthetic cultural account" that is "ideally suited to feminist research" (1991, p. 112). The flexibility of this emerging ethnographic methodology was strengthened using a blend of methodological techniques (Rice & Ezzy, 1999) to investigate childbirth experiences within a rural/remote context. These included fieldwork in four communities, participant observation, fieldnotes containing photographs and reflections on observations, 72 audio-taped in-depth interviews with 48 participants and content analysis of selected documents including 12 medical records. Shulamit Reinharz's principles for feminist ethnographic research guided the data collection; these are to:

1. document the lives and activities of women;
2. understand the views of women from their own point of view, and
3. conceptualise women's behaviour as an expression of social contexts (1992, p. 51).

Dingwall asserts that research employed for "programs of change" is "an underdog enterprise, speaking for the poor, the lowly and the dispossessed" at the expense of giving the privileged in social relations a "fair go" (1992, p. 172). While mindful of Dingwall's comment, this project is underpinned by an emancipatory intent; however it also attempts to deal fairly with both maternity care providers and the birthing women who receive their services.

Contemporary ethnography was valuable for this feminist study because it reduces the social distance between the researcher and researched, is non-oppressive, and accords to the participants a more active role in the research process (Fonow & Cook, 1991, p. 9). Furthermore, as Nel Glass (2003) has suggested, it not only enabled me to examine the social conditions of women's lives but also to incorporate discursive influences where these affected birthing relations. Thus, being in the field provided me

with a valuable means of observing interpersonal dynamics, and gaining a deeper understanding of the complexities of rural birthing.

From a critical theoretical position, Hammersley and Atkinson describe ethnographic methods as involving "the ethnographer participating, overtly or covertly" in the daily lives of people's within a specific cultural group "for an extended period of time, watching what happens, listening to what is said, asking questions – in fact collecting whatever data are available to throw light on the issues that are the focus of the research question" (1995, p. 1). However, within health research 'cultural group' has been re-defined (Rice & Ezzy, 1999) and the lengthy immersion in the field that was formerly required has been replaced by "a more contained version … characterised by an eclectic use of techniques" (Grbich, 1999, p. 158). These techniques of data production will now be discussed.

Inspired by feminism as both a philosophy and a practice, I used feminist research methods to generate qualitative, descriptive data from the social setting. Central to my approach were women's experiences and concerns. According to Lumby (1995) and Speedy (1997), this complements midwifery/nursing research by bringing a feminist consciousness to a women-centred professional domain. Ramazanoğlu asserts that most feminist research involves 'data production' rather 'data collection'. Differentiating between these terms she remarks that:

> 'data production' implies that information gathered by the researcher is produced in a social process of giving meaning to the social world. This is distinct from 'data collection' which … can imply that 'facts' are lying about waiting for the researcher to spot them (Ramazanoğlu, 2002, p. 154).

As such, the personal accounts of birthing women and maternity care providers produced data which I viewed as legitimate sources of knowledge about their social world (Brown, 1994; Jackson, 2003; Olsen, 1994; Ramazanoğlu, 2003; Reinharz, 1992). This is consistent with Jackson, Clare and Mannix's broad aims of feminist research which are "to illuminate, explicate and validate women's experiences, concerns and ways of being, and to challenge structures that marginalise and oppress women" (2003, p. 210). Grbich comments that, while feminism may not be widely recognised as a theoretical approach to research "in its own right", feminism makes an "important contribution to qualitative research processes" (1999, p. 26).

As a dynamic and evolving approach, contemporary feminist ethnography enabled me to adapt diverse qualitative methods to the topic of inquiry. Congruent with Denzin and Lincoln's (1994; 1998) concept of a "bricoleur" who, when considering the context, selects whatever tools can best meet the need to answer the research question posed, I

chose the most commonly used qualitative methods in the health area to gather and analyse information – fieldwork, participant observation, in-depth interviews and content analysis (Minichiello, Aroni, Timewell & Alexander, 1992; Minichiello, Madison, Hays, Courtney & St John, 1999; Minichiello, Sullivan, Greenwood & Axford, 1999; Berglund, 2001; Ritchie, 2001).

6.2.1 Constructing the field

Initially, a comprehensive profile was developed for each of the four selected communities. Historical sources, statistical data, general literature and documents from regional development and community groups, as well as discussions with local industry and municipal spokespersons provided a background to the study. Health and workforce statistics were gathered from the Queensland Health Epidemiology and Health information Branch, National Health and Medical Research Council (NEMIC), Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and Health Wiz, as well as the relevant Shire Councils. More precise information from the Queensland Perinatal Statistics Unit was valuable for looking at the specificity of data both across Queensland and in localised areas. Participating in a rural women's email discussion group and a farming women's network also provided important personal information that helped focus the issues I would explore.

6.2.2 Participant observation

The technique of participant observation involves an observer participating "in the daily life of the people under study, either openly in the role of researcher or covertly in some disguised role, observing things that happen, listening to what is said, and questioning people, over some length of time" (Becker, 1957, p. 28 as cited in Russell, 1999, p. 433). Consistent with contemporary, feminist ethnography, I adapted this method for a shorter time period and to cover four natural settings (Grbich, 1999; Reinharz, 1992). Through the use of both unobtrusive[85] and open participant observation, I was able to systematically record observations of people living and working within the social, cultural and political context of a rural town and in relation to their physical surroundings (Ritchie, 2001, p. 163).

As the researcher, I moved backwards and forwards along a continuum between total participation and total observation, taking the role that Goffman (1974) describes as

[85] Although the term 'unobtrusive' is used here, I acknowledge that in the small communities this was limited to the initial period when my presence blended with tourists. As I made repeated field trips, my observations were mostly overt.

'participant-researcher / researcher-participant'. This involves the researcher having some emotional involvement but with the ability to swap from role to role within the environment (Grbich, 1999, p. 125; Minichiello, Madison et al., 1999).

On the initial visits, I particularly noted the physical environment. I photographed the geographic features, townscape, selected houses, community centres and health agencies. Characteristics specific to the socio-economic base of the community, such as pastoral areas, sugar mill, coal mines and tourist attractions were also photographed. Later, when analysing transcripts, these photographs assisted with positioning participants' comments about their daily lives or their experiences with health services. As well, the images portrayed emerging concepts such as lack of privacy and social isolation. Selected photographs have been included in this thesis to enable the reader to situate the discussion within a material context (Appendix 12).

Accompanying the visual record, audio taped and written fieldnotes were made on the initial and subsequent visits. These included my observations of daily interactions in the community including shops, health centres, playgroup, churches, pubs and social centres like the Town and Country, and International clubs. Where possible, I attended local social gatherings and engaged in conversation. In addition, detailed fieldnotes were recorded before and after each interview and these commented on the interview setting along with my initial impressions and reflections upon the interactive processes.

Patton (1990; 2001) and Berglund (2001) recommend gathering background information from non-participants through wide-ranging, informal conversations to develop a picture of the context. When used in combination with participant observation this allows comparison with participants, thus improving external validity and enriching the final results. Therefore, my data collection included visual information and field notes outlining informal conversational interviews that illuminated observations and clarified meanings.

Participant observation was conducted in the largest district, 'Sugar Town' over six months. Spending one day each week and staying several nights over a sustained period allowed me to observe women's lives within the social context of a rural setting. My participation in the daily activities of the small town included being involved in the activities of a young mothers' group at their toy library; International Women's Day events and meeting local women from diverse backgrounds for informal discussions over either coffee or meals in both the town and surrounding farming district. As well, I frequently visited the local hospital, baby clinic and the Aboriginal and Torres Strait Islander (ATSI) health centre. Ongoing, less frequent observations in Sugar Town enabled me not only to ensure that the field notes remained current throughout the duration of the project but also to contrast and compare Sugar Town with the other three sites.

At the outset, more time was spent observing Sugar Town than the other three sites. This period provided an essential understanding of the milieu, including everyday life in a rural town across the farming seasons, as well as the institutional practices of the health agencies and the relationship between the community and health services. As the first and largest community in which I conducted fieldwork, this enabled me to refine the methods so as to develop my observation skills, hone the interview process, and focus my research questions. Consequently, I was able to gather the data more efficiently and effectively in the smaller, more distant communities.

6.2.3 In-depth interviews

Participants in this study included 27 birthing women and 21 health providers (as described in Section 6.5), most of whom were interviewed twice (totalling 74 interviews). In-depth interviews with a diverse cross-section of birthing women were conducted in their homes (Acker, 1991; Reinharz, 1992). Key health personnel chose to be interviewed either in their homes or in their workplaces.

Guided by the 'general interview guide approach' (Patton, 1990; Minichiello, Madison et al., 1999; Minichiello et al., 1992) and Rice and Ezzy's notion of a 'theme list', I created a short, flexible checklist of themes which I would aim to introduce throughout the course of the interview (Appendix 11). Not having a structured collection of questions set in rigid sequence promoted free dialogue with a natural, 'conversational' flow of discussion during the interview (Patton, 1990; Rice & Ezzy, 1999). This adaptable approach enabled me to "focus on whatever relevant issues [arose] and to explore any new information that might not have been expected" (Ritchie 2001, p. 158).

Each interview was a guided inquiry which included the key themes yet allowed for new information to emerge. The interview guide (Appendix 11) contained a set of themes for birthing women and maternity care providers. These themes afforded a focus on particular issues relevant to my research question which allowed for some comparability between the content of interviews while still providing "a valid explication of the informants'[86] perception of reality" (Ritchie, 2001, p. 92). Both the maternity care providers and birthing women were advised in writing of the general themes I wished to explore (Appendices 5,6,7) but, as this was an inductive process, they were also invited to talk about other issues they considered relevant or significant (Appendices 6 & 7). This is consistent with Taylor and Bogden's concept of in-depth interviewing as:

[86] Throughout this study, the term 'participants' will replace other interchangeable descriptors found across the literature, including 'informants', 'respondents' 'interviewees' and 'subjects'.

> Repeated face-to-face encounters between the researcher and informants directed toward understanding informants' perspectives on their lives, experiences or situations as expressed in their own words (1984, p. 77, as cited in Minichiello et al., 1992, p. 93).

The value and appropriateness of this inductive, non-standardised method of gathering data soon became apparent as participants raised issues and concerns that I had not foreseen. Participants' responses revealed their unique perspectives on their individual experiences. Consequently, participants' beliefs, perceptions, attitudes and opinions, that would otherwise have been hidden, were elicited and revealed. Similarities and differences between participants became apparent. I placed a high value upon the participants' views as I sought access to and understanding of their perspectives of their world through accounts communicated in a way that was natural for them (Minichiello et al., 1992; Spradley, 1980). This open-ended interviewing technique enabled me to explore the subjective meaning that individuals give to personal experiences and events in their lives (Ritchie 2001, p. 157).

As the quality and content of an interview is dependent upon the relationship between the researcher and participant, I aimed to develop a natural, free-flowing dialogue that resembled a conversational process (Rice & Ezzy, 1999). Minichiello et al. (1992) point out that this increases validity as it reduces the possible distorting effects of symbols and language which are not part of a participant's everyday language usage.

Prior to the first audio-taped interview, I endeavoured to establish a rapport with participants through informal telephone and face-to-face contact. Minichiello emphasises the importance of repeated social interaction and notes that such encounters create "an egalitarian concept of roles that contrasts with the imbalance of roles in survey methods" (1992, p. 93). This was reinforced by conversation, before initial and subsequent interviews during which I was also 'assessed'[87] by participants before they were prepared to disclose their personal and often intimate details. My experience was consistent with Oakley's (1981) comments on how these researcher-interviewee encounters extend into broader-based social relationships. Like Oakley, Finch (1991, p. 203) found that most women felt that it was "great to have someone to talk to" and enjoyed extended periods of time talking about their lives and relationships. I therefore achieved my aim to develop an atmosphere of trust in which participants could feel able to reveal sensitive information if they wished. With this careful preparation, most of the interviews I conducted resembled a free-flowing, extended narrative; however interviews with three participants were exceptions.

These were the single interviews with, firstly, a Filipino woman with whom I used an interpreter; secondly, with an Aboriginal woman within a constraining clinical environment and, lastly, there were two un-taped interviews with a 'cautious' medical practitioner. On these three occasions, I used the thematic guide to formulate semi-structured questions. When working through a translator, clear specific, focused questions were required. There was little opportunity to explore responses. As the doctor was suspicious of my research intentions and refused permission to audio-tape both the initial and follow-up interviews, my questions were specific and even probing elicited only brief responses.

As further discussed in 6.4.3, all transcripts were returned after the initial interview so that participants could verify and comment upon their content during the follow-up interview. In keeping with the egalitarian principles of feminist contemporary ethnography, this 'member checking' included participants in the knowledge produced, incorporated their reflections and (usually) developed the sense of trust and connectedness which is ideal for eliciting information on sensitive issues (Reinharz, 1992). Once initiated, many interviews became narratives of personal experiences requiring only the occasional guiding question. Catherine Riessman differentiates between traditional ethnographic accounts which view the language in narratives as "a transparent medium, unambiguously reflecting stable, singular meanings" and participants' construction of "creatively authored, interpretive rhetorical stories replete with assumptions" (1993, pp. 4 - 5). As Reissman (1993) points out, these stories do not mirror a world 'out there'. The second audio-taped interview and subsequent conversations yielded varied layers of personal information. Rice and Ezzy note that the first interview may be like a 'press release' with different content emerging in later interviews (1999, p. 54).

The deliberate construction of the story for an intended audience was most evident in follow-up interviews after I had established a relationship with participants. Often they would retell their stories with a greater depth and more disclosure than at the first interview, adding a different emphasis and new information, elaborating or minimising points they had previously made. At times it was as if a formal, carefully constructed layer was drawn back to reveal a deeper, more reflective version of the story beneath. This supports Riessman's (1993) assertion that discourse analysis of narratives of personal experiences challenge positivist notions of 'truth'. The accounts are highly subjective and "perspective ridden"; but it is precisely this that enhances their value (Riessman, 1993, p. 5). Thus, these subjective experiences can reveal so much about social life, gender relationships, practices of power, inequalities and

[87] "Sussing out" is the term some Aboriginal people use for this process of assessing someone.

oppression.

These ongoing interactions and participants' reflections upon their transcripts led to some participants expressing a desire to bring about local changes. Consequently, a spontaneous movement towards women-centred action eventuated. Together, data collected from the participant observation in the contexts and disclosure of personal histories during interviews led to the construction of exemplary case studies. As shown in Chapter 7, these provide an important background for the creation of new knowledge.

6.2.4 Document interpretation

Content analysis and interpretation of documents were undertaken to link the specific experiences of the women to the topic focus and context. To provide insights into local issues, I first analysed background information sources including historical records, statistical data, general literature and documents from regional development and community groups. As Lupton suggests, this "provides a way of understanding how notions and experiences of the social and material worlds are constructed and reproduced in textual form" (1999, p. 450). Second, following Brown, Lumley, Small and Astbury (1994), a content analysis of medical records and progress notes was undertaken.

Initially, I intended to add breadth and depth to the study design by comparing and contrasting the views of women, health providers and the official accounts found in birthing women's medical records. These official records are the source of perinatal statistics, which form the basis of policy development. Lupton (1999) is concerned that such official documents represent and, on their own, construct 'reality'. Brown et al. (1994) believe that these records should not be considered as the 'gold standard' by which women's experiences are judged. As the discursive construction of the birth event within text creates a medical event and an 'institutional' view, I contrasted these to the subjective meanings obtained from ethnographic interviews.

To maintain confidentiality, access to medical records became a selective process. Although most women gave permission for their records to be viewed, I consulted their records only if they were a) in the local hospital and b) where I could do so without threatening the woman's anonymity. Because medical records cannot be copied or removed from the hospital premises, it was not possible for me to gain access to records in distant major hospitals. Maintaining participant anonymity meant that, in the small towns where the Medical Superintendent is also the local private practitioner, I chose not to consult records. Not only were these held in the doctor's private clinic but the doctor would also know whose records I was reading. Safe access to twelve medical

records was obtained at two sites, allowing limited exploration of the differences between women's recollections and the official documentation of their birthing.

6.3 Access and ethics

This research was conducted in accordance with the National Health and Medical Council (NHMRC) Guidelines (1992), the *Guidelines on research ethics regarding Aboriginal and Torres Strait Islander cultural, social, intellectual and spiritual property* (1995), the Code of Ethics of the Australian College of Midwives (1989) and the Queensland Nursing Council Code of Practice for Midwives (n.d.). Approval to conduct the research was received from the James Cook University Experimentation Ethics Review Committee (Approval No. H 445), the Townsville District Health Service Institutional Ethics Committee and the Torres Strait and Peninsula Health Authority. Appendices 4 – 8 are the Volunteer Information Sheet, follow-up letters and consent forms.

The topic of birthing and relationships with and between health providers in small, socially diverse communities is perceived as "risky" research. That is, threats to research participants may "involve potential costs to those participating in the research such as guilt, shame, or embarrassment" (Lee & Rennet, 1993, p. 4). Birthing is "women's business", which in many cultures is not for open discussion. Discussing birth and motherhood experiences involves disclosing intimate physical, social and emotional issues. In keeping with my ethical obligation, I endeavoured not to exploit participants or to mar the sensitive relations between health providers and the women utilising their services. These ethical concerns created potential issues around trust and confidentiality which I reduced through rigorous, reflective research practices.

6.3.1 Avoiding exploitation: Ethical concerns about conducting sensitive research with vulnerable participants

Judith Stacey believes that "the exploitative aspect of the ethnographic process seem unavoidable. The lives, loves, and tragedies that fieldwork informants share with a researcher are ultimately data, grist for the ethnographic mill" (Stacey, 1988 cited in Jones, 1998, p. 439). However, as a feminist researcher, I endeavoured to explore the personal lives of birthing women from diverse backgrounds, along with the sensitive relationships with and amongst maternity care providers, in a non-exploitative way. Mindful of Oakley's (1981) admonition of unethical researchers who use women purely as data sources, and Cook and Fonow's (1991) concerns about power differentials

between researcher and participants, my approach attended to sensitive issues and avoided exploiting vulnerable groups through providing reciprocity and a more active, collaborative role for participants, which reduced the distance between us.

Being accepted by birthing women as an empathetic outsider, and by the health professionals as a researcher with an insider's (emic) perspective, created both advantages and potential problems for me. I was aware that, when women researchers interview women, the participants identify more readily with them. Interviews "can take on the aura of an intimate conversation and respondents can accept too eagerly … flimsy guarantees of confidentiality" (Cook & Fonow, 1991, p. 8). While developing a comfortable, friendly environment during interviews improved the depth and quality of the data I collected, I was behoved not to exploit participants who had revealed intimate details, trusting that these would be kept confidential. As participants had no control over how I would process and use the information, I have taken steps to avoid abusing the power differential (Fonow & Cook, 1991).

Sensitive topic research is considered to be potentially "threatening in some way to those being studied" (Lee & Rennet, 1993, p. 4). In attempting to understand potentially vulnerable individuals' subjective experiences and meanings, I was intruding into their private spheres, delving into some deeply personal experiences, or dealing "with things sacred to those being studied that they do not wish profaned" (Lee & Rennet, 1993, p. 6; Jansen & Davis, 1998). While some of these potential risks were anticipated when seeking ethical approval and informed consent, others occurred beyond the consent form. Successful interviews with participants from diverse backgrounds required me to create an environment in which they felt emotionally secure (Padgett, 1998) and able to talk openly about their deeply personal perceptions of birthing, mothering, family relationships and their encounters with health services. Within small remote communities and for women from indigenous or ethnic minority groups, these topics are particularly sensitive. Trust and distrust emerged as important issues not only in the relationship between participants and interviewer but also in their interactions with their partners, maternity care providers and the community. When given an opportunity to discuss confidentially intimate concerns and interpersonal relationships with a non-judgemental 'safe outsider', many birthing women disclosed sensitive information such as negative perceptions of health providers, birth trauma and experiences with postnatal depression and family violence. Similarly, when interviewing maternity care providers, interpersonal alliances, tensions and conflicts between health professionals and key community figures were disclosed. Specific health professionals and agencies were mentioned. Because of the limited number of maternity care providers in the study sites (in one remote setting just a midwife and

doctor), great care has been taken to maintain their anonymity. Maternity care providers were also keen to know how their services were perceived. Consequently, because of the sensitive nature of the information participants shared, care has been taken to conceal identities when disseminating findings to maintain an ethic of non-maleficence and avoid jeopardizing interpersonal relationships.

Two power differentials operated when researching the maternity care providers. The first was that I had control of the way in which the data would be interpreted. Although in ethnographic terms, I took an outsider's (etic) perspective, I was aware that some of the information was shared with me because I am a nurse/midwife and was therefore seen to be in collusion with them - usually they trusted me. Second, they held the power to influence the outcomes of this study. As key informants, their recruitment and retention were essential. They also had control over the information they were willing to share with me, for example by citing policy or through giving what they perceived as the 'correct' responses rather than ones which described 'actual' practices (Hardcastle, 2004). Within the medical hierarchy, my role as midwife/researcher was perceived as inferior to that of a male medical practitioner and attempts were made during two interviews to use this to intimidate me[88].

Oakley (1981) advocates reciprocity and many participants volunteered to take part for their own personal reasons. Although Patton (1990) would see this as an issue with the nature of a research interview, it often provided a therapeutic opportunity in which participants could, in confidence, share their stories with me. Although I presented myself as a researcher, my opinion as a health professional was often sought and sources of help and support were requested. Advice I gave birthing women included contacts for postnatal depression counsellors, the perinatal distress support group, domestic violence resources, lactation consultants or the Australian Breastfeeding Association[89] as well as information on how to gain access to their medical records under the Freedom of Information Act. Two women who were isolated and depressed sought a way to communicate and mutually support other women who were in a similar situation to them. Also, general reassurance and guidance about mothering and baby care was requested. In this way, the relationship moved away from exploitation to one of reciprocity. Several midwives sought collegial support and

[88] This took several forms including making me wait sufficiently long to feel insignificant and 'know my place', dominant body language, a belittling statement about the project, and what I perceived as passively aggressive silences.

[89] Formerly the *Nursing Mothers Association*

reciprocal information sharing.[90]

Other ways to avoid exploitation are through 'member checking' and 'giving voice'. By having verbatim transcripts returned to them for their perusal and comment, participants could be conscious of how their own voices would appear in the public arena (Lincoln & Denzin, 1994). Some childbearing women wished to have access to and discuss the background literature and offered their insights into its application and value. Others added reflections on their initial interviews which I incorporated into my field notes. These interactions minimise what Michelle Fine (1994) and bell hooks[91] (1990) describe as colonising the marginalised space inhabited by the "other". Fine believes that qualitative research commonly reproduces contradiction-filled, decontextualised voices of others by speaking for them. hooks adds that:

> Often this speech about the "other" annihilates, erases: "no need to hear your voice when I can talk about you better than you can speak about yourself. … Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine … I am still author, authority. I am still the coloniser, the speak subject, and you are now the centre of my talk" (1990, pp. 151-152).

From an Australian Aboriginal perspective, Burgmann (1984), Burney (1994), Finlayson and Anderson (1996) have discussed the problematic ways in which difference or 'otherness' is represented by white researchers. Colonial processes, they believe, emphasise essentialism which constructs an Aboriginal otherness exclusive of, and not valued by, mainstream Australian culture. Similarly, Casimiro (1995), Kelaher, Potts and Manderson (2001) and Woelz-Stirling, Manderson, Kelaher and Benedicto (2001) have looked at perceptions of Australian-Filipino women and explore the multiple, intersecting identities that, in reality, demonstrate the diversity amongst them. I recognise that the Filipina interviewed for this study is an individual example whose voice cannot represent the views of all Australian-Filipinas in rural/remote communities.

These critiques raised the need for caution and reflexivity to avoid extrapolating views expressed by individual participants of a particular ethnic group to the wider population. My ethical duty to the participating women from minority groups or those who were vulnerable was to ensure that their voices were heard and not decontextualised or overridden by me as author and authority. Therefore, care was

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[90] For example, on two occasions I was asked to provide rationales for changes to clinical practice. These midwives could have asked the doctor with whom they worked on a daily basis but did not want to reveal to him their lack of current knowledge.

[91] Lower case spelling is the author's preference.

taken to enable appropriate, safe and collaborative inclusion.

As a white, middle class researcher, I was cognisant of the past exploitation and current concerns of Aboriginal birthing women (Appendix 10). Culturally appropriate protocols were prepared so that I could include Aboriginal women from the general population[92] (Myles & Tarrago, 1992; Fejo, 1998, Carter, Lumley, Wilson & Bell, 2004; Central Australian Aboriginal Congress Alukra, 2004).

Although Filipinas in rural and remote towns were invited to participate, only one volunteer was eligible. The interview environment in which this young single mother felt comfortable, safe and supported involved her 'sister' translating while a roomful of Filipina friends discussed her responses and added to each point she raised.

Another vulnerable group which emerged during the data production was that of women experiencing domestic and/or family violence. Unsolicited information was disclosed; this largely related to psychological, social and emotional abuse. As physical violence was not involved, women were often not aware that the abuses of power they were experiencing were considered domestic violence as it was widely accepted within the hegemonic masculine norms of their community. The women's desire to maintain privacy and my commitment to maintain confidentiality meant that I was unable to alert local health professionals. Although I was able to validate their feelings, assure them that the abuse was unacceptable and offer telephone numbers for resource centres, I reflected on the issue of my duty of care when leaving women at risk following the interviews.

Maintaining privacy and confidentiality within a small town was a major concern for most participants. For example, after leaving one interview where a mother disclosed her feelings of inadequacy and discussed how she travelled to another town for private treatment of her depression, I went to another home where the same woman was being discussed by a local counsellor and well-meaning friend who tried to include me in the conversation! Consequently, trust emerged as a significant issue which is addressed in detail later.

6.4 Methodological design issues and limitations of this study

There are methodological issues and limitations in all research including naturalistic inquiry, most of which involve research design issues such as sample

[92] Culturally appropriate protocols included inviting key Aboriginal women to act as advisors and agreeing not to pry into traditional birthing practices. Support and approval to involve Indigenous women was received from the Centre for Aboriginal and Torres Strait Islander Participation and Development at James Cook University and the prospective communities.

selection, generalisability, rigour and 'trustworthiness' (Guba & Lincoln, 1989). In this section, the principal concerns about inductive research methods are discussed with relation to this project.

6.4.1 Sample selection

In purposefully recruiting participants for this study, the primary aim was to choose a sample that allowed exploration of rural/remote birth experiences, which I wished to examine. The participants did not constitute a random sample of birthing women and health providers in rural and remote areas of Queensland. As a qualitative study, randomisation and representativeness were not an issue; by contrast, the intent was to highlight differences not similarities (Saltman & O'Dea, 2001; Ritchie, 2001). As non-probability techniques were employed, the selection of participants utilised a combination of sampling techniques "to achieve the most desirable sample for the research question" (Minichiello, Madison et al., 1999, p. 188; Ravindran, 1992).

Participation in the study was voluntary so birthing women who became involved were those willing to identify themselves and divulge their experiences to me as researcher. More women volunteered than were accepted as many did not meet the inclusion criteria (outlined in 6.5: Data sources). From these, I attempted to recruit a heterogenous sample that showed variations in demographics, obstetric histories, social experiences and perspectives. However, it was difficult to find participants from minority groups as they generally preferred to remain inconspicuous in the mainstream community. Amongst the birthing women, the voices of articulate, mature, well-educated women predominate. However, the data collection also included discrepant cases. As Ritchie comments, an important aspect when sampling is:

> seeking to find and analyse diverse and opposing perceptions or experiences …, especially if it is expected that these perceptions may go against mainstream findings. Choosing negative or discrepant cases as part of our sample allows the potential for richer data through the need to explore contradictions (2001, p. 154).

Amongst the small workforce of health providers, randomisation was neither possible nor desirable. Instead, critical case sampling (Patton, 1990, p. 182) involved active, purposeful recruitment of all key personnel so as to thoroughly investigate their perspectives. Snowball sampling (Minichiello, Sullivan et al., 1999) amongst networks was found to be an effective strategy for recruiting both health providers and birthing women. Opportunistic sampling (Patton, 1990, p. 182) was also used on two occasions to recruit birthing women who met the inclusion criteria.

The relatively small sample (48 participants) and the particular social setting in which the interviews occurred were site-specific. Consequently, the findings are unique and "bounded" (Adelman, Jenkins & Kemmis, 1983, p. 3) and cannot be universalised. However, limited generalisations can be made about the cases presented and inferences can be drawn that may be useful for explaining phenomena in other similar contexts.

6.4.2 Transferability

Transferability refers to the possibility that what was found in one context by a piece of qualitative research can be applied elsewhere to another context (Lincoln & Guba, 1985). Ethnography facilitates the process by providing sufficiently "thick descriptions" for the "applier" to perceive the resonance between the findings and other settings (Geertz, 1973). The important issue, according to Schofield (1990) is the potential for qualitative research to shed light on issues generally, not just as they are experienced at particular sites.

This research was undertaken within a specific time period of births occurring during one calendar year within four locations. As such, the findings portray the two rural and two remote towns within a historically unique time frame. Even during fieldwork, the social structure of the four towns was fluctuating.

In-depth, guided interviews produced data from individuals' perceptions of experiences. Many variables affected how and why the participants offered particular responses. For example, they came from differing cultural backgrounds, and had had diverse life experiences. Day to day experiences prior to the interview also shaped what was said. Therefore selected birthing women's stories are presented as case studies. Consequently, as these cases are representative of a specific subject and circumstance they cannot be reproduced or generalised. However, they can be projected to similar situations (Maxwell, 1992; Schofield, 1990). Lincoln and Guba (1985) contest the legitimacy of the rationalistic, scientific definition of generalisation, adding that case studies make a valid contribution to knowledge. They suggest that "samples need not be representative in the usual sense to render generalisations warrantable" (Lincoln & Guba, 1985, p. 128). Rather, understanding is effectively gained from information through which the audience can draw naturalistic generalisations. For example, when disseminating the preliminary findings of this research, many women and health providers in other rural and remote contexts affirmed the emerging themes. These findings can therefore be applied to similar experiences and contexts. As such, they provide a 'naturalistic generalisation' that extends understanding (Lincoln & Guba, 1985) which is useful for policy development.

6.4.3 Striving for rigour – validity and trustworthiness

Rigour, according to Grbich (2001, p. 61) is the "researcher's attempt to use as tight a research design as possible". Extensive debates surround ways to ensure that qualitative research is sufficiently rigorous and between those who consider rigour inappropriate. I triangulated methods and data by applying several techniques to study the phenomenon of rural birthing to achieve rigour and trustworthy findings. These included collecting data in four settings from a variety of sources including birthing women, midwives, doctors, health workers and medical records[93] through the techniques of participant observation, interviews and reflective field notes (Chenail & Maione, 1997; Denzin & Lincoln, 1994; Berglund, 2001).

To improve rigour and establish the 'trustworthiness' of the data (Guba & Lincoln, 1989) the following processes were also followed. An audit trail enabled me to trace the development of the project from raw data through reduction, analysis and reconstruction (Grbich, 2001; Lincoln & Guba, 1985). Face validity was achieved by member checking as interview transcripts were returned to participants for comment and, through follow-up interviews, verification that what they said had been interpreted with the meaning they ascribed (Ritchie, 2001; Berglund, 2001). This sometimes resulted in contrary, disconfirming interpretations or variant descriptions which I have incorporated into the findings. Preliminary findings were also presented to rural health providers at conferences with the ensuing discussion confirming and occasionally adding further perspectives to the emerging themes. Self-reflexivity was integral to the 'sense-making' process (Chenail & Maione, 1997). These combined techniques contributed to rigour and enabled the research process to appear logical, sequential, predictable and credible despite contingencies that occurred while gathering data.

Because of the differences between initial and follow-up interviews conducted in this study, I suggest that there is no single 'true' account since relating personal experiences is dependent upon recollections of events, the relationship with the interviewer and the interview environment. The subjective nature of these accounts does not render them less believable or valuable. In particular, as a number of respondents were discussing the same setting from consumer or professional perspectives, the diversity of views and variations in narratives are acknowledged as contributing the richness of the data.

Feminist researchers present a genre in which undoctored versions of their research experience belie conventional, sanitised, research reports. Being open and

honest about the process, they reflect upon the unpredictable and untoward events that are inevitable and so expect diverse experiences. This approach deviates from the pre-reflective application of a formulated method. Most of all, there is a strong underpinning philosophy that, through shared reflection and open discussion, it is possible to learn from one another and create new ways of understanding (Maynard & Purvis, 1994; Stanley, 1990; Wolf, 1996). Morse comments that research projects should be open to "exploring serendipitous findings", "pursuing intriguing data" and answering "questions that arise during the collection and analysis of data" (1997, p. 18). Kelly, Burton and Regan also reflect on the feminist research process. They comment:

> Feminists have been stern critics of 'hygienic research'; the censoring out of the mess, confusion and complexity of doing research, so that accounts bear little or no relation to the real events. But many of our accounts are full of silences too (1994, p. 46).

This chapter contributes to knowledge about such silences. Like most projects, this research study began with a neat, tidy proposal; however, I encountered unforseen dilemmas as this dynamic project 'took on a life of its own'. As Dawn Francis (pers. comm. 1/10/03) points out, researchers are also a form of "research instrument" in that their "relationships and questions determine the data" they can collect and this in turn influences subsequent interpretations. This led me to rewrite the methodology and review the methods employed. By adopting flexible approaches which valued the individuality of participants who did not fit into neatly ascribed compartments or respond predictably, enabled me to create the friendly, productive and reciprocal relations feminists advocate (Fonow & Cook, 1991; Maynard & Purvis, 1994; Oakley, 1984).

Flexibility was required when several maternity care providers moved outside their professional domain by choosing to be interviewed in their home environment rather than in the workplace. There they discussed their personal lives and relationships, thus becoming individuals facing problems with gender, families and with each other. I had originally intended to consult maternity care providers just for information from their area of professional expertise within the health care system. However, the extensive, unsolicited personal information disclosed provided valuable insights into professional boundary maintenance, workplace relationships and other

[93] To ensure confidentiality for participating birthing women in the smallest towns, it was not ethically appropriate to view medical records at those sites.

factors affecting maternity care provision, such as workplace violence. Consequently, the interview data extended beyond their professional, public sphere to also become interview case studies. Therefore, the transcripts reflect the rich complexity of people's lives rather than discrete categories of information based on roles.

Although feminist research is founded on the women's movement and consciousness-raising, that was not part of my research agenda. However, the interviews provided a forum for women to speak out about their experiences. For some women, this narration promoted self-reflection, self-realisation and a desire for emancipatory action that would improve their lives. I felt it was important to facilitate this where possible. These women wanted to have some ownership of the process and saw constructive roles for themselves in the preliminary analysis and as supporters of other women in a similar situation. However, unlike participant action research, this project was not designed, 'owned' or controlled by a community (Street, 2003; Women's Research Centre, n.d.).

In stark contrast to the participants just described, others chose not to have a follow-up interview or ongoing contact. Several of these were health professionals, but some were childbearing women. Initially, I reflected upon my interviewing technique and wondered if perhaps this was the cause. However, Hayward Brown's (1997) work provided insights into this puzzle as she encountered a similar situation.

Like Hayward-Brown's (1997) research experience with parents of chronically ill children, interviews in this study were often emotionally charged occasions in which I listened to extended narratives rather than conducted an interview. As suggested by Hayward-Brown (1997), Mishler (1986) and Riessman (1993), after collecting background information and initiating the interview, I often allowed participants to set the agenda and focus on what was significant to them, only guiding the interview where appropriate. They took advantage of the opportunity to share their stories in a non-judgmental environment. The transcripts do not reflect the non-verbals and emotion generated within the interview frame. Often this appeared to be a cathartic experience with the interview becoming a time for disclosure and strong expression of positive and negative emotions about partners, family members, friends and maternity care providers. Hayward-Brown (1997) found that parents having narrated their experiences and expressed strong feelings did not wish to revisit the interview content; she suggests that it was uncomfortable, embarrassing or even painful to do so. Similarly, it is possible that, having shared intense emotions and deeply personal information, that some participants in this study did not wish to revisit the experience. However, I was unable to explore this possible explanation. Thus, inconsistency in the collection of follow-up interview data exists.

In accordance with Guba and Lincoln who equate rigour with 'trustworthiness', it has been established that in this study the reader is able to audit the events, influences and actions of the researcher (1985, 1989). Auditing is facilitated through being open and honest about the methods used and processes followed. Other elements inherent in trustworthiness are being able to establish dependability and transferability (Lincoln & Guba, 1985), which have been discussed earlier.

Potential bias

As a feminist researcher, mother and midwife undertaking interpretive research, I have located myself within the research. Consequently, I am aware of biases I bring to the research and am conscious of the way these may shape the analysis and outcomes. Qualitative analysis requires working with masses of rich, raw data in order to identify patterns, create explanations and develop theories (Glesne & Peshkin, 1992). The aim of turning participants' voices into text is based on the assumption that these words will enable the reader to get closer to their experiences. Ian Hodder draws on the work of Derrida when commenting that:

> …meaning does not reside in a text but in the writing and reading of it. As the text is reread in different contexts it is given new meanings, often contradictory and always socially embedded. Thus there is no 'original' or 'true' meaning outside specific contexts (1998, p. 111).

Accordingly, researchers need to be sensitive to their biases when selecting quotations from thousands of pages of transcripts (Gair, 1996). In this thesis, exemplary examples from the range of birthing women's experiences are presented to the reader. However, I acknowledge that even the selection of these exemplars may reflect my biased interpretation. So, participants' voices are integrated as direct quotations enabling the reader to engage with the transcribed text. This is also consistent with the feminist research principle of allowing women's voices to be heard (Reinharz, 1992; Brown et al, 1994; Gair, 1996; Ramazanoğlu, 2002).

Contemporaneous limitations

An extensive interdisciplinary review of pertinent, available literature was ongoing throughout this study. However, not only is knowledge rapidly expanding but there are also continuous changes in political priorities and health policies in Queensland. Therefore, the discussion in this thesis relates to the situation in the health settings at the time of data collection. Thus the policies and practices are located within a particular historical point in time. Although the impending indemnity

crisis is foreshadowed in some sources, the data collection pre-dates its impact on services and is not a focus of this study. However, as my workplace and professional college contributed to some reviews and helped shape certain recommendations, these are included.

6.5 Data sources

Participants in this study included 27 birthing women and 21 health providers who were situated within designated rural and remote locations during a set timeframe, thus enabling a snapshot of their lives and circumstances to be created. Therefore, to be included, participants were required to have either birthed or to be living and working within a 12 month period in one the four centres described in the previous section. The 48 participants from varying demographic backgrounds and life experiences voluntarily took part in the research and 74 interviews were conducted.

6.5.1 Childbearing women

Twenty-seven birthing women with a range of social characteristics and obstetric outcomes were selected from those who volunteered to take part in the study. Although many women from rural and remote areas in Western and Coastal Queensland responded to the invitation to take part in this study, some were excluded as participants either because they were not a resident within the four selected townships (and surrounding shire) or because their birth experiences fell outside of the required time frame. However, the stories they contributed provide a rich background to this study. As this study examined women's experiences with current health services, the women needed to be childbearing within a prescribed 12 month period. Three women were first interviewed in the last month of their pregnancy while the other 24 were interviewed in the year following their most recent birth. This set time frame also allowed for a comparison between the consumer group and the perinatal data for that year.

In order to encompass the diversity of birthing experiences within a social context, a variety of avenues was used to recruit birthing women. These included: advertisements and news releases in local newspapers; an interview on a regional Australian Broadcasting Commission (ABC) program; participation in community events to gain acceptance; networking with former colleagues and key figures in the community; developing a snow ball effect amongst participants and recruitment information distributed by Maternal and Child Health nurses.

Opportunistic and critical case sampling strategies were also used. For

example, while interviewing health providers in the Mining Town hospital, I met a young, single mother who was part of the clerical staff. She met the inclusion criteria and wished to tell the story of her recent birth and so I took the opportunity to interview her during her lunch break that same day. Similarly, because of the small number of births and the transience of the population in the remote towns, I also opportunistically interviewed a suitable young mother while she was visiting one of the other participants.

By contrast, I purposefully attempted to recruit women with diverse experiences and backgrounds in Sugar Town. I was concerned that the snowball effect had led to homogeneity in the volunteers. They were all part of the Italian community, of similar age, married, middle income, and private patients. So I actively sought participants from other ethnic groups, young single women and those who had utilised public maternity services at the local hospital. Similarly, in Western Queensland, I keenly sought to recruit participants from both pastoral districts and the townships.

A profile of the women who were included is shown in Tables 6.0 and 6.1. The second column shows that, although the majority of birthing women interviewed were in the 25-29 age group, they had birthed their first child(ren) when younger. While it is not evident in this table, more remote area participants first became pregnant after age twenty-five, which is in accordance with national trends, while rural women were more likely to have their first babies in their early twenties. Although I would have liked to interview more women from culturally and linguistically diverse backgrounds, the predominantly Anglo-Celtic and Italian descent shown in column three is reflective of the demographic profile of these districts. The fourth column shows 'parity'. Parity (P) indicates the number of viable births, while gravida (G) denotes the number of pregnancies. Miscarriages (misc) are also noted. A range of obstetric outcomes is reflected here as participants included nulliparae, women who had had a pregnancy but no viable baby; primiparous women who had one live birth; multipara who had more than one and less than five live births, and a grand multipara[94] who had birthed more than four live infants. As shown, it is possible to have had a number of pregnancies (multigravida) without having birthed several children (multiparity).

Educational level is indicated in the fifth column as this has been shown to influence the age of onset of childbearing as well as a woman's expectations and perceptions of mothering. It is notable that more women with post-school qualifications were recruited in the remote areas and well-educated women were more likely to have

[94] Definitions of grand multiparity vary across time and countries, with one older source stating more than eight births as the criteria.

delayed childbearing. Four of the remote women were in paid employment. While fewer women in the rural areas had gained post-school qualifications, five of these women also worked on a part-time basis. However, in both the rural and remote towns, it was unusual for women with young children to be in paid employment.

In the last column, nuptiality is shown. Perinatal statistics indicate that nuptiality influences maternal and infant outcomes (NHMRC, 1993; Queensland Health, 1995; 1999; NPSU, 2001; Laws & Sullivan, 2004). The social support aspect is of most interest here. Within the small sample in this study, only two of the birthing women were single parents, one in each rural town, while two other women lived in de facto relationships.

The aim of the interviews was to ascertain women's perceptions of the health delivery they received before, during and after the birth of their children. Guided interviews focused on birthing women's perceptions of the available options, their role in making decisions about the care they received, how these choices affected them and their families, their relationship with the care providers and overall satisfaction with the health services provided to them.

BIRTHING WOMEN: RURAL PARTICIPANTS (N=14)

Pseudonym	Age				Origin /Ethnic Descent	Parity	Post School Qualifications	Nuptiality
	<20	20-24	25-29	30-35				
Evangeline		X			Filipino	G1 P1	No	Married
Rose			X		Aboriginal	G?[95] P3, pregnant	No	De facto
Joy			X		Anglo-Celtic	G2 P2	Yes	Married
Kay		X			Anglo-Celtic	G1 P1	No	Single
Pam		X			Anglo-Celtic	G2 P2	No	Married
Tania		X			Anglo-Celtic	G2 P2	No	Married
Lois				X	Anglo-Celtic	G1 P1	No	Married
Maria	X				Italian	G2 P2	No	Single
Bella				X	Italian	G4 P4	No	Married
Julie			X		Italian / Anglo	G2 P2	No	Married
Donna		X			Italian	G2 P2	No	Married
Nikki			X		Italian / Danish	G2 P2	No	Married
Pia				X	Italian	G3 P3	No	Married
Madison				X	United States	G2 P1, pregnant	Yes	Married

Table 6.0: Matrix profiling participating birthing women from rural areas[96]

[95] Medical records were not accessible to confirm the number of previous pregnancies in another district.

BIRTHING WOMEN: REMOTE PARTICIPANTS (N=13)

Pseudonym	Age				Origin/ Ethnic Descent	Parity	Post School Qualifications	Nuptiality
	<20	20-24	25-29	30-35				
Olive			X		Aboriginal	G9 P5 Misc4	No	De facto
Jess			X		Anglo-Celtic	G1 P1	Yes	Married
Megan				X	Anglo-Celtic	G2, P1, pregnant	Yes	Married
Emma				X	Anglo-Celtic	G2 Misc1, pregnant	Yes	Married
Joanna			X		Anglo-Celtic	IVF/GIFT, P1 Misc1	Yes	Married
Paula			X		Anglo-Celtic	G1 P1	No	Married
Sally		X			Anglo-Celtic	G2 P2	No	Married
Linda			X		Anglo-Celtic	G3 P3	Yes	Married
Lyn			X		Anglo-Celtic	G1 P1	Yes	Married
Laura			X		Anglo-Celtic	G2 P2	No	Married
Claire				X	Anglo-Celtic	G2 P1 Misc1	Yes	Married
Dani			X		Anglo-Celtic	G3 P2 Misc1	No	Married
Lee			X		Anglo-Celtic	G3 P3	Yes	Married

Table 6.1: Matrix profiling participating birthing women from remote areas

6.5.2 Health providers

Twenty-one health providers participated in the study. This group included hospital-based midwives and medical practitioners, the local Child Health nurses, and Aboriginal health workers who were involved with maternity services. With the shortage of midwives, two nurses, one registered (RN) and the other enrolled (EN), who were involved in the care of remote area birthing women were also included. They participated in the study as both health providers and young mothers.

Table 6.2 combines the health providers from the rural and remote settings to provide a profile of their relevant characteristics, roles and whether they were married and parents.

Because of the small number of health professionals in small centres, concealing their

workplace on this matrix assists in concealing their identity, thus maintaining confidentiality. As marital and parenting status were recurrent themes in the interviews, they have also been included here. Both health providers with families and birthing women considered parenthood significant to the ability to understand and empathise with birthing women and mothers. Eight of the health providers invited me home to meet their partners and children. Three of those who did not have children made unsolicited comments about how they considered being a parent irrelevant to their professional practice.

Follow-up interviews were conducted with 26 of the 48 participants. Of the remaining 22, two had died, most were itinerant and had not left a forwarding address, and several others did not respond to the request for a follow-up interview.

Although only a relatively small number of people were involved in this study, the data collected during the 74 interviews was deep and rich with a large volume of qualitative data being generated. The sample also represented a significant proportion of the birthing women and health providers in the small towns.

6.5.3 The medical records

The final data sources consulted were medical records containing perinatal data, diagnostic reports and patient progress notes. Inspired by Brown et al. (1994) who valued women's voices over the official, institutional viewpoint, I compared and contrasted the 'gold standard' of medical documentation with participating women's accounts of the health care they received during their birthing experience. However, as outlined in 6.2.4, to maintain confidentiality this became a selective process resulting in the retrieval of only 12 records. Consequently, the information from these medical records is incorporated into the women's stories, not presented as a separate analysis.

HEALTH PROVIDERS: COMBINED RURAL AND REMOTE PARTICIPANTS (N=21)

Pseudonym	Characteristics	Position[97]	Married	Parent
Anna	ATSI Health Worker; Aboriginal	Aboriginal Health worker	X	X
Brenda	ATSI Health Worker; South Sea Islander	Aboriginal Health worker	X	X
Diana	Doctor: Ob & Gyn qualifications; Remote indigenous experience; Overseas recruit	GP/MSPP	X	X
Andrew	Doctor; No prior rural/remote experience; Overseas recruit	GP/MSPP	X	X
Susan	Doctor: Rural experience	GP	X	
Brian	Doctor: Extensive rural & remote experience	GP/MSPP	X	X
Charles	Doctor: Ob & Gyn & anaesthetic qualifications; Extensive rural & remote experience	Public GP, no private practice	X	X
George	Doctor: Ob & Gyn & anaesthetic qualifications; Extensive rural experience	Medical superintendent, no private practice	X	X
Emma	Midwife, Maternal & Child Health nurse Extensive rural & remote experience	Acting DoN; Midwife; Relief MCH	X	
Gloria	Midwife, psychiatric nurse Remote Indigenous experience	DoN		
Kim	Midwife; Rural & remote experience	DoN; Midwife	X	X
Beth	Midwife; Italian speaking; Rural experience	Midwife, CNC Maternity	X	X
Amy	Midwife; Emergency nurse	Midwife, CN Maternity		
Denise	Midwife; Maternal & Child Health nurse	DoN; Relieving MCH	X	X
Cathy	Midwife; Maternal & Child Health nurse; Rural experience	Acting DoN; Midwife; Relieving MCH	X	X
Hazel	Midwife; Rural experience	Midwife, RN	X	X
Ruth	RN, Maternal & Child Health nurse	MCH	X	
Iris	RN, Maternal & Child health nurse	MCH	X	X
Faye	Midwife, Maternal & Child Health nurse	MCH; Community nurse	X	X
Claire	RN, Operating Theatre nurse	RN	X	X
Lyn	Enrolled nurse	EN	X	X

Table 6.2 Profile of participating health providers from rural and remote health settings

[97] Abbreviations used: MSIPP – Medical Superintendent in Private Practice; DoN – Director of Nursing; RN – Registered Nurse; MCH – Maternal and Child Health qualifications; CNC – Clinical Nurse Consultant ('Charge Nurse'); CN – Clinical Nurse; EN – Enrolled Nurse.

6.6 Data analysis

Following transcription of the audiotaped interviews, data were analysed for emerging themes. According to Glesne and Peshkin, data analysis:

> involves organising what you have seen, heard, and read so that you can make sense of what you have learned. Working with data you create explanations, pose hypotheses, develop theories, and link your story to other stories. To do so you must categorize, synthesis, search for patterns, and interpret the data you have collected (1992, p. 127).

Thematic analysis is a well-established method for identifying within participants' stories the threads and "patterns of living and/or behaviour" which, when pieced together, form "a comprehensive picture of their collective experience" (Aronsen, 1994, p. 1; Leninger, 1985; Cooper, Bond & Irving, 2004). Leninger adds that themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (1985, p. 60).

According to Patton, this inductive process enables the findings to "emerge out of the data, through the analyst's interactions with the data" (2002, p. 453). Coding of the transcripts was undertaken manually and was an iterative process that occurred throughout the period of data collection.

As described in 6.2.3, the guided in-depth interviews resulted in 74 transcripts along with accompanying field notes. This vast amount of text constituted rich semi-structured raw data which required systematic coding in categories so as to reveal the concepts.

Initially, I had considered using NUD*IST as a tool to facilitate systematic coding and retrieval; however it soon became apparent that my exploratory, inductive approach allowed participants to respond in such diverse ways that finding key words or phrases was ineffective for eliciting the thick, contextualised descriptions of their experiences that I sought. I preferred to actively engage with the text while asking myself the question often posed by qualitative researchers "What is this thing I have /see before me?" (Minichiello et al., 1992; Lofland & Lofland, 1984).

The process I employed involved, firstly, repeatedly listening to the audiotapes and visiting the text (transcriptions and field notes) multiple times. As Miles and Huberman point out, preliminary analysis is part of an iterative process. At each "passing", new perspectives became evident which in turn "drove" the ongoing data collection (1984, p. 63). Second, as shown in the preceding tables, the guide questions posed at each interview provided some categories which could be compared across participants. These included demographics such as age, educational level,

employment, marital status and ethnicity, along with a birth history from the childbearing women who participated. Third, entering the text seeking sub-themes, I decided to code as follows:

1. General information about the context as it related to women's daily lives, their birthing experiences and health service delivery;
2. Patterns of experiences within each setting and noted similarities or differences across the four settings;
3. Participant's views on their specific, individual situation, in particular their attitudes;
4. Relationships, between childbearing women and health providers; and the interrelationships between health professionals.
5. Social structures, with dynamics such as class, the town/country divide, gender politics.
6. Specific activities and events which participants thought were significant.

These were loosely based on Bogdan and Biklen's codes (as cited in Minichiello et al., 1992, p. 296).

Initially, I listened to the audiotape recording of the interview while closely reading the transcript and making further notes as points of interest emerged. I noted patterns of experiences as participants described their lives by marking words, phrases and themes using colour-coded highlighting along with recording themal notes in the margins. While the six major codes enabled key features to be identified and patterns to emerge, finer units of analysis were also highlighted with thematic notations added to the margins. Summaries of perceived themes were attached to indexes on the front of each transcript and to field notes for ease of locating data when comparing and contrasting the content. My ideas, interpretations, relationships between themes and links to the literature were journalled.

This process involved identifying recurring themes in the text. These were then further catalogued as sub-themes. As units of analysis, the themes and sub-themes included words, particular vocabulary, phrases, topics raised, recurring activities or situations, meanings, experiences, feelings and even a whole interview.

The full text of transcripts and fieldnotes needed to be re-visited when new themes and sub-themes became apparent and similarities and/or difference across interviewees and settings needed further exploration. Electronic word and phrase searches were helpful; however, participants expressed ideas in many and varied ways which could not always be located this way or which did not make sense when decontextualised. As Aronsen (1994) points out, patterns of ideas can come from direct quotations or paraphrasing common ideas. Shank adds that this chunking and

coding is the essence of thematic analysis which is “first and foremost about searching for patterns in data” and involves the inductive approach, feedback and comparison, and saturation (2002, p. 129).

Finally, in addition to my interpretations, member checking was included in the process. Copies of transcripts were sent to participants prior to the second interview to enable modifications and feedback which were then incorporated into the analysis.

Minichiello et al. suggest that identified themes be organised into “participant concepts and theoretical concepts” (1992, p. 291). In this thesis for example, the following chapter, *A good birth,* is derived from participants’ concepts and is reflective of experiences shared in their everyday language. Theoretical concepts are explored in the later section on ‘Trust’ (Chapter 8), which includes concepts created by the researcher that may not necessarily be “immediately recognised by the informants as part of their terminology” (Minichiello et al., 1992, p. 291). Similarly, the use of relational genograms as outlined in the following section assists in visualising patterns that emerged from the coding categories listed above.

Through the rigorous, systematic processes described in this section, the selected findings presented in the subsequent chapters can be traced through the coded index categories of themes and back to the original data.

6.7 Presenting relational genograms

While the place of birth is very important to birthing women, so too are the social support networks available to them in the transition to motherhood. As indicated in the sections on the settings and participants, transience and interpersonal relationships were significant. As a strategy to illustrate the relationships between women and health agencies, and between health providers, genograms have been used in the chapter *Labour Relations.* One set of four genograms shows the relationship between women and the health providers in each town. The eight genograms in the second set provide ‘snapshots’ of the health providers in each community at the beginning and end of the fieldwork.

Genograms provide ”a visual ‘gestalt’ of complex patterns” (McIlvain, Crabtree, Medder, Stange & Miller, 1998, p. 490). Miles and Huberman (1984, p. 21) and Hercus (1999, p. 90) advocate the use of visual data displays such as charts, matrices, networks and conceptual maps as an integral strategy for qualitative researchers. Similarly, I found that constructing relational genograms assisted me to present in a visual form the complex interactions evident from the findings.

Family genograms have been used by family physicians as an assessment tool

when identifying patterns of family interactions. Based on this, McIlvain et al. (1998) adapted the use of genograms to describe relationships in clinical practice settings. Practice genograms provided a dynamic, relational model that enabled relational strengths and weaknesses within a medical practice to be identified. In this thesis, the use of genograms is based on the work of McIlvain et al. but the technique is further adapted to portray succinctly the complex relationships between health providers and birthing women, and the relationships health providers have with each other. In this way the social organisation of the setting is presented as a living system. These genograms are intended to promote understanding of the dynamics of these relationships through a useful visual tool.

Constructing a genogram involves a three stage process. First, the social structure of the setting is mapped. Second, significant information such as demographics, critical events and issues are extracted from the empirical data collected. Finally, the model is constructed to show informal, emotional and relational patterns (McIlvain et al. 1998, p. 491). Thus, through the genogram, the strengths and problems in the health care settings become apparent.

Using similar symbols and terminology to those of McIlvain et al. (1998), Figure 6.0 shows the visual concepts used in constructing a genogram.

After a pen and pencil genogram was developed, a computerised version was constructed using the software program *Inspiration*, version 8.0 (Inspiration Software Inc. 2006). This software program is specifically designed for creating visual tools such as flowcharts, network diagrams and organisational charts.

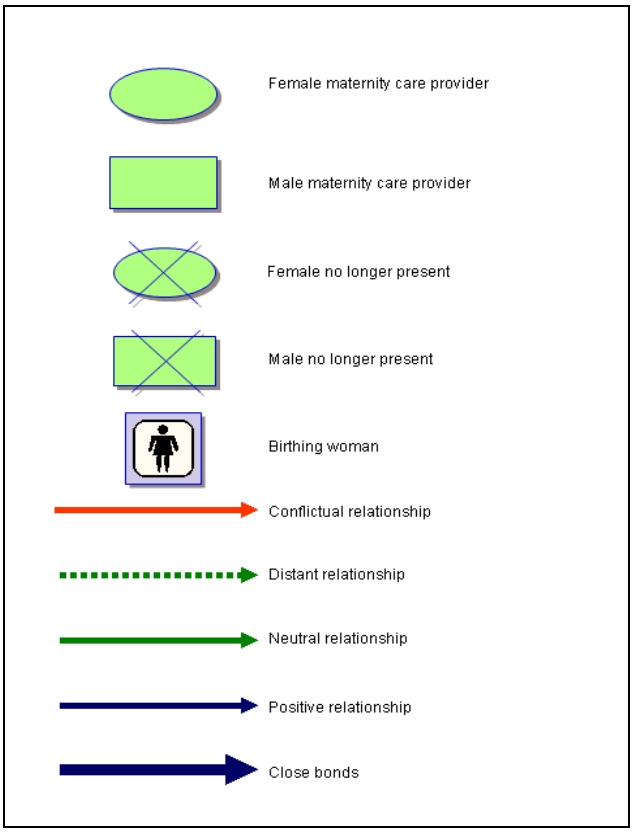

Figure 6.0 Symbols used in the relational genograms

6.8 Chapter summary

In this chapter, I have presented a retrospective, reflexive account of the feminist interpretive methods used to conduct this sensitive topic research. I have discussed how the techniques consistent with a contemporary feminist ethnographical approach were applied to exploring childbearing women and maternity care providers' perceptions of rural/remote birthing. Specific strategies, processes and data sources used when implementing the project are outlined along with critical reflections on research practices. The field settings and participants have been profiled. Issues that arose during the design, data production and thematic analysis have been discussed. Consequently, I have been able to distil participants' views to construct the principal findings presented in the following two chapters.

Chapter 7

A Good Birth for Rural Women

7.1 Introduction

Chapter 7 presents various perspectives on a 'good birth' for women and maternity care providers in rural and remote areas of North Queensland. Drawing on the large volume of rich empirical data, this chapter presents examples selected to reveal the multiplicity of views on what constitutes a positive childbirth[98] experience. Factors which birthing women and maternity health providers perceive as either facilitating or constraining a 'good birth' are described.

Part A is a synopsis of eight birth stories which exemplify women's diversity of perspectives. The stories move from a 'natural', non-interventionist birth, to women with complex considerations. Following the data presentation style of Lupton and Barclay (1997), Bourdieu and Accardo (1999), selected parts of participants' stories are displayed. My aim is not to explain in detail each woman's point of view separately, or to relativise them, but to simply juxtapose the stories in order to bring out the salient features (Bourdieu, 1999, p. 3). The data displayed in this chapter provides evidence to contest the claim of dominant discourse to represent unanimous views on birthing. These stories both humanise the birth experience and illustrate how the politics of birth are exercised through everyday social life. Themes highlighted within these stories are advanced in Chapters 8 and 9. Regretfully, the depth of detail found in Bourdieu and Accardo's (1999) case studies of social life is not possible within this thesis. Details of social contexts have been included only where a woman's social circumstances were exceptional or were relevant to the nature of her experience and the interview environment.

In Part B, rural and remote maternity health providers' perspectives on a good birth are condensed and contrasted. Drawing on two major themes in their interviews, this section principally focuses on how individual differences in background experiences and personal philosophies influenced maternity practices between and amongst the participating health providers.

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[98] As defined earlier, the term 'childbirth' is used to succinctly describe the childbearing cycle of pregnancy, birth, postnatal and early parenting (ACMI 1999).

Part A Birthing Women's Perceptions

Only the woman herself can judge the quality of her birthing experience

Although they are not explicitly referred to in this chapter, the stories of many birthing women contributed a rich, comparative background to those that follow. Most of the participants' stories described problematic experiences, raising a number of concerns about rural and remote birthing which support those outlined earlier in the literature review and well documented in reports such as Hirst's (2005). Recurring themes in the problematic childbirth stories were concerns about the lack of available choices, perceptions of the inherent risks, the experience of birthing in unfamiliar tertiary settings with strangers present; the effects of distance and isolation on diagnostic procedures; the need for continuity of care; the importance of social support during the transition to motherhood; the need to develop trusting relationships with health providers and the multiple ways in which institutional policies and practices prevent birthing women from achieving their desired event. By contrast, this section focuses on childbirth experiences that are considered by women to be positive overall. Although there were constraints and unsatisfactory aspects, it is evident that many of the issues identified by women as significant concerns have been addressed, thus resulting in a 'good' birth.

The following eight stories represent a variety of perspectives on what constitutes a good birth. Women's diverse backgrounds and life experiences affect their views of events. Factors such as parity,[99] level of education, ethnicity and personal relationships all influence expectations, attitudes and reflections on significant life events such as childbirth. These childbirth stories are presented within three clusters. The initial cluster contains three stories that describe 'natural', spontaneous childbirth in two remote and one rural hospital. One birth was unexpected in a first time mother (nulliparous)[100] and the latter two were planned for women having their second and third babies (multiparas). The next cluster contains three stories that describe interventionist births in both a remote public hospital and a private city hospital. Two of these were induced at the woman's request. One was a high risk, low

[99] Obstetric risk is attributed to parity. While gravida denotes the number of pregnancies, parity is the number of viable births. A primipara has one birth; a multipara has more than one and less than five. A grand multipara who has had more than four births enters a higher group for haemorrhage.

[100] The term nulliparous describes a woman who has not given birth, while primiparous describes a woman who has given birth to a viable infant. It is possible to have had a number of pregnancies (multigravida) without having birthed several children. A multiparous woman has had several births.

intervention birth in a remote hospital; the second was a low risk, high intervention birth. The third story describes a first-time mother who positioned herself as a passive patient and willingly complied with a highly interventionist birth resulting in a caesarean section. The final cluster includes two stories that challenge assumptions about what women from minority groups perceive as a good birth. First, a forceps delivery in a woman from a linguistic and ethnic minority background is related, followed by the planned 'good birth' of a multiparous Aboriginal woman whose views contrasted with the available literature on indigenous birthing. The diversity of experiences recounted in these selected stories demonstrates how only the woman herself can judge the quality of her birthing experience.

Cluster One: 'Natural' birth in rural and remote hospitals

A.1.1 Claire

From a lay perspective, this story is the most ideal in the study as it embodies a normal, uncomplicated pregnancy in an active 30 year-old woman who, without intervention, births a healthy son in remote Stockton hospital, her home town. As Claire was a first time mother (primigravida) who went into labour unexpectedly at 38 weeks gestation, she birthed locally, contravening hospital policy. Her positive experience was clouded by the sense of emergency and in obstetric terms was fraught with potential risks. Medically, a women's ability to birth normally without specialised obstetric assistance must be proven and the actual level of risk is judged retrospectively. A first birth[101] is considered potentially too obstetrically risky for a small hospital without operative facilities or experienced staff to manage emergencies, so the district health policy dictated that Claire should go to a major centre, preferably two weeks before her 'expected date of confinement'[102] and await birth. Instead, her unanticipated early labour enabled her to birth at her local country hospital, in a familiar environment amongst her support group, receiving continuity of care from the midwife she knew and trusted. The birth of Claire's baby energised the small community as many felt that this was 'their' child too.

Background

Claire was a well-travelled, registered nurse who had settled in Stockton six years

[101] Obstetrically, a woman over 28 years is considered 'elderly' for a first birth even though the age of primigravidas has risen in the last decade.

previously and felt she was "just about a local now". Her partner came from a large, extended Stockton family who for several generations had lived on surrounding properties and were very much part of the district's life and history.

As a nurse, Claire contributed to this study in two roles: first, as a birthing woman in a remote community; second as a registered nurse in Stockton. Throughout pregnancy and after the birth she continued to act as the theatre nurse for the Flying Surgeon and the Flying Obstetrician and Gynaecologist in both Stockton and Pastoral Town, assisting with elective surgical procedures like planned caesarean sections.

Social support

Claire's father lived in a coastal town about 11 hours away, her mother was dead and her sisters worked overseas. Consequently, her main social supports were her partner's family, along with local friends and colleagues. In line with health policy, Claire had chosen a large hospital for her birth, but in a coastal city where she had some friends. As both Claire and her partner were extensively involved in community life, she was warmly regarded by most townsfolk. During her labour, Stockton hospital staff and friends cared for her.

Antenatal preparation

Because she was a nurse, Claire found that her partner and the community incorrectly assumed that she would know "all about everything". The Stockton midwife allowed couples access to the hospital library for books and videos which Claire found very helpful. Although the midwife offered antenatal classes for couples, Claire's partner did not want to participate in these, so Claire enjoyed individualised sessions at mutually convenient times.

Claire's birth experience

This was a planned, longed for pregnancy. As she was almost 30, Claire was aware that her "biological clock was ticking" and was concerned about being "barren" before she became pregnant. She enjoyed an active, uncomplicated pregnancy.

Assuming that she still had two weeks of pregnancy remaining, and not wanting to be away from home longer than necessary, Claire had planned to travel alone to the coastal city

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[102] This quaint term describes a date that is calculated from the first day of a woman's last menstrual period. Ultrasound is routinely used to confirm or reassess the accuracy of this date.

during the following week to await the onset of labour. Her husband “was going to come down later“ and had been concerned that “he might not make it in time”. Yet he was horrified when she went into labour early. Claire expected a long first stage as is normal with a first birth and thought there was still plenty of time to drive to the city, eight hours distant.

At this time, Stockton only had one midwife. The doctor (MSIPP) was away so the young female locum with limited obstetric experience, who was covering his practice, had earlier told Claire to “get out of town”. Before leaving on the long journey by car, Claire went up to the hospital to check with the midwife. However, on examination, the midwife found that Claire had progressed too far for such a lengthy road trip. The hospital called the Royal Flying Doctor Service (RFDS) to transfer her to Mine City. Claire was to be reassessed before the RFDS was due to land to determine if evacuation was still feasible.[103] Meanwhile, the RFDS departure was delayed by a thunderstorm.

Several first time mothers in this study found that midwives disbelieved their personal understanding of the labour process. Claire, for example, recalled her labour rapidly progressing to second stage but the midwife was unconvinced. Her response was to “just look” at Claire and say “You've been reading too many books”.

Claire had been walking around for comfort as her contractions were increasing in intensity. This upright position also facilitated labour progress. Aware that the midwife and locum doctor were anxiously awaiting the delayed RFDS evacuation, Claire attempted to oblige them by slowing her labour, so cooperatively went to the birth suite to lie down. She comments that:

> I'm sort of trying to do the right thing by everybody. [But] By the time I'd got to the labour ward they examined me - I remember [midwife] looking at [doctor] and she said “Oh well mate, you’re going to have to do it here now”.

Claire sought support from her friend, another nurse, rather than her partner who was incapable of filling that role. She found herself trying to provide him with emotional support as he “looked very green”. Her friend was sensitive to the needs of both Claire and her partner. Claire describes her partner’s reluctance to participate and his attempt to leave, but recalls that the midwife said to him:

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[103] If a vaginal examination found that her cervix was 7cm dilated, she would not be evacuated. 10cm is full dilation and the beginning of second stage labour.

> "Get in here" and he came because he thought there was something wrong. And she said: "Cut the cord" and he said "Oh, I don't want to do that". I was on all fours sort of looking at the wall and I thought, "Why is [midwife] calling him back in?" This is the bit that he didn't want to see, all the gore.

Claire chose to give birth on 'all fours' — a new experience for this older midwife who was used to women birthing on their backs. Claire recalls:

> All through the antenatal [classes] she had said, "Whatever position you're comfortable in you do it". I pushed, and I was laying on my back and I thought, this doesn't feel right, so I just turned over. I just got on my hands and knees and I just pushed down that way. And that was the best way for me I found. So, I had one push on my back, turned over, one push. And she said, "The head is showing". One more and the head popped out. … So when I just turned over the poor old [midwife], I didn't realise, but when he came out, she said it was the first one that she had ever done that way. Because I didn't know, I was looking at the other end.

No interventions were required in labour. Suturing Claire's small internal tear was slow as the doctor was inexperienced. "She did a good job" according to Claire who experienced no pain or discomfort afterwards and astonished people by talking about her next birth.

Privacy during birthing was not an issue for Claire. Seven people come in to enjoy the unusual event. Apart from Claire's partner, all were women. Claire felt that this was just part of her community support. All felt the baby was 'theirs' too afterwards.

Postnatal period

As noted in the literature chapters, rural/remote women tend to stay in hospital beyond the required postnatal stay of 24 hours. Similarly, Claire enjoyed a five-day hospital stay, something that is not possible in a busy metropolitan maternity unit. Because she had thought there were still two weeks of pregnancy left to make arrangements for a new baby in the house, Claire was unprepared. Her partner was able to organise their home for the baby while she recuperated in hospital. Consequently, Claire was well rested, had time to bond with her newborn and experienced no problems establishing or maintaining breast feeding.

Comments on the health services

In the postnatal period, Claire supported visiting health services like Maternal and

Child Health and the Mobile Women's Health nurse, not necessarily for her own purposes but so that these services would be continued. She commented that the health staff had an ethos of showing support for all visiting services so as to "keep [them] going for people who do really need the service". It seems the services benefited more from her visits than she did from attending.

Important features of this story were the trust and confidence Claire had in the midwife and her own ability to birth. She was in a familiar, supportive, non-threatening environment and this is known to facilitate labour and lessen pain. Claire felt she had as much control and choice as she wanted over the number of people present, pain relief, position for birth and where she spent the postnatal period. However, even in this 'ideal' situation, Claire still felt concern for the needs of those around her, rather than being able to wholly focus on her own labour. Claire attempted "to do the right thing" when trying to delay her labour progress to please the doctor and midwife. She was also distracted by concern for her partner's distaste for participation in the birth. In this scenario, Claire's birthing was very much 'women's business' despite gruff attempts by the midwife to involve her partner.

Reflecting upon the experience, Claire believed that other women should be able to enjoy a local birth like hers but, lacking the obstetric experience and confidence, the GP disallowed this option. As a health professional as well as a client, Claire had been involved with other women giving birth, so was critically aware of the issues beyond her own inspirational experience. She observed:

> I'm glad I had [baby] here and I think for a lot of women it would be nice if they [could too], but working here I can understand both sides. If you've only got one midwife, there is a lot of pressure … it's not fair to have that pressure that if something did happen purely because someone has been stubborn saying, "I want to have the baby here and you should be able to do this". Therefore I can understand the doctor. … [He] is a very caring doctor and he would probably take it quite personally if something did happen. I don't think it's fair to put that upon anybody.

The solution, Claire considers, would be to fund doctor exchanges that enable obstetric training so as "to secure [him] that bit more confidence" to "allow" women to birth locally. However, Claire concurs with the GP that all first pregnancies and young teens should "have to go away".

The choice to birth in Stockton, Claire believes, is not possible for birthing women without the skilled support of the doctor and midwife along with RFDS back-up when

required. Her own positive experience of a non-interventionist birth as a first time mother did not alter her perception of the unpredictable and risky nature of the birthing process or the responsibility that local birthing places on the limited staff available. Operative obstetric procedures and those requiring an anaesthetic are not possible without the skilled backup from the RFDS. However, as shown in Claire's and two other participant's interviews, seasonal storms can make this service unreliable.

A.1.2 Linda

The following birth also took place in a remote hospital but by contrast with the unexpected events of Claire's birth, it was a planned birth of a third child in Pastoral Town. Continuity of care, convenience and not being separated from her family made this a positive experience for Linda.

Background

Linda was in her late twenties with a background in veterinary nursing. She had not been in paid employment since becoming the wife[104] of a professional man working in primary industry.[105] Having frequently moved between many small rural towns, they fitted the epithet 'blow-ins'. As long as these towns had the "basics", Linda believed rural living was preferable for busy families as it was possible to "really touch base" without "getting caught up in a world of other things." In Pastoral Town she found more companionship from couples at her life stage than previously.

Social support

Having extended family support nearby was not a priority for Linda. Visiting family appeared to be a burden rather than a help. Linda saw her parents several times a year, depending upon their farming conditions. Although her parents were a two-day drive distant[106], they were "only a phone call away". Linda remarked "Here you know, there's just you. We don't have family here". Linda relied on her partner and a reciprocal relationship

[104] Like most participants, Linda did not work following marriage. Most prioritised the roles of wife and mother and were critical of women who chose paid work. There was no local veterinary clinic or child care even if she had wished to work.

[105] Her partner not only was away with his work quite often but also belonged to the army reserve. This extra time commitment bolstered their income but meant that she was alone more often.

[106] Distance measured as kilometres has little relevance in remote areas as the time taken to cover it depends on seasonal road conditions. It is more common and accurate to describe distance in terms of traversing time.

with trusted friends who understood her situation and could provide support when necessary. Reflecting on mothers' needs for social support, she said:

> There is an understanding here that you help each other out. Everyone is just a phone call away if you're having a bad time… I think it happens to every mum at some point along the line. I think for the mums that have got one child, they probably don't feel it sometimes as much as the pressure that you've got when you've got two, three or more. I think there's a big difference between having one and having three.

Unlike most other participants, Linda did not express concern about people within a small town gossiping about her ability as a mother to cope with three young children.

Linda had readily made friends within the community. She shared the ability, observed in a number of itinerant families, to rapidly integrate into existing social networks. Through links with other professionals in town and her involvement with community activities like the local playgroup, Country Women's Association (CWA), Arts Council and Craft Association, she had made many acquaintances which cut across the societal boundaries found in rural and remote towns.[107] Linda said she "just gradually moved out [of the professional group] to meeting more mums in town" and friendships developed from there. She relied on these friends for emotional support, babysitting and so forth. Linda had organised local care for the children when she went into labour.

Previous births

Both previous children had been born in hospitals in coastal towns. There Linda had no choice of doctor (she saw five men). Both births were induced without obstetric complications; her partner had attended. However, Linda had experienced anxiety and postnatal depression, particularly after the first birth. As a young, socially isolated mother, Linda had been unsure where to turn for advice or help.

Antenatal preparation

As this was Linda's third pregnancy and the previous two births had been obstetrically uneventful, Linda was 'allowed' to plan for a local birth under the care of the experienced female GP, Dr Diana[108]. Linda enjoyed an uncomplicated, planned pregnancy.

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[107] Social divisions include: town/country, railways/shire council/professional).
[108] As described in Chapter 6, she was one of the medical superintendents in private practice (MSIPP)

The routine ultrasound scan at eighteen weeks required a trip to a major centre approximately six[109] hours drive away. Linda saw this trip as a positive experience, not the ordeal described by most participants. With her earlier pregnancies, she had gone alone for the scans but this time it was different. Her partner took time off work and the whole family travelled to Townsville and stayed overnight.

> We went as a family together to [Women's Hospital] and the kids came in as well. So it was all excitement… It was beautiful experience really, all of us being together and getting to see the baby.

As it was her third birth, Linda did not feel she required further antenatal education in this pregnancy. She had checked to make sure that Dr Diana was not going to be away and knew the roster of the midwife of her choice (Nr Emma). She had visited this midwife to discuss her imminent birth and become familiarised with the hospital facilities.

Linda's birth experience

Birth took place in Pastoral Town as intended. Linda went into labour at 38 weeks. Unlike her two previous induced births, her membranes ruptured naturally and this unfamiliar experience alarmed her. Because the hospital was so close, Linda could return home after being examined by the doctor to make phone calls and organise child-minding. Her partner was able to leave work and join her at the hospital where labour progressed very rapidly[110] without any medical interventions. No pain relief was required nor sutures necessary afterwards. Linda describes how she felt confident that her children were well cared for and, comfortable with her environment and with her partner there to support her, she was able to "just lay down and rest".[111] Dr Diana, who cared for Linda throughout her pregnancy, attended the birth. Linda liked and trusted this woman. Although her chosen midwife was unavailable, Linda was very happy with the care she received from a familiar midwife on duty.

According to Linda, there was "quite a crowd" in the small room during birth. With so few planned births at the hospital, this was an event not to be missed by staff. Although

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[109] Perceptions of distance and remoteness vary. People in Western Queensland were found to have a great tolerance for long distance driving. The time taken depends upon the road conditions, driving speed and number of stops. It takes me 7 hours in favourable conditions but some Pastoral Town families cover the distance in only 5 hours. When sent to Townsville for diagnostic tests they made the return trip in a day!

[110] From 5 cm to full cervical dilatation and effacement in 15 mins

[111] A sense of security and the ability to relax strongly influences the release of oxytocins and endorphins, and inhibits catecholamines, which enhances progress in labour and reduces pain.

it was “a hectic Friday morning” at the hospital, two nurses (one male, one female) were present as well as her partner. The doctor and the midwife were also “in and out of the room”. While it is not unusual for a birth to be treated as a dramatic spectacle, verbal permission should be sought from the birthing woman. Linda did not recall if the observers requested permission and was unaware that she could refuse to have spectators. However, Linda did not comment on being uncomfortable about their presence.

Linda gave birth on her back, on the delivery bed. This position advantages the accoucheur and spectators but is not conducive to efficient labour and can create complications.[112] When asked about whether she had a preferred position for giving birth, and if this was met, Linda responded:

> I hadn't no. The other two were delivered in a labour ward and I hadn't been into kneeling or standing or anything. Mostly because when I arrived at the hospital I didn't have that much time to muck around with that anyway. It was all sort of just happening and that was that … no it didn't worry me.

A highlight of this birth was the time Linda and her partner had together with their new baby immediately after she was born. This, she reflected, was another aspect not experienced with the previous births, as it was common practice for newborn infants to be removed for weighing, measuring, even bathing, during the first hour. Linda recalled:

> They didn't fuss about all that early on which was *really* nice. They did with the others. They just wrapped her up and gave her to me. …Yes it was good she was with me and [partner].

Like Claire, Linda enjoyed an extended postnatal stay in the local hospital. In this time she rested, established breastfeeding, and bonded with her new daughter. This opportunity to recuperate and be cared for can be contrasted to multiparous women birthing in metropolitan hospitals whose stay after a normal birth is less than two days.

Overall, this birth was an affirming, fulfilling experience for Linda and a strong contrast to her previous induced births. Linda described feeling “proud” of herself and “elated” afterwards. These strong, positive emotions were notably different from her earlier experiences and contributed to her postnatal well-being.

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[112] A semi-recumbent position on an obstetric bed is well recognised by midwives as creating obstacles to effective, holistic birthing (Boenigk, 2006).

Postnatal period

Once home, the early postnatal period held a number of challenges to Linda's well-being. She experienced agonising pain from a dislocated coccyx and pinched sciatic nerve[113], exacerbated by her domestic duties. Linda's partner went away on a work-related course shortly after the birth and within a month of the birth her parents came to visit for Christmas. So in the early weeks postpartum, she was not only managing three demanding young children in a high-set house and attending to visitors but also felt "lonely" without her partner's support. When he returned home and "infected everyone" with a viral illness, she wished that he had stayed away until he was well, as Linda then had to cope with a neonate, the midsummer heat, visitors and a sick family. Despite all these stressful problems coming within the postnatal period, Linda reflects that she did not experience depression with her third child and attributes this to the calm, natural birth experience and initial postnatal rest in hospital.

Comments on the health services

Linda was a client well satisfied with the maternity care she received. Continuity of care from familiar carers was important to Linda. Unlike her experiences when previously birthing, she knew all the local health providers involved in her care and felt they competently met her needs during this pregnancy and birth. Linda commented:

> I think from my experiences … I've felt happy with the delivery and the attention I've received and being a small community and getting to know your doctor really well - having that continuity of care. Yes, yes. I was very happy and comfortable and relaxed. You know, you just knew you could really trust them and their capabilities and that sort of thing. So overall I've been happy with them.

Although she did not have her chosen midwife for the birth and was aware that the attending midwife was "not as up-to-date", Linda was none the less very satisfied with the personalised care in the small hospital. Most significant for Linda was the care from her female GP, the opportunity for early parental bonding with the baby, and being able to stay in hospital for as long as she wanted to rest and establish breast feeding.

When comparing this birth with her previous experiences, Linda recalled that, with her first pregnancy, she had seen three doctors and two with her second. She was

[113] Probably due to being positioned on her back during labour and birth

unfamiliar with the midwives who attended those births which, she felt, contributed to her dissatisfaction. In addition, during her previous postnatal periods she had been anxious, depressed and uncertain as to whom she could turn for advice and assistance.

The opportunity to receive continuity of care from one's preferred health providers in a remote town is, however, dependent upon timing. The single medical practitioner was sometimes away on study leave and was replaced by locums who were not only strangers but who might not have obstetric experience. The turnover of doctors was also a problem. At the time of the follow-up interview, Pastoral Town was in transition between the popular female doctor's leaving and the arrival of a new doctor from overseas. Meanwhile, a male locum was filling the position. As locums might be either male or female, this further limited the options for women like Linda.

The gender of the doctor mattered to Linda. She commented: "You always feel more at ease as a woman having a female doctor, particularly if it comes to personal issues and that sort of thing". As the newly recruited overseas doctor was male, Linda stated that she would prefer to wait for the Mobile Women's Health Nurse to visit from Mine City to have her wellness checks. However, given the infrequency of the nurse's visits, this would also depend on how she felt about the new (foreign) doctor.

In the postnatal period, Linda needed to drive almost 200km with her newborn and two older children to see an unregistered chiropractor in another town about the back pain she experienced. At that time of year, summer storms and extreme temperatures make such journeys an ordeal. However, apart from offering analgesia and rest, the limited, conventional therapies available locally were ineffective, so Linda felt that travelling to another town for treatment was her only option for long-lasting relief.

Linda also regularly attended Maternal and Child Health clinics. This is unusual for a woman following her third child as most mothers tend to use this health service only with their first baby. Her principal motivation was the opportunity to socialise with other mothers at the clinic. Linda said:

> Yes, we go for advice and also being a small town you will catch up with a lot of friends when you're there too. So it's sort of a social gathering too… you sort of chat.

In addition, Linda thought the Child Health nurse was "really good", believed the child health advice offered was useful, felt that she was given plenty of consultation time and liked being able to drop in to the clinic without an appointment.

When reflecting upon the health services, Linda believed they could be further

improved by viewing her holistically. She commented on how health histories and examinations had focused upon her and the baby's physical health rather than on her psychosocial and emotional well-being. These aspects were not explored or discussed at her health visits. Given that she had experienced depression, stress and anxiety after her previous two births, she felt that this was a significant oversight. Linda felt that health providers should care for the whole woman "not just the physical stuff".

In addition, to improve women's mental health, Linda felt that some form of occasional child care service would provide much needed respite to young mothers, especially those without local family support. Pastoral Town had no childcare centre and no kindergarten. The playgroup required mothers to participate and childminding by friends was reciprocal. With young children and a busy partner in paid employment, she longed for brief spells of time to herself.

> Although Linda experienced some postnatal challenges and raised issues related to the psychosocial health of mothers, she perceived her third birth as the positive experience she had desired. Having been able to find another mother to care for her two young children, she birthed in a place of her choice with her husband there to support her. Seamless care by a female GP was important to Linda. Unlike her previous birth events, no obstetric interventions were required and she felt elated, with a sense of achievement rather than dysphoria afterwards.

As Linda pointed out, the type of birth has a profound effect on how a woman feels about herself and her baby afterwards, but her story also makes it clear that birth is only a small part of the childbearing experience. Linda's story describes the wider picture of mothering in small communities and highlights the need to provide holistic care that extends into the postnatal period.

A.1.3 Joy

Like Linda, Joy is a reflexive consumer who actively sought a desirable birth experience. As noted by Zadoroznyj (1999; 2001), while class influences women's birthing choices, parity is more significant. With subsequent births, women like Linda and Joy actively seek to shape their desired experience.

Joy managed to achieve the 'good' birth she sought in the small rural hospital in Mining Town. Her story demonstrates how a well-educated, articulate woman achieved her goals despite hospital policy and the doctor's discouragement. While Joy does not describe

herself as an assertive person, she persisted in requesting a local birth until her needs were met. Throughout the interview, Joy conveyed her elation about achieving the birth she desired. Like Linda, the postnatal period was the most challenging time for Joy.

Background

As teachers in their late twenties, Joy and her partner had been working in the Solomon Islands before coming to work in the small mining community the previous year. Joy was early in her second pregnancy when they arrived and knowing the town had a hospital, expected to be able to birth locally.

Social support

The major reason for Joy's determination to birth locally was the availability of social support from family and friends. She states: "I've got the support here and that's really what it was. [Partner] couldn't have got all that time off work." If Joy had been sent to the city three hours distant to await birth, she would not have had anyone to care for her young son during her hospitalisation, nor did she know anybody she could turn to there. Whereas locally, she had a trusted neighbour to care for her son while her partner worked and her mother could come from Brisbane to stay.

Joy had some insights into what it would be like to be away in hospital, separated from her family. A few months earlier, her toddler had broken his leg and she was transported with him to a tertiary hospital where he was an inpatient for three weeks. Knowing nobody in that city, Joy found the experience was very isolating and "tough". She reflected: "Yes, I think it would have been very lonely and very depressing - I wouldn't have liked it". However, Joy recalled that she started to feel "a bit guilty" about wanting to have her baby in Mining Town for social reasons:

> I was weighing up all that I had been told about the things that could go wrong and whether I was doing the right thing by the baby. You know you start to feel selfish. Ok, like I want to have it here because my family and friends are here. You know my family [support] consisted of [partner] at that stage, that was it. You know, but it meant Mum could [come up from Brisbane and] she would have somewhere to stay.

Previous birth

Her first birth had been in a major Brisbane hospital with "a lot of help". Joy recalls that, "The first one was a bit horrific … I was stuck in bed and being monitored … I was just

so tired being in labour for a long time" before being augmented[114]. That made her labour "extremely painful" for which she required multiple forms of pain relief, culminating in an epidural. Joy remembered that "it was very, very long" and she accepted "anything that was going - I couldn't have got through without the drugs". So it was not a frivolous decision to decide to birth in a small hospital where the range of pain relieving options, anaesthesia (such as an epidural) and operative obstetrics were unavailable.

Joy's faith in her ability to birth naturally was sustained by a midwife who "was just so positive and really worked on me psychologically [telling me]. You can do it yourself, you can do it yourself Yes she was the one that really helped me…"

From an obstetric perspective, Joy would be seen as a woman whose long, difficult first labour would make her unsuitable for birth in a small rural hospital without the backup staff and facilities she might require.

Antenatal preparation

Pleased that there was a local hospital, Joy consulted the local male GP (MSIPP) and informed him that she wanted to birth locally. In response, she recalled he was opposed to the idea and presented a biased account of all the potential risks:

> … doctors are under an obligation to make you aware of the problems and that sort of thing. And [GP] certainly made me aware of all the problems and the things that could go wrong. Things like … if there was something wrong with the baby when it was born that they're not set up to deal with that [or] if something was wrong with the pregnancy … that I would have to travel in the ambulance for three hours or they would get the helicopter in. He made me very aware of all those things. And I started to worry that maybe I shouldn't be having it here. Maybe I'm not doing the right thing by the baby.

When asked if this information was presented in a balanced way, Joy responded while laughing: "No, no, no definitely not". Instead she felt that "scare tactics" were used to dissuade her; however, she remained assertive and persistent. Joy recalled:

> I really think [GP] probably was really hoping that I would go to [tertiary hospital]. And that's my perception of it … I would often come home from my regular appointments and say to [partner], "He doesn't want me to have it here, he wants me to go to [city]".

[114] Joy's membranes were then artificially ruptured and the regularity, strength and duration of contractions augmented with a Syntocinon (oxytocin) infusion.

> But I was really pleased that he [GP] didn't push that point. He didn't ever say directly "No, you can't have it here" … but I did keep on saying "No, I want it here; I would really like to be here".

Women in Mining Town normally went to one of the large coastal centres for birth. As the few births occurring annually[115] at the local hospital were usually 'walk-ins' or emergencies, outcomes varied. Given Joy's determination not to leave Mining Town, it would have been routine for her suitability to be risk-assessed by an obstetrician. When asked if she had been referred to an obstetrician, Joy replied:

> No, no. I'm really not worried about the speciality side sort of thing. I still go for the belief that birthing is pretty natural. A lot of people I know see it as being this high risk event. Well you certainly know the risks are there but most babies are born without any dramas.

Her belief in the normality of birth despite her negative first experience and the pessimistic portrayal presented by the GP was remarkable. Joy visited the hospital and familiarised herself with the facilities and midwives, finding that the "birthing room [was] really quite lovely" and "the midwives [were] very supportive".

It was necessary for Joy to travel to the city for routine ultrasonography as the scanning available in the district was of inferior quality. This involved her driving three hours each way accompanied only by her toddler. Unlike Linda, Joy commented:

> that's an awkward thing. Because it is a long way to travel especially when you have to drink all the water that you've had to drink[116]. You have to take [toddler] with you. You're just bursting by the time you get there (laughs). And then you've got to drive back again. It's a big trip.

Given her decision to have a low intervention 'natural' birth, Joy was asked how she had prepared herself antenatally. She responded:

> I had thought I was quite prepared with [first] birth. I thought I knew a lot of what was going on and I had read an awful lot but when it came to the crunch - you haven't taken it on board. It's that sort of thing that you can read until you're blue in

[115] 8-12 births a year. The previous year had included an unviable, preterm baby and an undiagnosed multiple pregnancy in an itinerant woman.

[116] Ultrasonography of the uterus in pregnancy requires a full bladder as this pushes the uterus out of the pelvic brim to where it can be easily visualised.

> the face but unless you experience it you really don't know what it is about. I hardly read at all this time. Yes I checked things up again - doing a lot more recalling [like] oh yes I remember last time - this is different to the first pregnancy.

I asked Joy how she had planned to manage the actual labour, especially as she would be reliant on comfort from non-pharmacological forms of pain relief. Joy responded that she would like to have attended an antenatal class that addressed this need:

> The new matron [a midwife] was going to get some courses together … And I thought I would have liked to have found out a bit more about how to relax and different ways. They were going to organise a course because there were a few ladies pregnant in town but it just never got off the ground…If I was in a major centre I definitely would of been along to some of those.

Despite there being six nurses with midwifery qualifications in Mining Town and enough pregnant women to justify organising antenatal education, none eventuated, so Joy had no additional preparatory information on strategies to assist her to cope with the pain.

Townsfolk expressed surprise when Joy told them she was going to have her baby at the local hospital. Most opted to go to the city for three main reasons: first, because they had private health insurance as mine employees and so were entitled to private maternity care; second, they were discouraged by the risks of local birthing; or third, because they wanted privacy and had concerns about confidentiality in the small town. Joy discussed these points. Private birthing was not an option for her; not only was it too expensive but also because it still involved travelling to the city and being away from home. Having been made aware of the possible physical risks, she had decided that these were outweighed by psychosocial and emotional benefits. Finally, she discussed the concerns about privacy and confidentiality.

From her observations, the nurses and midwives were highly ethical people, and unless someone was evacuated by helicopter, no one would know who was a hospital patient. Joy reflected that while she was in hospital, another woman was airlifted for removal of a retained placenta,[117] resulting in town gossip:

> So this whole fear about privacy wasn't an issue. Everyone knew she had gone away

[117] While this is a simple obstetric procedure, it does require doctors with qualifications in operative obstetrics and anaesthetics. Although the GP had been obstetrically qualified, lack of use had led to deskilling. Even if this had not been so, there was no second person available in Mining Town to administer an anaesthetic.

> because the helicopter went up. And when the helicopter comes into town everyone knows that something is happening. So word gets around that [woman] went away. But as far as being from the hospital [[the breach of confidentiality] didn't happen with the staff while I was there. They certainly didn't say anything.

As the midwives who attended her birth were parents at the school where she taught, Joy was asked if this made her apprehensive. Instead of creating concerns about embarrassment and privacy, she responded that knowing them was a positive experience:

> … this is where the [lack of] privacy would have really hurt. Like if they were vindictive or gossipy… But professionally they shouldn't be and I haven't heard anything back since. I think my labour in there was pretty normal. It hurt and I cried and carried on and that could be really embarrassing if they talked about what you were like in labour. But I didn't hear any of that. I think they were very professional. I wondered at times what it would have been like for them, you know delivering the [teacher] (laughs). It might have been really weird. But it actually was a really nice close bond. Like I see both of them around town now and it's something special. They delivered my baby.

Joy's birth experience

The onset of labour came at 2.00 am when Joy was term. Her mother had come to stay but her partner was away at an isolated school camp. Contacting her partner at night was difficult and involved police and a park ranger. Although Joy's partner risked speeding back to Mining Town there was no urgency, as contractions still had not commenced.

Like Linda, Joy was surprised and filled with anticipation when her membranes spontaneously ruptured as this had not this occurred with her first induced labour. However, contractions did not follow. Although contractions usually spontaneously begin, [118] the GP was apprehensive. By late morning, he was threatening to transfer her to the city for induction of labour.[119] Meanwhile, to avoid this, Joy was walking around anxiously hoping the gravity would initiate the onset of contractions. Joy recalled the support she

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[118] 90% of women whose membranes rupture at term begin spontaneous labour within 24 hours (Zamzami, 2006; Hannah, Hodnett, Willan et al., 2000)

[119] Pre-labour rupture of membranes at term occurs in 60% of women who usually begin labour spontaneously. Research shows that while the risk of infection increases with time, there is no urgency to induce labour as long as mother and foetus are monitored for signs of maternal infection and foetal distress (Hannah, Hodnett, Willan, Foster, Di Cecco & Helewa, 2000; Tan & Hannah, 2002; Zanzami, 2006). While most obstetricians fear adverse outcomes and tend to induce (Zanzami, 2006), expectant management is favoured by midwives. However, creating maternal anxiety lowers oxytocin levels, reduces the stimulation for contractions and lengthens the labour.

received at that time:

> Yes that was really hard … they would come and check and just sort of say “come on”. I really felt the community spirit in that I didn’t feel like just any other patient you know, whereas when you’re in the [Brisbane] hospital you’re just another baby in the day. I was aware of that when in [Brisbane hospital] but felt here that everyone was there for you and you had staff come in and see how you’re going - even if you weren’t their patient. They would pop their head around and go “How's it going”. (laughs). Yes, I was really glad to be here.

At midday contractions finally began and Joy continued to walk around the hospital grounds supported by her mother and partner while her neighbour cared for her young son. When in active labour she found the midwives empathetic and, despite the low number of births annually, they were experienced at providing the required comfort measures and support. Joy went on:

> You would just look at the midwives’ faces through it - they just looked so much in pain for you and you could just see their eyes going “Oh you poor darling I just wish this would pass for you” ... And [midwife] actually said that a few times, “Oh ‘Joy’, I just wish this would just hurry up and this baby would come and it would all be over”. And the midwives in the labour ward actually had a lot of suggestions. You know like, do you want to have a shower? And that was terrific … it was good that those facilities were there.

Having no distracting concerns, Joy described how she could just focus on her progress in labour.

> It was all really, all handled. I'm sure that was a lot to do with it - just being there and knowing [first born] was fine. Everything else was in place. It was just this baby and we just had to wait for this baby to come. There wasn’t anything else to worry about.

Despite intense pain during transition, Joy proudly described how she managed to cope without requiring any nitrous oxide (gas) and experienced the resulting endorphin induced euphoria, recalling : “Well at the end of it all, I really had that song in my head, you know that, *I am woman hear me roar”*.

The birth occurred during the change-over from an afternoon to a night shift. Four people were in the small room. Joy knew the two midwives as school parents as well as

competent carers during her labour. One acted as encourager, the other as accoucheur. Her partner was also present and wanted to catch the baby. Although the GP was in attendance, he remained quietly in the room at the head of the bed, not intervening but available if needed. When the midwife (accoucheur) had finished her shift, she remained with Joy until she was safely through third stage and settled comfortably. This continuity of care was greatly appreciated by Joy who commented:

> She [midwife] was so concerned that she was staying and you really felt that. I felt so special, and it's not like there's a birth all the time and you really felt that in the hospital too. They seem to enjoy having people in there with babies and they were really excited. Two in the one week was a big deal.

Being able to choose a position for birth was also memorable for Joy. Being upright on the bed she was able to watch her daughter being born.

> I don't remember who actually caught her but it was just amazing. [Midwife] was saying "Look 'Joy' look". I'm going "Oh wow". … And then when it was a girl it was "Oh wow I wasn't expecting this". It was just so wonderful being alert and alive. … It was very magical. So different…

Comparing this 'magical' experience with the drugged exhaustion of her first labour, she remarked on how, previously, she had not even known that her son was distressed at birth until the following day whereas, with this birth, she was "aware of everything". Remembering the interventions of her first birth, Joy reflected that, by contrast, being in a small hospital where routine obstetric interventions were not an option "was quite an advantage in the long run".

A number of advantages of non-interventionist birthing are evident in this story. First, not being induced and under the influence of analgesics allowed Joy to be alert and an active participant in the birth providing a sense of ownership and control over her labour. Second, not having an epidural made it possible to be upright, allowing her to see the birth as well as equalising pressure on the perineum, thus facilitating stretching and reducing tearing. She recalled: "It was just so different and I didn't tear, whereas with [first birth] they cut me. So you've got all that afterwards too and all that pain." Joy added that all the facilities at a large maternity hospital, like bidets, are necessary and helpful following a traumatic delivery whereas with a non-interventionist birth in a small hospital they are neither available nor required. Finally, the natural endorphins released not only

induce amnesia so that the pain perceived is not clearly recalled but also induce elation. Joy illustrated this:

> I always remember the saying that the most easily forgotten pain is childbirth. Whereas I'm still very clear in my mind with [first birth]. It was just horrid. It was awful … But [this time] I really don't remember the pain. I remember intensity but I don't remember the pain.

Postnatal Period

The postnatal period was an anti-climax. Following birth, Joy recalled becoming "just another patient" in a general ward:

> You know I had people coming in and saying hello [but] I didn't have anyone ask me how I was going with breastfeeding or anything. It was sort of like, you're a second time mum, you must be able to cope… So they just thought that I was happy [and] they let me be. And I don't know whether they felt qualified enough to come and help with that anyway…They may have known me well enough to know that I would have asked if I was having trouble.

When comparing this to her previous birth experience where the focus was on postnatal recovery and establishing breastfeeding, Joy commented: "With the Maternity Hospital, almost every half hour it was 'How are you going with your breastfeeding? How are your breasts?' " This contrast, Joy reflected, was probably because she was not a first time mother and appeared to be well and coping while other medical patients had obvious needs. Joy laughed dryly when remarking:

> They've got a hospital full of sick people and not a lot of staff, so they're looking after the sick people rather than worry about a healthy baby and a healthy mum sort of thing.

Had this been her first birth, after which she was totally exhausted, Joy felt that the lack of support with breastfeeding and managing the baby could have been a problem. However, this second birth experience was totally different. Even so, like Claire and Linda, she took advantage of the opportunity to spend several days in hospital resting before returning to home duties.

As Joy had anticipated, the first few months were "tough" as she managed a demanding baby, a lively toddler and survived sleep deprivation. Joy described how she was "psyched up" for the challenge and considered passing the three month point as the

"light at the end of the tunnel". Given his busy professional roles, her husband was as supportive as possible and 'helped' with domestic chores after work. As well, trusted friends minded her son so that she could have some respite.

With so few babies being born in Mining Town and having a limited social network, Joy felt quite isolated in the postnatal period and needed someone to speak with about mothering. She reflected:

> At times I would have loved to have someone I could have rung or just to find out about things. There are those health lines and things and I had a number. [Next town] has got a Nursing Mothers' Association. And I did ring them one night actually just to talk with them. I mean it was really just more the support, I really don't think I needed the help. I called on my Mum a lot. And my sister. Mum actually bottle fed but it was just that I needed people to ring and talk to, especially about babies … it was sort of like "Is this normal?" And so you haven't got that support. And here I know that I was only one of two mums who had a small baby in town at that time. I probably should have organised something myself but you're so tired. You can't get on the phone and say "Hey let's have a mothers' support group meeting" or something.

Like Linda and several other mothers I interviewed, Joy found the postnatal period lonely and challenging. Liz McDonald has identified the "intermediate postpartum period"[120] as a time when many women feel psychosocially unsupported; this may be compounded for transitory rural/remote women (Croker & McDonald, 2002). Telephone help lines do not adequately meet these women's needs. For example, Joy emphatically suggested that if there had been a mothers' group in Mining Town:

> [I] Definitely would have gone. Yes definitely, just to talk about babies because with my friends I'm very aware of not boring them, you know, not wanting to just talk baby all the time. It becomes your entire life when you've got a little baby that's all you're really thinking about.

Although Joy did telephone Nursing Mothers on a couple of occasions, she was very aware that their focus was principally on breastfeeding, when what she needed was a local mothers and babies group which had a broader social purpose.[121]

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[120] In particular, the first six weeks between discharge from hospital and the first routine postnatal check.

[121] Two other participating mothers in Mining Town from established local families disagreed. Tania stated that she was "not into the playgroup or anything else like that" which is possibly why mother's support groups were unviable in that community.

Privacy had not been an issue at Joy's birth but it was a concern when coping with motherhood in a small town. Being a professional within the community, Joy felt limited in whom she could candidly share her feelings on "down days" and commented:

> I wouldn't talk about that to anyone. There's a girl next door who is an incredible support to me. … if she wasn't there it would have been really, really tough. I can't think of anyone else that I sort of just would have talked to at that stage … It's not having anyone to ring to talk to just generally and I mean I certainly prefer that face-to-face, not some distant person on the end of the phone who is trained to deal with distressed mothers.

However, if really distressed or depressed Joy says she would have called a help line. Joy felt inadequate when comparing herself to another mother in a similar situation but who was without a supportive partner. She reflected: "I often think about single mums and that sort of thing, how do they cope in this situation?" Joy continues: "You'd go insane; you'd go around the bend".

When asked if she had consulted one of the visiting maternal and child health nurses, Joy responded that she attended the clinic monthly for the first six months but she did not perceive the nurses as being able to meet her psychosocial needs:

> Just for the physical check ups not to talk about… No, that's a relationship thing I think, you either click with someone or you don't. I wouldn't have sat down and talked about my problems with them.

Joy was unaware that one of the hospital midwives whom she liked was also a certified child health nurse.[122] Had she known, Joy would have preferred to seek her care.

In Mining Town, the visiting Maternal and Child Health service was provided within the busy hospital outpatient clinic. This impersonal venue with its lack of privacy was a barrier for some women in this study. However, Joy responded that the personality of a child health nurse was more important than the clinic location. Joy recollects that the child health nurse she saw with her first child was "wonderfully positive" by comparison with the visiting nurses to Mining Town. Not only was there no continuity of carer during that period but also the visiting nurse was only available for a few hours a week and therefore was perceived by both Joy and Tania as "too busy to talk".

Apart from meeting other mothers at the hospital-based clinic, Joy found that

playgroup was the only other option for mothers with babies. While the informal organisation of the playgroup meant that it could be a positive opportunity to socialise, Joy discovered that, with the current group of women involved, it was a disorganised, unpleasant experience where older children were bored and unsupervised while their mothers chatted. Social isolation continued to be her main concern in the postnatal period.

Comments on the health services

Like Linda, Joy regarded the gender of the doctor as important. If available at the time, a woman doctor would have been preferable. Joy commented:

> [GP] is a shy sort of fellow. So when you're talking about, you know, the personal women's sort of side of things and where you are uncomfortable, I would have been much more comfortable talking to a female.

Adding to her embarrassment, Joy was friendly with the doctor's wife and so she also met him socially. For this reason, Joy appreciated the GP staying quietly at the head of the bed when attending her birthing. Following that time, a married woman doctor moved into the town causing Joy to change GPs, adding: "I think it's great that we've got a choice now".

While still glowing with elation at her birth experience and filled with praise for the midwives, Joy saw the first three months of the postnatal period as a bleak time when some local support services needed to be in place. Although the physical needs of the babies were well provided for, mothers' psychosocial and emotional needs were overlooked. This was especially a problem for women who were not from Mining Town as they were isolated from the extended support networks of family and friends. In addition, being a teacher within the community, as well as being married to a high profile professional, limited the people with whom Joy felt comfortable about disclosing her feelings and concerns. Had one of the maternal and child health nurses been more approachable and interested in maternal well-being (beyond infant health), Joy believed she would have been a suitable professional in whom to confide.

Aspects of Joy's story have notable differences from and similarities to the two preceding birth stories. Multiparity was a significant influence for Linda and Joy who, having had previous unsatisfactory birth experiences, became reflexive consumers who actively sought a local birth. Unlike Claire and Linda, Joy had to assertively and persistently work to

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[122] 'Cathy' as shown in Table 6.3

gain medical approval. Having been made well aware of the physical risks, Joy decided that the psychosocial and emotional benefits were more important to her well-being. Being an articulate, well-educated professional who was friendly with the GP's family was helpful in achieving his acquiescence to her goal. However, the fact that both Linda and Joy needed medical permission to give birth in a place of their choice raises questions about women's ownership of their bodies and experiences. Issues of women's choice and control when birthing will also be evident in Olive and Joanna's stories, which follow.

As with those of Claire and Linda, Joy's labour and birth took place in a small hospital where deliveries were infrequent and the personalised care provided made her feel special. Socially and emotionally, she was well supported during labour and birth. This enabled her to focus on her labour without distracting concerns. All the people at her birth were familiar and caring. No analgesia or obstetric interventions were available or required. This meant that Joy was active, alert and feeling in control of her labour. Her sense of wonder and elation at seeing her daughter being born was still evident months later, despite her postnatal dysphoria. However, Joy noted the lack of postnatal care offered to her as a second-time mother while the busy staff prioritised sick patients.

When maternity care is segmented, midwives often see women only during the brief time they are patients in hospital. Multiparous women, in particular, are generally regarded as experienced mothers and, therefore, able to cope and so are discharged as soon as possible. However, motherhood requires a holistic continuum of perinatal care. For itinerant women like Linda and Joy, the postnatal period was especially challenging. Although their babies' physical needs were met, both Linda and Joy commented on the psychosocial isolation they felt and the need for advice and support from people other than their partners. In particular, they sought contact with other women knowledgeable about motherhood. Both women had young children as well as a demanding new baby so this was exhausting and stressful. Joy was aware of telephone counselling services but felt that these were inadequate when a face-to-face contact was required. Their satisfaction with achieving their ideal births was tempered by the early postnatal months of mothering.

Cluster two: Interventionist 'delivery' in remote and city settings

These three stories of interventionist births range from low-tech assisted deliveries in a public, remote hospital, to highly interventionist, private obstetric care in two cities.

A.2.1 Olive

As an Aboriginal woman in her early thirties, Olive achieved the birth experience she wanted in the small remote hospital in Pastoral Town. From both an obstetric and a midwifery perspective, Olive was classified as a high risk patient because of her location, social history, grand multigravida status and gestational diabetes. However, her positive relationship with the GP and one midwife, and their holistic approach to her care, made it possible for Olive to negotiate a planned induction of labour at a time which suited her social circumstances.

While Olive's story contributes to several themes in this study, including the effects of social and cultural isolation on postnatal depression, this story focuses on the factors which made her sixth, live birth a good experience.

Context

Olive lived in Ghost Town, a tiny remote hamlet between Stockton and Pastoral Town in a small, immaculate house constructed of corrugated iron. Two caravans alongside were used as a distance education school room and extended accommodation. When I visited Olive in mid-summer, her older children were happily playing in artesian bore water nearby while her baby sat on her knee. Around us were her many domestic animals. It was a scorching hot day and the electrical power was off. There had been frequent power outages because of thunderstorms and this challenged her ability to use cooling fans, keep food frozen and to cook meals.

Background

In her youth, Olive worked in a southern district. During that time she had her first baby 'taken' from her, creating a strong suspicion of white authority, a concern about being 'inspected' and patronised, along with particular dislike of child health nurses.

After becoming a shearer's wife, Olive spent many years travelling around sheep stations and living out of a caravan. This made it very difficult to manage and educate her subsequent children. Although Ghost Town was far from her country and people, it offered affordable land and Olive was glad to be able to settle into a permanent home. Olive had five children living with her and they enjoyed the freedom and space to play. Since the local school had closed due to low enrolments, Olive had to manage School of the Air for three of the children as well as caring for the toddler and baby.

Olive did not drive, and as there was no public transport, travelling to town for

supplies or medical investigations and treatments was almost impossible when her partner was away shearing for long periods. She found her neighbours hostile, racist and unsupportive. This compounded her isolation and hardship, especially when the children were sick or she needed fresh supplies and when recently she had another miscarriage.

Previous births

Olive had a history of nine pregnancies resulting in six children and three miscarriages. Gestational diabetes emerged during the last two pregnancies and was likely to reoccur along with a concomitant risk of neonatal complications. Perinatal statistics show Aboriginal women as having a significantly higher incidence of perinatal mortality and morbidity.[123] Living in Ghost Town, unable to drive and with her partner often away, Olive's risks were compounded. Normally, she would have been sent to a major centre for the last six weeks of pregnancy for monitoring and possibly hospitalisation to ensure a safe outcome. This would have been very difficult for Olive. Her people come from New South Wales and she had no support locally. Not only would Olive not be able to afford to stay in a major centre with all her children for that period of time but accommodation is often not culturally appropriate for Aboriginal women. Mine City, the closest major centre to Ghost Town, did have hostel accommodation for Aboriginal women but not only were the three local Aboriginal clans[124] not her people, but also the hostel did not have facilities for a woman accompanied by that many children[125]. In addition, the hostel accommodation available at that time was described as being "just like the old mission days" (Croker, O'Connor, Usher, Harvey, Wilson & Sellen, 2002). Therefore, Olive chose to have her fifth and sixth babies in Pastoral Town under the care of an experienced woman GP she liked and trusted (Dr Diana).

Aware of Olive's difficult social circumstances, Dr Diana agreed to support her birthing locally. As no complications occurred despite gestational diabetes, Olive was able to negotiate her sixth birth with the doctor, overcoming the social difficulties. A social induction was planned for a set date to ensure that Dr Diana and an experienced midwife

[123] The national perinatal mortality rate for Aboriginal women is 24.7 per 1000 births compared to 6.6 in non-Aboriginal women (ACRRM & RDAQ, 2004; AIHW, 2004a). In Queensland, being rural/remote and Aboriginal compounds the perinatal risk factors (Panaretto, Muller, Patole, Watson & Whitehall, 2002; Trewin & Madden, 2005).

[124] Being a Koori, Olive had little in common with the predominantly Kalkadoon and Injilinji women of Western Queensland.

[125] Hostels for Aboriginal women tend to allow infants and young girls to accompany a mother but boys older than five are often excluded.

would be available, also so that Olive could arrange child minding and partner support.

Social support and preparation for birth

Having confirmed her planned birth date, Olive was able to arrange for her elderly mother to visit Ghost Town for a fortnight to assist with the children. This freed Olive's husband to accompany her for the birth. Arrangements such as this took time as Olive's mother could not be contacted by phone and lived several days' bus-trip distant. Olive's husband also needed to know when to leave from his workplace so as to be available.

There was a risk that Olive might go into labour spontaneously before the planned date. Compounding this risk was the possibility of seasonal storms making the road impassable. In either event, it was unlikely that she would have time to reach the hospital before birthing. So Nr Emma, an experienced Pastoral Town midwife, in her own time, visited Olive and her husband to discuss a contingency plan.[126] This included teaching them what to do during and after a home birth.

Olive's birth experience

Although Dr Diana and Nr Emma were supportive of Olive's desire for an induced local birth because of her social circumstances, Nr Gloria, the Director of Nursing (DoN) was strongly opposed. She was also a midwife and gravely concerned about the obstetric risks. The combination of Olive's grand multigravida status and gestational diabetes combined with the proposed induction of labour increased the likelihood of adverse maternal and neonatal outcomes. As the DoN, she was very conscious of their inability to electronically monitor[127] foetal well-being in labour or manage an obstetric emergency such as postpartum haemorrhage. With only one doctor, remote hospitals cannot perform emergency procedures under anaesthetic, or match and transfuse blood, and the staff would have difficulty in resuscitating and maintaining a distressed newborn. The DoN was also concerned that while the RFDS can be contacted for an emergency evacuation, considerable time delays are possible and thunderstorms can prevent landing. Thus, specialist back-up was unreliable. Olive was well aware of these differences in opinion

[126] Notable differences were found between several of the Western midwives who visited women in their own time thus holistically meeting their needs, and those in Mining Town who were aware of women's needs but were unwilling to provide unpaid care.

[127] The hospital did not have a cardiotocograph (CTG), which monitors foetal heart rate in relation to contractions, but did have a Doppler. Intermittent foetal monitoring in high risk pregnancies with a Doppler is effective in improving perinatal outcomes (Neilson & Alfirevic, 2002).

and subsequent tensions between her carers.

Dr Diana in Pastoral Town had had wide obstetric and neonatal experience both overseas and when working in remote Aboriginal communities. She was confident that Olive, although labelled 'high risk', would be able to safely birth in the small hospital. Dr Diana had provided continuity of care throughout Olive's last three pregnancies, her miscarriages and the previous birth. Aware of Olive's difficult circumstances, Dr Diana agreed to the social induction of labour. Olive was pleased and relieved about having her choice of place, carers and the time of birth.

Due to unforseen circumstances on the planned induction day, Olive's preferred midwife (Nr Emma) was not available and she felt animosity towards Nr Gloria who was the midwife on duty.[128] So, to ensure that a supportive, conducive environment was maintained, Dr Diana managed the induction and care throughout labour and birth herself. Olive's husband was present as her support person.

At that time, a professional woman expecting her first baby[129] asked if she could witness a birth. Aware of the limited number of planned births in the local hospital, Dr Diana asked Olive's permission. Self-confident of her proven ability to birth easily, Olive agreed to let the woman observe the event.

As she was full term and a grand multipara, Olive's labour was easily initiated with the artificial rupturing of membranes (ARM) and a low dose of Syntocinon[130]. The insertion of a cannula also meant that in an emergency, drugs could be given intravenously. Although obstetrically 'high risk', Olive's labour was low intervention, short and obstetrically uneventful. Olive gave birth to her sixth baby in a short space of time without complications. The expectant mother observing the birth described this as a marvellous experience. Dr Diana was vindicated in her decision to perform a social induction based on her experienced assessment of the potential outcomes.

Postnatal period

Olive breastfed this baby as she had all her other children, thus reducing the risk of postpartum complications. Her husband slept in their van in the hospital grounds for two days until she was able to go home to Ghost Town. Olive's mother managed the five

[128] Olive liked and trusted Nr Emma. However, Emma had gone to relieve in Stockton which had no midwife at this time. Olive had had an altercation with the midwife on duty and did not wish her to be at the birth.
[129] This witness was Joanna. Her story is told next.
[130] The ARM brings the foetal head down onto the cervix to initiate contractions while the Syntocinon (synthetic oxytocic) stimulates the onset of regular contractions.

young children for that brief time but, being elderly, could not have coped if Olive had stayed in hospital longer to rest and recuperate. During the early postnatal period, Olive did not seek access any health services and refused the visiting child health nurse entrance to her property, trusting only Dr Diana and Nr Emma.

A few months later, following another miscarriage, Olive developed problems with depression but felt that she could not discuss this with any of the local health providers and did not wish to utilise a telephone counselling service. She chose to confide in safe outsiders[131]. In Chapter 8 this is explored further.

In Olive's view, not only was this birth a satisfying, 'good' experience but it was also her only possible option. It was important for her to have choice and control over the time and place of birth and to be able to trust her maternity carers. Being able to have continuity of care from a skilful, confident woman doctor, legitimised Olive's decision and 'allowed' her the convenience of birthing in this remote location. Olive would have been unable to leave her children for an extended period if she had been transferred to the city to birth. It would have been an anxiety-creating, isolating experience which she would have avoided by passively "staying put" and becoming labelled as a 'bad patient'. Without the support of Dr Diana, Olive would have been non-compliant, with three potential consequences: first, she would be constructed as a problem patient; second, Olive would have been placed at a greater risk than if enabled to have a relatively safe, medically managed birth, and finally, her distrust of white authority and resistance to coercion would have been reinforced. This story again highlights how, in their comments, most birthing women prioritised social and emotional needs over physical considerations, even risking the possible unavailability of competent, capable health carers.

The stories so far have described one low and three non-interventionist births in rural and remote communities. With the exception of Claire's birth, all were multiparous women who chose not to the leave town and to birth locally. By contrast, the following two stories describe first-time mothers of similar age who opted for highly interventionist deliveries in private obstetric settings in major centres and for whom this was a positive experience. Joanna actively sought a medicalised birth while Paula passively acquiesced with "whatever happens, happens".

[131] Safe outsiders included a visiting nun who stayed and assisted for a while, Jehovah Witness missionaries and me.

A.2.2 Joanna

As an itinerant professional living in remote Pastoral Town, Joanna elected to go to a major Brisbane hospital where she could birth in a 'safe' hi-tech setting under specialist obstetric supervision. Like Olive, Joanna also requested a social induction and was happy with the choice, as it enabled control over place, time, people and pain relief during birth. However, Joanna was a well-educated woman who was eager to take advantage of available advances in medical technology.

Although Joanna had experienced difficulties with infertility prior to this successful pregnancy, and later became depressed following a subsequent miscarriage, she was delighted with her son's birth. These excerpts focus on this highly satisfactory episode of Joanna's story. Other features will be referred to in later chapters.

Background

Joanna was a well-educated woman in her late twenties with a background in agricultural science and finance. She was the wife of a professional man and the couple had been transferred to a company branch in this country town. The company had difficulty in recruiting staff for remote areas and so, through necessity, had become 'family friendly' employers who were willing to be flexible with her partner's leave.

This flexibility had been important for Joanna and her partner when they had been involved in investigations for infertility and then part of a gamete intra fallopian tube transfer (GIFT) program. Their only child was the result of years of reproductive procedures. In addition, Joanna had a history of depression and which reoccurred periodically.

Before her successful pregnancy, Joanna had experienced years of hidden grief[132] and the social stigma, assumptions and misunderstandings that accompany being a childless woman. She had found that a very difficult period of her life and was overjoyed about successfully maintaining a viable pregnancy.

Social support

Joanna and her professional husband were itinerant "blow ins". Frequent relocation made it difficult for her to receive continuity of medical care, neither was she

[132] Disenfranchised grief accompanies the unviable pregnancies, repeated loss and unsuccessful procedures that accompany artificial reproductive technologies.

able to participate in IVF[133] support groups. Within the local Pastoral Town community, Joanna had worked hard to develop social networks. Becoming actively involved in several community groups made social acceptance and integration possible. Joanna felt it was both important and necessary to show commitment and give something back to the community. As a result, Joanna found several friends across generations and social divisions to whom she could turn for emotional support.

Antenatal preparation

Joanna planned to have her baby in Brisbane where she and her partner would be able to stay with her mother in the weeks awaiting birth. Her partner's family lived relatively close to the hospital, but Joanna had a difficult, strained relationship with them. Although her mother wished to attend the birth, Joanna wanted only her husband present. As they had "been through so much together making this baby", it was important for them to share the birth as a couple.

As Joanna was a nulliparous woman, it was against hospital policy for her to give birth locally. However, Joanna never countenanced this as an option. After enduring years of medical procedures and treatments for infertility, birthing in a small remote hospital was unthinkable for Joanna. She intended to have her baby in what she perceived to be the safest possible place – as a private patient in the foremost public maternity hospital in Queensland. This tertiary centre was well equipped with both the medical expertise and neonatal intensive care facilities to meet her need for technological security.

Although privately insured and physically well, Joanna was exceedingly conscious of all the potential risks involved in birthing and saw this as a way to minimise and control them. She felt that the attractions of the various private hospitals were superficial and less important than security. Joanna commented:

> … if anything had gone wrong I would have to be transferred to Royal Women's or where ever. And because this baby was so precious to us, I was not going to take the risk.

While in Pastoral Town, she and her partner thoroughly enjoyed the personalised antenatal classes held for three couples by the midwife Emma. Consequently, Joanna was well-educated about the physiology of birth and her options. Forming friendships with the other two expectant couples was also a positive outcome of the classes.

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[133] 'IVF' has been replaced by the broader 'ART'; acronym for artificial reproductive technologies.

Joanna's birth experience

Joanna's pregnancy was uneventful until the last two weeks. At 38 weeks Joanna's blood pressure rose so her private obstetrician hospitalised her for rest. While in hospital she found that coming from a remote area made her a "novelty", which was "pretty good". The obstetrician asked Joanna to contact her partner, as it was likely she would be induced if her blood pressure did not settle. Over the four days she was in hospital, induction was mentioned repeatedly, creating an expectation that she would soon have her baby. Consequently, when her blood pressure normalised and the obstetrician wanted to discharge her, Joanna recalls being very upset as she wanted to have her baby before leaving hospital.

> I was wanting it [induction] by that stage. I was extremely uncomfortable. And they were going to send me home. And as soon as the doctor walked out of the room, I just burst into tears. After he left the room, of course, not while he was there. I just burst into tears and I just couldn't believe it. He had told me the week before because my blood pressure was dodgy he had been saying to me, "Look how soon can your husband get down if it comes to a point that we have to do something about this". [Then] He said, "Oh well we might have to induce you … if your blood pressure hasn't gone down" …

This proposition was repeated daily then, Joanna recalls: "Tuesday night he came up and said 'Oh no, we will send you home. You're doing OK'. He left, I burst into tears".

While many women complain that obstetric interventions are imposed upon them, in this instance the doctor sought to reassure Joanna that she could labour naturally, however she wanted otherwise. Joanna felt she had been a good patient – obedient and compliant. Therefore, she reasoned that it was not fair that she was being 'punished' for it. Joanna repeatedly stated: "I'd been very good" and "I'd just had enough". Her perceived reward was to have labour medically induced and deliver her long-awaited baby.

Aware of how upset she was about having the induction postponed, the midwives gave her a sleeping pill to "have a good nights sleep" while adding: "We'll talk about it in the morning". Joanna says that the midwives advocated for her. She continues:

> … when [doctor] next came and visited me … he walked into the room and said: "I hear you want it out". And he said "Well come on, let me have a look" [Then] he said "Oh OK, we will put some gel on you tonight and see how you are in the morning". I said "Oh OK". And that's how it went… So yes, I was quite happy to be induced

Joanna felt being a private patient entitled her to influence the decision about the induction.[134] Perinatal statistics (AIHW, 2004a) show a higher rate of interventions in private patients and Joanna supports this:

> I think I was lucky that I was a private patient that I could actually say 'Look I've had enough!' Because I've heard similar stories with people who have gone public … they just couldn't. There's no medical reason to have an induction so you can't have it sort of thing. So I think I guess in a way I was very lucky that I could have what I wanted.

When asked if the obstetrician had explained to her the potential cascade of problems that can arise with elective inductions in women having their first baby,[135] her response focused on the psychological and emotional reasons why she felt it was necessary.

> Yes … I was, like pretty bad that day with crying and all this sort of business. It was one of those things I really needed to [have the baby induced], I was too uptight.

According to Joanna the social induction went "very well". Her birth story describes an interventionist model of active obstetric management of labour.[136] Consequently, Joanna had a very short, intense labour requiring an epidural for pain relief. I asked Joanna why, given the progress she was making in labour, she required augmentation as well. Her response highlighted the subordinate role of midwife as obstetric technician and Joanna's own belief that the doctor knows best.

> My contractions were going OK but the midwife said "Well look I've got to put the Syntocinon in". And I said "Do you really think that I need it?" because my contractions were going along well. And she said "No, I don't think you need it but the doctor has ordered it" because the doctor had gone away, "and if I don't give it to you I could be in a bother". I said "Well fine but get that epidural here pretty quickly". And so I had Syntocinon but it probably wasn't necessary [or] medically required but because it was ordered, the midwife couldn't go against what the doctor ordered. And that's what she said to me. I went "OK.".

So Joanna consented to another intervention to "save the midwife trouble" and to comply

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[134] This is supported by Laws and Sullivan (2004) and the NPSU (2001) who report that most elective inductions in nulliparous women occur in older, Caucasian women who have a private obstetrician.

[135] Elective induction of labour in nulliparous woman results in a high incidence of forceps and caesarean section deliveries (National Perinatal Statistics Unit, 2001)

[136] Although Joanna's cervix indicated labour was imminent, labour was initiated with prostaglandin gel, her membranes artificially ruptured to stimulate contractions and later Syntocinon infused to augment these.

with obstetric orders, not because of a physiological need for augmentation. Having demanded the induction she again wanted to be a compliant, untroublesome patient. The resulting intense contractions led her to request a further intervention, an epidural. Joanna describes how she tried to manage without it but the "contractions were coming one on top of another, very quickly" and there was no "access to hot showers or that sort of thing". Having discussed effective pain relief with her obstetrician beforehand, Joanna felt an epidural was the best option in the circumstances and planned to try it. She reasoned that:

> [My baby] wasn't conceived naturally why should I go this natural childbirth way. Modern medicine has made these wonderful things so that you can do it without lots and lots pain, why not.

Joanna knew that she would be confined to bed so her baby could be monitored. She was prepared to forgo comfort measures to reduce pain, preferring constraint and the reassurance of electronic foetal monitoring. Further, Joanna felt this contributed to her sense of well-being:

> I actually think now that having the epidural was really good for me because I saw women especially walking around the wards later. [They] were drained out and … they really had no interest in their child. When [baby] was born we were just so happy. And I was on the phone straight away and I had [baby] in my arms. Yes, I don't know, I wasn't exhausted by it all.

Joanna elaborated on the benefits of epidural pain relief and the reassurance provided by electronic monitoring when a patient on a busy ward where personalised maternity care was not possible. Joanna felt the maternity staff preferred this model of care as well. Midwifery care during labour was "on and off". One midwife was managing labouring women in three rooms and so "popped in every now and then" to check on the foetal tracing and to see if Joanna was "all right". Once the pain relief took effect, Joanna's partner was "sent out for a break" and so she was left alone. However, Joanna was assured that she would call a midwife if she needed assistance. When asked if she felt neglected, Joanna responded:

> Well because I had the epidural, I just sat there and read a book. Which absolutely boggles some of these women who did it all by themselves. I'd say "Oh I just sat there

> and read my book". If I didn't have that sort of pain relief, yes I probably would of. … I can remember thinking, well gee aren't I glad I had that epidural. Because the midwife wasn't there a lot.

Once the midwife determined that Joanna was fully dilated, she contacted the obstetrician and they "chatted" until he and her partner returned. Joanna felt advantaged by having a pain-free second stage of labour devoid of the uncontrollable urgency to push, which enabled her to relax and wait for her doctor to deliver her baby. Joanna recalled that it was "really good… "no worries at all" for her and the midwife.

Aware that a caesarean section was a possible consequence of the cascade of interventions, Joanna had discussed this with her partner beforehand and was well prepared. She reiterated: "Our priority was to get [baby] safely rather than worry about going through it naturally…". Joanna later commented on how she had received negative remarks from Pastoral Town women about having had an epidural[137]. She defended her choice to have an anaesthetic designed to provide comfort to birthing women. Given the busy clinical setting and impersonal care along with Joanna's desire to have a private obstetrician present, this was a well considered rational decision. As Joanna reasoned, if the baby was conceived using advanced medical technology, then why be concerned about attempting natural childbirth. She felt that it was sensible to take advantage of the less exhausting, pain free option provided by modern medicine.

Postnatal period

Because of her past history with depression, Joanna's family and the hospital staff were observing her for signs of the 'blues'. Joanna also was expecting postnatal depression but "didn't even get the blues…the emotional crying or anything like that".

Joanna recovered well in the early postnatal period. The episiotomy did not trouble her and, after resolving initial difficulties with breastfeeding, she felt confident in mother-crafting. Discussing the maternity care she received, Joanna said:

> [The midwives] were very good. I couldn't fault them at all. I really couldn't. I guess if I had more hassles with things they would have checked on me more but everything just

[137] As discussed earlier, I also found Joanna's choices confronting as I endorse the midwifery philosophy of normal birth and oppose embracing unnecessary interventions. Reflecting upon this and other similar accounts was a turning point for me as I realised that women like Joanna were well-informed, consenting adults upon whom I had no right to impose my views if I truly believed in enabling women's choice and control over the birthing process.

> seemed to go so well. For once in my life everything just seemed to go so well, that I had no problems at all.

Joanna returned to Pastoral Town with her mother and partner to assist and support her. This was a pleasant, unpressured time for Joanna. She appreciated the maternal advice, including strategies for dealing with well-intentioned advice, such as:

> … listen, listen to the experts, people will keep giving you advice and that sort of thing, work out which ones you want to listen to and which ones you don't want to listen to and then go your own way.

The initial postpartum period went well. Australian research suggests that women who have interventionist births are more likely to develop postnatal depression (Johnstone, Boyce, Hickey, Morris-Yates & Harris, 2001; Brown et al., 1994). However, this was not perceived as a traumatic event by Joanna. It was a positive experience and she was very satisfied with achieving the desired obstetric care and felt well-supported once home.

When interviewed, Joanna had stopped breastfeeding to attempt another pregnancy and was again taking medication for depression following a miscarriage. Joanna described the stigma and isolation she experienced within the small town when people observed her depressive behaviour and avoided her company. However, Joanna had been surprised by the unexpected emotional support she had received from some older women in the community.

Comments on the health services

Alert to the potential complications associated with birth, Joanna felt that it was important to minimise the risks by being in a tertiary maternity hospital equipped to manage any problems. She had carefully selected a 'safe' place to birth under the care of a private obstetrician. Joanna desired a medicalised, interventionist birth because it provided active obstetric management of the labour process and this control was comforting. Joanna expressed satisfaction with the labour, birth and early postnatal period. In her story, Joanna compared how sore and exhausted other women in the ward looked in comparison with her. According to Joanna, avoiding a long, painful labour contributed to her mental well-being after the birth. Joanna repeatedly commented on how she felt that she had choice and control in this birth because she was a private patient and contrasted her experience with that of women who had adverse experiences in the public system:

> I didn't realise how much going private did give you the control until I've heard horror stories afterwards about people who hadn't gone private. … friends who have had forty hour labours and they've been ripped to pieces and that sort of thing because they couldn't get what they wanted …I don't know whether it would have happened if they had been private patients but anyone I had seen that made the choice to go private just seems to have had a better time of it all than the public patient … you know with our medical system with the way that it is - if something is necessary the doctors do it. I think you really get choice with private health. … I think it's worth it, I really do.

Joanna felt it prudent to embrace available medical technology that would facilitate a comfortable, safe birth at the time and place of her choosing. To have this choice, it was necessary to be the private patient of an 'expert' obstetrician. Although well-educated and prepared for a hi-tech birth, Joanna was unaware of the perinatal statistics that reveal how public patients (which encompass more high-risk women) have care that is more likely to be based on research, resulting in better outcomes than private patients (Senate Community Affairs References Committee, 1999; AIHW, 2004). She draws on anecdotal horror stories to substantiate her beliefs about the disadvantages of being a public patient. However, her perception of having received special care was significant to her sense of satisfaction. Interestingly, she selected a large, busy public hospital as the optimum place to receive this private care, as it had the advanced level of neonatal intensive care facilities she required as a safe backup.

These decisions led to Joanna being criticised by young women in Pastoral Town and having to justify her choices. However, given the contrast between the place of her birth and experiences possible in a small centre, Joanna's preferences make sense. The previous stories about good birthing experiences describe a situation in which the women received constant, individualised support from skilled maternity carers whom they knew and trusted. They were also the only person birthing at the time. By comparison, Joanna's situation in a busy maternity hospital meant that many women were in labour simultaneously and so one midwife was managing patients in three different rooms. Being alone, amongst strangers in an unfamiliar, clinical environment, feeling anxiety and pain could have made this an awful experience for Joanna without the epidural for pain relief.

When compared, Olive and Joanna's births contain similarities and stark contrasts. They exemplify the nexus between class, parity and consumerism described by Zadoroznyj (2001). Both were determined to achieve their chosen place, type and time of birth. With her poor socio-economic circumstances and lack of formal education, Olive's

previous experiences with childbirth and health services made her a reflexive consumer. She sought continuity of care from trusted health providers. Social and emotional considerations were paramount. Olive was very satisfied with her individualised, low-tech birth in a remote public hospital.

By contrast, as a well-informed woman experiencing her first successful pregnancy, Joanna had a heightened sense of risk and carefully planned her birth in a physiologically 'safe' setting. Joanna perceived her choice of a highly interventionist and obstetrically controlled birth to be a rational and logical follow-on from her difficult conception through artificial reproductive technology. She was certain that having private health cover enabled her to actualise her choices.

In the next story, Paula also relocates from a remote area to be induced on a busy weekday in a private city hospital, resulting in an operative delivery during daylight hours. While Paula is a nulliparous woman of similar age to Joanna, they differ significantly in their socio-economic and educational background, preparation for birth and reflexivity. Having private health insurance was financially difficult for Paula, but given the unpredictable quality of remote health services, she felt it was essential. Both women share similar notions of the doctor-patient relationship and a reliance on 'expert' knowledge systems.

A.2.3 Paula

Unlike Olive and Joanna, Paula did not actively seek the highly interventionist birth she experienced. Unaware of alternative options and trusting in her obstetrician's expertise, Paula believed that her birth "went well" and that the caesarean delivery was a satisfactory outcome. This story illustrates how first-time, working class mothers tend not to be consumerist or desire the knowledge that will enable them to make informed decisions (Zadoroznyj, 1996, 1999, 2001). It supports Lupton's contention that some women feel more comfortable taking on a passive sick role and placing their trust totally in the charismatic authority of doctors and expert knowledge systems (1996; 1997). Paula perceived that the unpredictability of birth meant that it was out of her control so having chosen private care, entrusted her doctors to expertly manage events. Her understanding and choices were limited but this did not affect her satisfaction. Paula felt her story was "not very interesting".

Background

Paula came from a property near Stockton but she and her husband had both moved to live and work in Pastoral Town. She was employed by a local business and he had given up shearing for work in the shire council so as to be closer to Paula and the baby. As one of the few participating mothers in paid work, Paula had experienced criticism and felt a need to provide an economic justification for her decision.

Pregnant for the first time in her late twenties, rhesus negative with a 'thyroid problem', Paula was a woman who required competent management. Despite financial hardship, she chose private care shared between the local doctor and an obstetrician in a coastal city. Paula found that shared care worked well for her and she was unperturbed by not having continuity of care when the GP or chosen specialist were not available. She stated that it "wouldn't have mattered who was there because the majority of the doctors have been good down there".

Birthing locally was unthinkable to Paula; she sought the privacy, safety and comfort of a private hospital with specialist care. She believed her medical problems precluded the option of having even future births locally. For Paula, like Joanna, safety was very important and she equated this with private obstetric care. As a caesarean birth was not possible in the single doctor, remote town, it provided satisfactory evidence of the need to birth within a 'safe', hi-tech environment. When asked about her chosen place of birth, Paula replied:

> I feel safer down there because if there was anything wrong with the baby then you know, out here they've got to fly you out and just that time that they waste could cost the baby's life.

She compared the alternative choices of hospital on the coast or Mine City:

> I'd go to [coastal city] yes …I hate 'Mine City'. I wouldn't like to live down there. … well they have flown ladies from here to Mine City to have babies. I was talking to a lady that had a caesarean too but she had a drain on her. They drained all her stuff and I said "Well I never had that". So it's not worth it. I'd rather be down there where they've got all the equipment if anything goes wrong.

A further attraction of coastal birthing for Paula was being able to stay with her sister and go shopping when she went to the city for required ultrasounds and the birth.

Social support

As Paula's extended family lived on remote cattle properties, they were not readily available as sources of social support. However, she valued her sister in the coastal city while awaiting birth. Paula mainly turned to her partner for support. He had no family in Queensland.

Antenatal preparation

Although antenatal classes were offered both locally and at the private hospital while she was awaiting birth, Paula chose not to attend. Paula remarked that she had been loaned two very old books about childbirth. Her preferred birth preparation involved talking with trusted friends and relatives about their personal experiences. She said, "It didn't worry me to find out. I just talked to different people around town. That's about all".

Many of their accounts were lurid tales spanning decades and many settings but they provided the background knowledge on which Paula based her choice of doctor, place of birth, choice of anaesthetic and her evaluation of the quality of her experience afterwards. In particular, she was influenced by the "hard troubles" her sister, sister-in-law and mother had encountered. Paula resolved:

> I just thought I'd just go in there and whatever happens, happens. You know, you can't, as much as you read and things you probably [can't make a difference] … I just had an open mind. I just went in there not knowing too much; I thought it was best.

Paula perceived birth outcomes as unpredictable and not influenced by preparation. She preferred not to think about the possible 'troubles' and just focus on events when they occurred.

Paula's birth experience

As advised, Paula travelled to the coastal city at 36 weeks and stayed with her sister while awaiting birth. Paula's husband joined her three weeks later and was able to be with her throughout labour.

When her membranes ruptured in the early morning, contractions did not immediately follow. Paula was admitted to the private hospital where an initial vaginal examination showed that her cervix was 'unfavourable'. Although most women will

spontaneously begin labouring within a few hours, Paula received an oxytocin infusion[138] and was confined to bed for monitoring. There is a significantly increased likelihood of caesarean section for nulliparous women in this situation (Seyb et al., 1999; Yeast, Jones & Poskin, 1999) which is why expectant management is recommended instead (Wilkes & Galan, 2002). Therefore, it was not surprising that despite painful contractions, by 3.00 pm "nothing had happened". Although Paula had strong back pain, she was not in established labour. So the obstetrician, appearing to practise 'daylight obstetrics', decided to perform a caesarean section. Paula recalled her reaction: "No. No it didn't worry me, I was fine by that".

Paula was asked if she knew why she had needed a caesarean section. Her understanding was that she was physically incapable of giving birth "naturally" (vaginally) although both Paula and her baby were an average size.[139] The information and explanations Paula received from the midwives and obstetrician did not promote her understanding of why she was not given the opportunity to go into labour spontaneously, the effects of restricted movement during labour or why her labour did not progress. Paula believed the doctor's explanation that it was her body at fault when told an emergency caesarean section was necessary (before 5.00 pm!). Paula explained:

> [Doctor] said he wouldn't have come naturally anyway if I'd waited. … All that he said was that he was lodged too far towards my back. That's all.

Skilled support in labour seemed to be lacking. I inquired about the midwives' role. Paula remarked that they:

> didn't say a real lot because [doctor] came in and he checked to see [but] I wasn't going anywhere at one stage. Also they were checking the baby's heart beat … they had the monitor on. That was the major concern. …they just sort of left us most of the time. Yes and they would just come and check to see if I was having any contractions and things like that and I wasn't doing much.

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[138] Research evidence indicates that (in the absence of infection) it is safe to wait up to 24 hours after the membranes rupture before inducing labour with an oxytocin infusion (Goer, 2002; Tan & Hannah, 2002; Seyb et al., 1999). Goer (2002) advises that women with an unready cervix and/or little or no dilation should consider refusing induction as it greatly increases the probability of caesarean section, regardless of the use of cervical ripening procedures.

[139] The baby weighed 3500gm (71b 14oz). Australia's mean birthweight was 3360gm (Nassar et al. 1998).

When asked if her husband helped maintain her comfort she responded laughing: “He tried. He was really watching the TV they had in the ward there”. Her younger (childless) sister and a friend came to offer companionship.

Paula declined epidural anaesthesia for the operation, and chose to “get knocked out” (with a general anaesthetic) because a relative had related her “real bad experience” with an epidural. Paula was told that she “could feel everything when she had the baby - you know, them cutting, the pain, and all that”. Hence, Paula “decided to go under”. The hospital policy only permitted husbands to be present at caesarean births if their partner had an epidural and was conscious. So, this decision meant that he was excluded, which he did not mind.

Postnatal period

Paula recovered well. In the immediate post-operative period, pain relief was effective. Paula had an intravenous infusion and urinary catheter for 24 hours. She recalled that: “I was excellent … up the day after. Went out shopping on the third or fourth day”. She spent five days in hospital and proudly described her stoic recovery:

> Yes, yes, I just recovered really quick because they said that they were surprised because I had a shower by myself and they said that I shouldn't have probably done that. … they tell you that sometimes it takes seven to ten days to recover. But I was up and about. Yes, people are different I suppose.

However, Paula did have problems with initiating breast feeding and felt uncomfortable asking for help, so her questions and concerns were not addressed while in hospital. Paula was not advised that the obstetric interventions would contribute to the delay in onset of lactation and affect her baby’s suckling ability, so she felt concerned and inadequate. Neither did Paula receive guidance on the importance of early suckling to promote lactation nor on correct attachment to reduce nipple soreness. Her shyness and reluctance to ask a midwife for assistance not only led to problems establishing feeding but also caused nipple injury, pain and anxiety. However, despite these early problems Paula was determined to succeed with breast feeding, and continued to feed even after she returned to work.

On returning out west, Paula returned to a share care arrangement with the GP. Because she was working, she did not attend child health clinics.

Comments on the health services

As Paula did not visit antenatal or maternal and child health clinics, comments

about her maternity experience were largely focused on the doctors. At the time of interview she was satisfied that her care was of a high standard and that the operative birth was a good outcome. She was pleased to have been a private patient in a city hospital and liked the shared care between the city obstetrician and local female GP.

Although the childbirth literature suggests that most women prefer known female carers (Tracy, 2005b; Pascali-Bonaro & Kroeger, 2004; Homer & Davis, 2002), Paula was unconcerned about not knowing the midwives or child health nurses. Being a shy person, she felt comfortable with anonymity in hospital and privacy in the small town.

Paula's main concern following the birth was the lack of child care available for working women. As most women stayed home with their babies, no family day care services were available. She had an informal arrangement with a neighbour and returned home at lunch time to feed her son and check on his welfare.

Although the necessity for the highly interventionist birth described by Paula could be challenged by research evidence and was not in accordance with recommendations for best practice, she was very satisfied with her private obstetrician and the outcome. Having heard the dreadful accounts of birth from family and acquaintances, she welcomed this relatively quick, painless experience as both necessary and positive. Paula was now convinced that educational preparation for 'natural' birth would have been a waste of time as her body was defective and incapable of birthing, then and in the future, without a caesarean section.

Paula's resulting satisfaction with her antenatal care, interventionist labour and operative delivery is in stark contrast to the predominant experiences of first-time mothers in this study. Most had made detailed plans for their births and anticipated an uncomplicated 'natural' event in a caring context and so expressed disappointment when these expectations were not actualised. Conversely, Paula believed that the unpredictability of birth made preparation pointless. Her labour took place in a busy impersonal setting and she passively adopted a compliant, patient 'sick role'. She was satisfied that induction, electronic monitoring and subsequent 'emergency' caesarean section in a private hospital constituted quality maternity care. Believing she was physically flawed, Paula expected to have an elective caesarean section in the future. This event vindicated her belief that preparation for birth was pointless and 'wait and see' was the most sensible approach. Paula's statement that "whatever happens, happens", sums up her perspective. Once again, this story highlights the diversity of women's views on what constitutes a 'good' birth.

Cluster three: Preferences of women from culturally and linguistically diverse backgrounds

This final cluster is included to illustrate how culture may influence perceptions of what makes a birth experience 'good'. These two contextualised stories describe the individual perceptions of two women, as well as demonstrating diversity within indigenous and ethnic minority groups.

The first experience is that of Evangeline, a non-English speaking Filipino woman and first-time mother. The work of Pranee Liamputtong Rice and others (Rice, 1994; Yelland, Small et al., 1998; Rolls, 1999; Small, Rice et al., 1999; McCourt & Pearce, 2000) has raised awareness of the needs of women from culturally and linguistically diverse (CALD) backgrounds. However, this can lead to assumptions about what birthing women of a particular ethnic group desire, which may not be consistent with the thoughts and feelings of individual women, as is evident in Evangeline's story.

Similarly, in the second story Rose, an Aboriginal multipara, describes birth preferences that are contrary to what the literature on indigenous birthing suggests (Myles & Tarrago, 1993; 1994; Norbury, 1996; Chamberlain & Barclay, 2000; Callaghan, 2001; Chamberlain, Barclay et al., 2001), and what I had expected.

A.3.1 Evangeline

Evangeline had what most Australian women and health professionals would describe as an undesirable birth experience. However, being a recent migrant, Evangeline favourably compared her physiologically safe birth to what she would have expected in her country of origin and was therefore pleased with the outcome.

Background

Coming from a poor community in a developing country, Evangeline had arrived in Queensland as a bride earlier in the year, already about seven months pregnant. Now in her mid-twenties, Evangeline had worked in her mother's shop between leaving school and migrating. Having recently left an abusive husband, Evangeline was now a single mother dependent on female relatives and friends. She hoped to one day have her own home. At the time of interview she was feeling "a little home sick" and "lonely".

When exploring health issues among Filipino woman in rural and remote areas of Queensland, Kelahar, Potts and Manderson (2001) found that the women were often

pregnant before or soon after immigrating to Australia. They comment that "Contraception tended to be seen as a way to stop having children altogether rather than as a method of delaying conception or spacing children" (Kelahar, Potts & Manderson 2001, p. 153). Consequently, these women were adjusting to an unfamiliar country and a new relationship while becoming mothers under these difficult circumstances. Kelahar et al. (2001) also found that domestic violence was a common and poorly reported problem, as the women feared being stigmatised and so instead turned to their countrywomen for support. These observations are evident in the situation Evangeline described.

Context

Evangeline was interviewed at a relative's house in Sugar Town in the presence of an assembled group of Filipino women. They cared for Evangeline's four-week old baby and other small children while contributing background comments. As Evangeline was still learning English, her 'sister' acted as translator.

Social support

After leaving her abusive husband, Evangeline came to Sugar Town to join a community of Filipino women living in the district. She described them as a sister, cousins, nieces and friends. They formed a close-knit group who appeared prepared to protect and support Evangeline however they could.

Antenatal preparation

Evangeline described how she had learned about pregnancy and birth from women in her family. She had recently attended her sister's birth in their village. Home birth was "normal" and "cheaper" but women aspired to hospital birth if they could afford it. Births were attended by local, traditional birth attendants. Evangeline described these women as being of low social status and "not trained like nurses". She added that "when a woman becomes pregnant she starts saving her money" in case she needs medical care. If a complication arose during a home birth, the family then had to pay for transport to the hospital and subsequent treatment. While in Australia, homebirth is an almost unattainable ideal for many women, in Evangeline's village it was the lot of poor women who could not afford the advantages of modern medicine and professional healthcare. Her views on her Australia birth were coloured by her comparison between the two systems of health care. Being able to freely birth in a modern, well-equipped hospital was seen as a privilege.

Evangeline's birth experience

This pregnancy was diagnosed in her home country where she attended a monthly clinic run by a midwife. After coming to Australia, Evangeline attended clinics at a tertiary hospital where she had ultrasonography and numerous pathology tests. Evangeline would take her own translator with her so that she could have the various tests explained to her. She compared the waiting time at the hospital to that of the clinics she had previously attended in her home country where women had to wait "a very long time" because there was no appointment system. It was "very good" by comparison.

When Evangeline separated from her husband and moved to Sugar Town, the local hospital obtained her records from the tertiary hospital. Evangeline then attended the Sugar Town antenatal clinic where she was allocated to the care of one of the hospital doctors. Being seen by this doctor on each visit during the last four weeks of pregnancy impressed Evangeline. In addition, with the help of her 'sister' who interpreted when necessary, the clinic midwives explained what they were doing and allowed time for Evangeline to ask questions. However, although pleased with this care, Evangeline was concerned and anxious about miscommunication as the hospital staff had difficulty understanding a Filipino accent.

Evangeline's labour began in late evening. When the contractions became stronger, she woke her sister. Together with a cousin, the three women went to the hospital at midnight. Although Evangeline said that she did not know what to expect at the hospital, she describes being "sore" but not frightened.

On admission Evangeline had a routine examination by a midwife[140] who also explained the labour room equipment and its purposes to the group of women. Evangeline was shown how to use the nitrous oxide gas for pain relief. The gas was helpful but it made her feel drowsy. As the foetal (CTG) monitor indicated that the baby was distressed,[141] a doctor was notified.

That night, the doctor on call was a stranger to Evangeline, not the one she had seen in the antenatal clinic. However, Evangeline says she did not mind this. She could not recall being asked her permission for any of the interventions which followed but trusted in his expert knowledge and authority. When he ruptured her membranes, the

[140] In Sugar Town, most public births are capably managed by midwives, several of whom can also suture if required.

[141] As documented in her medical record, CTG monitoring showed decelerations and decreased variability in the foetal heart rate.

amniotic fluid was meconium[142] stained which, combined with the 'non-reassuring' foetal heart tracing, confirmed foetal distress. As Evangeline was in second stage labour, the doctor then anaesthetised her perineum, cut an episiotomy and used forceps to lift out the baby. Suturing followed later.

Once delivered, the baby was taken away and resuscitated. Later, Evangeline's new baby son was returned having been cleaned, weighed, measured and, according to his records, given a routine Konakion injection,[143] again without her knowledge or consent. Although exhausted, Evangeline then unsuccessfully attempted to breastfeed. Not surprisingly, her baby was uninterested at that time.

While these are common interventions for foetal distress, language barriers prevented the maternity carers from explaining the interventions. Evangeline was unable to give informed consent. According to Evangeline, the midwife attempted to describe what was going on as it happened but both she and her sister were confused about what was occurring. To have an operative delivery for foetal distress as one's first birth could be an alarming experience for any primipara. Additionally, for this to take place in a foreign setting, amongst strangers, without understanding what was being done to your body, your baby or why, could be expected to be frightening and traumatic. By contrast, however, Evangeline expressed satisfaction with having a live and healthy baby.

Postnatal Period

Evangeline found Australian maternity practices foreign. In addition, Sugar Town hospital had some idiosyncratic postnatal practices which had developed over time. Because several women shared a bay in the public ward, babies were put in a nursery at night to enable mothers to have undisturbed sleep. While 'rooming in' is standard 'Baby Friendly' policy[144] in most maternity units, in Sugar Town they prioritised the need for women to rest.

For Evangeline, being hospitalised after having a baby had both advantages and disadvantages. Removing the babies kept the bay peaceful, which she saw as beneficial because it allowed her to have "a good rest"; however it did make it difficult to establish

[142] Meconium is the baby's first stool. It is a tarry, thick (mucilaginous) substance which if inhaled during birth may obstruct the airways and cause respiratory problems.

[143] With maternal permission, babies are routinely injected with 'Konakion', a form of vitamin K, to prophylactically protect them from haemorrhagic disease of the newborn.

[144] The WHO guidelines for a 'Baby Friendly' hospital are intended to promote breastfeeding and reduce neonatal morbidity.

breastfeeding. Although there were three women sharing the bay, Evangeline was not concerned about the noise and loss of privacy but she was concerned about her breastfeeding problems.

Being unfamiliar with postnatal policies, Evangeline had no idea how long she would be an inpatient. Had she known she could have been discharged sooner, Evangeline said she would have come home to her sister's place. Her "birth cut" was painful (and the area was still sore at the time of interview) and she was confused by the conflicting advice she received about mothercrafting.

When asked about this contradictory advice she had received, Evangeline responded that she found it confusing being told different ways to do things by different people. So, she experimented until she found what was best for her and managed to successfully breastfeed her way.

Another aspect she found difficult was advice on controlled crying. In her home country, the baby is either with the mother or is picked up every time he cries. This was discouraged in Australia. Her sister explained Australian childrearing practices to Evangeline so now her baby would "lie and whinge for while" so his mother could rest sometimes.

While in hospital, Evangeline relied upon her sister or cousin to come and interpret for her.[145] However, they were only marginally familiar with how the system worked themselves. None the less they could advise her that, while in their home country it is normal not to bath the baby until three days after birth, it was usual in Australia to do so daily. Evangeline remarked that she had no trouble adjusting to the "normal way" in Australia. Similarly, there were some special foods Filipino women would customarily eat after birth, for example to increase lactation, but these were not available in Australia.

Comments on the health services

Language and culture were significant barriers for Evangeline. Despite having a number of women from her ethnic group within the community, the Sugar Town hospital appeared to be ill-equipped to work with this diversity. While Evangeline's female relatives attempted to be with her whenever possible, their understanding of the health system, interventions, and procedures was limited to their own personal encounters. Maternity

[145] A free interpreter service is accessible 24 hours but this was not utilised. Although the Filipino women were a significant ethnic minority group, appropriate patient information resources were not available for them.

staff, although well-intentioned, made assumptions about her understanding and assimilation so did not explain Australian cultural practices which they considered ‘everyday’ and ‘normal’.

Despite these observations, when asked about her views of the care she received, Evangeline commented that she found the midwives excellent. According to her they were kind and caring. When they tried to explain things they spoke clearly and slowly. Their good intentions were appreciated and she felt it was often her fault either for not understanding them or when they misunderstood her. Nevertheless she favourably compared their efforts to the care she would have received from the birth attendant in her home country.

It was difficult to evaluate at this point in the interview whether Evangeline was being courteous and not wishing to offend, or whether she sincerely held these views. As Kelahar et al. (2001) point out, Filipino woman in rural Queensland tend to be uncomplaining and reluctant to seek help even when they are experiencing postnatal problems after high intervention births and when trying to cope with motherhood. Their concern about confidentiality and reluctance to ask for support are major barriers to health utilisation (Kelahar, Potts & Manderson, 2001).

Others sources indicate that dissatisfaction is common. McCourt and Pearce (2000) found that women from ethnic minorities experienced a significant dissonance between their expectations and experiences of maternity care. The women valued highly concepts such as communication, support and control, and favoured continuity of care from a midwife, but those receiving conventional care were generally disappointed. McCourt and Pearce (2000) concluded that minority ethnic women do not receive a high quality of maternity care in conventional services and suggest that this is related to the institutional organisation of care.

Small, Rice, Yelland & Lumley (1999) and Yelland, Small, Lumley, Rice, Cotronei & Warren (1998) found high levels of dissatisfaction amongst the Filipino, Vietnamese and Turkish birthing women they studied in a metropolitan centre. Those who were not fluent in English experienced the same communication difficulties described by Evangeline and her sister. Small et al. (1999) and Yelland et al. (1998) found that this barrier was reflected in less positive experiences of care. Issues related to culture and cultural practices were not of primary concern to women in their study; rather the unkind attitude and unsupportive behaviour of health providers was their primary complaint. Staff were too rushed to spend time assisting women with their needs. In particular, women expressed concern about the

lack of support with infant feeding (Yelland, Small et al., 1998; Small, Rice et al., 1999). By contrast, rather than having too little support, Evangeline found the rural midwives well intentioned, kind and caring but she was confused by the amount of conflicting information she received. While the women studied by Small et al. (1999) and Yelland et al. (1998) reported that they suffered from a lack of rest, Evangeline was in a maternity unit where rest took precedence over rooming-in and establishing breastfeeding. In summary, her expression of satisfaction is quite different from the feelings expressed by women from linguistically and culturally diverse backgrounds in a busy metropolitan hospital.

It is possible that the outcome of Evangeline's birth would have been very different in her home country and she raised my awareness of how the quality of the childbirth experience is less important to some women than having a live baby and well mother. High perinatal morbidity and mortality are everyday occurrences amongst poor women in developing countries. While I considered her birth traumatic, Evangeline expressed contentment with her medicalised experience within the relative safety of a rural hospital environment and receiving free, 'expert' medical care.

Evangeline's ability to cope with the Australian hospital system and new motherhood was dependent upon the support and guidance of her countrywomen. At the time of interview, with her sister as support person, she was attending child health clinics monthly and also expressed satisfaction with that service.[146]

A.3.2 Rose

Although health services have become increasingly responsive to the different needs of women from indigenous backgrounds, this story reveals that there are still gaps between what is offered and what women want. In addition, Rose's birth preferences challenge generalised assumptions about rural Aboriginal birthing, highlighting how individual preferences must also be considered. In attempting to achieve the birth she desired, Rose actively resisted the surveillance and disciplinary power of medicine where possible.

[146] The child health nurse had informed them about this study. With 'Evangeline's' consent, details of her experiences were confirmed when accessing her medical records.

Context

Rose was interviewed once only while she was 37 weeks pregnant and expecting her fifth baby. Her three-year-old son and three of her sister's children accompanied her. Rose's older children were at school. We met in the Aboriginal and Islander medical centre in Sugar Town where the Health Workers helped to mind the children. Rose groaned about the burden of being so pregnant and managing all these 'kids'. The interview was interrupted several times either from noisy play or because Rose wanted to check on the children.

Background and previous births

Originally from a larger northern town, Rose had moved to Sugar Town where her partner worked for the town council and she had family support. Now in her late twenties, Rose had three living children spaced over the previous 13 years. I was unable to determine accurately the number of pregnancies and miscarriages Rose had had, as she seemed to find that line of questioning invasive. Instead, Rose compared her urbanised experiences to the lack of knowledge about 'women's business' in the young 'girls' who came from the former 'missions'[147] on Cape York to have their babies. For example:

> One young girl she was raped and you know fell pregnant with a little baby and she really didn't know much eh. Didn't know about her pregnancy or nothing. She knew there was something - she was telling me, she knew there was something inside of her but she didn't know what it was until the baby came out. She was frightened … she's from a mission so she really didn't know what was going on, not even with her body. Even her own mother was saying to the doctor and the nurses [she knew nothing]. I'd hate to be brought up on a mission like that eh. She knew nothing. Nup.

Rose described how, when in hospital, she attempted to share her knowledge with a young 'mission' girl who was struggling with caring for her baby but was reproached by 'staff. She commented: " 'cause I even tried to help her a few times but I got into trouble for mucking around with someone else's child instead of my own". According to Rose, she learnt not to be seen helping younger Aboriginal women while in the maternity unit. Rose remarked that: "them nurses …are pretty strict" then added "but some of them were nice".

[147] Although the Cape communities have not been 'missions' for decades, there is a perception of cultural difference to urbanised indigenous people; compounded by educational deprivation and social isolation.

Regardless of staff censure, Rose felt that she should share helpful Information with the young inexperienced 'girls', for example about infant hygiene.

> I know you've got to wash your hands before going touching from one child to another. So I used to do that [tell the 'girls'] …you clean yourself eh before you touch your own child that's all. I know.

Having been criticised by staff for trying to help, she also went on to compare the double standard of care in another hospital. Rose had found the "night nurses" neglected to change the newborn babies' napkins all night and were "very lazy".

Rose's first two children had been born in a rural coastal hospital, the eldest at 41 weeks and the second at 36 weeks gestation. Although her second baby "came early", Rose commented that "there was nothing wrong with her". So when she came to the Sugar Town hospital with her third pregnancy she did not tell them about her last birth to avoid being labelled "at risk". However, when she went into premature labour at 32 weeks she was transferred from the rural town to a tertiary centre where there were suitable neonatal intensive care facilities.

When asked about the experience of being 'sent way' to a major centre, Rose said she was pleased to go for two reasons. First, it was easier to give birth to a small baby and second, it was a "good" place for an "early baby". She did not find it daunting and remarked: "It was alright there - for a big town hospital. It's small eh, only small facilities, but it works- you meet a lot of people."

Postnatally, Rose had stayed in hospital for a week to be close to her pre-term baby. Because of his prematurity she was unable to breastfeed and was not encouraged to express. She recalled: "No. No. He was too small eh. They were tube feeding him eh and then he was bottle fed". This contravenes lactation research on the benefits of breast milk for premature infants.[148] Rose returned home alone, leaving her baby in the neonatal intensive care unit. Later, he was transferred back to Sugar Town hospital.

Between that birth and the current pregnancy, Rose had had a miscarriage. She had maintained continuity of care with the same male doctor in Sugar Town through her past three pregnancies.

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[148] Lactation research indicates that colostrum and breastmilk provide the essential immunity and nutrients for premature infants (Anderson, 2001; Lawrence, 2001; Hamosh, 2001; Picciano, 2001). In particular it provides lifelong benefits for low birth weight indigenous babies (Elder, Hagan, Evans, Benninger & French, 1999; Oddy, 2001; Singhal, Cole & Lucas, 2001) as well as being affordable for a low socio-economic family (Bonuck, Arno, Memmott, Freeman, Gold & McKee, 2002).

Social support

One of the reasons for Rose's move to Sugar Town was to be close to her sisters for mutual support. As an aunt, Rose had a significant caring role as well. When asked who looked after her children when she was sent away to hospital, Rose responded: "One of my sisters. She's looks after them anyway, even if I'm just sick". Rose added: "[And] they'll have their father. They hardly see him during the day. It's good for them to have him…"

In addition to their own children, Rose and her supportive sister shared the care for an older sister's four children. She explained the informal, family fostering arrangement:

> … see those two little ones … their auntie, my sister, looks after them but my other sister owns them - you know what I mean. They're one of my sister's kids but they're born too close, not even a year apart … So she had four babies [in 4 consecutive years] - she couldn't handle it. So she took the two biggest ones and I took the two little ones. But they're all split up now. But they're all in our family - adopted out in the family. She's not a mother - doesn't like kids, not used to them. She has them and then gives them away.

Rose went on to compare this to her pregnancies which were spaced 3 or 4 years apart so that she could give the children "plenty of love and attention". To ensure that all children within the family were properly cared for, sisters and aunties helped one another. However, Rose complained that caring for her sister's children brought her under scrutiny from health and welfare authorities. She resented being asked about her sister, who also had a "drinking problem", and Rose felt that her family had little privacy and tried where possible to avoid this surveillance.

This pregnancy

Rose knew that she was pregnant at about two months but, because of the previous miscarriage, waited another few weeks "just to be sure" before going to the hospital for routine tests. When asked about the various tests, Rose could not recall having their purposes explained to her. Rose knew that she was checked for anaemia and gestational diabetes but did not care to know about all the other "ordinary" tests as long as the results were "good" and there were no problems. Rose remarked: "When they tell me the bad news then I'll know what it's for". This undermines the assumption that all birthing women wish to be 'empowered' through information about all aspects of their care.

According to Rose, this pregnancy proceeded like her previous ones. The only difference now was how exhausted she felt managing all the young children while close to term.

When asked about her antenatal care, Rose described how she attended the local midwives' clinic. When required, she saw one of the two male GPs, preferably the one she had known throughout her previous pregnancies. For a short while there was a relieving female GP and Rose found it "really good" and "really nice" to see a woman instead.

Rose particularly commented on feeling shamed. She disliked the male doctors "looking down there" and hoped the blood tests would tell them that what they needed to know instead of having a vaginal examination. It was acceptable (but still embarrassing) for a female GP, women's health nurse or midwife to examine her and take a smear so she said would avoid it when possible.

Antenatal preparation

Interested in the antenatal education available to indigenous women in Sugar Town, I asked Rose about the cultural appropriateness of the preparatory materials and resources available at the hospital clinic. She responded: "I never take notice of the booklets or anything. Just go along". Rose did not consider the information applicable to her; she did not watch the educational movies (preferring to sit on the veranda). Although the Aboriginal and Islander health centre also had for loan some culturally specific resources, personal experiences and those of other women were the most commonly used sources of information.

When asked about her plans for this birth, Rose was very definite about her wishes. Although the 'doula'[149] concept (Auntie) is promoted for Aboriginal woman, Rose stated emphatically "No!" that she did not want anyone with her as a support person. She clarified:

> [Except] the women nurses eh. Yes them. But not the male doctor. Well if they call him in … But its shame because they're looking right there. Yeah. But I suppose if they're got to be there, then [shrug]… But I prefer to have women there. I had mainly all women there when he was born, then the doctor came in. So I suppose you've got no choice eh …by the time you have pushed the baby out you're that buggered…

[149] A 'doula' is an older experienced woman who provides skilled support to a woman in labour. It has been shown to reduce pain and improve perinatal outcomes.

Shame was Rose's most significant concern. For this reason, she emphatically refused to see even her aunties and sisters until after the birth. The anonymity of being amongst strangers reduced the inevitable shame and embarrassment associated with birthing. Taking this further, Rose refused to give birth at the small local hospital where she distrusted the staff. Expanding, Rose went on to describe how she wanted to be in an impersonal environment amongst strangers as this increased her feeling of control over her privacy, gave anonymity to those who saw her intimately and reduced the risk of gossip. Rose was demanding to go to the large, impersonal city hospital where she had had her last baby. She stated empathically:

> No. I'm *not* having it here. I'm going to ask for a transfer [to city] …I just don't want to have it here. This is a small town. I *won't* have it here."

Rose planned to travel to the city a few days before her expected date of confinement. Given her history of pre-term labour, I asked what would happen if she began contracting while still in Sugar Town. Rose insisted that if she "went early …then I'll get rushed down by ambulance".

As this would be Rose's fourth birth, I assumed she would labour with minimal intervention. When asked about her preferences for pain relief, Rose responded: "I try and go without them things. Epidural, I had that once". She would request pain relief if required.

Traditionally, Aboriginal women had rituals surrounding the placenta and now, given the option, there is a renewed trend amongst women towards taking the placenta home. I asked Rose if she had considered this.

> *NO!* No (laughs) What for? Aren't they ugly to look at? They are. I don't want any of that stuff (Laughingly calls out to the health worker). You want my afterbirth when it comes out?

While Rose definitely did not want her placenta, she considered herself a modern woman, but went on to talk about her grandparents "up north" and some of their "old ways".

Postnatal preparation

Finally we discussed her choices around the postnatal period. Given her present exhaustion and that her family were prepared to care for the children while she was away, I asked if she would stay in hospital for a few days to rest, recuperate and enjoy her new baby. Although she would like to rest, Rose felt she had to "come straight home" to her young son.

Although it was possible to come home soon after an uncomplicated birth, she would probably be “too sore” and so would stay a couple of days.

Rose had also considered postnatal contraception. She said that the doctor wanted to sterilise her “right after birth but I told him no, I’ll wait”. As her mother had ten living children, Rose was not sure that she wanted this to be her last baby. When pressured by the doctor to consider some form of birth control after this baby she opted for a non-permanent method. However, Rose felt uncomfortable about the unnatural way long-lasting injectable contraceptives caused amenorrhoea.

Contributing to this controversial discussion about contraception, the senior health worker described an Aboriginal woman in town who, some years earlier, had wondered why she couldn’t become pregnant again following a caesarean section, only to find later that she had been sterilised without having given consent. This fuelled local suspicion about white medical control of Aboriginal women’s bodies and fertility.

Because I was unable to interview Rose after the birth, it is not possible to comment on the actualisation of her birth plans. However, the health workers informed me that she had a rapid labour and, contrary to her wishes, Rose had her baby in Sugar Town hospital.

Comments on the health services

As an experienced multiparous woman, Rose had very definite views on the health services she utilised. The interest shown in the welfare of her family and her fertility was invasive, so Rose tried to avoid services where she felt scrutinised and prioritised personal privacy. Rose considered herself to be an urbanised Aboriginal woman who was living in a rural community for family reasons. However, she had no intention of birthing there. During her pregnancy she saw a male doctor because there was no local alternative, but was adamant that she would have her baby in a large maternity unit where she was unknown and with only (female) midwives present. The shame and embarrassment of having familiar people seeing an intimate part of her body was abhorrent. The anonymity possible amongst strangers was preferable and provided some control over her personal privacy and emotional safety. Other advantages included having a few days away from her heavy child care responsibilities and being able to have an epidural if required. Chamberlain et al. comment on the common policy in rural centres to:

> transfer … mothers in late pregnancy to hospitals in urban centres. For many Aboriginal families this policy has been far from ideal. As a result, some Aboriginal

> women fail to seek early health care when pregnant. In order to counteract this, it is necessary to offer culturally sensitive maternity care that Aboriginal women will accept (Chamberlain et al., 2001, p. 81).[150]

By contrast, Rose felt that her psychological well-being and her expected baby's physical safety were assured in a large, impersonal maternity hospital. That was her ideal birth. However, as Chamberlain et al. point out, care in any centre needs to be culturally sensitive. Rose's story also highlighted the cultural inappropriateness of men's attending Aboriginal women during birth, the ineffectiveness of many educational materials distributed by the hospital, and the pressure she felt to comply with the doctor's attempts to limit her childbearing to white norms. There is great diversity amongst Aboriginal women and the cultural practices they value. Assumptions cannot be made about the support during birth, preferred place of birth, desired family size, or practices such a taking home the placenta. The importance of asking each individual woman about her preferences is again evident.

A.4 Summary and Discussion of women's perceptions

In this chapter, a distillation of the empirical data demonstrates the diversity of women's perspectives about what constitutes or constrains a good birth. 'Birth' is described as encompassing the childbearing cycle of pregnancy, birth, postnatal and early parenting, not just 'confinement', labour and 'delivery'. In particular, these components of the birthing cycle are not seen as just physical events in a woman's life, but each involves significant psychosocial and emotional aspects as well.

Women's perceptions of the birth experience and of themselves as mothers were internalised and subsequently actualised in their identity (self-perception) and in their social practices, as demonstrated by the way in which they described themselves in the speech encounters illustrated here. The discursive position of these women is evidence that the groundwork for self-perception is founded upon their experiences during this vital period of their lives. Interactions with health providers and medical 'permission' to make limited choices, along with the quality of information provided to birthing women, contribute to shaping these self-perceptions.

Of the 28 women interviewed, eight stories were selected to represent differences between women's social and cultural background, location, parity, preparation, place of birth, personal preferences and perceptions of the birth experience. The stories have

[150] This is consistent with my former experience as midwife in a remote Aboriginal community.

been organised into three clusters. The first cluster included three spontaneous births; the second considered obstetric interventions in relation to risk factors, while the final cluster examined cultural difference in relation to personal preferences. The diversity illustrated here demonstrates how only the woman herself can judge the quality of her birthing experience.

What is evident from these women's stories is that it is not possible to generalise about the factors that create a good birth for women in rural and remote locations. However, these stories reveal that there are several areas in which their views overlap and concur and a number of common themes emerge. Paramount for all women was the desire and need to make choices. For some, the decision-making was well-informed and encompassed all aspects of the child-bearing cycle, for others it was as minor as choosing the doctor and place of birth. All participants felt that they had considered available options, made decisions, and so had some sense of control over the process. Continuity of care throughout the cycle was important to many women and the gender of the doctor was significant for most, with a woman doctor being preferred but seldom an option. Every woman commented on the importance of the social and emotional aspects of the birth. For some, this took precedence over physical safety; for others, being in a 'safe' place provided them with the comfort and security they required. Place of birth was identified as important by all the women for various reasons. The people present at the birth also mattered. For many, having health providers and support people who were familiar and trusted was important. Others emphasised the value of anonymity during the intimacy of birth. Preferences over health providers, support people, place, type of birth and interventions varied but again reflected individual choice.

While the type of birth profoundly affected how women felt about themselves and their babies afterwards, these stories also make it clear that birth is only one part of the childbearing experience. The postnatal period was often the loneliest part of the cycle and the one which new mothers found most challenging and unsupported in small rural and remote communities. Postnatal and early mothering experiences tempered the achievement of a 'good birth'.

When asked what it is that rural/remote birthing women want, it is not possible to generalise; however I can conclude that having options and support is of paramount concern to most women while a sense of control is significant to many. Rural/remote women are as diverse individually, socially and culturally as metropolitan women and this

is reflected in their varied preferences and perceptions of what constitutes a good birth experience. This broader picture of rural/remote birthing highlights the significance of accessible, holistic, woman-centred care during the childbearing years.

Part B Maternity Care Providers' Perceptions

The indepth interviews with rural/remote maternity care providers were guided around their background (as profiled in Section 5.7.2), the roles and relationships they had with birthing women, and their perceptions of issues that they considered affected the health and well-being of childbearing women in their community (Section 5.2.3; Appendix 7). In most interviews, participants included exemplary stories, some of which involved birthing women who participated in this study, thus adding another viewpoint.

As with the birthing women, maternity care providers' perceptions of what constituted a good birth were diverse. These varied both within a professional group and across the professions, being largely influenced by differing professional and personal background experiences and individual philosophy. Time and place also emerged as significant intersecting themes. Notably, the maternity care providers' descriptions of birthing were framed in negative terms. However, with few exceptions, they described both the inherent risks and the factors that do *not* create a situation conducive to a good birth and which resulted in poor outcomes. Consequently, the examples in this section tend to illustrate what maternity care providers considered the reverse of what should happen.

B.1 Personal, professional and philosophical factors

Aboriginal and Torres Strait Islander Health workers' views are presented first, followed by those of midwives and doctors. While there are some overlapping themes between these health providers, there are also significant differences in views, such as the emphasis on culture, gender, holism and shame in the health worker's perspectives.

B.1.1 Aboriginal and Torres Strait Islander health worker's views

In Sugar Town, Anna and Brenda endeavoured to provide a culturally safe and healthy outcome for indigenous and South Sea Islander birthing women. A good birth for them was one in which a woman received culturally appropriate information and family-centred maternity care, preferably from female health providers, facilitated by effective and mutually respectful information sharing between the hospital and health centre. In

addition, Anna and Brenda identified the importance of an expectant mother's age and parity to healthy childbearing.

The health workers had modified mainstream antenatal information to create culturally appropriate, visually appealing and comprehensive kits for expectant mothers in their district. Ideally, these women would visit the hospital maternity clinics for regular monitoring before and after they had their babies. Anna and Brenda would "tell them" how important it was to visit the hospital doctor and go to antenatal classes, especially the first-time mothers. However, this had limited success. Anna commented:

> Some of them don't often go, they only go maybe 2 or 3 times before they have the baby but they should go all the time… A lot of people don't go to antenatal birthing classes because they probably feel out of place in the white community.

Commenting further on lack of attendance, Brenda adds:

> Aboriginal people haven't turned up. And I think because of the white people, because it's all white ladies that come. Some of them don't feel comfortable with that. I mean a lot of coloured people in this town aren't comfortable with just seeing white people.

This was exacerbated by communication barriers between the hospital and ATSI Health Centre, which made it difficult to provide seamless care. Anna remarks, "Well the hospital doesn't even ring up to ask us to follow them up. So I think it's up to them". However, Brenda states that, "If we got that follow-up [notice] the first time we'd keep an eye on those ones".

The health workers described how, with an Aboriginal registered nurse/midwife from the clinic, they provided extensive outreach to the small communities around Sugar Town. Although women could drop into the clinic in town anytime, the outreach program provided by an all female staff was more successful. Anna attributes this to gender, culture and holism:

> I think that because we've always had male doctors, we've only ever had one female as far as I know, and if one of the doctors has holidays we get a relieving doctor and sometimes it is a female. I mean there is all male doctors in this town. There are no female doctors whatsoever.

Whereas “Most of the time the girls[151] go out and see them in their homes where they probably feel more comfortable. We ask them if they’re doing OK. And what not” (Anna). Brenda adds: “We just go out and do a check-up with them and ask them how they’re going with their pregnancy and things like that. To see if they’re going to antenatal [clinic]”.

Being family centred, the health workers provided a range of care for all family members as required, not only for mothers and their children. This included diabetic care, identifying pregnant women, antenatal and postnatal advice, infant health checks and opportunistic pap smears and immunisation.[152] While in the home, they commented that “You’re noticing all these things – yes” (Anna) and “You’re are not just in that one place where the kids are getting immunised, your eyes are everywhere, you know” (Brenda). If mothers were not accessing health care, then “you just got to keep jogging their memory” (Brenda). However, there was an ongoing problem with staffing this valuable outreach service with suitably qualified indigenous health professionals.

The expectation that health workers would issue health directives to Aboriginal and Islander women was one of the misunderstandings that occurred with the white maternity and child health staff. According to Anna and Brenda, health workers cannot tell women that they *must* see a doctor or attend a clinic. The inappropriateness of this was reiterated several times throughout the interviews. For example:

> I’ve said [to the Maternal and Child Health Nurse] “Look, I can do my best in asking them but it’s up to them if they go” A lot of ladies don’t go (Anna)

> … we encourage them to come in anytime. Just whenever they want to come. We don’t push them or anything like that (Anna).

As for seeing a male GP, this was a personal preference. Brenda points out: “The male doctors that are up there - I mean like for me, I’d go and see them but I can’t say to the other people that they should go up there”. Anna emphatically adds: “No!”

The health workers believed that a positive birthing and mothering experience was more likely if women did not begin childbearing when they were teenagers, did not have their babies too close together and preferably stopped at about four children. Giving local examples, Anna and Brenda discussed when women should decide “that’s it” and know

[151] Aboriginal and Torres Strait Islander (ATSI) Health Centre staff

[152] With the introduction of a requirement that pap smears and administration of immunisations could only be provided by suitably trained and endorsed health professionals, they were very concerned that so many of their clients were now not up-to-date with screening and vaccinations.

"when to stop" and "have their tubes tied". However, neither health worker felt she should impose these views on women, nor was it perceived as appropriate for them to offer contraceptive advice. However, the increasing number of young, first-time mothers was of concern. Anna comments that "Some of them have just finished school or just a couple of years out of school, 18 or 19, they're very young. Some of them don't even get to 20 and have children."

The visiting family planning clinic was perceived as being for white women and concerns about confidentiality made it difficult to access contraceptive advice in the small town.

> Because everyone watches when you go in. And if you are young, you might be 15 or 16 and you're going to the doctor and want to get the pill. Then everybody else knows all about it. "You know such and such is…" and they're talking about it behind her back (Anna).

Supporting the concern raised by Rose earlier in Part A.3, the health workers went on to discuss issues of privacy and shame. Both were significant concerns for local indigenous women and a barrier to accessing care.

Given the limitations of the local maternity services and cognisant of the cultural constraints on the care they could deliver, the health workers were trying to provide an optimum experience for Aboriginal and Islander women in their district. Interestingly, both Anna and Brenda had themselves experienced problematic births in Sugar Town,[153] involving some of the current white maternity staff. This influenced their perceptions of the quality of care available. By contrast, only two of the white maternity care providers raised concerns about the particular needs of this client group or the need to improve relations with the ATSI Health Centre.

B.1.2 Midwives and doctors' views

Midwifery or obstetric experience, especially in low-tech rural/remote settings, along with currency of knowledge and skills, were significant to health providers' confidence and perceived ability to offer quality care and women-centred services.

[153] They described their experiences in detail and sought further information from me as they thought I could access their medical records. Instead I assisted them with FOI requests.

Rural and remote midwives

Amy and Beth recalled the transition from novice to competent rural midwives. Beth's practice was advantaged by being a local mother, while Amy was single and childless with little contact with childbearing women outside of work. Although Amy was a recently qualified midwife, she was an experienced Accident and Emergency nurse. Amy was aware that this background influenced the way she tended to treat women as patients and endeavoured to hurry those waiting in clinics through to see the doctor. When she had begun practising as a rural midwife, Amy had felt a "novice", "hopeless" and had no confidence in her skills. Similarly, Beth was initially unsure of her abilities as she had had limited opportunities to practise midwifery in a rural hospital. They both commented how they missed the support and backup of experienced midwives, obstetric registrars and the security of a high-tech setting. Beth added:

> I was frustrated because there weren't as many deliveries [and] … I was more geared to using machinery than midwifery skills … I wasn't comfortable with my own skills … I was much more inclined to rely on machinery and things to assist women.

Thus, a good birth experience at that point in their careers had been one without unmanageable complications. Both found it took time to adapt to rural practice, as it was "a lot less interventionist" [Beth] but finding that most births were "straight forward" [Amy] built their confidence. As Amy and Beth grew to embrace the low-tech rural environment, and became secure in the knowledge that high risk women were sent to a tertiary hospital, they were able to re-focus their skills on supporting physiological labour and developing a woman-centred approach.

Having gained experience and confidence in rural practice, and expanded their professional skills, several midwives were exasperated when normal births were evacuated to major centres, just because doctors were unavailable.[154] Rural midwives Cathy, Amy, Beth and Hazel considered that the major flaw in their health delivery was gaps in the after-hours medical service. To make things worse, in Sugar Town several of these women had been assured by the doctors that they could birth locally and had planned accordingly. Amy remarked:

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[154] As defensive practice, in the rural settings two doctors were supposed to be on call in case an emergency eventuated. One was required to perform operative obstetric procedures, the other to manage anaesthesia. This policy was increasingly difficult to follow.

> If there's not two doctors in town … then it's sorry, bye bye. We supposedly have this service but when they come in to have their baby they're told they're going to [city, 2 hours away].

Beth agreed, adding that most women aligned with the concept of risk:

> They have to go, don't they? They're not going to put their baby at risk. I guess they've come to see birth as a dangerous process themselves, when it's put to them like that. It's very frustrating, yes, very frustrating. We had one weekend when we transferred four multis[155] to [tertiary hospital] for straightforward deliveries. We [midwives] definitely could have delivered them. It reflected on us and our unit. It's really annoying.

However, there were women who challenged the lack of out-of-hours services. Beth recalls one who questioned being evacuated, after giving birth, for a procedure which should have been available locally:

> The outcome was ok. It was only a 5 minute job to remove the placenta once they got her to theatre. But this was an intelligent woman who asked a lot of questions. It was sort of brushed under the carpet and nothing ever came of it, but, you know, I was put in a predicament because this woman rang me asking for my opinion. I find that a [difficult] situation to be in. You've got to be very careful what you say. … Sometimes midwives feel very powerless…

Rural midwives, Cathy, Amy and Hazel, also related tales of labouring women who had been sent by ambulance to the nearest hospital with obstetric facilities. As some of these women were multiparas with previous uncomplicated births, the midwives argued that it was riskier to send them on a long road journey than to enable them to birth locally in a familiar, supportive environment with a skilled midwife. In addition, there were undesirable consequences, as described by Beth:

> We have had episodes of women delivering in the back of an ambulance … and not nice deliveries in the back of an ambulance. It's just that it's not – not on.

She adds:

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[155] In this context, 'multis' refers to low risk, multiparous women who have 'proven' their ability to successfully birth without obstetric intervention and so would be suitable for a rural birth.

> … And they had other young children so it's an upheaval for their whole families to have to go and deliver somewhere else. It doesn't happen often but it's still a trauma. They don't like to go away from home. It's a nuisance. They like to see their other children too.

Not only were women transported in an uncomfortable and physiologically inappropriate position on a stretcher, but this also had a psychological impact which contributed to their subsequent dissatisfaction with public maternity care.

Beth applauded the actions of 'Bella', an Italian woman expecting her fourth baby who stayed at home until in well-established labour and too advanced in the birth process to be transported to the city. Bella was able to enjoy a non-interventionist, local birth with three generations of family members present.

Given the opportunity to birth in Sugar Town hospital, women could expect a high quality, family-oriented experience. The facilities had been refurbished to be homely, rather then clinical. Of the hospitals in this study, Sugar Town was the best equipped to provide comfort measures during labour[156] as well as epidural pain relief (if an anaesthetically qualified doctor was available). As the accoucheur was usually a midwife, women were encouraged to adopt their preferred birthing position.[157]

Significantly, there was no limitation on support people during labour unlike that of the nearest tertiary training hospital which set a limit of two (usually partner and either friend or mother) yet allowed several attending students and staff. Beth relates the benefits of rural birthing:

> People don't tend to get in the road as much as in a big hospital … because we don't have a rush on deliveries … My attitude is that the woman [who is] birthing, it's her room and if whoever she wants to be there, well, that's it. … They'll usually tell you who they don't want and I usually check with the woman. I think it's important to treat it as her room and what she wants goes.

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[156] Including easy access to hot showers in birth suite, birth balls, Tenns machine, and a private verandah overlooking the garden where women could walk during labour.

[157] Recently trained midwives encouraged women to make choices around positions for birth. A couple of older doctors and midwives were described as having "gammy knees" which made it hard to birth women in unconventional positions. Private doctors preferred women to birth on their backs for accoucheur convenience.

> I mean, we've had deliveries where they've even had brothers-in-laws. I actually had a really nice delivery last year where the woman's father was present. It was one of the best deliveries I've ever been at. It was very relaxed and grandad was videoing away [but] he was so tearful and excited that he forgot to put the film in his video camera!
>
> I've actually had one [where] the woman wanted her daughter there. She [little girl] actually was with her grandmother when the baby was delivered and she handled it all very well. …I don't see a problem with it as long as they've got a grown up with them - a support person and not on their own.

Although Amy concurred that women should have choices over birth positions and support people, she added that there was not a consensual view; it "basically depends on the midwife on duty". This was evident across all settings. In effect, the midwife on duty became the gatekeeper. Amy added that it was important to let a labouring woman know beforehand that should a problem arise, she would have to adjust her plan but "most people are happy with that".

Further linking the negative examples to timing and place, the midwives in Sugar Town, Stockton and Pastoral Town noted that women were increasingly choosing to take out private health insurance to achieve some certainty and consistency in maternity care[158]. However, in Mining Town, Cathy stated that "seven out of eight" women were privately insured as part of their mining company package so, rather than being actively consumerist, pragmatically felt that they "may as well use it".

With fewer women birthing in the district hospitals, rural/remote midwives[159] expressed regret about the loss of a long history of local maternity care as well as personal concerns about deskilling and their professional role becoming devalued. Mining Town midwives, Denise, Cathy and Hazel described how they had had undetected pregnancies and labouring women unexpectedly 'walk in' with complications. As this resulted in several adverse outcomes, they recognised the importance of being able to respond competently to such events[160]. However, none of the ageing maternity staff were

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[158] In Mine City, women's lack of confidence was evident in the refrain "when in pain, catch a plane" (Croker, 2001).

[159] Beth, Amy, Emma and Cathy.

[160] Although the adverse outcomes (such as the premature birth of undiagnosed twins in an itinerant woman) could not have been averted, improved assessment skills and responsiveness could have ameliorated the consequences.

prepared to leave Mining Town to update their professional knowledge and skills unless it was fully funded by Queensland Health or the mining company. Furthermore, they noted, they were already short-staffed and their work time was increasingly being taken up with ageing medical patients. By contrast, the other midwives interviewed had all undertaken some form of professional development and education in the past year and felt this enabled them to provide quality care.

Given the number of nursing staff in Mining Town who held both midwifery and child health qualifications,[161] I was surprised to find that holistic maternity care was not being provided. Most midwives were long-term local residents and, although they were experienced practitioners, neither professional development nor ensuring continuity of care were priorities for them. There were exceptions. As shown in Joy's story, the quality of care in labour could be excellent and those particular midwives gained immense satisfaction from being involved in such positive experiences. Similarly, Cathy described how she had once been asked by the doctor to provide individualised antenatal education for a mining couple. This she did in her own time, recalling with satisfaction:

> And that was really rewarding actually. That was about probably the best time that I had because the husband was there, the dad, and he was really, really interested.

However, this was unusual in Mining Town where there remained both a demonstrated need and the opportunity to expand midwifery practice to include collaborative antenatal and postnatal care that articulated with GP care and the visiting Maternal and Child Health nurses. Due to nursing staff shortages, family commitments and a factionalised workforce, no action to provide continuity of maternity care was forthcoming. Without paid overtime or formal inclusion of such roles into their workloads, midwives were generally unprepared to expand their scope of practice. This attitude seemed to be consistent with that of the unionised miners.[162]

In the remote settings, Emma and Kim stand out as experienced midwives who

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[161] In the period in which they trained (1960-1980s), it was normal for aspiring general nurses to add midwifery and child health certificates. Five Mining Town nurses were also midwives and three of these held Maternal and Child Health certification.

[162] In consistency with my methodology, this led me to critically reflect upon my biases whereby I have been socialised to value altruism and conscientiousness. Rather than admiring the Mining Town midwives for avoiding unpaid work and financial exploitation, I felt prejudiced against their lack of commitment to midwifery care. Conversely, I find myself holding in high esteem the remote midwives who, enacting the midwifery ethos, provided the best possible experience for women, even when it encroached on their personal time. I try not to let these biases colour my interpretations.

were not only comfortable in that isolated context but who had adapted and expanded their scope of practice to ensure that the majority of women birthing in their district had an optimum experience. Both Emma and Kim grew up in Western Queensland and were well regarded in their communities. Proactively, they sought out women who they noticed were pregnant and worked collaboratively with the sole medical practitioner in an endeavour to provide seamless maternity care.[163] Although most women relocated to give birth in a major centre, Kim and Emma offered individualised antenatal preparation[164] and, if possible, postnatal support. They often followed up with home visits to assist with breast feeding and respond to other concerns. This was demonstrated in Claire, Joanna and Olive's stories.[165]

Not all the midwives interviewed shared the passion for midwifery practice as discussed above. In stark contrast to Kim and Emma, who positioned themselves foremost as midwives, Gloria and Faye were primarily nurses. Although they had acquired midwifery qualifications as young professionals, maintained their endorsement and had rural/remote nursing experience, neither Gloria nor Faye was sufficiently current or confident in her midwifery knowledge and skills to support local birthing. Gloria in particular felt that it was professionally irresponsible to encourage or enable birthing without adequate obstetric technology and expertise as back-up.

If a continuum were to be drawn, the farthest from an individualised, holistic, woman-centred approach, and closest to an obstetric nursing focus was found with Gloria's practice. Despite her experience in remote indigenous communities, she endorsed the risk management approach, believing in a rigid model of care dictated by safety policies with minimal flexibility or choice for women.

Currency of practice and skills maintenance were frequently raised by the participating midwives as concerns affecting quality of care. Being 'out-of-date' or lacking recent experience decreased confidence and led to criticism from colleagues. This is evident in their different perceptions of birth experiences, a shown in the next section.

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[163] Sole practitioners, as medical superintendent in private practice (MSIPP), provided private, bulk-billed antenatal and postnatal care. Consequently, patient records were not held at the hospital. This meant that woman could present at the hospital in labour or with a complication and the staff would have no access to her records if the doctor was unavailable.

[164] This enabled them to meet the diverse needs of birthing couples so that, for example a poorly educated ringer and jillaroo weren't feeling silenced next to an articulate professional couple in a joint class. It also ensured that couples/women were comfortable when exploring sensitive topics like sexuality and depression.

[165] As well as in other birthing women's stories which are not related here, such as those of Megan and Jess.

Philosophical differences

'Sally' was expecting her second child and unexpectedly went into labour during the night at 37 weeks gestation. Her husband was drunk so he and Sally were brought to the remote hospital by a male friend capable of driving. The regular GP was on leave and the inexperienced male locum wanted to "bounce her out of here as fast as possible" but stormy weather prevented evacuation by the RFDS. However, "all went well" according to Faye, the midwife-on-call, even though she had not "delivered a baby" for many years. She recalled with elation: "It was well controlled. I haven't lost my touch and I felt really proud of that because it has been a long time…"

Faye practised midwifery as she had learnt it decades before, pre-reflectively following the same routines. She assisted Sally during her labour with comfort measures like back-rubs and walking. When the pain became intense, Faye got Sally onto the labour bed in the designated delivery room, administered intramuscular pethidine and later cut an episiotomy to facilitate birth. Sally's husband and three male staff witnessed the birth. Sally reportedly was happy with the birth experience. Faye was pleased to be able to follow-up later on 'her' baby and Sally in the child health clinic.

This scenario is viewed completely differently by Emma, the most experienced midwife and child health nurse in this study. She was "very distressed" about Sally's birth for a number of reasons. Foremost, for safety reasons, Emma did not believe in using narcotic pain relief as it causes neurological and respiratory depression in the baby so that resuscitation and drug reversal may be required at birth. Proactively avoiding paediatric emergencies was important in low-tech remote hospitals. Emma asserted that Sally had not requested narcotic pain relief, that it was administered too close to birth for safety, without adequate examination beforehand, and that the baby was not appropriately monitored for problems after birth. Secondly, narcotics affect an infant's ability to suckle for up to 72 hours. This was compounded by inappropriate postnatal lactation support. Additionally, the small baby was incorrectly weighed and measured before discharge from hospital.

Further, Emma was very critical of how Faye had managed maternal care. Emma followed current evidence for best practice. She believed that Sally had had an episiotomy unnecessarily cut "when they have been out for years and you [would] only do one when you really, really have to". Emma also felt the birth environment needed to be conducive for a good birth. First, this meant that a woman in labour should not be surrounded by unfamiliar men, even if they are staff. Second, Emma avoided using the labour bed and

delivery room. Instead, she would set up a homely, non-clinical environment in an available space close to the hot shower and where a labouring woman could use the floor mattress, bean bags and whatever else she desired for comfort during labour. This would have reduced Sally's pain and anxiety in labour.

This stark contrast in perceptions of a particular birth event is one illustration of how both an individual midwife's knowledge and philosophical approach to practice influence what she views as a 'good' birth experience. Where the birthing woman and midwife's perceptions are aligned, mutual satisfaction with the event is more likely. Philosophical disagreements over best practice frequently occurred between maternity health providers.

Philosophical differences were most common between midwives and doctors, rather than between midwives. Adopting a midwifery perspective, Beth found that ensuring an optimum experience for birthing women often involved her being assertive, politically aware, and an advocate for women's interests. Despite her efforts, Beth was concerned about the continuing medical dominance in the model of care provided in the rural maternity setting. She expressed the rural midwives' frustration with the lack of autonomy in their role and limited scope of practice, especially the minimal midwifery involvement in antenatal care and postnatal follow up. This prevented women having access to the continuity of a holistic model of midwifery care.

In the remote settings, Gloria and Kim described tense relations and frequent disagreements over the type of maternity care they should provide. While Kim advocated for low-risk local births for multiparous women, the MSIPP disagreed. He was prepared to provide antenatal and postnatal care, but perceived the intrapartum period as too risky for a one-doctor remote community. Claire discusses his views in her birth story. Gloria holds the same viewpoint. As shown in Olive's story, Gloria's views are in conflict with those of both Dr Diana and Nr Emma who were confident of their ability to provide safe care and satisfactory outcomes.

Infant feeding policies could also lead to disagreement and confusion, as shown in birthing women's stories and midwives' accounts. While best practice guidelines support 'baby friendly' lactation policies, the inconsistencies in implementing these created confusion for new mothers and frustration for midwives like Kim, Emma, Beth and Amy. In the remote settings, Kim and Emma endeavoured to ensure that new mothers received breast feeding support. Kim wrote a policy for Stockton staff and, where possible, provided lactation counselling to local women. Emma distrusted the quality of lactation advice being

given by the inexperienced MCH nurse/midwife so would visit local mothers unofficially to monitor their babies' progress. This resulted in tension between her and the MCH nurse who felt undermined. However, infant feeding was most contentious in Sugar Town.

The hospital prioritised a quiet, restful postnatal environment and this had become a community expectation. Although 'rooming in' is standard practice elsewhere, as it allows mothers to adjust to their newborn and demand-feed to establish lactation, in Sugar Town babies were usually placed in the nursery (with maternal acquiescence). Amy commented on how this emphasis on rest could have untoward outcomes on women's success in establishing breastfeeding, especially as babies received supplementary bottle feeds to make them less demanding. This practice further inhibits successful lactation.

Conflicting advice from midwives was an additional problem when they did not uniformly practise according to current evidence on lactation.[166] Disregarding unit policies, in Sugar Town they continued to give babies additional feeds or advise women according to their own subjective experiences. When asked if inconsistent advice created problems for new mothers learning to breastfeed, Amy remarked:

> Oh. Yes. Goodness me, does it what. … It's a very difficult issue [to manage] … breast feeding is one of the most contentious issues… I get very frustrated by it. All I can see to do is I just say to the lady, 'Look, you're going to get this, this and this advice, everyone is going to come in with their personal opinions and you've just got to pick what you think will work for you' and I give them as much literature as I can to back up what I'm saying because I know I'm right. You know, and I just hope that they can come out making sense of something. We're getting better. We've got a lot of younger midwives, or newly trained midwives coming through and we're fairly similar in our thought processes … But then we have got a few old schools, you know, that spoil things. … I can call a midwives' meeting and say, 'Blah, blah, blah' But I can guarantee that no one would take any notice of me and all that would happen is the comps[167] will go on and they won't be written down! I know that's what will happen. So it's really just a matter of waiting for the old school to go and the new school to take over, I think.

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[166] New mothers in this study identified conflicting advice as affecting their satisfaction with their birthing experience. Notably in Sugar Town, two new migrants, Evangeline and Madison, described their confusion. Madison's case notes stated that she was "Mothercrafting poorly", placing the blame on her whereas the advice she received was inconsistent.

[167] 'Comps' meaning additional, complementary feeds of milk formula. This practice has been outdated since the 1980s.

Distrust and dishonest documentation were obviously issues of concern.

Beth observed that mothers were confused by the conflicting advice but, as it was too difficult to change the problem with midwives, she left the decision-making to the new mothers. Shifting blame, Beth's expectations place responsibility for success with the bewildered new mothers, rather than the midwives:

> Some women get very upset about it. But I've decided that's going to happen no matter where you are and you know, if a woman is sensible enough, she can take it all in and decide what she wants. I don't know how you get around conflicting advice. … Well, we have got a breast feeding policy you know, [but] there are still some that have their own views and what can you do? I mean, it's been an ongoing struggle with us. And I really believe that if a woman wants to breast feed she will do it. If it's neither here nor there to her she'll make her own decisions and I don't really think there's anything we can do about it.

Pre-reflectively, Beth goes on to draw upon her personal experience with breastfeeding and determination to succeed despite conflicting advice.

It was suggested that it is the new mother's fault if she cannot sort out useful information and disregard the rest, even when it is all given by 'experts'. Issues around conflicting breastfeeding advice were frequently cited by birthing women. For example, Evangeline waited until she went home and sought advice from other Filipinas. Another Sugar Town participant (Madison) described how confused she was by the advice on feeding her fretful baby while her patient progress notes had recorded that she was "mothercrafting poorly", thus placing the blame on her inability to cope.

Sugar Town midwives wished to improve women's birthing experiences in antenatal classes and clinics. Continuity and familiarity for public maternity clients were desirable through a 'know your midwife' program. However, antenatal classes seldom included singles, very few public patients attended and Amy had never seen an indigenous person or "any other ethnic group" there. The class participants were usually well-informed, privately insured, professional couples. When asked how the public patients received antenatal education Amy replied:

> Oh, I don't know that they'd be getting anything. Just family and friends and – some come to the booking in where you can sit and have a fairly good talk, but often times it's education on the day as we go along.

This meant that appropriate antenatal education was not reaching the bulk of birthing women; in particular, it could be argued that the groups most in need of educational preparation were those least likely to receive the information to make them informed consumers.

Midwives' satisfaction with the care they could provide was further reduced by the reluctance of the Sugar Town doctors to relinquish medical control of maternity care. Antenatally, midwives were limited to "shepherding women" to maintain efficient throughput and not "keep the doctors waiting" (Amy), "blood tests, urine tests, blood pressure and that's about it!" (Beth). In accordance with a midwifery philosophy, Beth had attempted to initiate a midwives' clinic that would cater for uncomplicated pregnancies and women who preferred to see a midwife. Not only would this reduce the waiting time for pregnant women and the patient load on the two doctors, but it would also allow time for building a positive relationship between the women and the midwives. Opportunities for antenatal education or responding to queries about discomforts in pregnancy, or birth options, breastfeeding and so on would then be enhanced.

> Midwives see themselves as having an important role antenatally [but] it's very hard if they [women] have got any problems to do any sort of education because there are so many ladies and the doctors get through them so quickly that you haven't got time to stop and talk, you've just got to fly through them. …We've tried to change it but we just haven't come up with an [acceptable] option yet. That's the way it has always been done here.

During the postnatal period, this status quo continued with the focus very much on the doctor as care provider with a minimal, marginalised role for midwives. Beth notes:

> I get asked to do a Pap smear every now and then on a postnatal lady, or asked to weigh the baby, that's about it. So you can't follow up women - unless you see them in the supermarket. Nothing formal. We might get asked for suggestions if there's a problem with breastfeeding. But no, no. The doctors might pass on the message if you're lucky

The preferred model in the small community, according to Beth, would be one where midwives could "follow up on your own women", [just] "seeing them about town is not the same". If these issues could be addressed, Amy and Beth believed that both the midwives and birthing women would have a more satisfying experience.

Variances in views also occurred when health providers differed over the importance of maternity care in their practice. To practise in a rural or remote setting, midwifery and/or obstetric knowledge and skills are generally considered a necessary background. However, other aspects of their practice were of more interest or significance to some health providers so they failed to remain current or to expand that role. Amongst the doctors, differences in professional and personal experience, as well how they prioritised maternity care, were also evident in their practice.

Rural and remote doctors' views

As sole remote practitioners (MSIPP), Diana and Tim can be contrasted. Dr Tim for example saw himself as a family GP who was recruited to the remote, sole medical practitioner role with limited obstetric experience from a busy U.K. teaching hospital supported by readily available technology and expertise. Like the rural doctors, Brian and Susan, he pointed out that maternity care was not a major focus in his family practice. The low number of births annually did not warrant specialist training nor, as Dr Brian also commented, enable the retention of obstetric procedural certification.

Dr Tim was concerned about professional isolation, deskilling and indemnity issues, and so was alert to the risks inherent in local birthing. Tim's views on birthing as a risky process were accentuated by his partner's complicated pregnancy and birth. While he could not "make women go away to have their babies", he could "present them with the available information and evidence so that they can make an informed decision". By involving and recruiting women in the decision-making, he believed they would not "resist the system and turn up fully dilated". When asked about local childbearing women's options and preferences, his perception was that they were mostly working class, without preconceived ideas about how they wanted to deliver and "very undemanding" in all areas. Tim added that his "patients" realised that the doctors and nurses were busy and under pressure, so they tended to be uncomplaining, did not have fixed ideas and were apologetic if they called him out of hours. He commented that local families were very conscious of the rapid turnover of doctors and so tended to "look after" him. Despite the rural economic crisis and his concerns about the potential prenatal effects of nutritional imbalance, smoking and alcohol consumption, Dr Tim thought women had good social support from their extended families. When necessary, he was prepared to work with the Flying Obstetric and Gynaecology (FOG) team to provide specialist antenatal care and allow elective caesarean section. However, this service was seldom used and so far any

woman requiring a caesarean had chosen to go to a city hospital. With his lack of confidence and limited obstetric experience, a good birth experience for Dr Tim was one where compliant women had an uneventful pregnancy, gave birth in a major centre and consulted the midwife for postnatal advice and lactation support.

Dr Diana, also recruited from overseas to a remote practice, had a totally different approach. The stressed doctor she replaced had been described as "a person who literally needed to have somebody to hold his hand most of the time" (Gloria). Of the six participating doctors, Dr Diana was the least reliant upon technology and the most concerned with the quality of women's overall childbirth experiences. As a mother herself, she also had trained in a busy tertiary hospital like Dr Tim but had since combined that with extensive remote area experience amongst indigenous women. There she had learnt that high risk categories were seldom actualised in adverse outcomes and had developed a firm belief in women's ability to give birth in low intervention settings with skilled support. Diana had been criticised by a senior specialist obstetrician at the tertiary hospital for her "risk-taking" approach. Because the remote hospital did not have foetal monitoring equipment (CTG), on one occasion she had been ordered to send a woman by ambulance to Mine City against her judgement. The woman had delivered in the ambulance which, while vindicating Dr Diana's clinical decision-making, also upset her to know that one of her patients had had this adverse experience. Dr Diana's woman-centred care is mentioned in Linda and Olive's stories in the previous section.

In Sugar Town, the two (public) hospital-based doctors interviewed practised in the largest and best resourced centre in this study, with a significant number of annual births, and they could cater for women obstetrically classified as moderate to low risk; however this was dependent upon the availability of competent medical staff with obstetric and anaesthetic qualifications.[168] Both doctors were family men, well-qualified, with extensive rural and remote experience. They could also competently perform operative obstetrics and manage anaesthesia. Consequently, I had anticipated that they would provide a positive model of rural maternity practice. However, it became apparent that, in their view, a good birth in Sugar Town was one which occurred during normal office hours on a weekday in a multiparas woman who was experiencing an uncomplicated birth. As described by the rural midwives, maternity care was observed to be medically dominated.

[168] Women with more complicated risks were sent to the tertiary hospital.

When the interview data of the Sugar Town midwives and doctors were compared, significant dissonance was apparent. Doctors George and Charles had a very positive view of the quality of care they provided to women and of their collegial relationship with midwives and health workers. The maternal and child health nurse was, however, disrespectfully described as a "cow".

Charles saw maternity care as crucial for doctors forming relationships with families and communities:

> Obstetrics, I find … becomes a cornerstone to health services for a whole community. For example, people often, despite what we like to think about the benefits of preventative health care … will simply not come in contact with any health professional, let alone a doctor, unless there's something either wrong with them, or it's expected that they might, and so if you're working in any community … most women having a baby, either feel they need to - or will in any case, come in contact with a health professional person and usually that'll end up being a doctor at some stage. You certainly are less likely to see Dad … and then of course if you take someone through their antenatal care, if you're involved with their birth, you're then inevitably involved with the children and then sooner or later you'll probably see Dad as well. So obstetrics, to me, especially in small communities … especially Aboriginal communities, obstetrics to me has often turned out to be a bit of an entry to the community, and in fact, almost paradoxically the people in an Aboriginal community[169], if you are involved with them long enough, who you'll become closest to in terms of familiarity will in fact be the childbearing women, because you'll see them more than you see anybody else. … because antenatal contact is serial and it's often, … and it inevitably leads on to early child health and again at some stage you'll come in contact with Dad and other kids and, to my way of thinking … whether you want to practise obstetrics or not - you see more women of childbearing age than any other individual group of people … So obstetrics is almost sort of a cornerstone of health care really, especially if you're a new practitioner in an area.

While the Sugar Town midwives' perceived Charles medico-centric model as reducing the quality of care and a source of their dissatisfaction, he derived significant satisfaction from developing relationships with women and their families.

In rural Mining Town, Dr Brian contrasted the professional and geographic isolation

[169] Aboriginal women in this study preferred Dr George to Dr Charles. It is paradoxical that despite his rhetoric of holism and inclusiveness, they found him "strange" and avoided him if possible.

and limited available services he now experienced with his previous work in a Cape York township which was well serviced by air and visiting medical specialists. Being realistic about his inability to manage obstetric emergencies, he preferred women to give birth in the city. As a family man with several children, this applied to his wife as well. If women insisted on birthing locally, his "base line" requirement was a "previously uncomplicated pregnancy … but not ten of them". Unlike Dr Diana, Dr Brian made no allowance in his practice for women like Olive who could not manage to relocate with their children. Complaining about the inadequate hospital budget, he commented scathingly:

> There's one women that's about para twelve and she refuses to go away. But there's enormous problems there and it's a person that you can't talk any logic to at all. To the extent where if the only way that you can get her away was to let [the] Social Work crowd rent an apartment and it had to have a swimming pool so the whole family could go. … the only thing was if she had a problem here she was dead. Ok that wasn't much of a trade off … but that was the cost, the cost if she would have carked it, bled...

For Dr Brian, a good birth was one in which a compliant client had an uncomplicated pregnancy followed by labour and delivery somewhere else. He states:

> That was the rule I used to use [previous remote practice] and people were pretty happy with that. And I don't feel too bad about being firm with people, sending them away because if they come back with a healthy kid I'm happy …

As Joy pointed out earlier, Dr Brian would use "scare tactics" to achieve his goal. However, when women like Joy did birth locally, he was comfortable acting as medical back-up to particular midwives whom he considered suitably experienced and trustworthy.

B.2 Chapter summary

Maternity care providers had diverse views on what constituted a satisfactory birth experience for themselves as professionals and for childbearing women. By contrast with the birthing women, risk was the predominant theme. Their perspectives were influenced by personal background and values, and philosophical beliefs, combined with professional factors such as confidence, level of experience, current knowledge and skills. Interpersonal relationships also affected professional practice.

In general, rural and remote childbirth practices focussed largely on antenatal care and initial postnatal follow-up. Intrapartum care (labour and delivery/birth), with its

associated risk management, was the most contentious phase. It varied across settings and was debated amongst maternity care providers. Relocation for birthing was a common maternity policy, a preference for most doctors and some midwives, and a personal choice for privately insured women. Overall, it emerged that a good birth in a local rural/remote setting was one which occurred during normal office hours on a weekday in a multiparas woman who was experiencing an uncomplicated birth. Timing was widely perceived as important so that the most experienced midwives and doctor(s) could be present, antenatal records could be accessed, and continuity of care made possible. This enabled provision of the required medical supervision, skilled support and if necessary, obstetric intervention.[170] When women birthed in a local setting, most maternity care providers' and new mothers' accounts indicated that it was a satisfactory experience which energised their small community. However, new mothers identified gaps in maternity care during the intermediate postpartum period and social support beyond the first few weeks after birth.

Safe birthing and risk management were significantly more important to most rural and remote health providers than the quality of the experience for a childbearing woman. Physiological safety meant relative predictability and control over the risky process, with security of technological and obstetric expertise as back-up. While some birthing women also aligned with risk discourses, others prioritised their social and emotional safety.

In this chapter, I have endeavoured to outline what constitutes a good birth experience for birthing women and maternity care providers. The first part presented a range of childbirth experiences, which women described as positive overall. Given the women's diverse desires, needs and expectations of the birth process, it is apparent that the health system needs to be flexible.

Maternity carers tended to describe factors which did not create a good experience and provided examples of circumstances which they individually believed adversely affected the quality of care and led to unsatisfactory outcomes. In the following chapter, birthing is explored as a site of conflict both between and amongst maternity care providers and birthing women

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[170] Remote health providers added that this did not apply when an inexperienced locum GP was in town, or when stormy weather prevented RFDS back-up.

Chapter 8

Labour Relations

8.1 Introduction to relationship issues

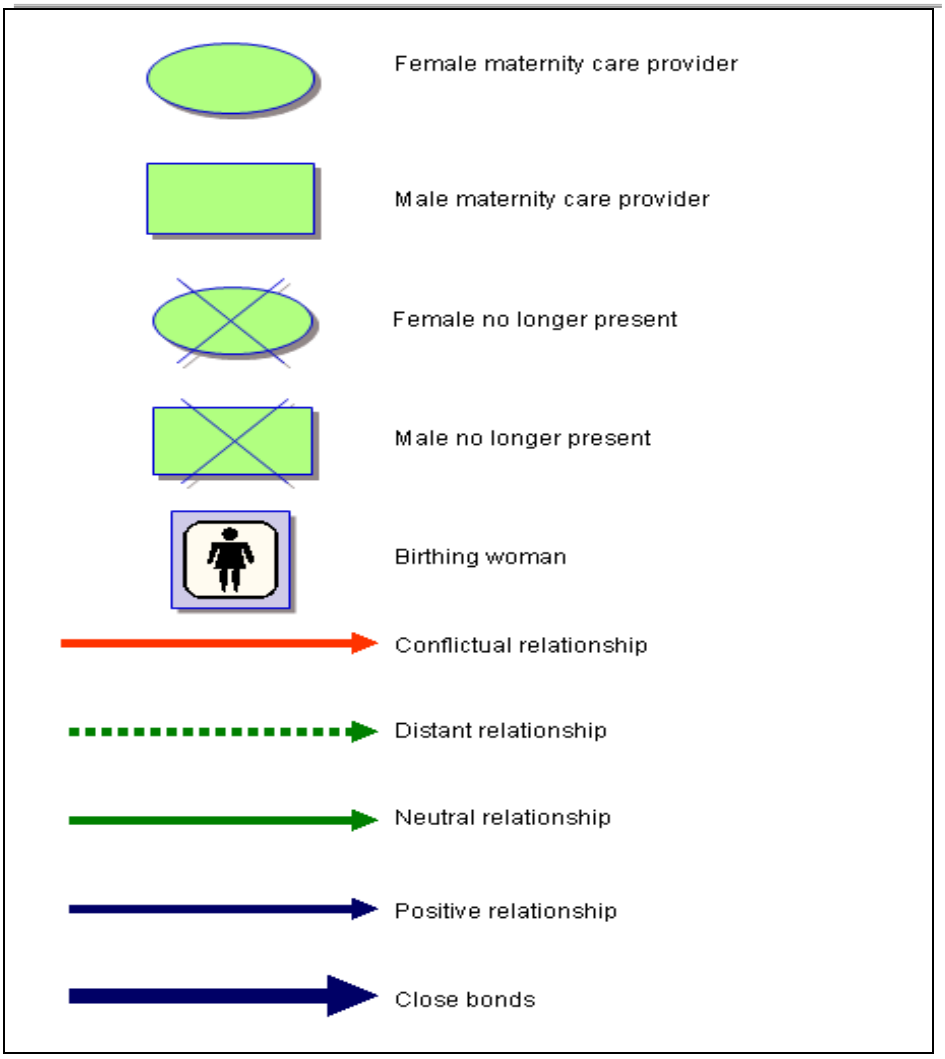
Maternity services involve sensitive relations between all participants. These relationships impact upon health outcomes, but not in simple and obvious ways. Perceptions of childbirth, the quality of the care provided and satisfaction with the outcomes were all found to be influenced by the nature of relationships between birthing women, their families and maternity care providers as well as amongst the health professionals providing maternity services. Issues surrounding sensitive relations were introduced in Chapter 1 where choice, risk and trust were identified as foundational concepts. In Chapters 2 and 3, 'Labour relations' were explored within the literature on the socio-cultural and political influences on birth and the organisation of health services. Through the use of relational genograms and interview data, this chapter will build upon, illustrate and extend concepts discussed within the literature review.

Chapter 8 is divided into three parts. In Part A, interactions between maternity care providers in this study are profiled and discussed. The analysis links to earlier discussions of unhealthy workplace relations amongst health providers. Labour relations are viewed from maternity consumers' perspectives in Part B. Choice, risk and trust become apparent in the outline of women's care preferences and satisfaction with the birth experience. In both Parts A and B, relational genograms are used to provide visual models that succinctly portray the complex relationships between people. In this way, the maternity setting is presented as a living social system with the genograms enabling relational issues to be identified. Factors which either enhanced or acted as barriers to the optimal care of rural/remote childbearing women are identified and the implications discussed. Finally, in Part C, the discussion on interpersonal relations focuses of two aspects of the findings. First, issues of trust, which arose in relation to childbearing women, maternity care services and the community, are examined. Second, emerging concerns about the forms of violence which affected childbearing women's experiences, are analysed.

Part A Relationships amongst maternity care providers

In this study, negative workplace interactions emerged as a significant barrier to quality outcomes, not only inhibiting optimal care for childbearing women, but also reducing acceptability of the health service for staff. As outlined in section 3.2, an unacceptable workplace environment contributes to dissatisfaction and the subsequent staff retention problems experienced by small rural and remote hospitals. After modelling and interpreting the relationship patterns between care providers in each maternity setting, I employ the four theoretical approaches introduced in Chapter 2 to analyse the identified workplace bonds and tensions.

Figure 8.0 Symbols used in relational genograms[171]



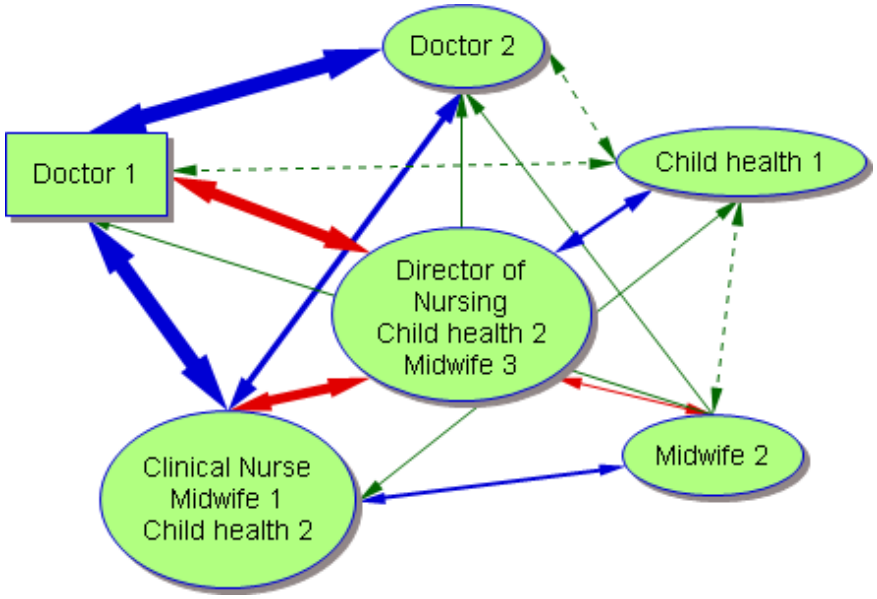
[171] Figure 8.0 replicates Figure 6.0 to assist the reader to interpret the following relational genograms.

A.1 Rural Maternity Services

Mining Town

In Mining Town,[172] provision of maternity care was segmented between visiting health providers,[173] a private GP practice where patients' records were not accessible to the hospital staff if the doctors were unavailable, and care from casual nursing staff who worked when 'called in' during busy times. However, the most apparent barrier to quality care was the factionalised permanent workforce. As can been seen in Figure 8.1, the experienced male doctor (MSIPP) had a strong, positive relationship with both the recently arrived female GP and 'Cathy', the Clinical Nurse/ Midwife 1, who was also a qualified maternal and child health (MCH) nurse.

Figure 8.1 Relationships between Health Providers: Mining Town: 1st visit

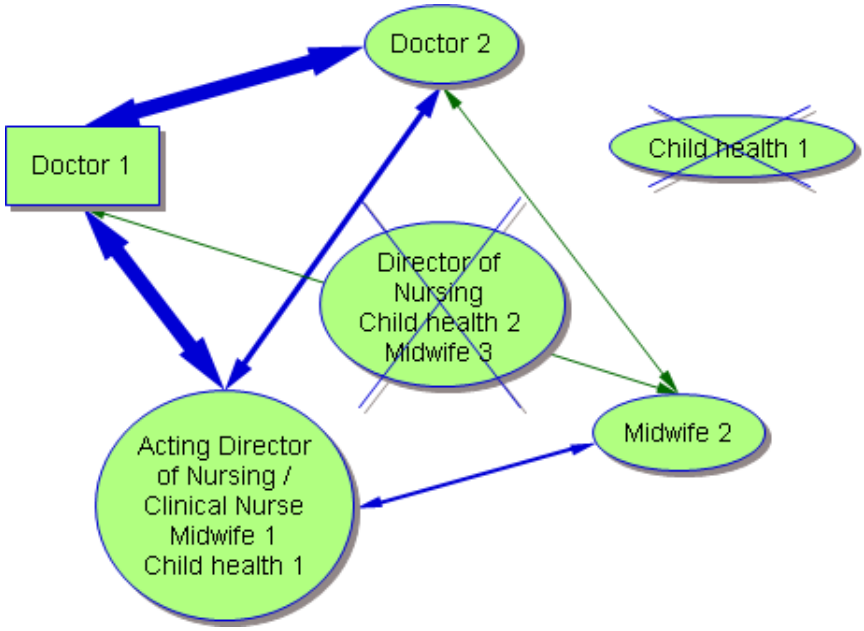


Cathy was a Mining Town local whose experience and understanding of the context was valued by the doctors. She had been acting Director of Nursing (DoN) on several occasions and had a good working relationship with other resident midwives and nurses. Trust and mutual respect were evident between these care providers – they shared information and supported each other's practice.

[172] The maternity context in Mining Town is described in Chapter 4, section 4.2.2.
[173] Maternal and Child Health (MCH) nurses, RFDS, and intermittently other medical specialists visited.

At the first visit, 'Denise', the DoN was observed to have a positive relationship with the visiting child health nurse but was engaged in bitter, conflictual relationships with the male MSIPP, clinical nurse/midwife 1 (Cathy) and other hospital staff.[174] Denise was not widely accepted by the Mining Town hospital staff and this in turn influenced community perceptions. Much of her interview was focussed on her adverse experiences in the DoN role. The MSIPP refused to communicate with her. Workplace relations had become so problematic that the midwives and nurses had sought intervention from the district manager and their union. Contributing to the general perception of this DoN was a history of poor management at a district and local level. Denise had been preceded by another career-focussed nurse who was perceived to have spent most of her time completing her postgraduate studies and who had used the position as a stepping stone for professional advancement. A mistrust of outsiders was already existing prior to Denise's appointment. As she was an older woman from an urban background, they doubted her current knowledge and skills and her understanding of the rural, mining context. This was compounded by her evident lack of management skills and a perception that she was favouring certain staff members who aligned with her.

Figure 8.2 Relationships between Health Providers: Mining Town: Last visit



[174] I misjudged 'Denise' to be a key informant in Mining Town. Interviewing her first, meant that I then had to earn the trust of other maternity staff before being able to progress with data collection.

As can be seen by the genogram of the last visit (Figure 8.2), the DoN had changed. Without powerful allies in the local setting, Denise was alienated, isolated and her position made untenable. Cathy, with her experience, recognised competence and local knowledge, was a popular choice as Acting Director of Nursing. The transient MCH nurse, also an outsider, moved on, again illustrating the lack of continuity of postnatal care for mothers and their babies.

Sugar Town

Sugar Town, the largest centre in this study, presents a different dynamic.[175] The following Figures (8.3 and 8.4) show relations between the key, public health providers. Four distinct professional groups are evident in Figure 8.3. Strong bonds are shown within professions while weak, neutral or conflictual relations are shown between professions. Each participating professional pair shared values and beliefs and mutual trust; however, the two doctors, two midwives and the two Aboriginal and Islander health care workers did not get along well inter-professionally.

As described in the previous chapter, philosophical differences and distrust characterised their professional relationships. These images show that this maternity setting lacked the strong, harmonious working relations that would enable both job satisfaction and seamless, quality care.

The sole MCH nurse in Sugar Town was marginalised. She replaced a popular local child health nurse who left to have a baby. As a childless, community outsider the MCH nurse described her initiatives and efforts to engage with families and forge positive bonds with colleagues. However, as shown, she was unsuccessful and instead experienced distant, neutral relations or animosity from the others. As with the scenarios in Mining Town and Pastoral Town (Figures 8.2, 8.6), it was not surprising that her professional and personal isolation led to her leaving.

Although one health worker also left, this was not as a result of work relations; she had been filling a temporary position while a permanent staff member was away.

Medical hegemony and patriarchal power were evident in both rural workplaces. Midwives who disagreed with the doctors and who resisted their control were more likely to be disempowered and alienated. The midwife who aligns with the (male) doctor was most likely to succeed in becoming the Director of Nursing. Through garnering support from

[175] The maternity context in Sugar Town is described in Chapter 4, section 4.2.1.

other colleagues, the traditional line of medical, patriarchal authority was perpetuated rather than challenged by collective power.

Figure 8.3 Relationships between Health Providers: Sugar Town: 1st visit

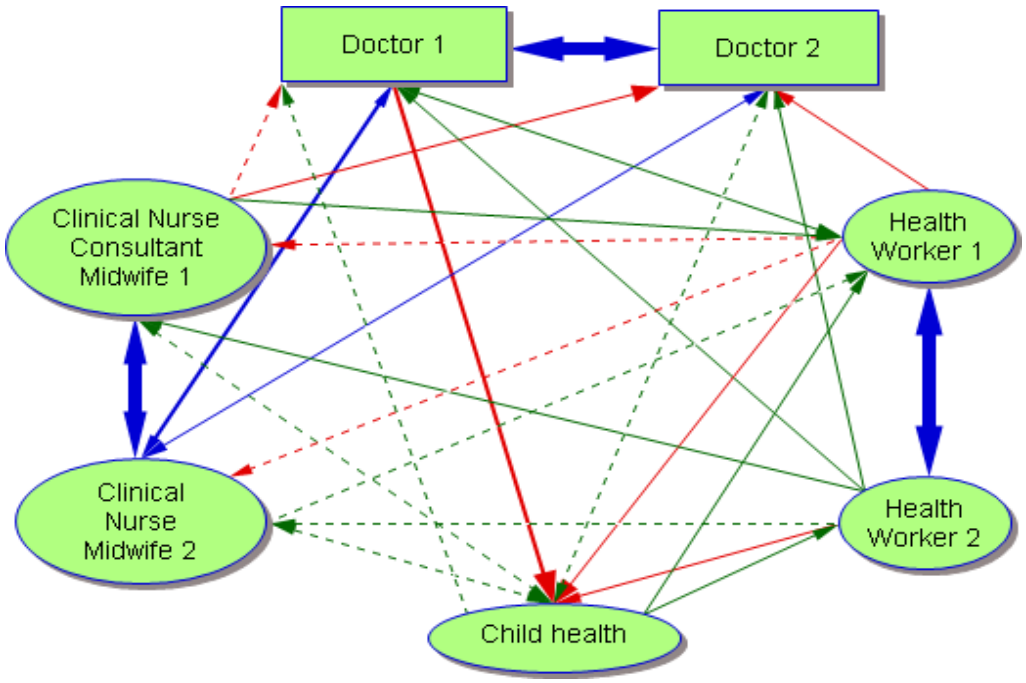
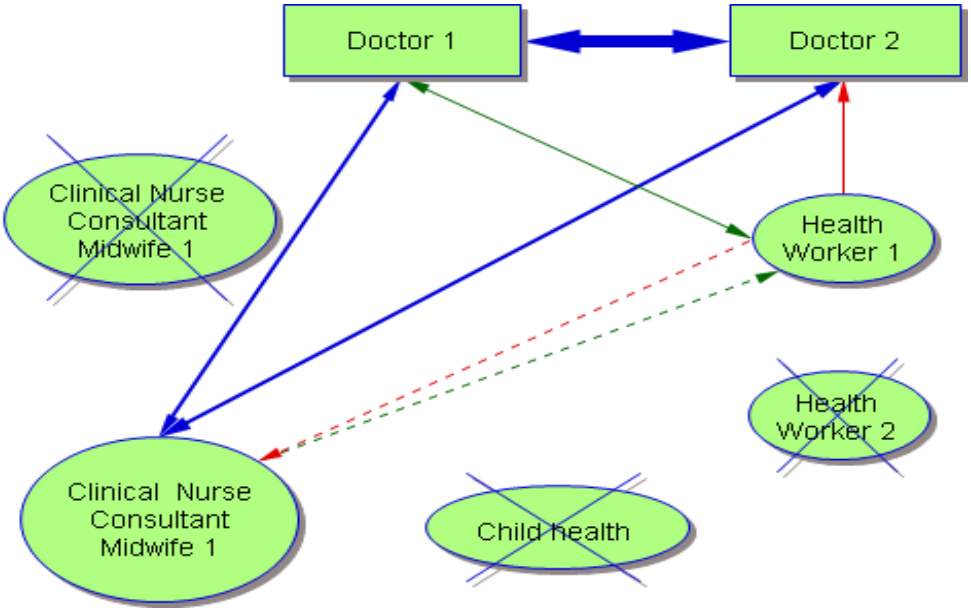


Figure 8.4 Relationships between Health Providers: Sugar Town: Last visit



As was the case with Mary-Ann Hardcastle's (2005) observations of renal nurses, in these maternity settings hegemony had shaped the understandings and practices so that midwives, nurses and health workers reinforced medical power and unconsciously contributed to their own professional domination. These patterns will also be evident in the Pastoral Town genograms (8.5, 8.6) which follow. However, it is suggested that forming constructive, mutually respectful relations across professions would create stronger positions, improve retention and provide higher quality care.

A.2 Remote Maternity Services

Pastoral Town

Unlike the situation in Sugar Town, in Pastoral Town[176] strong, supportive bonds were formed inter-professionally, creating two conflictual factions. The relationship between maternity care providers and the influence of these on birthing women's experiences has been well illustrated in Chapter 7. Olive's story highlights the tensions between the doctor (Diana), the DoN (Gloria) and experienced local midwife and clinical nurse (Emma). Similarly, philosophical differences and issues about competency and currency of practice were described comparing Emma to Gloria (DoN) and Faye, shown as the MCH and Midwife 3 in Figure 8.5. Aligning with the DoN Gloria, a dominant character who was in conflict with key people at a district and local level, made Faye's position untenable.

Again, conflictual relations led to retention problems with the departure of Gloria and Faye shown in Figure 8.6. Their interviews describe the alienation and unhappiness they experienced in Pastoral Town. They felt undermined and devalued. As outsiders, both women had been unable to form supportive networks either at work or in the community. In addition, Faye's children were being bullied at school.

Figure 8.6 shows Emma's promotion to DoN, a position she had filled previously. Dr Diana had described her trust in and respect for Emma as a midwife. They shared a similar woman-centred philosophy and minimally interventionist approach to remote area practice. As a local person with strong ties in the community and district, Emma was well qualified, competent and popular. The new male doctor who replaced Diana was quick to realise this and formed a mutually beneficial professional relationship with Emma,

[176] The maternity context in Pastoral Town is described in Chapter 4, section 4.3.1.

engaging her to provide midwifery care at his private clinic. While this reinforced his credibility and authority, it also enabled valuable continuity of care, which benefited birthing women, especially those who preferred a female care provider. Also redressed was the problem experienced by Gloria when childbearing women arrived at the hospital but their medical records were inaccessible at the doctor's private clinic.

Figure 8.5 Relationships between Health Providers: Pastoral Town: 1st visit

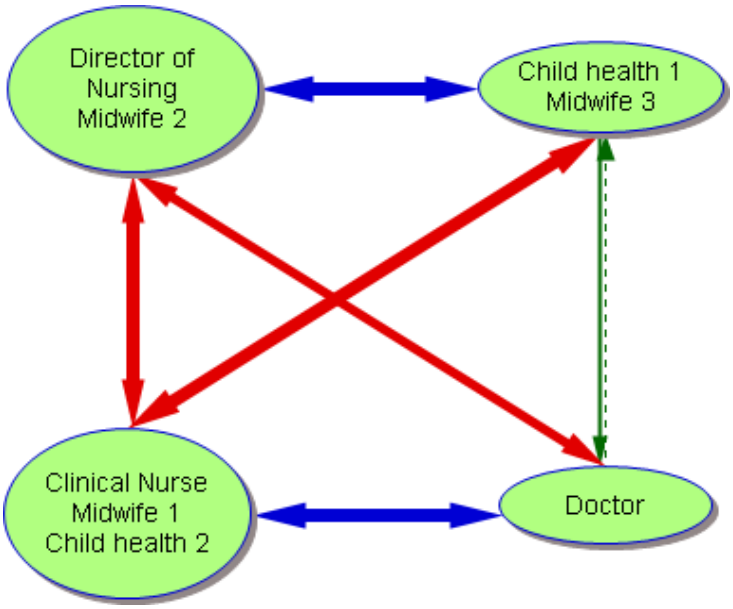
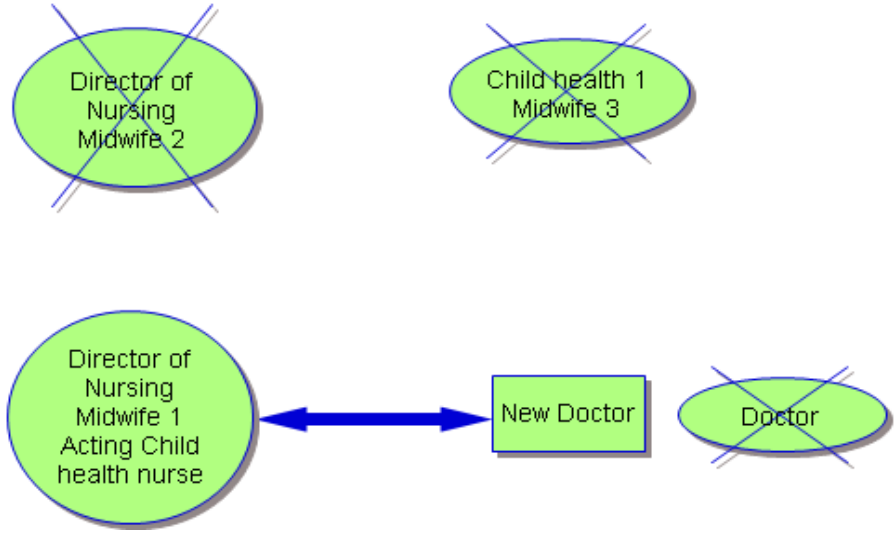


Figure 8.6 Relationships between Health Providers: Pastoral Town: Last visit

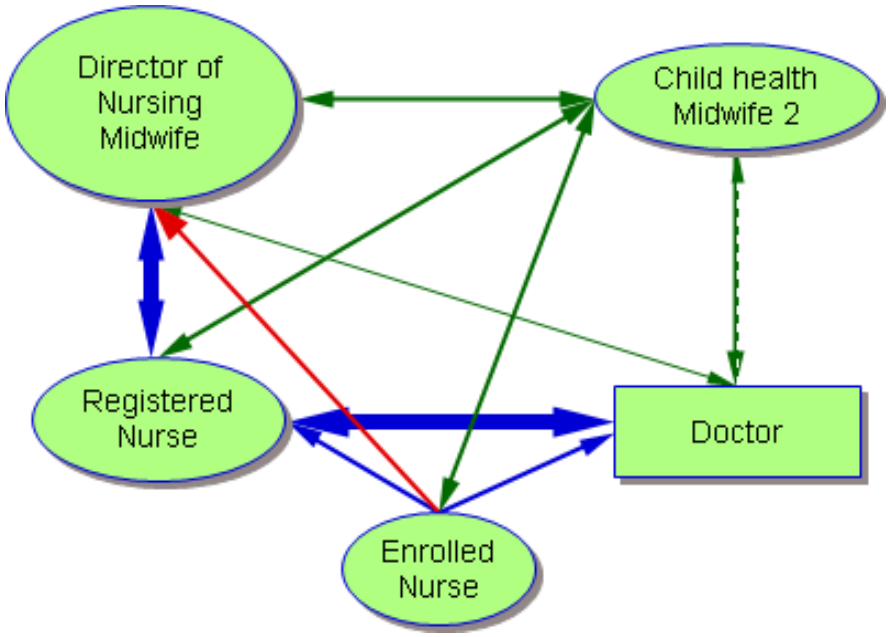


Stockton

As the smallest health service, Stockton[177] demonstrated both inter-professional alliances and cool, yet functional relations. Overt points of conflict were minimal. Although, 'Kim' the DoN and sole midwife had philosophical differences about remote maternity practice, she was able to work with the immigrant doctor to provide effective care. Both the Registered and Enrolled Nurses had the dual participant roles of being health providers and birthing women. Mutually high regard existed between the doctor, DoN/midwife and 'Claire', the RN (Chap.7, section A.1.1). The Enrolled nurse, who disliked the DoN's management style, left the district along with her husband, an overworked professional man who was hard to replace.

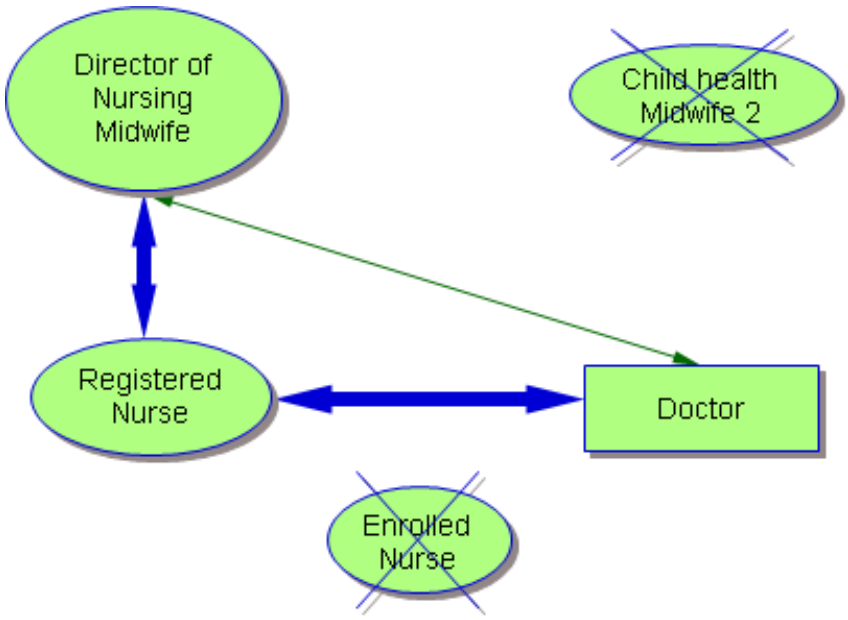
As Nr Faye worked across two remote districts, she was also shown as the MCH and second midwife for Stockton. In contrast to Pastoral Town, Stockton was more accepting of Faye where her role was principally that of a visiting MCH nurse, rather than a midwife. Her departure shown in Figure 8.9 is a consequence of her experiences in Pastoral Town.

Figure 8.7 Relationships between Health Providers: Stockton: 1st visit



[177] The maternity context in Stockton is described in Chapter 4, section 4.3.2.

Figure 8.8 Relationships between Health Providers: Stockton: last visit



A.3 Unhealthy relationships

Although unhealthy relationships between maternity care providers were not an initial focus of this study, it rapidly became apparent that workplace conflicts were a significant concern. Considerable interview time was taken up by midwives, maternal and child health nurses and indigenous health workers in sharing their conflictual experiences with me as a 'safe outsider' (as discussed in Section 5.3.1). By contrast, the doctors only touched upon the topic of workplace relations. Overall, indepth interviews with the maternity care providers revealed frustration, poor communication, misunderstandings, distrust, lack of acceptance or support, degrees of ineptitude, strategies to undermine and devalue each other and spiteful, divisive actions by otherwise caring people. Internal politics and collective action were not used for professional advancement, but instead to deliberately target certain people within the health service. Working in a stressful context, professionally isolated with a constant turnover of itinerant staff, exacerbated the problems.

Interactions within rural/remote health settings are complicated by many complex factors. As outlined in Chapter 3, these include an inadequate health workforce, staff recruitment and retention issues, professional and social isolation, the degradation and

loss of health infrastructure, the medico-technological imperative, medical indemnity concerns, the impact of changing health policies, rising costs and each community's' capacity to sustain services and maintain well-being (NRHA, 2005c; AIHW, 2004, 205; AHMAC & NRHA, 2003; Barclay & Kildea, 2004; Cameron, 2001; Humphreys, Jones, Jones & Mara, 2002; RDAA, 2004; Wainer, Strasser and Bryant, 2005; Wilkinson, 2003). These factors and stressors contribute to unhealthy workplace relationships.

Recognising the undesirable effects of the violence which occurs both between individuals and within organisations in rural/remote communities, the National Health and Medical Council (2002a) has developed strategies for analysing, preventing and effectively managing situations. Through accessible educational resources and training tools, the NHMRC promotes caring for the rural and remote health workforce (2002a, b). In addition, the Queensland Health response has been to follow the UK and USA in adopting a policy of zero tolerance. The Aggressive Behaviour Management for Healthcare Workers course is intended to reduce the impact on its workforce and enterprises (Queensland Health, 2001). Colin Holmes (2006) argues that zero tolerance policies are not only ineffective in health care settings but subvert the quality of care. He identifies resource allocation and marginalisation as modifiable contributing factors (Holmes, 2006). Any initiatives to manage occupational violence require health service district involvement in the planning and implementation of risk management strategies, appropriate processes for reporting and responding to episodes, continuous monitoring and review.

During this study, there was no evidence of commitment from health service managers to meet their legal obligation to worker's well-being, or to provide leadership and encouragement in implementing processes which address occupational violence. Observing these behaviours over time, it was evident that senior staff were not only implicated in perpetuating bullying but were also at times the victims of mobbing. Although district management intervened in Mining Town following complaints from the Nurses' Union, in none of the towns did management implement strategies to resolve conflicts or to find some way forward. Consequently, staff retention and satisfaction were issues in all four health services. Successful measures would require the workforce's active participation in violence-related initiatives (Mayhew & Chappell, 2001; NHMRC, 2002a b; Queensland Health, 2001). Occupational violence operating procedures for Queensland Health staff, including those for rural and remote areas, continue to focus on aggressive patients/clients, their family members and visitors (Queensland Health 2001).

Not being part of the workforce, or in a position to mediate, I could only empathise with participants, but not intervene, when they disclosed their experiences of workplace violence. Their disclosures gave me troubling insights into individual perceptions and misperceptions but I was bound by confidentiality.

A.3.1 Applying theoretical explanations

Professional rivalry

In seeking to analyse the phenomena, I applied four theoretical explanations (2.3), the first of these was professionalisation. Where one profession is struggling to expand occupational control and scope of practice and raise its status, tensions arise with intrusions into the territory of another group. Professional boundary maintenance occurs. The professional project is evident in the move to raise the profile of midwifery and challenge obstetric dominance.

Inter-professional rivalry of this type was evident in Sugar Town and Stockton. Beth in Sugar Town was critical of the medical model being applied to maternity care. She endeavoured to set up a midwives' antenatal clinic and provide postnatal support. Both Beth and Amy were critical of the way in which women experiencing uncomplicated labour were being transported by ambulance to a tertiary centre, when two doctors were not available. This practice failed to acknowledge midwifery competence in managing normal labour. Dr Charles' comment, noted in Chapter 7 (Section B.1.2), clearly expresses this medico-centric view

Exploring the mutual disrespect and conflictual relationships between obstetrics and midwifery, Kerreen Reiger (2001b, 2005) revisits the notion of power as domination and the positioning of midwives as gendered other. She argues that midwives' narratives perpetuate this dynamic and advocates avoiding 'turf' wars. This was evident in Beth and Amy's accounts of inter-professional relations in Sugar Town. Their desire for a women-centred, midwifery model of care was defeated and the status quo of (male) medical hegemony maintained.

Kenny (2004) argues that medical dominance and power within the health care system has been eroded in metropolitan areas by contemporary social trends such as managerialism, proletarianisation, corporatisation and competition from emerging health professions and alternative health management systems. However, in rural Australia, medical dominance and professional autonomy are strengthened by medical shortages. Most rural doctors are neither corporatised workers nor publicly employed and, as Kenny

points out, they retain significant independence as fee-for-service providers (2004, pp.158, 164). This perpetuation of medical authority is exemplified by the Medical Superintendents in Private Practice (MSIPP) included in this study.

In Stockton, as DoN and sole midwife, Kim was able to enjoy an extended scope of practice but was frustrated by the doctor's lack of confidence and his eagerness to send women to town for birth. He had the ultimate decision-making authority. However, recognising her professional knowledge and skills, Dr Tim ensured that all birthing women also were counselled by Kim antenatally. Postnatal care and education, including lactation counselling, were also recognised as the midwife's domain. This minimised the possibility of conflict.

Evidence of professional rivalry as a cause of workplace hostility is partially supported by views expressed by the Aboriginal and Islander Health workers. While their monopoly of an area of practice was acknowledged, Brenda and Anna were seeking recognition of their professional status and the contribution health workers could make to maternity care. However, they had recently lost an area of practice, the authority to immunise, and felt unfairly criticised for not ensuring that more indigenous women attended the clinic regularly. Lack of inclusiveness in the maternity team and ineffective communication from the hospital added to their sense of frustration.

The professional project is evident when one group encroaches upon the practice of another and begins to undermine the dominant group's privileges and manipulate its markets (Turner, 1995; Wicks, 1999, 2002). Professional boundary maintenance creates tensions. None of these examples support the notion that territorial threats to medical authority were being felt by the doctors, the dominant professional group. By contrast, professional alliances between medicine and midwives were apparent in two health settings. The national midwifery action plan proposes lead-carer status for midwives, as a viable model for small communities affected by the rural doctor shortage; however this did not arise as an issue in this study (Maternity Coalition, Association for the Improvement of Maternity Services and Australian Society for Independent Midwives, 2002)

Oppressed group behaviour

Oppressed group behaviour is a second possible explanation for workplace hostility amongst midwives and nurses; however it is also problematic. As discussed in sections 2.2 and 2.3.2, power relations within the health care system are asymmetrical as it is dominated by a medical, technical and patriarchal ideology. It has been argued that

intra-professional bullying amongst nurses and midwives is congruent with Paulo Freire's (1971) theory whereby members of oppressed, subordinate groups, aspire to resemble the higher status oppressor. This both reinforces and perpetuates the oppressor's dominant position (Hastie, 2002a, b; Crookes & Knight, 2001; Papps & Olssen, 1997). While Linda Shallcross (2003) focuses on malicious 'mobbing'[178] as a means of maintaining the status quo, Nel Glass (2003), Carolyn Hastie (2002a, b) and Susan Clements (1997) comment on horizontal violence as a part of everyday reality in feminised health settings. Alternatively, Marie Hutchinson, Margaret Vickers, Debra Jackson and Lesley Wilkes (2006) describe how the status quo is perpetuated when nursing teams are dominated by bullies. The perpetrators' abusive indoctrination of new staff and use of power as domination have tragic consequences (Hutchinson et al., 2006).

During this study, there were apparent manifestations of both overt and covert, non-physical violence such as back-biting, undermining co-workers, denigration, subversive and manipulative behaviours; these are not necessarily consistent with oppressed group behaviour. Although medical hegemony is reinforced by such behaviours amongst midwives and nurses, the doctors were not observed to be using 'divide and conquer' tactics to serve an oppressive agenda.

Deconstructivist analyses reveal the flaws in this theoretical approach to workplace violence (Glass, 2003; Gore, 1990a, b; Lather, 1990). Workplace violence within dysfunctional organisations is a manifestation of power being exercised (Hutchinson et al., 2006; Speedy, 2006). The perpetrators cannot be viewed as "misguided collaborators in a patriarchal system" (Wicks, 1999 p. 3, 4) who operate in a pre-reflective manner which inadvertently maintains oppressive structures (Hardcastle, 2005). Masculine and medical hegemony was reinforced when midwives strategically aligned with the doctor; a collaboration that led to career enhancement. However, the conflicts observed in this study were often over philosophies of care, such as the disagreements in Pastoral Town and Sugar Town, or over management styles, as seen in Mining Town and Pastoral Town. Nor does oppressed group theory apply to the marginalisation of the designated MCH nurses and the lack of respect for their role in the health team.

The practices and behaviours I observed were consistent with the Nietzschean

[178] Workplace 'mobbing' is described by Shallcross (2003) as abusive behaviours which occur in a dysfunctional workplace. The dominant group 'gang up' on the target with the malicious intent of forcing them out of their employment. Their behaviour is discreet and indirect, and managers and supervisors are particularly vulnerable to being 'frozen out'.

notion of *ressentiment* as described by Patton (1993) and Tapper (1993). Within the rural/remote maternity settings, the spirit of *ressentiment* was apparent when, instead of resisting oppressive forms of power, health providers within the feminised professions became preoccupied with power as individual control. Tapper (1993) argues that instead of seeking positive forms of power, such as enabling strategies, women's practices may instead be complicit with its negative forms such as surveillance, normalisation, control and a desire to overpower others. Consequently, through discursive and non-discursive practices, midwives and nurses enact violence against each other rather than seeking positive expressions of power which would advance a unified approach to women's position in the workplace. Reflexivity would assist in revealing these practices.

A vocabulary of complaints

A third alternative conceptual approach to the dysfunctional interactions within maternity settings is Turner's (1986) 'vocabulary of complaints'. As outlined in 2.3.4, a dissatisfied occupational sub-group, such as nurses and midwives, finds unity in these subversive discourses of discontent. In situations where there are inherent conflicts between norms and actual practices, such discourses act as devices to delineate authority and official ideology.

Although informal 'backstage' complaints were common in interviews with nurses and midwives, and acted as powerful sub-cultural ideology in the rural/remote context, the formal, 'frontstage' discourse was less apparent. Two exceptions occurred when interviewing Sugar Town midwives and health workers. Having recorded 'backstage' disgruntlement with the doctors during an interview in the hospital, we were interrupted by Dr Charles. The midwife switched to her 'frontstage' persona of compliance. Similarly, the health workers' discontent was concealed when our interview was interrupted by the MCH nurse.

Forsyth and Mackenzie (2003) argue that the vocabulary of complaints has shifted from backstage discontent about lack of autonomy and recognition to frustration with industrial conditions and the need for health system reform. I would argue that, while there were concerns about the urgent need for maternity reform and frustrations over staffing levels, discourses of discontent were more directed towards 'outsiders' who tried to impose their ideology, authority and processes onto an existing social system. In this way, the vocabulary of complaints acted as a social leveller, a means of deflating idealism and pressuring individuals to conform with cultural norms so as to avoid ostracism.

Mary Stewart's (2005) interpretation is closer to the counter-productive and subversive discourses that I observed. She describes how midwives circumvent the dominant knowledge system to avoid unnecessary interventions, by actions such as not documenting observations of clients. This means of destabilising legitimate authority was not observed as a form of resistance to medicine but as a means of undermining other midwives and MCH nurses. For example, concerned that mothers and babies in Pastoral Town were not receiving quality care from the MCH nurse, Nr Emma would covertly monitor their well-being, performing assessments such as maternal mood, infant feeding and growth measurements. These observations were not formally documented in patient records. Turner describes how individuals justify their motives for such actions, accepting responsibility but not seeing the negative consequences. In this instance, the covert monitoring functioned as a means of protecting local mothers and babies from 'incompetent outsiders' by undermining the MCH nurse's credibility and authority in the community. Another counter-productive and unintended consequence was associated with concealing medical data. This is problematic, not only because it is unethical but also because medical records form the basis of perinatal statistics and are used to define norms. Such actions are neither constructive nor representative of effective resistance against oppressive systems or ideology.

Counter-productive resistance to an outside directive was also seen in Mining Town. The hospital's services had recently been degraded with its bed capacity and staff numbers reduced. Aware that the new 'rationing' was affecting ability to provide adequate care to the community, the hospital staff continued to fill beds. When the staff-patient ratios exceeded the requirements, this was concealed. Although the motive was commendable, by delegitimising broader institutional controls the local discourse of discontent again bypassed official documentation, so that statistics would not reveal the workloads, safety risks and need for more budgetary support. The effects of this were to add to staff tensions and to make the staff who were both nurses and maternity carers feel less willing to undertake professional development or to extend their practice to providing antenatal classes or postnatal support.

The vocabulary of complaints has the potential to provide a space for resistance to hegemonic discourses which destabilise and delegitimise authority. However the culture of silence is counter to an oppositional politics. The potential remains for women and midwives to work together effectively through a powerful sub-culture that challenges existing structures and brings about positive changes in maternity care.

Conflicting cultures of care

Finally, workplace hostility can be attributed to conflicting cultures of care. As described in Section 2.3.4 and illustrated in Figure 2.0, the Review of Maternity Services in Queensland found two conflicting paradigms vying for predominance: these were labelled 'mechanic' and 'organic' models of care. Each 'culture of care' has distinct ethical foundations and brings "a rich complexity of knowledge, skills and commitments" to the maternity environment (Hirst 2005, p.16).

The mechanistic model has a medico-legal and technical focus. The best possible outcome for mothers, babies and the health service is perceived as one where safety is ensured and risks contained. Childbirth is treated as an illness requiring obstetric management. As accountability rests with the maternity care providers, this medico-centric approach tends to provide less choice for women. In a health service evaluation it would be viewed as effective, allocative efficiency (Campbell & Garcia, 1997; Duckett, 2004); however, it reduces accessibility and acceptability for consumers (Chap. 3, section 3.3).

In the rural/remote context, the mechanistic model results in risk reduction policies. These include restricting local birthing options, the need for doctors to have current procedural skills, reliance on diagnostic tools and obstetric interventions, a shift to private obstetric care and relocation to obstetric facilities for birth. Controlling outcomes minimises the known risk factors and reduces litigation concerns. However, this model fails to consider sufficiently the risks of routine and emergency transportation when decisions are made to seek advanced centralised care (as evidenced by Beth and Amy in Chap. 7). In focussing on the medico-legal risks, the broader social and familial issues are ignored. For example, when relocating women for birth, family separation, loss of social support and the risks to partners/husbands who drive long distances on country roads to be in time for the event are not adequately considered.

Within this study, the maternity policies in all districts demonstrated this paradigm. In Sugar Town, women were sent to the city when two doctors with procedural skills were not available in case of emergency. In the other districts birth in major centres was actively encouraged. Childbearing women were labelled according to their existing and potential risk factors and accordingly channelled into pre-determined care pathways. All the doctors, except Dr Diana, embraced this approach to maternity care. Also aligned with this model were midwives like DoN Gloria (Chap. 7, sections A.2.1, B.1.2) and several birthing women, including Joanna and Paula (Chap. 7, sections A.2.2, A.2.3).

The second 'organic' culture of care is a social model described by Hirst as one

which “stresses normality and espouses care that respects and involves a woman as the person in control of care” (2005, p.15). This is consistent with Karen Lane’s productivist approach in which knowledge and reality are constructed through interaction between the birthing woman and maternity carers (2002). Feeling comfortable with this model of care requires a belief in normal birth, the knowledge, skills and confidence to facilitate normal birth processes, the ability to justify decision-making, effectively communicate, and an ethical commitment to “ensure childbirth is a safe, supported and empowering transition that welcomes new life” (Hirst, 2005, p.16). Hirst recognises that ‘organic’ practitioners will experience pressure on their decision-making from conflicting sources. Accountability in this paradigm is both to the childbearing family for a satisfying birth experience and to health administration to ensure standards of safe practice (Hirst 2005, pp. 15-16).

The contextual and relational considerations that characterise the organic model of care are exemplified by Dr Diana and Nr Emma. They are positively acknowledged by all the participating birthing women in Pastoral Town, including those who birthed elsewhere. Notably, in Olive’s story (Chap. 7, section A.2.1), they took into consideration the local social context along with the need and desires of the birthing woman and her family. Both Diana and Emma shared similar philosophical beliefs and had the professional competence to apply a family-centred approach to their maternity care with high quality outcomes from a consumer perspective (Chap. 7, section B.1.2; Chap. 3, section 3.3).

Rather than being in binary opposition, there is an area of overlap between the two cultures of care (Figure 2.0) While Hirst (2005) see this as a space in which maternity care providers can cooperate, Lane (2002) pejoratively describes the ‘hybrid’ midwives who pre-reflectively ‘slip’ between the contradictory models of knowledge. For Lane, the practice of these midwives shifts between the obstetric and midwifery models of care drawing “variously on each of the major discourses according to contextual factors” (2002, p.26). Lane believes that they require education to raise their awareness. For Hirst, maternity services which have the ability to bring together the strengths of both models into “a rich tapestry of skills and understandings” would benefit consumers. Coordinating cultures of care would enable a birth process “which is at once natural, yet unpredictable in its unfolding” (Hirst 2005, p.16). Despite differences in perspective, this overlap creates a space which enables a cooperative and caring environment for everyone involved in maternity care. As Weaver, Clark and Vernon (2005) point out, there is a need for a *modus vivendi* if rival professionals are to work together for the greater good.

Envisaging cultures of maternity care as a continuum

Like Mavis Kirkham (2005), I can see little value in thinking in absolutes. Kirkham advocates avoiding polarised positions and seeking to develop more inclusive concepts. I propose that it would be constructive to envisage cultures of care as a continuum set within the context of the local maternity setting, rural/remote society and the Queensland Health system, as shown in the following Figure 8.9. The position of maternity care providers along this continuum is dynamic and influenced by both internal and external factors. Not only will personal philosophy, self-perceptions of risk, competence and confidence influence where they position themselves, but this will also tend to shift in accordance with the professionals with whom they are working, staffing levels and skills mix, their interactions with birthing women, changing maternity policies, and the material conditions at a given time.

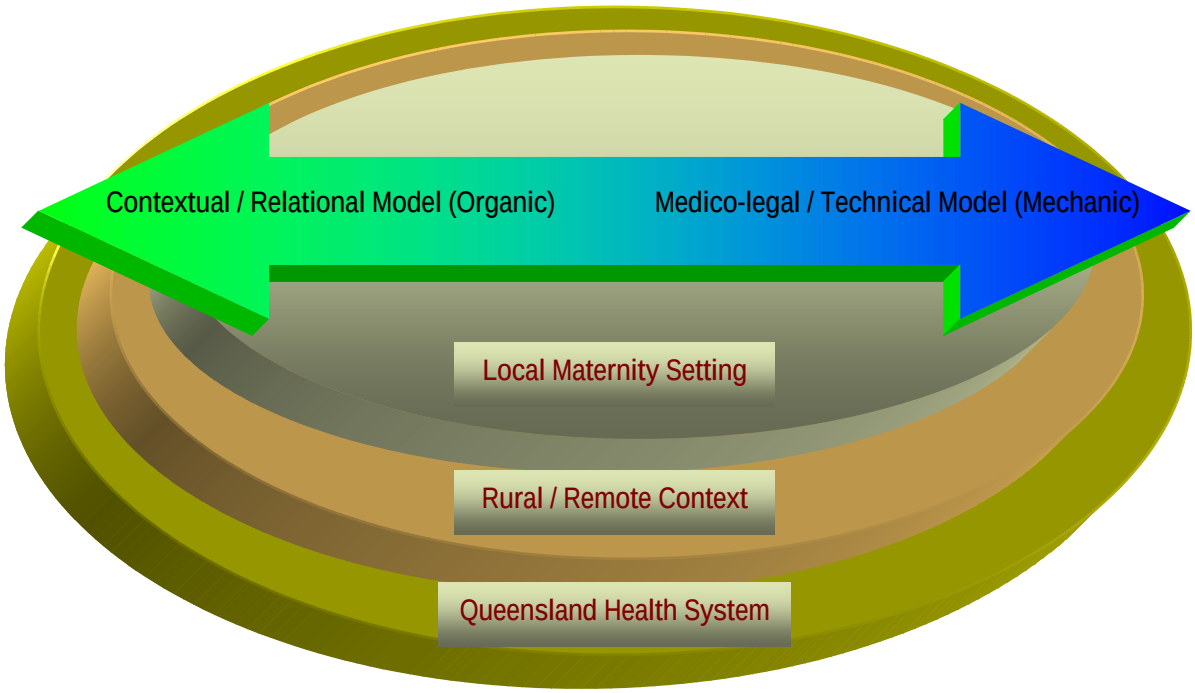


Figure 8.9 Cultures of maternity care: Continuum within a context

Reviewing the data from the participating maternity care providers reveals that this model (Figure 8.9) is better suited to the phenomena I observed. For example, Dr Diana's lived experiences as a rural/remote medical practitioner and mother led her to grow towards the 'organic' relational model. Dr Tim in Stockton lacked remote experience,

confidence and obstetric competence and so, as a sole practitioner, felt safer towards the mechanic model. Dr Brian in Mining Town had diminishing obstetric procedural abilities and so had shifted towards the mechanistic pole. Amongst the midwives, Emma, Beth and Kim, with their midwifery models of care, were located towards the organic pole but they were also pragmatists and recognised the need to adjust their practice when skilled support was not available, such as when an inexperienced locum was the sole doctor. With the exception of Gloria, most of the remaining midwives occupied a central space of possibilities which enabled them to adapt to contextual factors and practice cooperatively.

Rather than being viewed as indecisive 'hybrids' (Lane, 2002), the midwives in my model are portrayed as socially oriented carers who preferred to avoid cultural clashes and inter-professional rivalry. At times their views were contradictory as they justified why it was more expedient to align with one model (or discursive position) rather than another in a given situation.

Of the theoretical approaches presented here, the notion of cultures of care is the most applicable. I argue that, with further development as a continuum of maternity care, this useful concept has the possibility of further application when analysing workforce interactions. However, it provides only a partial explanation for the unhealthy relationships observed during this study. While tensions arose when midwives, maternal and child health nurses and doctors were positioned within opposing cultures of care, there was also another dimension to the workplace violence. Some maternity care providers held precarious social positions, because they were regarded as outsiders. Positioned as the 'other', they were marginalised and professionally isolated.

A.3.2 Exploring the insider-outsider phenomenon

As has been shown in the relational genograms of each maternity service, all three designated maternal and child health nurses had the experience of being outsiders to the rural/remote community and external to the main arena occupied by doctors and midwives. The midwives who resigned were also outsiders, while those whose careers were enhanced were both 'locals' and accepted as key insiders within the workforce.

Little is available within the current sociological literature to assist in explaining the persistence of an insider–outsider phenomenon in Australian rural communities in late modernity. Earlier rural studies have explored social inequality and belonging (Dempsey, 1990) and the influence of gender, patriarchy and masculine hegemony on rural relations (Poiner, 1990; Alston, 1990b, 2000, 2005a). Research within the same region as this

study provides valuable insights into social relations and notions of difference from multicultural (Elder, 1996) and gender perspectives (Pini, 2004). While gender relations are relevant to the feminised workforce situated within a patriarchal setting, xenophobia and class inequality were not issues associated with the social marginalisation of rural maternity care providers.

Faith Tucker and Hugh Mathews' analysis of gender relations in a UK rural community "discloses geographies of anxiety, tension and disharmony" in which a "contested countryside culture" contrasts with the myth of rural harmony (2001, p.161). While the findings of a contested culture and rural disharmony resonate in this study, the workplace gender relations added a different dimension. In contrast to both Pini's (2004) and Tucker and Matthews' (2001) rural studies, where (female) gender led to marginalisation and exclusion, the perpetrators I observed were also women.

Current discussions within rural sociological literature discuss notions of a globalised network society, the influence of neo-liberalism, issues of governance and the role of social, human and institutional capital on community sustainability (Cocklin & Dibden, 2003; Cocklin & Alston, 2005). These concepts are also applied to Queensland towns (Herbert-Cheshire, 2003; Cheshire & Lawrence, 2005). However, none of these Australian sociological studies adequately explain the phenomenon I observed.

From a postmodern perspective, Nancy Naples' (1996) ethnographic study suggests that being an insider or outsider in a rural community is not a fixed or static position, but rather an ever-shifting and permeable social location. Recognising this 'permeability', several participants outlined strategies that they had used to gain inclusion.

A.3.3 Strategies for inclusion

When seeking to understand the social relations in this study, and to find a way forward, I both questioned rural health providers about how they achieved inclusion and sought answers within the literature on community work. Health providers believed it was possible to gain acceptance both within the workplace and wider community if one followed certain social 'rules'. These included accepting invitations from locals, volunteering with community groups, never adopting a superior attitude and, with the exception of the doctors who were expected to be omniscient, avoid positioning oneself as an 'expert'. Pragmatically, incorporating local ways of doing things and adopting a strengths-based approach were preferable but at times this conflicted with evidence-based practice. Even though they were designed with the best of intentions, practices which

contributed to alienation included the Maternal and Child health nurses' quit smoking and weight loss groups, parenting classes and other health promotion campaigns. These were organised and imposed without community consultation and as such, were either considered intrusive or unsupported.

The most useful guidance for gaining inclusion is found in social work and community welfare literature. Alan Twelvetrees (1985, 2002) extends Bob Holman's (1981) practical advice on how to gain entry and acceptance into small groups and large organisations within a community. Twelvetrees suggests beginning with a community profile, which analyses needs and assesses resources followed by 'rules' for contact making. He remarks that "unless you cultivate goodwill and mutual understanding widely, you may find that the natural conservatism and resistance to change of most people will turn into opposition to you and your proposals" (Twelvetrees, 1985, p.22). This was certainly evident with the MCH nurses and Mining Town DoN. Given the rapid turnover of health providers (and itinerant professionals) in rural/remote communities, such resistance to constant change is understandable. Twelvetrees six principles for successfully making contact include networking; reflection on the impression one is making on others (both in appearance and interactions); establishing credibility; active listening and observation; corroborating information and opinions through one's own assessments; and becoming visible and familiar with people in informal settings, such as shops. Finally, employing exchange theory, Twelvetrees advises that "in order to get, you must give" (1985, p.26). This is underpinned by effective communication skills, empathy and awareness that others may perceive the newcomer as threat (Twelvetrees 1985; 2002).

For Paul Henderson and David Thomas (1980, 2002), negotiation is the keystone both for gaining entry into 'neighbourhood' agencies and communities and for forming relationships with decision-makers who may perceive the newcomer as a threat. Their valuable suggestions include processes that support such negotiations as well as practical ways to deal with friends and enemies and for coping with social isolation (Henderson & Thomas, 2002).

To enhance the competence of 'front-line' workers within a community setting, Andrew Jones and John May (1992) suggest several useful strategies. In addition to the importance of "[taking] care of yourself", those applicable to rural health providers centre on the need to assess carefully one's personal and professional position, then to develop strategic political and organisational plans (Jones & May, 1992, p.285)

It is evident from these practical guides for community practitioners, that exclusion

should be assumed and newcomers should be prepared to earn inclusion. While tertiary programs for nurses and midwives include generic communication skills, guidance on forming therapeutic relationships and subject content designed to ease transition into the reality of the health environment and workplace cultures, they would also benefit from the practical guidance found in the Social Work and Community Welfare literature. For health providers going to rural and remote contexts, such explicit strategies combined with reflective practice would enable the formation of understandings, the ability to respond appropriately to challenging interactions, and the skills to manage such situations. In this way, inclusion is possible and retention of rural/remote maternity care providers could be improved.

A 3.4 Summary of labour relations amongst maternity care providers

In Section A, relational genograms have provided a visual gestalt of the interactions between maternity care providers at the outset and completion of fieldwork in each of the four health services. To analyse the intra- and inter-professional hostilities which I observed, four theoretical models were applied. As possible explanations, the professionalisation project, oppressed group behaviour and Turner's (1986) 'vocabulary of complaints' had limited support but all were problematic. Hirst's (2005) notion of conflicting cultures of care emerged as the most applicable. To further advance this notion, minimise oppositional thinking and explain the shifting discursive positions I observed, I developed the cultures of care into a continuum (Figure 8.9). However, within the sociological literature, no adequate theoretical explanation was found to explain the persistence of an insider-outsider mentality in the rural/remote communities into late modernity. Naples' (1996) concept of social 'permeability' disrupts the rural insider/outsider dichotomy and provides a constructive means for shifting social positions. An assumption of the 'otherness' of newcomers was found in the Social Work and Community Welfare literature which provided insights into the processes of earning credibility and gaining acceptance. Rural and remote maternity care providers would benefit from the practical strategies for negotiating inclusion both within the workplace and wider community. Through the acquisition of professional skills and application of reflective practice, I propose that it is possible to shift away from the dichotomy of the insider/outsider to a position that encompasses permeability and which enables integration into relationships and organisations within small rural/remote contexts.

Part B: Labour relations - maternity consumers' perspectives

Through relational genograms, birthing women's perceptions of their maternity care are portrayed in Figures 8.10 – 8.13. As with the previous section, the colour and width of the arrow indicate the type and strength of relationship. These responses included antagonism and dissatisfaction with care (red), distant (dashed green) or neutral (green) relationships, positive perception and satisfaction with care (blue), and a high level of satisfaction and/or close bond with a carer (wide, blue arrow).

As several women (such as Joanna and Paula in the previous chapter) specifically commented on the importance of having private health insurance and being able to choose private obstetric services, the genograms depict the maternity services as divided into the public (green) and private care (pale blue). However, as shown in the genograms, most participating women accessed both sectors. In Mining Town, Pastoral Town and Stockton, share care was the most common model as the doctors (MSIPP) bulkbilled antenatal and postnatal care provided in their private clinics. In some cases, women birthed in a public hospital under private obstetric care[179] (purple triangle).

Birthing women's perceptions of choice, risk and trust influenced which services and maternity care providers they utilised. The physical milieu of the hospitals and MCH clinics was a barrier for women who wished to disclose matters affecting their psychosocial well-being (Appendix 12d, f). Constrained by the lack of privacy, they felt restricted to discussing physical health issues. Women's preferences for maternity carers, and views on their professional competence, were shaped by personal experiences, material circumstances and outside social influences.

Amongst the maternity consumers are four birthing women who were also staff in the local hospitals filling the roles of registered nurse, enrolled nurse, midwife and clerk. Their friendships with other local childbearing women influenced consumer perceptions, especially with regard to whom could be trusted to be professionally competent and credible. Other participants had family members who were local health professionals. Consequently, some of the relationships shown in these genograms mirror those of the health providers in the previous section. Once again this illustrates the complexity of interpersonal relations in small rural/emote communities and the challenges which maternity care providers may experience when negotiating acceptance in a community.

[179] Such as Joanna, (Chap. 7, section A.2.2) and several Italian women in Sugar Town.

B.1 Rural maternity services – birthing women's relationships

Mining Town

Joy's story is related in Chapter 7 (Section A.1.3). With her second birth, she was an assertive, reflexive consumer. Joy's high level of satisfaction with the midwifery care she received and her strong preference for the female GP are evident in Figure 8.10. Contrary to the male doctor's practice, Joy achieved a non-interventionist birth locally and was elated. His eventual assent to her plans is shown as a neutral relationship. Joy was dissatisfied with the MCH services and found postnatal support for mothers inadequate.

Tania was a Mining Town local who was experiencing difficulties with depression and mothering, as well as in her strained relationship with her partner. Having previously encountered a lack of understanding from her extended family about her inability to cope with her difficult circumstances, along with suspected breaches of confidentiality by local health providers, Tania had significant issues around risk and trust. The red arrow between Tania and the local hospital (Figure 8.10) indicates her distrust. She remarked on the problem of personal privacy in small, close knit communities:

> Everyone knows everyone's business. And you really like some things in your life to be private. Yes private. Because I find that I have a lot more to do with the hospital now… and you know, just little things that they've done… [She then concedes] But you have your good nurses too… It's just that they have been the same nurses since I was a baby.

As a miner's wife, Tania was covered by private health insurance and so chose to access private obstetric care in the city. With her low educational level and insular lifestyle, she found this an overwhelming experience.[180] Following her return home, a midwife from the private hospital telephoned to see how she was managing. Tania's husband screened the call and informed the inquiring midwife that all was well. As a result, Tania felt silenced, unsupported and unable to share her concerns with anyone.

Given Tania's positive regard for the local female GP and her routine visits to the MCH nurse, I asked if she felt comfortable confiding in either of them:

[180] Tania described her anxiety when she got lost in a city shopping centre near the hospital.

> I probably wouldn't of [sic] said anything. I think I would of [sic] kept it with the doctor. Because I know that she's not going to go to a party and say “oh so and so has got this”.

As Dr Susan was new to Mining Town and not yet embedded in the local community, Tania perceived her as being potentially safe and professionally trustworthy, hence the blue arrow in the genogram. Similarly, Tania felt that she might be able to share her problems with an ‘out of towner’, such as the visiting MCH nurse, but this person only came once a week and her office was conspicuously located in the hospital outpatients department.

Pam and her partner led an itinerant lifestyle as they followed work opportunities. Consequently, Pam had access to a number of health services across north-western Queensland. She expressed a general ambivalence with the care she received, as well as dissatisfaction with some encounters with particular health professionals who, she felt, disregarded and disbelieved her lived experiences.

‘Class’ differences between Pam and the maternity care providers appeared as a cause of dissatisfaction. Although Pam’s low educational level affected her ability to be articulate, she did not like being disrespectfully treated and inadequately informed as if she were incompetent. Pam felt that many health professionals tend to take a “we know what’s best for you” attitude[181] accompanied by unsolicited, prescriptive advice. Problems with her first birth and recent pregnancy resulted in Pam’s insisting upon having a caesarean section in a tertiary hospital. She distrusted the quality of rural/remote health services and had developed a general mistrust of health professionals and ‘expert’ knowledge systems. So Pam based her consumerist preferences on personal experiences and information from trusted family members.

[181] Pam was passionate about the importance of breastfeeding for infant welfare – but was drinking Coke and smoking while doing so. Although, as a midwife, I found it difficult not to comment on this, I avoided being relegated to the group of health professionals she was criticising.

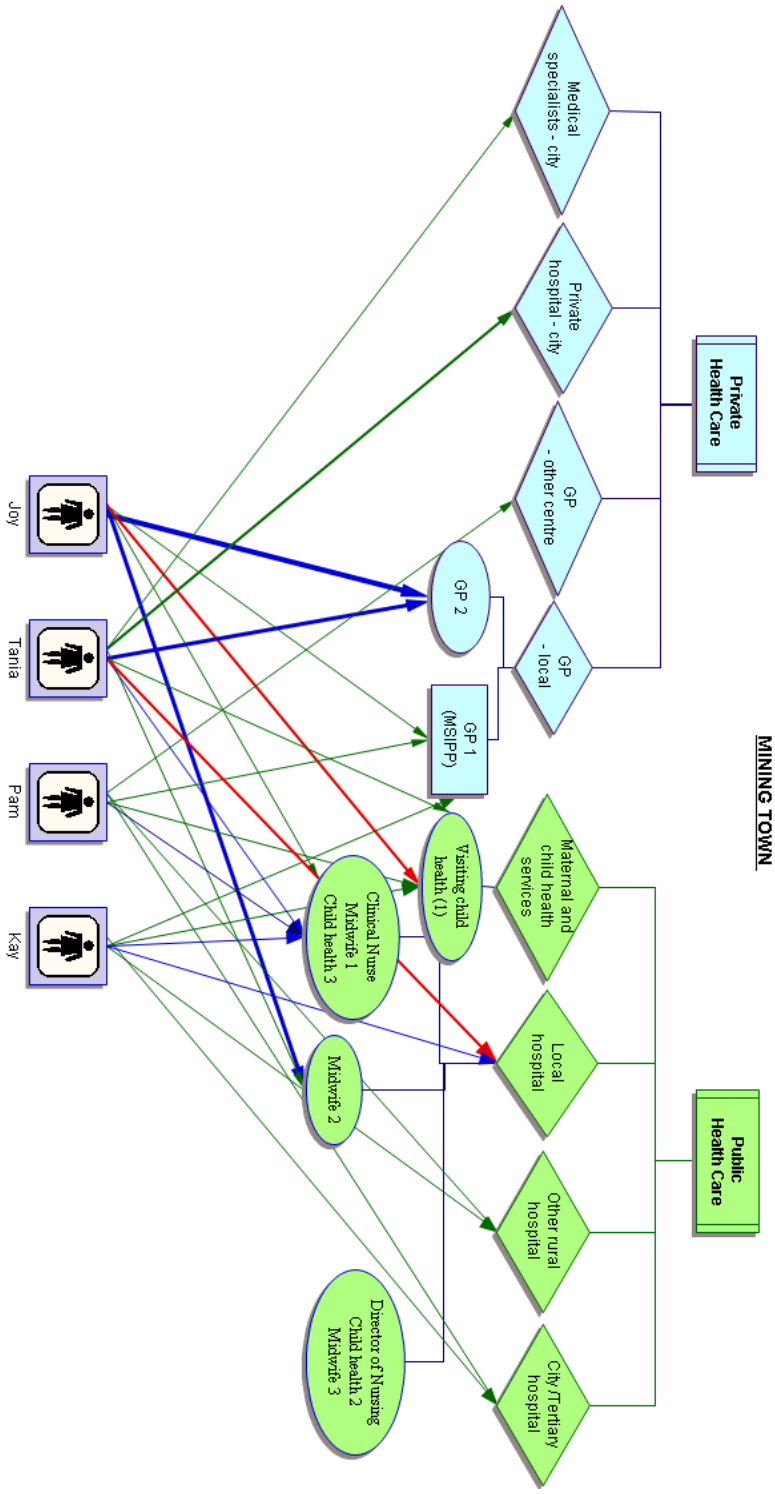


Figure 8.10 Birthing women's relationships with health providers: Mining Town

In contrast, Kay, the Mining Town hospital clerk, wanted to birth locally. She was a single, first-time mother, she would have preferred to receive all her maternity care from people she knew well and trusted. However, being a young primiparous woman, she was not allowed to birth locally. During labour, Kay experienced the disruption of being relocated to a better resourced rural hospital and then transferred again to a city centre. Anxiety, pain and the lack of social and emotional support during her first birth affected Kay's satisfaction with the experience

Sugar Town

Figure 8.11 depicts the perceptions of the ten women interviewed in Sugar Town. 'Class' and cultural differences were evident in Sugar Town with Italian women generally accessing private health services and the Filipinas and Aboriginal women using public maternity care. Interestingly, most women commented that they felt that Dr George, the Medical Superintendent, was the best doctor in Sugar Town. Being a parent involved in family activities in Sugar Town enhanced his acceptability. However, Dr George did not take private patients and most public maternity clinic work was covered by the less popular Dr Charles.

Evangeline, Rose and Bella's stories have been outlined in Chapter 7 (Sections A.3.1, A.3.2, B.1.2). Despite the language and cultural difficulties Evangeline encountered as a Filipina and first-time mother, she expressed satisfaction with the obstetric interventions and her overall maternity care. Because she came from a poor family in the Philippines, this freely available 'expert' knowledge and technology contrasted with her former experiences of home birthing. Although separated from an abusive Australian husband, Evangeline did not seek access to any counselling services but relied on support from an older female relative. Along with other Filipinas and their children, she attended the Child Health clinic.

Rose's relational genogram reflects her bond with the Aboriginal and Islander Health workers, suspicion of white health professionals and her resentment of their intrusiveness into her family circumstances. The bond between Rose and the Aboriginal Health Workers cannot be assumed. As discussed in Chapter 7, and depicted as a bold blue arrow on the genogram (Figure 8.11), credibility and trust were earned by Anna and Brenda and they were respectful of Rose's views. Desiring to avoid male doctors, Rose would have preferred female carers to minimise 'shame' during birth. She aspired to achieve privacy and anonymity in a tertiary hospital.

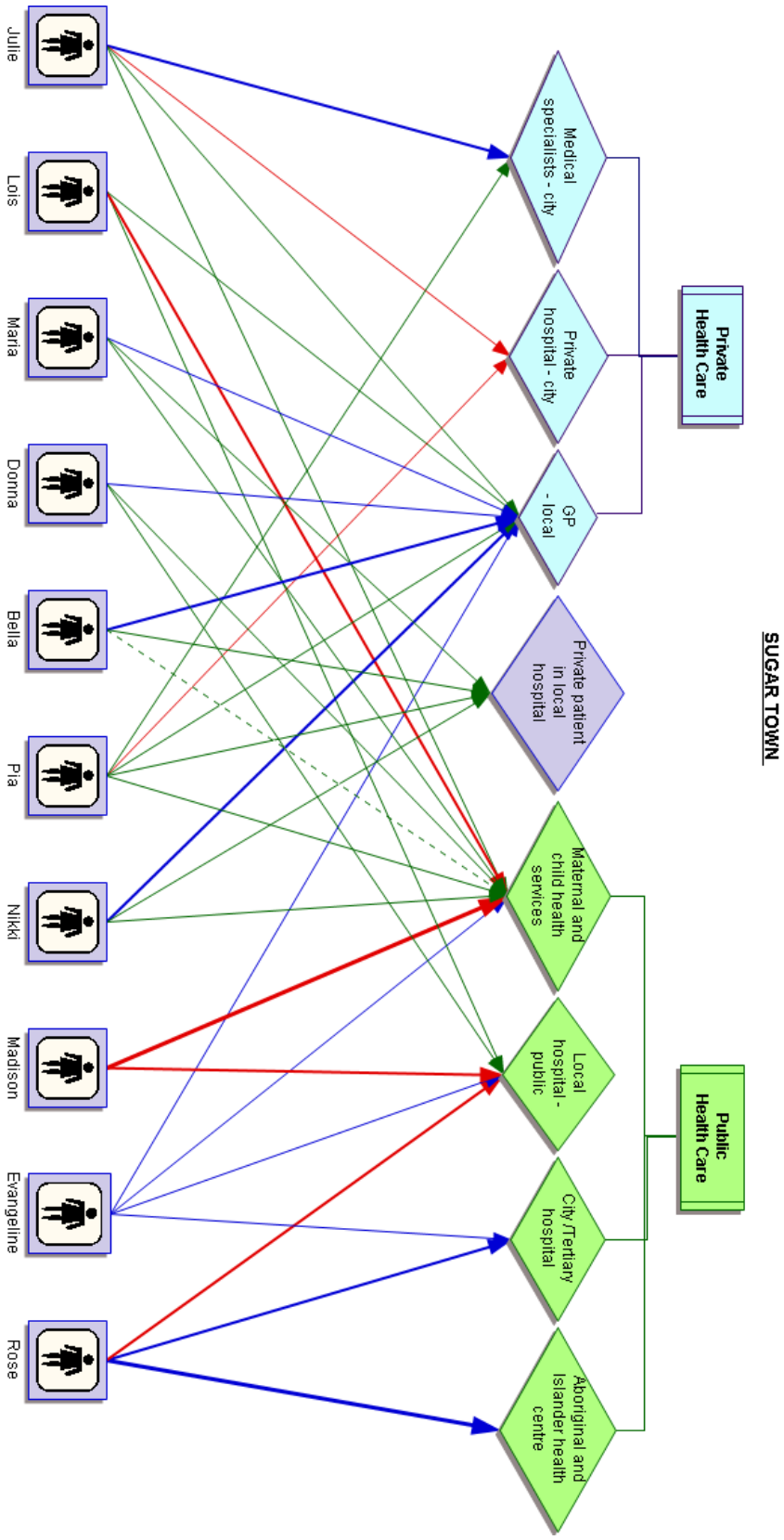


Figure 8.11 Birthing women's relationships with health providers: Sugar Town

Maria, Donna, Bella, Pia and Nikki were all Italian (including Sicilian)[182] women with private health insurance and so received care from their preferred family GP. They chose either private care in the Sugar Town or a city private hospital.

As a single mother of two, Maria was unusual in the Italian community where marriage was the cultural norm. For her maternity care, she chose share care with the family GP, whom she had known since childhood and who had cared for her mother when Maria was born. She liked his flamboyant, fatherly manner. His age and years of experience led her to trust in his professional competence. She was unaware that he no longer practised obstetrics according to current evidence. Interestingly, this familiarity with the GP meant Maria did not feel comfortable in disclosing an episode of domestic violence and so sought anonymity at the hospital, discharging herself soon after initial treatment. Maria's circumstances led her to have both babies in the local hospital, followed by routine infant monitoring from the MCH nurse.

For her second birth, Donna would have preferred a female GP, but none were available in Sugar Town. With her first pregnancy, Donna had placed significant trust in a male GP's advice and care. In preparation for birth, he had advised her to read one book only,[183] stating that "If you read more you will only get confused". Trusting his paternal advice, Donna obeyed. With her first birth Donna was a compliant, managed body. She commented on how she had relied upon the doctor and midwives to tell her when she was in labour, when to push and what to do. By contrast, she responded to her body's messages with her second pregnancy and stayed home until in advanced labour instinctively using pelvic rocking and hot water to relieve discomfort. Donna had a normal birth assisted by a midwife followed by privately-funded postnatal care.

It was difficult to assess Donna's expression of satisfaction with maternity care. She favourably contrasted the second birth with her first experience; however, she remained poorly informed about the possible alternative options available to her. Donna was neither reflexive nor consumerist. Her reliance upon her GP's medical advice and her faith in his expertise appeared unchanged.[184]

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[182] The Italian community was heterogenous with immigrants coming from many regions and separated by dialects, class and period of migration e.g. The Piedmontese considered the Sicilians to be 'peasants'. These divisions were breaking down with successive generations (Elder, 1996; Menghetti, 1981).

[183] This was Llewellyn's *Everywoman.*

[184] Her satisfaction, despite an obvious information deficit, was difficult for me. I had to resist the compulsion to shift roles from researcher to that of a midwife with a consciousness-raising agenda.

As the mother of three adolescent boys and unexpectedly pregnant in her late thirties, Bella was anxious about being 'old' so requested multiple tests to exclude foetal abnormalities, including amniocentesis and multiple ultrasounds. As with her previous births, she expected a long, medically-assisted labour. However, she had developed a strategy for coping with pain alone. For her fourth labour Bella said: "I just locked up the house … so I could be by myself and do my own thing". She retreated to a warm spa in the quiet, familiar surroundings of her home.[185] Bella delayed going to the Sugar Town hospital until she was in advanced labour and was elated when she achieved the non-interventionist birth she desired, with family members present. Following a period of postnatal rest as a private patient, Bella felt a minimal need to access MCH services as this was her fourth child.

Pia also had an unplanned child later in life.[186] Her third pregnancy, birth and postnatal period were complicated by a medical condition which required surgery a few weeks after the birth. She chose to access both an alternative therapist and specialist obstetric care during childbearing. On returning home from a caesarean birth in a private city hospital, she appreciated the MCH nurse's visits to check on her and the baby's well-being. As a mother, birthing in a distant city hospital created problems for Pia. She relied upon extended family support in the postnatal period.

Although the obstetric expertise Pia required was available through the two public hospital doctors, she felt that private care offered in the city was preferable and expressed concerns about maintaining personal privacy at the local hospital. While she knew and trusted the confidentiality of the doctors and midwives, the ancillary staff was known to gossip.

Marrying outside of the Italian community to a seasonal worker meant that Nikki was one of the few Sugar Town mothers in paid work during her pregnancies. In her small, hot house,[187] she struggled to keep her baby and toddler quiet as her husband, who worked night shifts, slept. Her preference for private health care was a significant financial burden but she considered it important to maintain continuity of care with her GP and have

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[185] Research shows that higher levels of pain-relieving endorphins are released in a familiar, secure environment and inhibited when a woman feels threatened, thus affecting duration of labour (Odent,, 1984; Raisanen et al., 1984; McLean, Thompson, Zhang, Brinsmead & Smith, 1994; Pert, 1997; Robertson, 1998, 2004).

[186] Although Pia was still in her thirties, the eldest child was now in her late teens.

[187] The house was a former cane cutters' barracks with tin walls and few luxuries. She dreamed of building a new home and having a holiday one day.

the option of specialist care if required. However, at the time of her second birth, her chosen GP was not available, so she was delivered by the on-call hospital doctor. Nikki felt that the hospital setting was very clinical but comfortable. She felt reassured by the medical equipment and in knowing that two of her sisters worked there as nurses. The maternity unit was quiet while Nikki was there so, for three days, she was the only patient with two midwives to care for her and the baby. The delivery, subsequent rest and attention she enjoyed could all have been freely available to her as a public patient. Nikki not only routinely attended the MCH services with both her children but also used the 24 hour phone counselling service provided by the private health fund.

Julie married into an extended Italian family and experienced disapproval and criticism when she did not fit with their motherhood discourses.[188] Against the cultural norm, Julie delayed childbearing until her thirties and then experienced fertility problems and a miscarriage before having two children. Following her first birth, she sought psychiatric treatment for postnatal depression and, when interviewed for this study, was employing previously learnt strategies to cope with the second postnatal period. Very aware of gossip amongst the Italian community,[189] Julie preferred private care in the city for both births. Achieving this privacy necessitated a two-hour journey each way and created problems with finding child care. Julie's second birth in the private hospital was complicated and not only did she feel poorly informed during the decision-making that preceded the caesarean section, but her accompanying husband felt "alarmed" and "abandoned". Postnatal pain and a wound infection exacerbated her problems in coping with pre-existing ill health and depression. The satisfaction with medical specialist care shown in the genogram applies to the artificial reproductive treatment and psychiatric care she received in the city. As shown in Figure 8.11, Julie was dissatisfied with the private obstetrician, anaesthetist and private hospital care.

The remaining two Sugar Town participants, Lois and Madison, were initially interviewed as a friendship pair. This helps to explain their shared antipathy for the MCH nurse who, they felt, almost harassed them into attending her parenting education sessions and clinics. As well-travelled career women, Lois and Madison were in their thirties, had married late to Sugar Town men and were now struggling financially and

[188] Julie's interview led me to explore the ideology of motherhood and the oppressive power of such discourses on maternal dysphoria and coping.

[189] Her concerns for privacy in the small community were well founded. While I was at another home, a visiting community professional breached confidentially by openly discussing Julie's situation and asked me if I had met her yet!

emotionally. Locally, they were perceived as old first-time mothers despite the national trend towards older primiparity. Both women attended antenatal education classes at the hospital and each experienced postnatal difficulties. Neither Lois nor Madison was able to meet her personal expectations of mothering capably, nor could they match the cultural ideal of motherhood.

Lois was satisfied with 'shared care' involving a GP and a public hospital birth. She had a small, irritable baby, a husband with limited parenting capacities and an expectation from the extended family that she should not only cope but flourish as a mother. Lois was distressed by judgemental comments and gossip about her skills as a first-time mother. Madison was her confidante and main source of emotional support. Exhausted from lack of sleep and social support, Lois had sought medical assistance for depression. For Lois, being diagnosed with postnatal depression was not stigmatising but was liberating. Although at the time of the study Lois was taking prescribed antidepressant medication, as well as being sleep deprived, she found that the 'sick role' enabled her to legitimately call upon assistance from family and community sources, which had not been previously available.

As a new immigrant, Madison had no affordable option other than public maternity care. Concerned about maintaining her persona as a competent professional woman and support person for Lois, and wanting keep details of her marital relationship private, Madison asked to be interviewed alone as well. In the subsequent two interviews and follow-up conversations,[190] Madison unravelled a distressing story containing feelings of social isolation, lack of understanding and inadequate emotional support both from maternity care providers and her husband. Despite careful antenatal preparation, Madison not only found the birth process traumatic and disempowering but also received conflicting lactation advice and unsatisfactory postnatal care. She discharged herself from hospital. Her patient chart records that she was "mothercrafting poorly". Madison complained that when following the advice of one midwife she would then have her breastfeeding technique corrected by another. Postnatal 'blues' combined with a small demanding baby and sleep deprivation, exacerbated her feelings that she could not cope. By discharging herself from hospital against medical advice, Madison risked being perceived as a non-compliant, difficult patient. Madison's husband, a health professional, was asked to

[190] The interviews with Madison, with the layers 'unpeeling' as we developed a trusting rapport, led me to explore Catherine Reissman's (1993, 1994) work on narrative analysis.

monitor her. For Madison, this home surveillance meant there was no safe haven or trusted person with whom she could talk.

Compounding Madison's postnatal distress was her perception that because of her professional position in the community, people had exceptionally high expectations of her as a mother. Madison recognised that it was very important to her self-concept to be perceived as the assured, capable person she had been before becoming a mother. Consistent with the notion of 'knowledge as power', she remarked that lack of confidentiality and gossip amongst competing cliques of local women, restricted individual freedom in Sugar Town as "everybody knows your story before you are ready to tell it". With no personal privacy and no one she felt she could trust with her intimate feelings, Madison believed that she was "sitting on an emotional time bomb".

Madison's recommendation for maternity services was for there to be a suitably qualified person, to whom local mothers could easily, confidentially and privately seek access for support and guidance. This person needed to be non-judgemental, accepting of difference, supportive and trustworthy. An impersonal help line was inadequate for her needs;[191] neither were local maternity care providers, the Nursing Mother's Association[192] or her church women's group seen as suitable. Madison felt there was no one she could to turn to in Sugar Town.[193]

In the rural towns, postnatal dysphoria and depression emerged as a significant problem that was not adequately met by the maternity services. There is not space in this thesis to debate the social, emotional and physiological causes of postnatal depression. The paramount importance of social support has been cogently argued by scholars such as Oakley (1993a, c; 1996), Crouch and Manderson (1993), Brown, Lumley, Small and Astbury (1994), Kaplan (1996), McVeigh (1997), Barclay, Everitt, Rogan, Schmied and Wyllie (1997), Cooke and Barclay (1999) and Elsenbruch et al. (2007). Drawing upon their combined experiences with rural and remote childbearing women, Croker and McDonald (2000) have presented the problems encountered when mothers are unsupported during the intermediate postpartum period. In addition to recommending continuity of midwifery care and social support during the transition to motherhood, they identified the need for access to a suitably qualified person who women felt was trustworthy and acceptable.

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[191] All women in this study who experienced signs of depression were provided with the contact details of a 24 hour hotline to which they could have access for free, private counselling and support.

[192] Breast feeding groups are made up of local women experienced with lactation who support new mothers. Both Julie and Madison felt confidentiality was a barrier to attending.

[193] Madison subsequently returned to North America where she had family support.

B.2 Remote maternity services – birthing women's relationships

Pastoral Town (including Ghost Town)

In the Pastoral Town and Ghost Town district, eight birthing women were interviewed. Of these, Linda, Olive, Joanna and Paula's stories have been discussed in Chapter 7 (Sections A.1.2, A.2.1, A.2.2, A.2.3). By comparison with the women of Sugar Town, most women in Pastoral Town knew the local health providers well and so had definite views on their acceptability and competence. In Figure 8.12, this is evident in several red lines linking women to the MCH nurse (Faye), and the predominance of strong blue arrows depicting confidence and satisfaction with the midwife (Nr Emma) and MSIPP (Dr Diana).

As shown, mixed views were held about the MCH nurse/Midwife 3 (Nr Faye) and DoN/Midwife 2 (Nr Gloria) as women related to them with antipathy, neutrality and liking. Influencing these responses was the friendship group between Emma (both midwife and young childbearing woman), Jess and Megan. Extending her influence, Nr Emma's holistic practice included home visits to Sally and Olive. Antenatal preparation and postnatal support was provided by Nr Emma to most of the women except Linda and Paula. Joanna refers to the value of these preparatory sessions in her interview.

Being an experienced female doctor with a woman-centred outlook, and the mother of a young family, ensured Dr Diana's acceptability to local women from all social backgrounds in the remote community. However, as a sole practitioner, Dr Diana was sometimes relieved by a visiting locum who probably would not have the same philosophy, experience or obstetric procedural skills. This created some uncertainty and was one reason why Olive wanted a predictable induced labour and Megan chose to give birth in the city.

For Olive, concerns about social and emotional safety were paramount over physiological well-being. This is consistent with the findings of Chamberlain, Barclay, Kariminia and Moyer's (2001) study of remote Aboriginal women. Feeling vulnerable, Olive carefully selected non-judgemental, supportive maternity care providers. Both Nr Emma and Dr Diana could meet this need but, living in Ghost Town with limited access to transport, Olive could not depend on their being available when she visited Pastoral Town. Olive spoke particularly strongly about a male locum she encountered on one visit. His questions about her finances and whether she could adequately manage her many children were offensive and "none of his business".

Dr Diana recognised Olive's concerns and, despite strong opposition from the DoN (Nr Gloria), enabled her to have the birth experience she desired. Given Olive's distrust of white health professionals, and particular antipathy towards Nr Gloria, this was valuable in paving a way forward to a positive, concordant relationship. However, Olive remained selective in her use of health services.

Following that birth, Olive had another miscarriage and when interviewed was depressed. She was also experiencing racial, social and emotional abuse from her neighbours and was concerned about her husband's infidelity. Olive was reluctant to disclose her feelings to local health providers, nor did she want to call the telephone help line in Mine City.[194] Olive was concerned that she might be judged as unable to cope adequately with her combined roles and responsibilities of mothering and educating her young children.

Olive's genogram shows a high level of satisfaction with the personalised and enabling care provided locally by Nr Emma and Dr Diana; strong disapproval of the DoN/midwife Nr Gloria, and mistrust of the MCH nurse. 'Facework' was important when Olive assessed the trustworthiness of care providers. Although confidential, a telephone support service was not perceived to meet her needs. However, following face to face conversation, she also trusted 'safe outsiders', such as myself and a visiting pastor, with confidential information.

Like Rose in Sugar Town, Olive was aware of the asymmetrical power dynamic created by her cultural background and socio-economic disadvantage. Having had her first child 'taken' by punitive welfare authorities, Olive mistrusted institutions of social control. Fears such as 'losing one's children' are recognised by obstetricians Kajubi (1999) and Thomas (1999) as potentially obstructing to successful maternity care delivery. Like Leppert, Partner and Thomson (1996) and Chamberlain et al. (2001), they advocate gaining trust through effective interpersonal communication, cultural awareness and sensitivity.

[194] As mentioned in Section B.1, all women experiencing depression or violence were provided with information on support services and encouraged to make telephone contact.

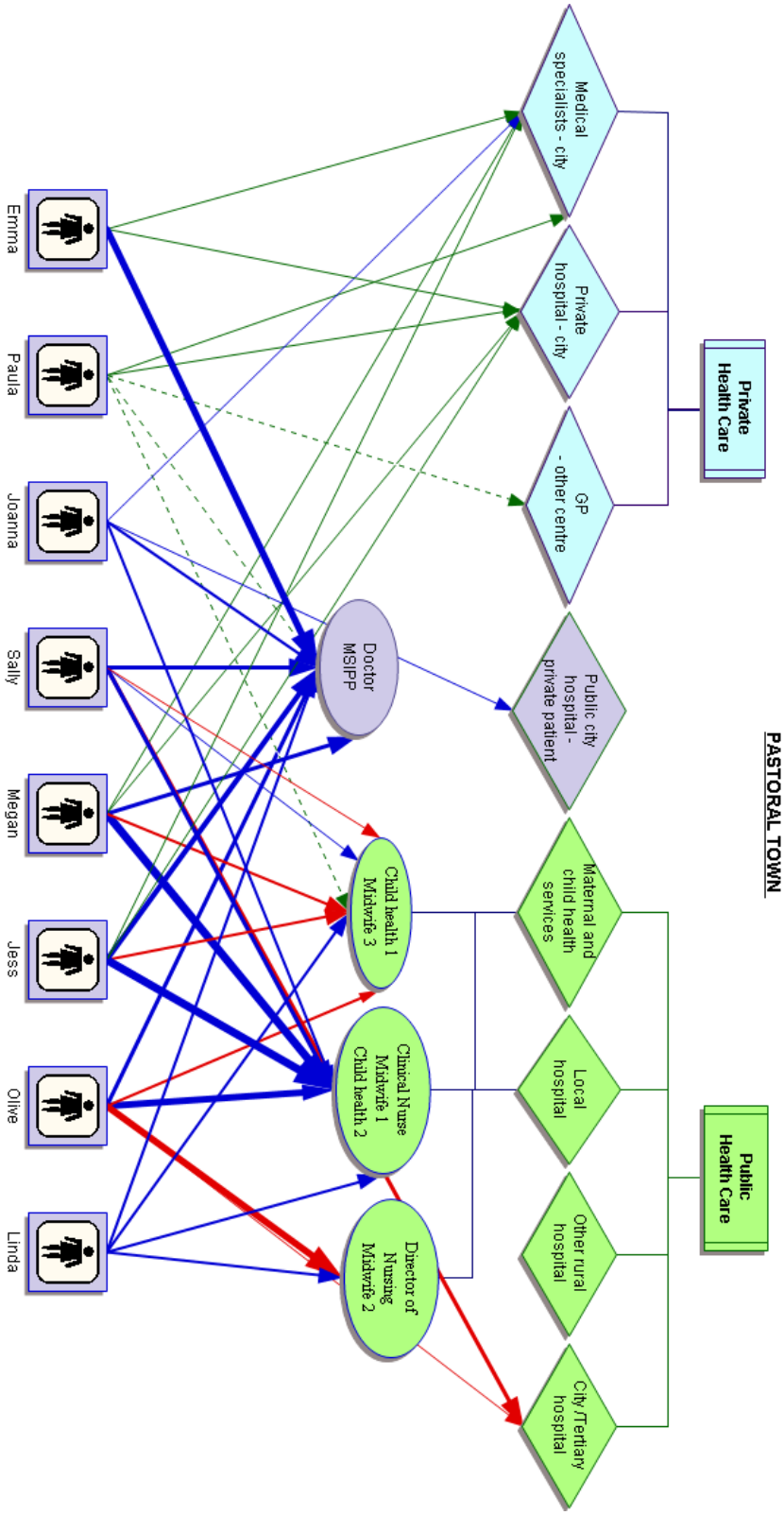

Figure 8.12 Birthing women's relationships with health providers: Pastoral Town

In Pastoral Town, both Olive and Linda were experienced birthing women who made consumerist decisions from a very limited range of maternity care options. They both knew what they wanted and, accordingly, planned to birth at the local hospital. Like Olive, knowing her carers was also important for Linda who remarked: “You just knew that you could really trust them and their capabilities and that sort of thing”.

For her third child, Linda achieved the continuity of care and non-interventionist birth she desired. Linda especially liked having a female doctor. She also enjoyed the opportunity to interact with other mothers at the MCH clinic. However, as clinics were held in the local CWA hall (Appendix F), this hindered private discussion about maternal emotions and coping. Her only dissatisfaction was the need for maternity care providers to also consider the psychosocial needs of mothers.

Joanna and Paula were both privately insured, first-time mothers who were satisfied with their highly interventionist births in city hospitals (Figure 8.12). Joanna was well educated and highly consumerist in her risk assessments and choices while Paula was simply satisfied that, as a private patient, she would receive quality care. Paula commented that, although the cost of health insurance was a financial burden, “You’ve got to have it [private insurance] in these small towns. It would be hard if you didn’t.”

Paula had minimal contact with any of the local health services and the arrows on her genogram show these as distant relationships. Growing up in the Pastoral Town district, she had little confidence in the quality of remote health services. By contrast, Joanna, a ‘blow-in’, had formed positive relationships with both Nr Emma and Dr Diana and respected their expertise. When Joanna was undergoing artificial reproductive treatment and experiencing episodes of depression, Dr Diana provided local care. During individualised antenatal preparation, Joanna bonded with Nr Emma and postnatally sought her advice rather than that of the visiting MCH nurse. However, Joanna felt a gap in the local services when requiring further sources of support when depressed.

As discussed in Chapter 7 (Section B.1.2), Sally’s birth and postnatal care were a source of contention between nurses Emma and Faye. In Figure 8.12, two arrows depict Sally’s ambivalent relationship to Nr Faye. The green arrow shows satisfaction with her midwifery role and the red indicates dissatisfaction with Faye’s interpersonal style and distrust of her professional competence as a MCH nurse.

Sally’s second pregnancy was troubled and included being sent on an eight hour road journey to the tertiary maternity hospital while experiencing cramps and bleeding. At the hospital, her threatened miscarriage was mismanaged by a series of trainee doctors

who gave her conflicting diagnostic assessment results. Once stabilised, she returned to Pastoral Town and was reluctant to return later in her pregnancy as advised by her GP. Figure 8.12 shows this hospital encounter as a red arrow.

When Sally went into early labour on a stormy night, there were no options available to her. It was too late to drive to the city, the thunderstorm would prevent a RFDS retrieval, she had made no arrangements for the care of her toddler, and her husband was drunk. The maternity care providers she knew and trusted (Nr Emma and Dr Diana) were both away. An unfamiliar relieving doctor and a midwife without current experience were on call. Sally commented that:

> No one knew me when I went up there. I found that really scary …If something went wrong … you knew you were just stuck. I was really worried.

As she had no choice but to place her faith in the on-call midwife (Nr Faye), her labour was short and the small baby safely delivered following outdated procedures. Sally found the midwife supportive and helpful and so was satisfied with her care. Consequently, Sally felt uncomfortable discussing her mistrust of the subsequent postnatal and infant care she received from Nr Faye. Several incidents led her to doubt Nr Faye's infant assessment skills and to comment on her "sloppiness" and "forgetfulness" with MCH documentation. Summing up, Sally remarked "I feel really bad because she did deliver [baby]. But I just don't trust her and just don't have confidence in her". Instead, Sally relied upon Nr Emma for infant monitoring and the lactation support essential for low birth weight babies like hers (Lawrence, 2001; Olds et al., 2004). While this gap in the maternity care was filled by these unofficial visits from Nr Emma, the local services were unsuited to assisting Sally with the relationship issues she was experiencing with her partner.

Emma, Jess and Megan were three tertiary-educated, privately-insured women who formed a selective friendship group with other young mothers in the district. Consequently, they were well informed and shared their dissatisfaction with the appointed MCH nurse. As a key health professional, Emma had a good working relationship with the local GP. However, as confidentiality was not possible in Pastoral Town, she carefully chose private obstetric care and hospital services in the city.

Jess and Megan had contrasting approaches to childbirth and mixed responses to the outcomes. As shown on the genograms, Nr Emma was significant to both Jess and Megan as a trusted friend who also provided personalised midwifery and child health advice.

As part of an extended farming family, Jess been involved with animal breeding and rearing all her life and this influenced her expectation that childbirth would be a normal, uncomplicated life process. Although she was required to relocate to a major centre for her first baby, she expected a straightforward birth. The neutral lines in her genogram show that Jess was non-committal about the private obstetric and hospital care she received. She consulted the busy obstetrician only once before birth. While the private hospital was conveniently located close to her family support person, it was hectic, so she found the care segmented and impersonal. In addition, the allocated midwife disbelieved Jess' self-evaluation of her progress in labour,[195] so she birthed without assistance. Adding to her dissatisfaction with the city birthing was her separation from her partner. For financial reasons he was supplementing their income by working away from the farm and was unable to be contacted.

Jess experienced social and emotional abuse from her parents-in-law. While Jess was a member of the "squattocracy", she had married into a family that was new to the district, poorly educated and deeply in debt during the rural economic downturn. They were resentful of both her social connections and the financial burden[196] they perceived she and the newborn placed on the family. Jess's father-in-law refused to talk to her directly and the constant ill-informed criticism from her sceptical mother-in-law left Jess doubting her capabilities. With her husband absent and travel to town restricted, Jess was physically isolated on the farm. She relied upon telephone conversations with her wide social network and occasional visitors to assist her to emotionally cope.[197] Aware of Jess' circumstances, Nr Emma provided outreach maternal and infant care including the essential psychosocial support. Consequently, Jess was better able to survive the family violence than Lee and Dani in Stockton district, who will be discussed later.

When interviewed, Megan was expecting her second child in less than two years. As shown in the genogram she was ambivalent about the private maternity care in the city, highly satisfied with the local doctor and midwife and yet had not planned to birth locally.

With her first child, Megan had chosen the same comfortable, well-resourced private hospital and obstetrician as Paula. By birthing on a Saturday night, Megan had

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[195] Jess was told she was probably just constipated!

[196] This abuse began with the pregnancy. While she was productively working and earning, their interference was minimal. After the birth, every aspect of her daily life was criticised. Visits to the clinic, mother's group and essential health care like infant vaccinations, were questioned. Access to a vehicle was restricted.

[197] Her parents-in-law also tried to curtail her telephone usage but she used passive-aggressive strategies to maintain this social 'life line'.

minimised obstetric interference during labour and birth. Megan achieved her planned 'natural' birth, supported by two midwives. Never the less, several events in that birth made it far from ideal and although her second labour was imminent, these led her to be indecisive about the place and type of birth that she wanted this time.

Dwelling on her first childbirth experience the previous year, Megan was haunted by memories of the unmitigated pain in labour, perineal trauma and postnatal discomforts. Megan reflected on how she could intellectually prepare for childbirth and parenting but was unprepared for her own physiological and emotional responses to the experience.

The first, unplanned pregnancy had been "distressing" and highly disruptive to her active working life, which involved extensive travel in rural/remote areas. Describing herself as a practical person she decided that having a second planned child as soon as possible would minimise interruption to her life plans.[198] The siblings, she assumed, would also be companions for one another.

At an intellectual level, Megan was the most knowledgeable participant in this study. She thoroughly prepared for childbirth by extensively researching evidence-based practices and reading scholarly literature on issues surrounding women, birth and motherhood. Reflecting further upon her theoretical preparation, Megan commented:

> I've read just about everything they put out on childbirth and pregnancy. … I'm one of those people - I quite enjoy research and I like to know just about as much as I can about anything before I do it - that's probably a work habit. I don't like to go in uninformed if I can avoid it [and] you can't have too much information. It's hard to be assertive if you don't know what's expected and what choices there are.

In addition, Megan relied upon her midwife and friend (Nr Emma) to assist her to practise techniques, positions and strategies that would be helpful in childbirth. Megan was a highly reflexive consumer for whom risk assessment, assertively achieving planned goals and having a sense of control, mattered. When immersed in childbirth, she found that being assertive and in control of decision-making was not achievable and necessitated dependence upon trusted others. This is reflected in her memories of her first birth.

Megan recalled being disbelieved by maternity staff when she went into labour at 37 weeks pregnant. The large baby was considered to be in an 'unfavourable position' so

[198] Childcare was not available. Affordable, suitably qualified 'nannies' are difficult to find for remote areas.

she was sedated.[199,200] She had a rapid labour supported by two midwives. However, as hospital safety protocols disallowed water birth,[201] Megan was required to leave the comfort of a hot tub and walk across the floor to climb onto a delivery bed with her baby's head presenting. Against her wishes, Megan was assisted to give birth in a sub-optimal position rather than one she had practised beforehand. She remembers thinking: "No. Oh my god, no! … Because I really think the [birthing] on your back procedure is pretty outdated". Her views are well supported by research.[202] These combined factors increased Megan's pain and contributed to the third-degree perineal tear and subsequent suturing she vividly remembered.[203] As the pain had been excruciating and pain relieving measures ineffectual, Megan was reliving agonising memories and dreaded the forthcoming birth.[204]

On her genogram, Megan's relationship with the private maternity carers is shown as neutral (green arrows). While the attending midwives were able to competently assist women to birth in various positions, the private doctors found delivering supine 'patients' on the bed more convenient. Traditional power structures prevailed in that private setting. So, although the midwives were highly skilled, they were obligated to follow each doctor's protocol. Megan's birth plan and desire for a natural birth had been honoured by the midwives who cared for her. They provided a high level of competent support within the constraints of hospital and obstetric protocols.

Being a reflexive consumer, for her imminent second birth, Megan had revised her plans. She intended to be assertive about her birthing position and, despite her awareness of the disadvantages, was considering pharmacological options, which concerned her partner.

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[199] As a primigravida whose large baby was in a posterior position, Megan was not believed to be in 'true' labour. The obstetrician prescribed a sedative and intended to induce her labour in the morning. She gave birth 4 hours later!

[200] Already weighing 3980gm (8lb 12oz), the baby would have gained significantly more body mass in the last 3 weeks of pregnancy. The baby was also in a posterior position which had not fully rotated, so the head presented its widest diameter.

[201] Warm water provides pain relief. Although women could labour in the hot tub they were required to get out of it at the onset of second stage because of unresolved safety concerns about staff potential back injuries and managing an unconscious patient.

[202] For example, Enkin et al. (2000) show that this position, although still commonly used, decreases the size of the pelvic outlet and results in uneven pressure on the perineum (unlike squatting or kneeling on all fours).

[203] A third-degree tear means she tore from the vagina to the anus, but not through the sphincter. For Megan, the suturing was especially traumatic. She added that: "with me it was psychological too … what an awful place to have stitches".

[204] Being sedated and anxious, Megan did not experience the endorphin release that contributed to Joy and Claire's sense of elation and amnesia.

Remote birthing had been considered by Megan. She rejected this option as it depended upon the availability of Nr Emma and, as Dr Diana had left town, a locum without obstetric procedural qualifications. Both were uncertain. Her ideal birth would be one in Pastoral Town, close to home, with her partner and daughter present, and not "having to deal with being away for weeks and weeks". There was also a possibility that remote seasonal work would prevent her husband attending the forthcoming birth in the city. Last time, he had taken considerable risks to be with her during labour by driving at high speed, on country roads, at night. She was "resolved" to coping without him.

Megan chose to birth in the same city hospital as previously but changed to a younger obstetrician. She liked the atmosphere of the private hospital and commented that the midwives were "really good, really caring down there. They don't treat you like you're sick because you're really not".

Many women commented on the importance of familiar carers, so I asked Megan if she would have also liked to have known the midwives before her birth. She replied:

> I don't know that it would have made a lot of difference. … if you click with someone you immediately become intimate. You know, it's a very unusual situation to be in labour - you feel so close to someone that you've never ever set eyes on before.

The childbirth literature states that most women prefer known female carers (Tracy, 2005b; Pascali-Bonaro & Kroeger, 2004; Homer & Davis, 2002) and this is consistent with the notion of face-work being important for trust-building. In contrast, Megan felt there were also advantages to anonymity:

> In some ways I think [knowing your midwife] would work the other way, well, it's almost nice having an anonymous person there because it's a pretty undignified experience in some ways. … I suppose you can rest assured you're never going to see her again. You know you can be completely vocal and not worry if you scream and yell …

When asked if she had attended child health clinics, Megan said she only went a few times to have her baby weighed and measured as she had not "hit it off" with the MCH nurse. Concerned about the nurse's interpersonal skills, Megan commented: "I think she's got very good intentions but her approach to people leaves a lot to be desired". Megan gave examples of remarks, sometimes intended as humour, which she thought inappropriate from a health professional:

> Because mothers go through stages when they are really sensitive, really sensitive to those sorts of comments, they pick up on things. And you don't need [remarks] coming from a professional, like they have to be very careful about what they say. Because you can feel very insecure about what you're doing … I just think that sometimes she's not as professional as she should be.

Like several other young mothers in Pastoral Town, Megan preferred to wait until Nr Emma made a social visit and informally ask her for advice then.

As many other women in this study have commented, the postnatal period was very challenging. In contrast to being isolated, Megan not only had a supportive partner but also was "exhausted" by numerous well-intentioned but inconsiderate visitors, many of whom had young children. They "overwhelmed" her with mothercrafting advice. [205]

Megan found mothering in a remote town unfulfilling and craved intellectual stimulation. Within weeks she was censured by the community for returning to work. There are few available employment options for rural/remote women. Megan observed that even though a number of the women were well-educated with tertiary qualifications, in a small town their role centred upon domestic work. This frustrated Megan who thought:

> There's an individual there, not just a mother and a wife, you're also a person. I just cracked up one day and I went out the next week and bought a computer and went back to work. In a part-time way but it suited me. I could still go out and see those people and talk about different things. [Toddler] has just been very adaptable and come along. I think I would have gone mad otherwise. But I think it's been better for me as a mother to sort of acknowledge that I have a life outside of motherhood.

With no available childcare, working part-time from home was one way to manage. However, while working for financial reasons (like Paula) was tolerated, Megan was criticised by locals for 'selfishly' doing so for her own mental well-being. She said: "It was hard to explain that you just needed it for yourself".

Megan reflected that for many women, contact with other mothers was essential but for her it was not. While she had plenty of social contact on a daily basis, Megan did, however, seek opportunities for her toddler to socialise with other children. Recognising that social support could be a problem for some rural/remote woman, Megan reflected:

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[205] One day 15 people dropped in to see her and the new baby.

> I think that's probably a big problem for a lot of Australians because so many people don't live near their families anymore. Social fabric has changed. I think that if you don't have close friends here, there's no professional people, there's no counsellor types. I couldn't imagine going and confiding … there's not even anyone here even if you did want to talk to someone.

Like other new mothers in this study, Megan's ambivalence about her new maternal role, her sense of a loss of self and of being alone in the life-changing transition to 'becoming a mother' is an experience well articulated by numerous authors such as Rich, (1976), Wearing, (1984), Crouch and Manderson (1993), Barclay et al. (1997), Rogan et al., (1997), McVeigh, (1997), Wolf, (2001) and Olds et al, (2004)[206]. Their insights highlight the need for health providers to consider the significance of each individual woman's perceptions of her situation and social context rather than just providing physical care.

Stockton

Of the five birthing women depicted in Figure 8.13, three lived within Stockton township and two were isolated on pastoral properties in the district. As Claire and Lyn both worked at the local hospital, this affected their perceptions of the DoN/midwife, doctor and MCH nurse.

Lyn and Laura were married to itinerant professionals and interviewed as a friendship pair. As they were transient members of small remote communities for limited periods of time, their views differed from the long-term residents. As the local policeman's wife, Lyn never felt accepted or trusted in the community. She commented on how guarded people seemed in her presence, even when discussing everyday matters. In return, Lyn felt her behaviour was constrained and she was insecure about trusting locals with her personal matters. As a first-time mother needing someone to confide in, Lyn turned to Laura for support. They shared a number of views on the inconsistent quality of remote health services. Further, Lyn's negative workplace relations and dislike of the DoN/midwife influenced Laura's views.

Laura led a peripatetic life so chose to receive continuity of maternity care from private providers in larger towns. Despite recounting the cost of travel and inconvenience of weeks

[206] Within the constraints of this thesis, it has been necessary to omit the extensive discussion on motherhood.

away from home,[207] separated from her partner while managing older children, she returned to the same obstetrician and private hospital for each birth. She also continued to consult the GP in her town of origin. Familiarity with the maternity setting, confidence in the standard of care, and ongoing care from a known doctor were important to Laura.

In contrast, Lyn accessed local health services, as well as continuing to consult her family GP in her town of origin. She also chose to have her baby in the rural hospital in her home town. Lyn had known the midwife who delivered her baby all her life. In Pastoral Town, Lyn was most satisfied with the women-centred approach provided by the visiting women's health nurse and Claire, the Registered Nurse. As Claire was a health professional and young mother, Lyn valued her friendship and advice over that of the doctor and midwife.

Claire's uplifting birth story has been related in Chapter 7, section A.1.1. The unexpected birth of her first child in remote Stockton was a life enhancing experience for both Claire and the women who shared the event with her. Having married into the local community, Claire was actively involved in working towards maintaining social and health services. Consequently, she regularly accessed all available services, including visiting child health and women's health clinics. As shown in Figure 8.13, Claire was well satisfied with the care she received. In particular, she commented on how the immigrant male doctor was "very caring" and the personalised antenatal and postnatal care from the midwife was exceptional. This included friendly home visits to advise on breastfeeding when required. However, Claire was aware that several young mothers in town were not taking advantage of the services provided and felt that they would benefit from doing so. Cognisant of the limited health resources and that medical evacuation was undependable, she also cautioned against routine first-time births in remote communities.

Of the two remote area farming women shown in Figure 8.13, Lee chose not to access Stockton health services and Dani had limited contact with the doctor, midwife and MCH nurse. Both Lee and Dani were experiencing isolation and family abuse at the time of the first interviews.

[207] In this context, 'home' describes the current, nuclear family residence in contrast to 'home' as a place of origin.

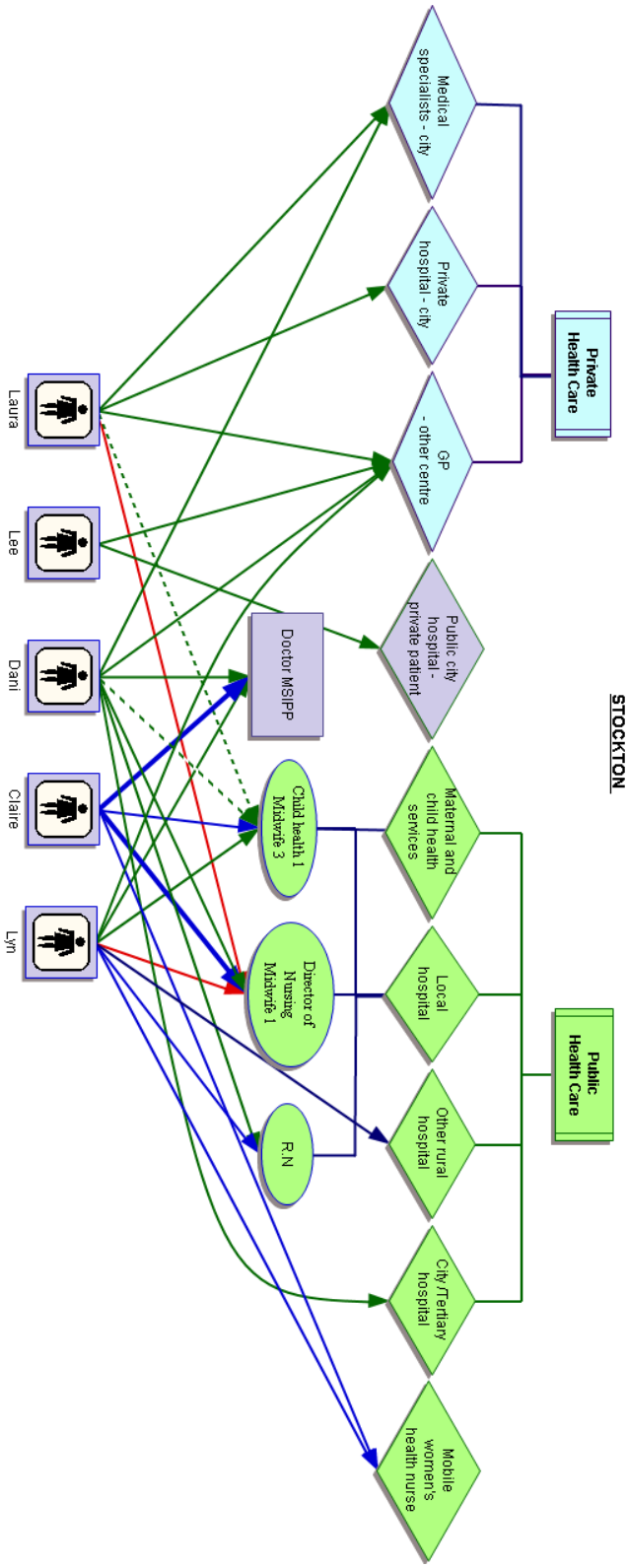

Figure 8.13 Birthing women's relationships with health providers: Stockton

Lee was a tertiary-educated woman with an urban background who married into a family that was also new to farming in the district. Financially in-debt to her husband's parents, the couple and their three young children were struggling to remain viable during the rural economic downturn on marginal pastoral land.[208] Adding to the hardship, they provided for seasonal workers,[209] a series of trainee jackaroos who came for work experience, and extended visits from her parents-in-law. Lee's family were not made welcome by her husband and in-laws. Although Lee would have valued her mother's occasional support and assistance with domestic work and the children, this was actively discouraged. On a previous visit, Lee's mother had found the resentful atmosphere intolerable. When returning home with a newborn and juggling two older children requiring Preschool of the Air tuition, Lee was also required to cook and wash for a fencing gang and the jackaroos, do all the domestic work for the extended family, educate the older children[210], and manage their business affairs.

Lee felt aggrieved that her parents-in-law were entitled to live with the family without contributing their labour. Not only did she find their presence an additional workload, but they criticised her efforts. Experiencing stress from multiple sources and having little privacy as a couple meant that Lee and her husband tended to argue a lot. During her last pregnancy, Lee felt overwhelmed and despairing. She remarked:

> I just got so depressed. I've never been so depressed in my life. I was continually sick … I didn't even want anything to do with my kids … I didn't worry where they were or who they were with …

When asked how she survived, Lee identified four ways that she coped. First, she was successfully breastfeeding, so the baby was doing well despite the constrained circumstances. Second, she lowered her self-expectations of mothering, describing how sometimes she would just "hose down" the children and nappies.[211] Lee reflects that the children became "like little heathens".[212] Third, although it was limited, she had long-distance social support from her mother, selected neighbours, and a friend in Mine City. Finally, she

[208] Compounding their financial hardship was the loss of valuable stock during extended periods of agistment.
[209] Such as during mustering and when fencing.
[210] The older children's learning was through the School of the Air.
[211] In hindsight, this concerned Lee as the artesian bore water is hot.
[212] Highlighting for me, her valuing of a 'civilised' urban life with available social support and amenities.

owned an old car. At times, Lee would take the children and "escape" to Mine City over a seasonally-affected back road.[213]

Isolation was both compounded and alleviated for Lee by the attitude of neighbouring pastoralists. As impoverished newcomers, Lee's family were positioned at the bottom of the hierarchical 'squattocracy'. Even pastoral managers could afford nannies or domestic assistance and Lee felt marginalised in the gendered and classist groupings at musters and School of the Air events. However, she did form a reciprocal bond with a couple of women on neighbouring properties. When Lee unexpectedly went into labour early with her last baby, she relied upon the country ethos of neighbours 'helping out' in times of need. One neighbour came and took care of Lee's two children while Lee drove herself to the inadequately resourced Boomtown health centre, two hours distant. From there she was transferred to Mine City hospital.[214] The following day the second neighbour came and minded the children, together with her own, until Lee's husband returned to take over their care.

At the onset of Lee's labour, her husband was away repairing a windmill and would be gone for three days. Without the windmill, no artesian water would be pumped to the stock. Given the decision between whether to be with Lee for the birth or ensure their economic survival, he had to prioritise their livestock and livelihood. For similar reasons, he had been unable to support Lee during any of her births. Being deprived of his presence and prioritised below the husbandry of the livestock had "really upset" her. The rural necessity to consider production before reproduction rankled with several women in this study.

The unpredictability of such circumstances, explains why some rural/remote women request social inductions and seek the certainty of set a delivery date and place of birth. Despite the potential cascade of obstetric interventions that can result from the artificial induction of labour, the need to plan safe travel to hospital, organise the care of older children and ensure partner support are not trivial reasons for requesting this procedure. Accessing social inductions is easier with private obstetric care.

As shown on her genogram, Lee had neutral feelings about the maternity services she had chosen to access as none of these adequately met her needs. Lee did not utilise any health services in Stockton; she considered them limited and unreliable. As the four

[213] When I last spoke with Lee, she and her husband had left the farm and moved into a mining community where there was a reliable income and a school for the children. Away from his abusive parents, their relationship improved.

[214] As shown in Figure 3.1, Queensland has more births before arrival at hospital than any other mainland state.

hours travelling time to Mine City from her station was equivalent to Stockton, she preferred the continuity of care from a private doctor there. Lee felt that private health insurance was a necessity given their location and circumstances.[215] This expense was justified. She was the authorised RFDS First Aid person for the area and had managed several remote medical emergencies. In addition, during each of her three pregnancies, Lee had experienced complications. In the last pregnancy, this necessitated an expensive evacuation in a private plane for an extended period of maternity care in Mine City.[216] As her doctor informed her that she could not be trusted to rest and follow recommendations if allowed to return home, Lee was separated from her two young children for a several weeks, which added to her distress.

It was of interest that Lee's doctor perceived her as untrustworthy and held her responsible for her own ill health during pregnancy. The broader social circumstances, domestic burden or family violence were not addressed. Lee was given no advice on advisory or support services she could access.

Like Lee, Dani found herself geographically, socially and emotionally isolated on a pastoral property with several children, far form her family of origin, while also over-burdened with domestic labour. As the only woman resident on the Stockton property, little consideration was given to her health needs before or after operative childbirth and a miscarriage. Dani experienced complications during and following her last successful pregnancy necessitating her driving to Mine City, with two young children, for obstetric monitoring by a GP.

The paternalistic attitude of the GP was a concern for Dani but her options were limited to doctors with obstetric procedural skills within driving distance of her home. He expected unilateral trust yet disbelieved her ability to accurately recall her menstrual cycle[217], her experiences (like foetal movements) or symptoms. Instead of believing an adult, multiparous woman, he relied upon technology, such as ultrasonography, for 'reliable' information.[218] Dani would like to have given birth 'naturally' but did not recall being given that option. She says that she was confident that her doctor would try to do what was best for her.

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[215] The RFDS supply emergency medical "boxes" to designated people in isolated areas. With limited training, they responsibly administer vital, interim medical care.

[216] Lee was bitterly resentful that this evacuation had to be privately funded.

[217] Dani's was made to feel that her unusually long menstrual cycle was unlikely. This 'deviance' defied the GP's ability to calculate her due date using Nägele's system.

[218] Ultrasonography is inaccurate as a predictor of foetal age in the second part of pregnancy and cannot be relied upon to confirm a woman's due date or to assess foetal maturity.

The GP "took control" and decided to induce Dani's labour too early, necessitating an emergency caesarean section for foetal distress, which resulted in a distressed, premature baby. Dani and the sick baby were then transferred by air to a tertiary women's hospital which had neonatal intensive care facilities. There, she was alone, anxious and unsupported for several weeks.

During that time, Dani's husband cared for the two toddlers but she was expected to pick up her domestic workload soon after returning home. Although she was still recovering from the caesarean section complicated by a wound infection, within three weeks of coming home she was cooking and washing for the mustering men while caring for a frail baby and two toddlers. Dani had a distant relationship with her mother and found herself far from family support, experiencing social and emotional abuse; she felt there was no one she could turn to locally.

As shown in Figure 8.13, Dani was ambivalent about the health services from which she had received care. She no longer placed unquestioning trust in the Mine City GP who had provided her previous maternity care. Fear that she would have another premature, sick baby was very powerful and the perceived risk of that outcome outweighed her trust in that GP's abilities.

Dani was also asked specifically about her utilisation of the Stockton maternity services as she had been hospitalised there following a miscarriage and for a period of postnatal recovery. At those times she was experiencing grief, depression, relationship issues and had unresolved fears about how she would cope with the risks associated with subsequent pregnancies. When the Stockton midwife approached Dani and made herself available for counselling, Dani decided not to take advantage of this. She stated:

> Me, I don't go to anyone. That's what I've always done. No, not me. You know, possibly – see I don't find it hard talking to you - so possibly if someone came out [to the station] I could talk to them. But I know that I won't go looking … I don't know if I find it hard to talk to people … I've never talked about my problems.

In addition, Dani had concerns about several health and behavioural problems with two of her children. The MCH nurse was one health provider who may have been able to meet Dani's needs. Home visits are within the scope of practice for MCH nurses if a maternal or child health need warrants it, such as following a caesarean section. However, in contradiction to this practice, the MCH nurse was disallowed to go 'off-road' in the health service vehicle and had limited time to cover the large geographic area.

I asked Dani if she would have liked to discuss her concern with this nurse. She declined, stating that she consulted a MCH nurse once and found the advice impractical and inappropriate for her context. In addition, the nurse's visits to Stockton were at an inconvenient time, the clinic times were too limited and inflexible for a mother travelling in from a station, and the venue lacked privacy. Dani felt uncomfortable discussing her personal worries with others, including her husband.

Dani had married into an established pastoral family whose vast but marginally viable holdings extended across two states. This asset rich and cash poor family company relied upon the labour of its members to survive. Consequently, Dani's husband was away from home for extended periods of time. The few women on the properties were stoically expected to contribute their unpaid and undervalued domestic and reproductive labour to the common good of the family. This family structure was patriarchal, masculinist and typified the stereotypical male attributes popularly associated with outback men. Accordingly, her husband was a self-reliant man 'of few words' who had difficulty expressing himself, and preferred outdoor roles in the company of men. While the family did not maliciously abuse Dani, she was none the less isolated and oppressed. She experienced unrelenting physical hardship, social deprivation and emotional neglect.

Disclosing her feelings and needs was difficult for Dani as maintaining personal privacy was associated with an assessment of risks and trustworthiness. Like Joanna, Dani experienced disenfranchised grief and unresolved fear about future pregnancies. Expanding on her communication problems within her marital relationship, Dani commented that she had not adequately discussed the miscarriage with her husband:

> The way he looks at me, I don't know, [if] he feels sorry for me. … When I asked him something like "What do you think?" [he said] "I dunno. It's you that had it".

Given the family expectation that she would provide further children, broaching the subject of preventing subsequent pregnancies was also awkward for Dani.

Giddens provides insights into relationships such as this. In his work on intimacy, Giddens' (1992) discusses the risks of opening oneself to another. He describes the high level of anxiety and insecurity involved in forming close relationships with others. As the level of intimacy increases, the greater the tension is between trust and risk. If sharing is mutual, and each party can 'open out' to the other, then the uncertainty about disclosure and loss of autonomy is balanced by ontological security (Giddens, 1990; 1992). However, given the difficulty that remote maternity services have in meeting basic needs,

delivering appropriate, counselling that would assist women like Dani have such insights into their relationships is unlikely.

B.3 Summary of birthing women's perceptions of labour relations

In Section B, childbearing women's perceptions of the health services they utilised are shown as relational genograms. Women in Sugar Town, the largest health district, were less likely to have strong views about particular maternity care providers while in contrast; women in the remote Pastoral Town had strong views about the doctor and individual midwives and nurses.

Drawing upon the interview data, each woman's views on her maternity care has been positioned within a holistic framework. Outlining selected aspects of each woman's social and material context reveals the circumstances of her life; thus the factors that enable or constrain the quality of her childbirth experience become apparent. Key themes which emerge include choice, risk, trust and violence. The nexus between trust and risk, along with forms of abuse, were most significant to childbearing women's relationships so will be explored in Section C.

Part C Labour relations: Trust and violence

C.1 Trust

Although issues related to trust were significant for both the maternity care providers and consumers in this study, this section will focus particularly on aspects of trust, distrust and mistrust found in the birthing women's narratives. Equating trust with ethical practice and honesty, Australians reportedly consider nurses the most trusted professionals and doctors also rate highly in third place[219] (Metlikovec, 2007; Morgan, 2007). As birthing women's everyday notions of trust are embedded within the rural/remote context, this analysis will encompass their general perceptions of health services and their interpersonal relationships with maternity care providers. These findings will be compared with, and contrasted to, the literature reviewed in Chapter 1 (Section 1.5), which discussed

[219] Academics were rated by Australians as the second most trusted professionals.

the diverse and contested conceptualisations of trust within nursing/midwifery,[220] medicine and sociology.

While 'distrust' can be defined succinctly as a loss of confidence, and 'mistrust' as regarding someone with suspicion (*Shorter Oxford English Dictionary*, 1993), the nature of 'trust' is contentious and confused by the use of synonyms which inadequately describe attributes of the concept. When applied to relationships and services, forms of 'trust' range from pre-reflective emotions like hope, faith and confidence in the face of anxiety, vulnerability, uncertainty and insecurity, through to a rational, reflexive decision to depend or rely upon something or someone to meet a need following assessment of the risks and options (Johns, 1996; Lupton, 1999; Giddens, 1990; 1994; Luhmann, 1998; Cook, 1997; Zadoroznyj, 2000; (Anderson, Anderson & Glanze, 2002).

'Trust' is widely recognised as the touchstone of effective health encounters and foundational to successful relationships. Within the health literature, it was considered essential to a person's willingness to enter into a relationship, seek assistance or care, disclose sensitive details and follow advice. However, while midwives and nurses are inclined to value building reciprocal, respectful relationships with clients (Zadoroznyj, 2000; Kent, 2000; Maher, 2003; Hupcey et al., 2001; Norcom, 2002), the medical literature tends to expect unilateral trust from patients and in return is apt to be distrusting, as evident with indemnity concerns (Lupton, 1997; Mechanic, 1996; 1998; 2004; Walton, 1998; Hall et al., 2002). A notable exception is Stevenson and Scamblers' (2005) proposed concordant relationships in which harmonious agreement is based on mutual trust between patients and doctors.

Within the literature, there is a commonly held perception of a 'crisis' in trust at general and global levels incongruently accompanied by an increasing desire for trustworthy interpersonal relationships in everyday life. Rampant public distrust, a growing awareness of risk and the emergence of health consumerism are cited as potentially detrimental influences on therapeutic relationships. Conversely, high levels of interpersonal trust are reported between patients/clients and 'their' individual doctors, midwives or nurses (Buresh & Gordon, 2000; Mechanic, 2004; Godlee, 2006).

Within the sociological literature, late-modern, postmodern and poststructural

[220] Nursing and Midwifery literature are combined here as most published references to trust are found within nursing literature. However, email discussions within midwifery and maternity interest groups (e.g. OzMid; Birthrites) emphasise mutual trust as an essential component of the relationship between a birthing woman and her midwife if an optimal outcome is to be achieved).

scholars have examined the micro and macro processes of trust and risk within interpersonal and medical encounters. Characteristics they have identified include the role of emotions in forming trusting relations, pre-reflexive trust in expert knowledge systems, the desire for ontological security, a yearning for a return to forming interpersonal trust through face to face interactions, as well as the importance of life experiences to reflexive consumerism (Luhmann, 1988; Giddens, 1990, 1994; Lupton, 1996, 1997, 1999b; Zadoroznyj, 2001). Therefore, trust as an emotional response may or may not be a conscious process.

The diverse and contested notions of trust within therapeutic encounters are influenced by medical and liberal ideological discourses. Medical discourses contain a distinct contradiction which will become evident in the following examples from birthing women's stories. On the one hand, medical ideology perpetuates the Parsonian (1951) notion of the docile, compliant patient who trusts in the charismatic authority of the doctor (Cook, 2004; Latham, 2002; Irvine, 1999; Walton, 1998) while simultaneously promoting the liberal notion of the autonomous individual who is a reflexive consumer capable of assessing risk, making informed decisions and being accountable for the outcomes (Lupton, 1999; Zadoroznyj, 2001). As childbearing women feel responsible for the welfare of themselves and their child(ren), they form a vulnerable group. The ways in which childbearing women responded to these contradictory expectations is explored next.

So as to reveal the ways in which trust enabled or constrained women's satisfaction with their birthing experience, I posed several questions when interrogating the interview data. Based on the interdisciplinary work of Hupcey, Penrod et al. (2001, 2002) and Hupcey (2002), I questioned:

- whether trust was immediate or built over time;
- whether it was conditional on need;
- the ways in which trust intersected with choice and risk;
- if establishment and maintenance of trust involved overt and covert testing behaviours;
- whether a person was trusted by virtue of their identified role or status (for example as a health professional or mother) or because of certain personal characteristics;
- what circumstances and experiences elicited trust and which created distrust and mistrust, and
- what the ramifications of loss of trust would be.

In the following discussion, I consider the proposition of Hupcey et al. that the preconditions of trust include “a need that cannot be met without the help of another”, “prior knowledge about the other” and some assessment of the risks (2001, p.290). As Hupcey et al. indicate “Trust is a willing dependency on another’s action but it is limited to the area of need and is subject to overt and covert testing” (2001, p.290). That is, a childbearing woman requires maternity services and, based upon her prior knowledge about either the individual maternity care providers or the professional group, she finds someone who can potentially meet her need. However, as trust places the birthing woman in a vulnerable and dependent position, she must calculate the benefits of trusting against not trusting maternity care providers before willingly entering an encounter. If the outcome of trust is not expected to be positive, then a trust relationship will not be formed.

To prevent being engulfed by insecurity and anxiety, birthing women’s stories reveal that they consciously placed their trust in specific health professionals at particular times. Thus, trust was vital to a sense of security. According to Giddens “What is seen as ‘acceptable’ risk - the minimising of danger - varies in different contexts, but is usually central in sustaining trust” (Giddens 1990, p.35). Lupton adds that trust:

> allows individuals to develop a cocoon of invulnerability which enables them to get on with life, to fend off their knowledge of the risks that await them at every turn. This protective cocoon is sometimes pierced by experiences [‘fateful moments’] that highlight the existence of these risks and calls in question established routines (1999, p.78).

Such ‘fateful moments’ were evident in most women’s accounts of childbirth.

In trusting, anxieties are pushed into the unconscious so that fear is displaced rather than dispelled. Trusting someone implies an expectation of risk minimisation and a positive outcome (Hupcey et al., 2001; Giddens, 1990). Building on Giddens, Lupton describes other reactions to risk as “sustained optimism” based on faith and “providential reasoning”, “cynical pessimism” which uses a “world weary perspective” and humour to manage anxiety, and lastly “radical engagement” which approaches perceived risks with an “attitude of practical contestation” (1999, p.79). Although these means of managing risky circumstances are consistent with some birthing women’s responses and influence the formation of trust, it is questionable whether they constitute trust. Prior knowledge and life experience were more likely to influence trusting encounters with health professionals and maternity services.

In the absence of previous experience or reliable information, trust was also given conditionally. As will be illustrated in the following sections, women tested the trustworthiness of maternity care providers and withheld trust if their expectations were not met, they were dissatisfied, or they would limit their trust to a particular individual in a particular role rather than globally awarding trust.

Birthing women conceptualised trust in a number of ways to describe their interpersonal relationships and general attitudes to maternity services. Within their narratives, trust was associated with confidentiality, privacy, reliability, certainty, security, faith, dependability, competence and mutual obligation. Distrust and mistrust were evident when women discussed unreliable health services and unpredictable quality of health care, doubts about privacy and confidentiality, and a lack of professional expertise or incompetence. Birthing women spoke of trust in relation to health care professionals as individuals and as professional groups embodying expert knowledge. Trust was also implied in the health care services they chose. In addition, trust arose in discussions about relationships with their partners, families and people within the small communities particularly in reference to caring for children, and in attitudes towards birthing women's untrustworthy, unpredictable and wilful bodies.

Trust in maternity care provision

Childbearing women's desire for physiological, psychosocial and emotional safety shaped their expectations of a 'trustworthy' health system and their preferred place of birth. Need, security and risk were significant considerations. All the women interviewed had made an assessment of the risks and benefits of the maternity services they chose to access across their childbearing experiences. This equates with notions of trust as something that you can confidently rely upon. The five principles which underpin quality outcomes and client satisfaction with maternity services (Section 3.2) were recurrent sub-themes. As maternity consumers, women required an accessible maternity service that could be depended upon to meet appropriately, efficiently, effectively and consistently their perceived needs and wants (Duckett, 2004; Enkin et al., 2000; Campbell & Garcia, 1997). Distrust and mistrust occurred when there was incongruence between this expectation and their childbirth experience. Adverse experiences resulted in loss of confidence at a conscious level and loss of faith as an emotional response. Consequently, whether or not individual women entrusted their care to public or private health providers was influenced by parity, interpersonal experiences and their perceptions of a particular maternity service.

Women views varied on whether or not local health services specifically, and the public health system in general, could be trusted. Willingness to access Maternal and Child Health services was limited and highly dependent upon both the clinic setting and each woman's relationship with individual MCH nurses. As access to an Aboriginal and Torres Strait Islander Health Service was available only for women in Sugar Town, perception of the trustworthiness of the service is limited to one client in this study. Shared care was the predominant model (Table 4.0). Of the 27 childbearing participants, most felt comfortable receiving local antenatal and postnatal care with either a public or private hospital birth. While several women preferred to give birth in a small rural/remote hospital, for others this decision was either conditional or undesirable. Specific concerns that affected women's confidence related to the unreliable and unpredictable quality of care in small rural/remote hospitals. Lack of continuity of care and uncertainty about whether or not trusted health professionals would be in town and available when needed created insecurity and led some women to choose either relocating for birthing and/or private care where they perceived the quality of the service was more consistently reliable. While physiological safety was of primary importance for some women such as Joanna, Paula, Evangeline and Laura, for others like Rose, Olive, Lois, Madison, Joy and Julie, psychosocial and emotional security was identified as essential components of trustworthy maternity care.

Whether or not parity influenced women's trust of maternity services was examined. As multiparous women, Joy, Linda and Olive had actively sought to give birth, as public patients, in the local rural/remote hospital. Their views that the isolated hospitals were secure birthplaces contradict conventional opinion. However, following their previous experiences in major centres of segmented, impersonal, and unsupportive care, these women now sought an alternative, individualised model of maternity care which did not involve separation from their families. Their trust was neither immediate nor unconditional. Following a rational assessment of the risks and available resources, they felt confident that they would receive appropriate local care from competent maternity care providers. Of these women, Olive was generally distrustful of health professionals; she specifically mistrusted several nurses and selectively entrusted her care to two female staff only. Joy, by contrast, had no expectations that anything abnormal would happen and had had complete confidence in the Mining Town hospital doctor and midwives, seeing no reason to inconvenience her family by going elsewhere for private care. As local birthing was discouraged, she was prepared to defend her right to make this choice.

Amongst the other multiparous women, Pam, having felt patronised and poorly informed about the reason for her first caesarean birth, mistrusted all rural health professionals. Rose felt safest receiving antenatal care from female Aboriginal health workers and avoiding the shame of being examined by male doctors. Although she found the hospital staff friendly she resented their surveillance of her family, and like Pam, disliked their judgemental attitude and unsolicited health advice. Therefore Rose intended to give birth amongst strangers in a large, tertiary women's hospital.

Conversely, Sally unfavourably recalled the mismanagement of a threatened miscarriage at the same public hospital. The traumatic ordeal destroyed Sally and her husband's confidence in public maternity care.[221] It involved a return road journey with Sally in pain and bleeding, followed by misdiagnosis, inappropriate treatment and conflicting information from three doctors. Sally declared that she felt unable to trust any 'expert' medical advice by the time she left the women's hospital. For Sally, being exposed to the uncertainty and fallibility of medical opinion, especially when ineffectively communicated with her during a time of high anxiety, raised doubts about the quality of that care.[222] By comparison, when highly vulnerable, Sally hoped for a positive outcome when she had no option but to seek care from the on-call remote area staff to safely deliver her baby and was satisfied with the midwife's outdated but caring practice. Lacking both physical and emotional security, I would argue that Sally response could not be considered trust. However, it compared with Gidden's notion of ontological security whereby individuals in late modernity place their faith in expert systems to provide the required services.

Lack of a simple trust in obstetric care was apparent in the 'doctor shopping' described by multiparous women like Pam, Lee, Megan and Pia. They did not unconditionally place their trust in a charismatic authority figure but tested each doctor. Laura, Lee, Megan, Dani, Pia, Nikki, Donna, Tania and Julie liked individual, known health professionals but distrusted public maternity services in general.

The notion that trust is awarded following overt testing, and a conscious evaluation of the outcomes, is contradicted in some accounts. Despite unsatisfactory experiences, some women like Laura and Dani still felt confident that being a private patient would ensure higher quality care and positive outcomes, while other private consumers like Julie and Megan were

[221] When interviewed, Sally repeatedly returned to the details of this traumatic experience.

[222] The Pastoral Town doctor had suspected a twin pregnancy. It is possible for a woman to miscarry one twin and continue with a normal, singleton pregnancy to term. In Sally's case, this was never confirmed or refuted. The couple believed that the ordeal accomplished nothing as the cause of the pain and bleeding were never identified. Sally's pregnancy continued to a normal birth.

ambivalent about the quality of the care and undecided where optimal maternity services could reliably be found.

Disparate views were also found amongst the first-time mothers. Evangeline trusted Western medicine to deliver safely her baby, even through a rural maternity service and amongst unknown carers. Although Claire, Jess and Kay were willing to entrust all their maternity care to local health providers, district health policy dictated that relocation was required because primiparous birthing was considered inherently too risky for a small rural/remote hospital. By contrast, distrust and mistrust were evident in Madison's and Lois' accounts of inconsistent, indiscrete and judgemental maternity care in Sugar Town.

Joanna and Paula were adamant that only private obstetric management, in a major centre, could be trusted to provide satisfactory outcomes. Relying upon the vicarious accounts of peers and family, their decisions on what constituted a safe, trustworthy setting were by virtue of an identified health agency or role along with a mythical trust[223] in their chosen obstetrician. Having made a calculated choice of the private hospital and obstetrician Paula was confident that "it probably wouldn't have mattered who was there [on call] because the majority of doctors are good down there". Joanna, as a well-educated and highly consumerist woman, wanted the best features of both private and public maternity care for her first successful pregnancy. Joanna explained she why felt safest birthing her "precious" long-awaited baby in a tertiary women's hospital with her private obstetrician in attendance:

> I chose to go there, yes. … I did want a public hospital. There is a private hospital very close to [relatives]. But if anything had gone wrong I would have to be transferred to the Women's [hospital]. … look I'm not going to take the risk. We will go there first. I'd much rather go without [non-essential luxuries] but have the security of knowing where you were [if anything went wrong].

Should anything adverse happen, Joanna wanted the assurance of access to neonatal intensive care facilities.

Lupton (1996) asserts that not all patients wish to be well-informed, autonomous individuals. This is illustrated in some women's birth stories in which sometimes they preferred to be compliant, trusting patients rather than undertake the emotional and cognitive work required by consumerist risk assessment and calculated choices. As Lupton observes:

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[223] Mythical trust as a basis for interpersonal faith and confidence in private obstetricians is described by in Riewpaiboon et al. (2005) and outlined in Chapter 1.

> There are times in which people derive reassurance and comfort from allowing themselves to become dependent upon others … Rather than alleviating the inevitable vulnerability and anxiety accompanying this dependence, the continuing emphasis upon autonomy, individualism and distrust in consumerist discourses may only serve to generate further uncertainty and vulnerability (1996, pp.169-70).

Interestingly, the birthing women who were private patients in a 'traditional' relationship with a paternalistic male doctor were content to have faith in his expertise. They were consumerist only so far as to select a doctor they could trust. In a contradictory way, they then became dependent patients – one of his 'girls'. This creates a quandary for a feminist researcher who sees these women in need of 'consciousness-raising'. However, following reflection, I believed that if these women were satisfied with their care and its outcomes, it would be inappropriate to raise awareness of their disempowered state thus creating insecurity, distrust and discomfort.

Of the women interviewed, 17 subscribed to a private health fund. Although a number of these families were struggling for economic survival at a time of rural recession, they felt that health insurance was essential when living so far from well-resourced medical services.[224] An awareness of the shortage of obstetrically experienced rural/remote doctors and ongoing cuts to health services fuelled birthing women's lack of trust and insecurity about being able to depend upon their needs being met outside of the private health system. In addition, personal and vicarious experiences with public hospitals contributed to their perceptions.

In the small towns, where the doctors practised as MSIPP, no cost was incurred by women when they attended either the Medical Clinic as all patients were bulk-billed. Any local admissions to the hospital for obstetric procedures (e.g. birth) were as public patients. This meant that the doctors did not require costly medico-legal insurance. However, many birthing women felt it was vital to have further choices if they needed medical investigations, specialist care, or admission to a hospital in a major centre. Consequently their Share Care arrangement involved routine maternity care from the local doctor as well as an obstetrician in the city. The Flying Obstetrician's[225] clinics were poorly attended and there was concern that with demand waning, this under-utilised service would be withdrawn. Although private

[224] The observation that private health cover was not a class-based luxury but a necessity was supported by the health providers

[225] The publicly funded Flying Obstetric and Gynaecological Service (FROGS) provided specialist care to remote areas, including elective caesarean sections.

obstetric care is strongly associated with a cascade of interventions and a high percentage of operative procedures (Lagrew & Adashek, 1998; Roberts, Tracy & Peat, 2000; King, 2000; NPSU, 2001; AIHW, 2002) being able to depend on 'expert' care from a private obstetrician gave these women a sense of security.

Because a lack of trust in the public health system appeared to be pervasive and widespread, I sought explanations from the women about the services that they chose to access. Expressing a viewpoint shared by others[226], Dani remarked that it was important not to get a "dud doctor" who "was an intern or something" and might "bugger you up", adding that:

> I figure you know if you've got private insurance you can pick and choose your doctor and you don't have to just go with anyone. I have private health cover so it doesn't worry me, I could go and see who like. … I've always had the doctor I want. I don't understand people who don't have it especially with kids and things like that. … What's expense when it comes to health?

Dani's story appeared to be full of contradictions; however, as perceptions tend to be affective rather than rational decisions based on evidence, it provided insights into how such views are formed. Making a choice provided a sense of control at time of uncertainty; it also demonstrated self-confidence in her judgement. Dani was satisfied with the public care she had received at the local hospital in Stockton. She was also pleased to be transferred (at no personal expense) to a tertiary women's hospital for specialist care not available in Mine City. Dani still believed firmly that private health cover was necessary despite describing multiple problems with the unsatisfactory private care she had received. One such unpleasant experience occurred when Dani was hospitalised with an infected wound following the last caesarean section. Being a private patient did not necessarily provide quality care.

> [I am a] private patient, I pay for private cover, and they had me up in this great big four bed ward all by myself … It was with an old air conditioner that blew water and dust on to the end of my bed. And I kept asking my private doctor "Can I go?" And he sort of didn't want me to go because of it [infected wound] but in the end I just got sick of it. So I got an opinion from the public doctor. I said "Do you think I can go if I go to [Stockton] hospital and get it dressed every day". She said she thought it would be all right. So I

[226] Paula, Lee, Joanna, Sally, Laura and Lyn

> just discharged myself, signed the papers disclaiming anything. Came home and I went in and out from [Stockton].

I questioned if the private doctor was considering whether her healing could have been impaired by returning home to three children and heavy domestic work on the farm, but Dani was not aware of this rationale.

Lee, Lyn and Laura's justification was a surprising allegation about inequitable access to public health services in remote areas. They complained that the services provided by the regional health authority and RFDS were biased in favour of Aboriginal people and that as 'whites' they could not rely upon the public health services to provide them with same level of care as 'the blacks'. Overlooking relative disadvantage and the social determinants of ill health, each gave examples of situations and incidents where they had felt discriminated against and economically disadvantaged.[227] Having private health insurance was the only way these women felt they could reliably get the care they required or desired. Having their own doctor in a major town was important. Laura added that she had wanted to have all three of her babies at the same private hospital as well. Even though the staff changed, she felt confidence in the consistent standard of care there.

As described by Riewpaiboon et al. (2005) and Potter et al. (2001), childbearing women who chose to access private obstetric care, even when delivered in a public hospital, were found to believe that their choice created a basis for interpersonal trust and confidence that they would receive higher quality and more beneficent care. In addition, Mechanic and Schlesinger (1996) point out that there is a relationship between general and interpersonal trust. Restoring general trust in health services (whether public or private) has implications at an interpersonal level and vice versa. Trusting one's doctor, midwife and nurse can flow from confidence in the competence and commitment of the institutions with which they are affiliated: clients who trust their chosen health care providers are less likely to be anxious about the trustworthiness of the hospitals. Interpersonal trust therefore transfers to health organisations (Mechanic, 2004).

Aboriginal women have a very different perspective on disadvantage and trustworthy maternity care when compared to Lee, Laura and Lyn. Western medicine has been intent on providing physiologically safe birthing to indigenous women, thus reducing perinatal maternal and infant morbidity and mortality (Muhlen-Schulte, 1989; Panaretto et al, 2002; Trewin &

[227] In particular, these examples included the cost of charter flights or airfares to access medical services in a major centre.

Madden, 2005). However, in order to achieve these outcomes, medicine has introduced forms of surveillance and control when managing indigenous women's physical health and rather than considering their psycho-social and emotional wellbeing (Litherland, 1994; Myles & Tarrago, 1994; Norbury, 1996; Chamberlain & Barclay, 2000; Chamberlain et al., 2001; Kennedy & Leap, 2001). Historically, one of the outcomes of being placed under the medical gaze has been interference in indigenous women's private lives. The 'Stolen Generation' resulted from a belief that Aboriginal women were incapable of 'properly' raising their children. As described by the ATSI health workers and in the related literature, many Aboriginal women still have a strong distrust of medicine as an institutionalised form of white authority (Bush, 1994; Croker, 1995; Nixon & Engelhardt, 2003; Campbell & Brown, 2003). They find it paternalistic, with a power dynamic that situates them as incompetent and childlike. Aboriginal women, Like Rose and Olive, fear that its disciplinary power may take their children from them (Burgmann, 1984; Leppert, Partner & Thompson, 1996; Fejo, 1998). Paternalistic, disciplinary power does not inspire reciprocal trust, respect or compliance.

In contrast to the Aboriginal women's resistance to and distrust of the disciplinary power of medicine, other women passively accepted or actively sought obstetric management. It can be argued that medicine has not only colonised women's bodies but its discourses influence their ways of thinking as well. Trust in medical science is privileged while trust in 'nature' is devalued. As such, within obstetric discourses, the birth process is portrayed as unreliable, unpredictable and irrationally essentialist. Consequently, many women no longer believe that their bodies are capable of labouring or birthing without obstetric assistance. A growing number of feminist and midwifery scholars address this issue (e.g. Kitzinger 1972, 1987, 1991; Kitzinger & Jessel, 1980; Flint, 1986; Donnison, 1988; Robertson, 1988; Oakley, 1984, 1993, 1996; Hunt & Symonds, 1995; Tew, 1995; Kent, 2000; Kukla, 2006). All women unquestioningly expected to birth within a clinical environment and their stories showed the ways in which a medico-centric, technocratic view pervaded their experiences. When women like Claire, Megan and Jess who trusted the normal process of birth described their progress in labour, their experiences were distrusted and disbelieved by the midwives and doctors. First-time mothers (Paula, Evangeline, Kay, Joanna) obediently submitted to being colonised and obstetrically managed while in contrast, multiparous women like Bella, Donna and Nikki pre-reflectively described how they naturally responded to and trusted their bodies' innate messages when in labour.

Childbearing women's conditional trust and mistrust of both public and rural health services could also be attributed to wider social concerns about medicine. It could be argued that the medical ideology is less dominant in late modern society. With the escalating medicalisation of everyday life, and childbirth in particular, there is a tension between an increasing reliance on medical technology and obstetric interventions, and cynicism about the flaws in medicine and accompanying risks of iatrogenesis. As outlined in Chapters 1, 3 and 4 and shown in Appendix 2, numerous reports and reviews of Queensland's maternity services have not resolved issues with the quality of maternity services. Both Hirst's (2005) review and Welch, Hinnant and Moon's (2005) analysis support Eva Cox's comment that trust in government and its provision of services "is low and possibly reducing" with many people doubting that the government can be trusted "to do the right thing" (1995, p.10). Media coverage of inquiries into the public health system, exposure of workforce shortages and the effects of economic rationalism on the quality of care have contributed to people questioning the safety of rural services (Anderson, 1999; Sommerfeld, 2005; Campion, 2005a, b, c; Lavelle, 2005; AAP, 2005; NRHA, 2005b).

While confidence in public health care is being undermined, private health care has been subsidised and promoted as the socially responsible alternative for all who can afford the insurance, to the detriment of Medicare with the exclusion of midwifery care (Duckett, 2004; ACMI, 2002a,b,c; AMWAC, 2004a, b; AIHW, 2006). The AMA supports the Federal viewpoint that Australia needs a healthy private sector to take the pressure off the public hospital system asserting that private obstetrics gives patients excellent care and choice, for which they are willing to pay (AMA, 1998). Further, the AMA adds that there was a need to change public perception that there is always going to be a public system to fall back on. The only way to change this system is to get taxpayers to lose faith in the public system (AMA, 1999).

Sociological critiques question the excellence of the private health system for the community and for the individual woman (Doyal, 1995; Cheek & Rudge, 1996; Collyer & White, 1997; George & Davis, 1998; Moynihan, 1998; Palmer & Short, 2000; Gardner, 2002). Obstetrics and gynaecology have been identified by the Cochrane Collaboration as the specialty area whose practices are least likely to be supported by scientific evidence with (Enkin et al., 1995, 2000; Moynihan, 1998; Jordens et al., 1998; Wagner, 1994b, 1998; 2002). Further, older obstetricians in private practice were less likely to use systematic reviews for best practice than younger, full-time doctors in public hospitals who were familiar with computers (Jordens et al. 1998; Moynihan, 1998; Roberts, Tracy & Peat, 2000; Croker et al.,

2002). However, as shown in the birthing women's data, a single, charismatic authority figure was likely to inspire trust, even if his/her opinion was not based on current evidence, so their perceptions that they were getting the best doctor within the private system could be challenged. This unconscious desire to 'trust' and feel secure with a patriarchal figure refutes the notion that trust is the consequence of a rational decision-making process in which risks are consciously assessed. Furthermore, women also based their evaluation on the views of trusted family and friends. Some women, notably in Pastoral Town, also checked with trusted health professionals whether the care received was appropriate.

A number of general and global factors also influenced their views. The erosion of public confidence in the health system is exacerbated by rural workforce shortages and the 'crisis' in rural maternity services. Various schemes attempt to redress the problem (Anderson, 1999; Kildea, 2001; RDAA, 2003, 2004, 2005; RDAA, ACRRM & ACMI, 2005; NRHA 2005b, c; Campion, 2005a, c). Rural/remote women are well aware of the downgrading of their local maternity services with increasing centralisation of health resources (NRWC, 2005). During fieldwork, women discussed their concerns about inexperienced locums, inappropriate health professionals and retention concerns. In addition, women complained of a lack of continuity of care from services such as the Flying Obstetrician and Gynaecologist, and the Flying Paediatrician, and the limitations in the services that they could provide. Other specific, local factors also affected general trust.

Community trust in maternity care provision

From a different perspective, social trust and distrust at a community level was another phenomenon found in the data. As a group, the community evaluated rural/remote health professionals and decided upon their trustworthiness. Fukuyama (1995) alleges that societies with high family values and a strong family orientation tend to have low trust outside the family. According to Fukuyama (1995) Italian society, is one of these. Elder (1996) refutes this as a poorly founded conclusion. Within this study, the strong family orientation was not only evident in the largely Italian community in Sugar Town but also common in the other small, close-knit rural and remote communities. As discussed in Section A.3.2, the insider-outsider phenomenon was apparent in permanent residents' distrust of outsiders and incoming health professionals had to overcome this (gendered) barrier if they were to be accepted and able to practise effectively (Twelvetrees, 2002; Pini, 2004; Tucker & Mathews, 2001; Elder, 1996).

Lyn and Emma discussed community attitudes to transient nurses in Stockton. The small hospital had a constant turnover of nursing and locum staff with the average duration of stay about three months. Temporary staff tended to be either young, single health professionals seeking the experience of working in a rural/remote environment or older de-skilled nurses. The community felt uncertainty about their reliability. According to Lyn, the young professionals' partying lifestyle and misbehaviour 'at the pub' added disrespect to the existing uncertainty and mistrust of outsiders. So while the local residents trusted the hospital service and the core of permanent health professionals, there was a distrust of the young, itinerant ones as a group.

In Sugar Town, several women followed the example of Dr George's wife who chose to birth elsewhere with a private obstetrician. Her choice undermined confidence in the maternity care available in Sugar Town as it was interpreted as an indication of inferior quality. On the contrary however, the two hospital doctors were the most qualified and experienced in this study. Sugar Town mothers were unaware that for the doctor's wife, as with Nr Emma, birthing locally meant being cared for by close social and professional acquaintances. Birthing away from the town minimised discomfort by maintaining a comfortable personal distance and privacy.

Issues of security and risk were commonly associated with women's apprehension about utilising one or more local maternity services. Personal privacy was a major concern for many women in the small communities and lack of confidentiality, both perceived and actual, was frequently mentioned as a problem. Several women either avoided or selectively utilised the available local services because of concerns about their affairs becoming known to the wider community. The most common complaints related to the physical location of health services, particularly the Maternal and Child Health clinics (Appendix 12). Lack of privacy while awaiting a consultation, and the risk of being overheard during it, created discomfort and led to women withholding sensitive information.[228] Although the birthing women had the pre-requisite need for the assistance of these services, they were not willingly dependent upon them, so in consequence of their risk assessment trust was withheld.

Interpersonal conflicts and backbiting amongst the health workforce (Section 8A) were discussed amongst women in the community. This led to family and friends of those involved wanting to avoid certain maternity services, most notably in Mining Town and

Pastoral Town where the workforce was factionalised.

During early fieldwork in Pastoral Town, there was a rift between the townspeople and the hospital management. This caused deep mistrust and was a result of conflicts between personalities and the objectives of the major stakeholders in the hospital and district. The Hospital Auxiliary was abandoned, community dissatisfaction was high and there were rumours the hospital might close, which would have dire consequences as the next remote area service is hours away. With the resignation of the existing Director of Nursing and appointment of a person acceptable to the community and remaining staff, the volatile situation was resolved.

Hospitals have traditionally been at the heart of small rural communities. Muus, Ludtke and Gibbens (1995) found that rural hospital closure had devastating, long-lasting medical, economic and psychological effects. Similar to areas of rural Queensland, their study found influences such as an economic downturn, dwindling population, low quality and unstable health workforce, poor hospital management, exacting government regulations and under-utilisation of services were responsible (Muus et al., 1995). The downgrading of rural/remote hospitals affects their viability and patient's perceptions of the trustworthiness of the quality of that service. Consequently, local rural/remote hospitals were increasingly bypassed by patients who sought specialised medical care in urban areas (Buczko, 1994; Lavelle, 2005). Current State and district health policies actively encourage women to birth in major centres and, as already mentioned, medical defence bills cause many doctors to refuse women local births (SCARC, 1999; Campion, 2005c; Hirst, 2005; Ross, 2006). As shown by the high level of private health insurance cover amongst the women in this study, they did not believe that the public health system in major centres was able to meet their health needs either. When seeking the views of birthing women, it is evident that they would prefer local birthing if it was reliable, safe and appropriate to their needs (Tracy et al., 2006; RDAA et al., 2005; Campion, 2005a; Cameron, 2001) otherwise relocation for a private care was trusted to provide more satisfactory outcomes.

In contrast, to the distrust described so far, in each community almost all the birthing women identified particular midwives and/or doctors as trustworthy people. These trusting relationships had been developed over time and reinforced by positive community impressions. Frequent comments were made such as "If only [x] had been here I would

[228] This was supported in the Croker et al. (2002) study which also found evidence of indiscretions relating to confidential information, such as medical results and incidences of violence.

have felt safe" (Sally), "I don't know who we can turn to if [x] leaves" (Jess) and "Although the doctor was away, [x] was here so I felt it was OK" (Linda). "If I could have had [x and x] for my birth that would be ideal. I possibly wouldn't have gone away [to a private, coastal hospital]" (Megan).

There were several things in common with the selected health professionals who had this reputation. All had been resident in the community for more than two years. They all had current experience with obstetrics/ midwifery and women's health care. With one exception, all were parents and this added to their credibility. Several were local women who had gone away for education and training and returned to the town. Within small communities women (and their partners) share perceptions and experiences. This led to the establishment of a reputation that these health professionals were competent and trustworthy. Similarly, some less experienced health professionals were prematurely and unfairly condemned as untrustworthy by this informal system of community evaluation.

Trusting interactions with maternity care providers

Birthing women were found to take up various, contradictory positions when trusting maternity care providers. Women were found to be either pre-reflectively trusting, or consumerist in their approach when selectively seeking particular health professionals they could trust. Paradoxically, both behaviours were found in some relationships with health professionals, highlighting the complexity of such relationships. However, where choices were limited or non-existent, birthing women trusted in the expert knowledge of maternity care providers. As discussed by Lupton (1997), some people position themselves as 'patients' and trust in the charismatic authority of the doctor. In this study, women were more likely to have positioned themselves as patients following their consumerist action in choosing private obstetric care. Then, satisfied with their selection, they relinquished responsibility, trusting the obstetrician to act in their best interests. The power differential in these relationships tended to be paternalistic and not always satisfactory.

Lupton (1996, 1999b) and Walton (1999) explain this contradiction. Childbearing women, even those who are normally assertive and confident people in their daily lives, can feel powerless and vulnerable during encounters with medical authority. For Lupton (1999b), this response is most likely for first-time mothers, especially when confronted by the risk discourses that accompany childbirth. Walton observes that there is a "persistent

conflict between patients' childlike wishes to be free of all responsibilities and their adult wishes to be fully informed and consulted (1998, pp.17-18). Consequently, some women, sometimes, adopt the sick role and abrogate responsibility. Trusting one's doctor can mediate the anxiety created by the inequality in power and the need to manage risk. Conversely, maintaining control and choice have been widely identified in the literature as important for childbearing women (Howell-White, 1999; Zadoroznyj, 2000; Gibbins & Thomson, 2001; Nolan, 2002; Barclay et al., 2003; Tracy, 2005b).

Lack of choice and loss of control are common concerns, even when experiencing uncomplicated pregnancies. This was evident when the majority of childbearing women described their inability to be assertive and the expectation that they would be compliant patients during one or more of their births. Personal experience during the first pregnancy and birth was a strong influence on women's subsequent birth plans and choice of maternity care provider. As shown in the stories of women like Linda, Joy, Olive, Lee and Megan, multiparous women tend to be more reflexive and consumerist as they seek to actualise their preferences.

Trust and distrust of health providers as groups and individuals

Lupton points out that trust "presupposes an awareness of risk, offering reliability in the face of contingent outcomes and thereby serving to minimise concern about possible risk" (Lupton, 1999, p.78). Similarly, Giddens (1990, 1994) and Luhmann, (1988, 2000) observe that without trust and a faith in the reliability of people, expert knowledge systems and technological advances about which they have little understanding, anxiety and dread could be overwhelming. Without trust, perceptions of risk could paralyse action and adversely effect birth experiences.

As outlined previously, both Claire and Sally went into early labour unexpectedly and had no option but to access the staff on call at the small remote hospitals. In both instances, the RFDS could not be depended upon for retrieval. Claire's lack of anxiety about the potential physiological risks stems from her confidence in the midwife, familiarity with the setting and her emotional security. By contrast, Sally felt "stuck", apprehensive and unsupported by her drunk partner. A relieving doctor and an unfamiliar midwife without current experience managed her care. None-the-less, in retrospect Sally was happy with this birth. Because of their certified expertise as health professionals, she depended upon these strangers could care for her appropriately in her time of need. Sally recalls:

> The midwife was really good compared to the one I had with (1st baby). She was really good and she was very supportive and she was very good to me. … I found the midwife much better this time…

In this vulnerable situation where there was no choice, hope, faith and dependence displaced trust and confidence. Neither did trust develop beyond this time to the midwife's principle role as the MCH nurse. With discomfort she explains why her relationship with the nurse was mistrustful.

> …for the birth, she was great, for the record she was. Yes, but after that I didn't find her… I don't believe her. I don't trust her. With the information she gives you. You just wonder if she really knows. … Also, she didn't pick up that [baby] was losing weight. She doesn't always remember to write up your [baby] book … and she doesn't always track [chart] it anyway. So to me it's sloppiness and I just wonder. She forgets to write things down… Through the whole thing, not only the feeding and the weighing or anything. I just found she can't seem to measure properly… she can't seem to plot it even. Even from friend's babies … I feel really bad because she did deliver [baby]. But I just don't trust her and just don't have the confidence in her.

Sally did not immediately experience trust. Her initial faith in the relieving hospital staff as a class/group of health professionals was limited to a particular time of need and dependency. Once she had time to get to know individuals she was able to re-evaluate. Her confidence was lost when the midwife/nurse changed roles. The MCH nurse's lack of expert knowledge and 'sloppy' practice created mistrust which was reinforced by her friends' views. They turned to an alternative midwife (Nr Emma) for infant monitoring, advice and lactation counselling.

Shared personal experiences, such as childbirth and motherhood, were found to contribute to initial trust or mistrust. Like Sally, Megan was attended in labour by two midwives who were strangers but whom she trusted. Of these, Megan relied on the midwife who had also experienced birth herself and observed:

> I think she was just better at the empathy part of it. Knowing how I felt. I didn't like her leaving the room at the end … I wanted to make sure that she was just there where I needed her the whole time. And that made me sort of feel confident, much more confident.

Similarly, women in Pastoral Town described how they related positively to Dr Diana because she shared the attributes of being a woman and mother. Conversely, lack of personal

experience by the single MCH nurse in Sugar Town influenced whether several mothers chose to access her services. These birthing women commented that they doubted her parenting advice and compared her background to that of her predecessor who was a local mother. However, according to one participant, this criticism and mistrust was ill-founded as the advice offered was surprisingly constructive and evidence-based, rather than a subjective view.

Although Lupton (1999) and Giddens (1991, 1994) describe people's desire to re-embed their trust through face-to-face encounters, in this study familiarity with caregivers was found to contribute to trust, distrust and mistrust at both interpersonal and general levels. As Lupton (1999) suggests, a personal relationship with a caregiver creates different sorts of risks. Knowing the doctors, nurses, midwives, health workers, lactation counsellors and other similar sources of support either enhanced the therapeutic relationship, promoted trust and enabled continuity of quality care by a known health professional, or inhibited it and led to women seeking care elsewhere. Face work was significant for establishing and testing trustworthiness. As shown in the genograms, certain maternity care providers (such as the female GPs and some midwives) were repeatedly identified as trustworthy in relation to their professional roles, their competence and their proven ability to keep sensitive matters confidential within a small community.

Trust was strongly associated with social and emotional safety. Being amongst trusted people or being unknown to carers was important. Several women avoided familiar carers and preferred anonymity as a means of maintaining privacy. Maria, when experiencing intimate partner violence during pregnancy, chose not to access her family GP but instead chose the anonymity of the Emergency Department. Sally found that there was no one locally to whom she could disclose her relationship issues as it might endanger her partner's high profile in the town. Lois, Madison, Julie, Rose, Tania and Olive were also amongst those women who felt under surveillance and so were constrained from sharing their difficulties with local professionals. As Tania remarked when explaining why she avoided the health professionals she had known all life: "Everyone knows everyone. Everyone knows everyone's business". Each woman had experiences which supported their distrust. However, when Joy risked her professional reputation by testing the trustworthiness of midwives and nurses in Mining Town, she found the general distrust expressed by Tania to be unfounded.

Seeking maternity care in a major centre was one way to achieve social and emotional safety. As described by Megan, Rose, Pia, Paula and Tania, the intimacy, indignity

and 'shame' of birth were easier to cope with amongst strangers. They felt less inhibited when privacy was assured and several women would not have chosen to birth locally even if it had been an option. Likewise, for the women who had experienced problems with teenage pregnancy, depression, mothering and intimate partner violence, being under surveillance by local maternity care providers with whom they were acquainted, created feelings of anxiety and insecurity.[229] Distrust and mistrust were evident in their encounters with particular maternity care providers, while out of town care or interactions with a 'safe outsider' were preferable options for disclosure and/or consultation.

Lee and Dani were amongst the women who described their distrust of a group of health professionals while maintaining trust in individuals. Although Stockton had the closest health services, Lee perceived the doctors there as "unreliable". Over the past few years, Stockton had no permanent doctor, so even though the current doctor had been there for two years, in Lee's opinion the service was undependable and unable to meet her particular needs. In addition, she not only felt that the community was too small for her needs but also that the people were "not very nice" and "too cliquey". In seeking alternatives, Lee had also tested the quality of care in Boomtown and commented:

> The doctor there, he's the one that didn't deliver babies. … I went in and he really didn't know what to do, they were a bit slow and he put me on a drip and then he tried one drug and it wasn't working and he tried another drug and it didn't work

After unsatisfactory experiences with public health services in Stockton and Boomtown, Lee then decided to risk the dirt road to Mine City[230] where she entrusted her care to a GP with obstetric qualifications. When undergoing numerous antenatal tests and receiving long periods of (private) hospitalisation and medication during her pregnancy, Lee felt poorly informed about her treatment. In particular, her concerns about the potentially iatrogenic effects of the medications on her unborn baby were not addressed although the doctor had explained that her health was paramount. Having chosen a private doctor Lee was prepared to relinquish her consumerist position and become dependent upon him. She had faith in his medical expertise to do what was right for her and the foetus. As Lupton (1996) describes, people trustingly place their lives in their

[229] One or more of these sub-themes were found in the stories of Maria, Joanna, Evangeline, Rose, Olive, Sally, Julie, Madison, Tania, Nikki and Paula.

[230] It takes about the same time to reach Mine City as Stockton via the unsealed road in the dry season but much longer and with greater risks during the wet season.

doctors' hands when they are ill.

Dani's story demonstrates both distrust of MCH nurses as a group, and class trust of private doctors' specialised knowledge and expertise. Dani had three children. Her experience with Child Health with her first child put her off using the services thereafter.

> And some of them I don't like their advice either. The first one I was sort of having trouble, still am having trouble with [child] … The one that was there, oh ages ago, I thought that [her advice] was ridiculous. So, I don't know whether they are correct or not.

The incumbent MCH nurse "seemed nice enough" when Dani met her once at the Stockton hospital. She invited Dani "to see her whenever" and "even asked about coming out and doing station visits". However, Dani avoided the MCH nurses following her first encounter in which she received questionable advice. In contrast, Dani showed enduring trust in her private doctor's skills even though she did not trust the information he gave her and his misjudgement has resulted in her premature sick baby. While such contradictions were not uncommon in the interview data, women usually either gained or lost trust after testing the reliability of the advice and care provided by health professionals.

Thiede (2005) asserts that, through an iterative process, trust plays a critical role within interactions between health care providers and patients/consumers and as such, it influences whether or not an individual decides to utilise a health service. In shifting the focus from the availability and accessibility of health services to consumer demand, Thiede reveals that a low trust environment becomes a barrier to access. As effective communication enhances trust, and this in turn develops trust in the health provider, this becomes especially significant for health care provision within a culturally diverse society (Thiede, 2005).

Communication and compliance: Trusting information giving

One aspect of the interpersonal relationship that requires further exploration is how women perceived the trustworthiness of information they received from maternity care providers. Misinformation, lack of quality information and poor assessment skills concerned most women while conflicting advice and socio-cultural barriers also arose as issues. This especially applied to their first pregnancy and birth where birthing women felt misled, misunderstood, disbelieved and disempowered. Consequently, not having their expectations

met made women more likely to become reflexive and assertive in subsequent pregnancies as described by Zadoroznyj (1996, 1999, 2001) and Gibbins and Thomson (2001).

If a health care provider is trusted to use their professional knowledge and expertise for the benefit of the patient, in return the patient complies with the advice or treatment regimen (Walton, 1998). Bilateral trust is desirable within a therapeutic relationship, however within medicine the interaction tends to be contractual and fiduciary (Clark, 2002; Banks, 1995; Kutchins, 1991). Patient compliance is one measure of quality health care (Johnston, 1999). Open, honest communication and information-sharing is considered to build trust and contribute to improving compliance, particularly if knowledge is shared and treatment goals mutually agreed upon (Thiede, 2005; Stevenson & Scambler, 2005; Welch, Hinnant, & Moon, 2005; Levinsky, 1998; Thom & Campbell, 1997; Leppert, Partner & Thompson, 1996). The following examples from birthing women's stories allow this to be theorised further.

Lee for example was satisfied with the care she received from individual midwives but expressed distrust of advice given to her by them as a group. She suspected that the analgesia given in labour was intended to keep her manageable and quiet rather than for relieving her pain. Lee retained control during her third labour:

> I didn't have anything for this labour. The first one I did, I had the gas and pethidine. *Truly, they don't take the pain away. They don't tell you this beforehand* … I had the pethidine an hour before he was born[231], so it didn't really take effect until afterwards anyway. And on the gas, you think the pains going to go, it's going to relieve the pain, but it doesn't. *What it's really supposed to do is to settle you down between the pain.*[232]

Pam, a transient resident of Mining town, had utilised maternity services in Western and Coastal Queensland. Not only had she experienced fertility problems and found it difficult to receive the care she needed, but her pregnancies were complicated and births highly medicalised. As an itinerant public patient with a limited education, she had received conflicting diagnoses and inconsistent, patronising advice from various doctors and now was cynical about the information she received. Although constrained by her social circumstances, Pam kept trying health services in nearby districts in an attempt to find a doctor in whom she could put her faith.

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[231] Sally and Lee were inappropriately given Pethidine close to birthing. It causes respiratory depression in the newborn.

According to Dani, doctors withheld information from her on a number of occasions including about her health status during pregnancy and the seriousness of her premature baby's condition. When discussing how the doctors treated her like a child rather than an adult capable of making rational decisions, she commented:

> I feel that I should be told things straight out. I really do but then… I suppose I'm a bit frightened to ask, in case I get an answer I don't like. I was like that with [premature baby]. When she was really sick I'd never ask if she would live or die because I thought they would tell me that she'd die. And I knew in my heart she was really sick but I just wasn't prepared to ask it in case they gave me an answer I wouldn't want.

Dani described her mixed feelings about the fear of the unknown and reluctance to know the worst possible scenario. She felt dissatisfied about the lack of open, honest communication between herself and the doctors. When Dani discussed this with her husband, he supported the patronising way doctors concealed information "for her own good" so as "not to worry her". When unexpectedly and unprepared for relocated to a coastal city, Dani recalled:

> It really cheesed me off … [Husband] said "Well you would have been a mess". You know, I would have been crying all the way down there [to the tertiary hospital] and back thinking that I was going to die or something. So possibly, even though I'm annoyed that [doctors] didn't tell me, possibly it was better. Because I might get too upset.

While a patient in the city, Dani felt her lack of knowledge about the medical condition affecting her and the newborn baby was disturbing her. She remembered:

> I had no-one to talk to. Yes, very neglected that way. I was not informed until the moment [baby] was born and taken off for tests and they came back and they said what could of gone wrong … I wasn't informed about anything about it. [So] I went to the library and tried to read up

The information Dani found led her to be believe that important details had been concealed from her. Being excluded from shared decision-making resulted in distrust and led her to an act of non-compliance.

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[232] My emphasis

> It ended up, I bailed up on everything. I was sick of taking drugs. I was sick of worrying about [baby] … So I just told them all that I wasn't going to do it anymore. … I lost it, that was just it.

Rose ignored the information provided by Sugar Town hospital during antenatal clinics. Finding the information culturally inappropriate and unhelpful, she preferred to draw on her multiple childbirth and parenting experiences. The ATSI Health Centre tried to overcome this barrier to quality information by adapting and providing culturally suitable resources.

C.1.2 Summary of trust findings

In this section, the selected examples support the proposition that trust emerges from the need to rely upon another for assistance when seeking security in a time of vulnerability and uncertainty. There is an obligation from the trustee to meet this need satisfactorily, so experiential knowledge (such as parity) becomes essential to future trust. Trust is established and maintained where there is a congruence between the trustor's expectations and the care received. Therefore, trust may be an immediate, pre-reflective response to a situation or person which provides certainty and security, such as a charismatic expert (like an obstetrician). From the examples given, this willing dependence seems most likely when the birthing woman is unable, or lacks the knowledge and experience, to make a rational decision. Trust in this form fits with the docile patient within a sick role. I argue that in this form of trust where a person places 'one's life in their hands' is a willing dependence that resembles faith. It may or may not survive rational evaluation such as covert and overt testing to evaluate trustworthiness and assessment of the risks and benefits entailed. These conscious approaches are congruent with the reflexive consumer who, in taking responsibility for her own and her baby's health, awards trust in knowledgeable yet conditional way. Trust may be withheld or reinforced following testing behaviours to evaluate trustworthiness. This awareness is a process and outcome of trusting behaviour and is, in varying degrees, influenced self-confidence, educational background and life experiences. The outcome of trust was that it moderated the effects of life stressors, reduced anxiety and enabled birthing women to cope either by feeling in control or relinquishing control to a trusted other.

The behaviour of health professionals' behaviours can promote trust. These include thoroughly evaluating problems, understanding a patient's individual experience, expressing

care, providing appropriate and effective treatment, communicating clearly, building partnership, and being honest and respectful to the patient (Thom & Campbell, 1997). Further, midwives argue that reciprocal trust evolves when a birthing woman and her midwife work in partnership with each other to openly and honestly discuss risks, concerns and benefits so as to achieve an optimum outcome. This is consistent with the notion of concordance (Stevenson & Scambler, 2005), which emerged in the practice Dr Diana and Nr Emma. Concordance is an approach enables a pathway through the contradictory expectations that birthing woman will be both docile, compliant patients and individuals capable of making autonomous, well informed decisions in the face of risks and a medico-centric maternity culture.

Distrust and mistrust are also complex phenomena. Rural and remote birthing woman are well aware that the quality of care available through local health services is inconsistent and unreliable. Also, distrust of outsiders to a small community affects trust of health professionals; even if they belong to an 'expert' group. Familiarity over time ameliorates this. Personal judgments and the shared impressions of trusted friends, family and known health professional influence a woman's willingness to conditionally trust a maternity care provider. Consequently, the factionalism and workplace violence described earlier in this chapter have an impact on patient/consumer trust. Face to face encounters (face work) build experiential knowledge of who can be trusted, that is, who one can have confidence in, depend and rely upon in times of need. The significance of these behaviours on trust has supported by the women's experiences outlined in this section.

C.2 Subjugate relations: Childbearing women and gendered violence

Another emergent theme in the interview data was the various forms of violence that constructed and shaped the everyday experiences of the childbearing women in this study. As argued in Sections 2.4.3 and 3.8, the intransigence of masculinist discourses and patriarchal ideology in Australian society create a detrimental environment for women, especially young mothers. The impact of structural, social, familial and intimate partner violence on women's wellbeing became apparent during fieldwork. As sketched earlier in the chapter, being subject to abusive relationships influenced women's perceptions of risk, trust and the choices they made.

Although only two of the 27 women feared physical violence, 17 of them described social, emotional and cultural experiences which affected their wellbeing. Walsh (2003) highlights the importance of documenting the extent, level and type of violence to avoid

reinforcing the assumption that violence is only about physical assault, thus silencing other experiences. In this study, social and emotional forms of violence predominated. Given the sensitive nature of this finding (as discussed in section 6.3.1), its inclusion created a dilemma for me. Cognisant of the vulnerability of childbearing women in small rural/remote communities, and their concerns about privacy and security, I considered restricting access to this chapter. Instead, I have de-identified the women, ensured the anonymity of those most at risk while including distilled aspects from their data.[233]

At the time of the interviews, the Queensland domestic violence initiative, which included screening for violence against women in pregnancy and at MCH clinics, had yet to be implemented in these study sites (Queensland Health, 1999, 2001; Stratigos, 2000a). However, dissemination of initial findings from this project contributed to knowledge of the issues confronting rural/remote women (Croker, 2000, 2004a; Appendix 13).

C.2.1 Social and emotional violence

Inequalities and social divisions are entrenched in rural society, these are based on creating a diminished and devalued 'other'. As explained by Irwin and Thorpe (1996), conceptions of what constitutes violence are contingent upon cultural and historical contexts so that oppressive behaviours that were once tolerated are now regarded as unacceptable. They contend that Australia has a multidimensional culture of violence evident in the structures, institutions, actions and processes which diminish another individual. While this notion applies to the prevalent oppositional thinking (them/us; insider/outsider, town/country, husband/wife), in this section the focus is on gender relations. As outlined in Section 2.4.3, the subjugation of women is embedded into the social fabric of rural/remote society. In this section, I am arguing that, beyond the physical violence described by two birthing women, the subjugation, neglect and diminishment experienced by childbearing women constitutes social violence. In addition, social and emotional abuse of some women by their intimate partners and families is described.

According to Connell, gender inequity is sustained by cultural and social institutions and re-enacted and re-constituted in people's daily lives to maintain the status quo and provide a 'patriarchal dividend' (Connell, 1998, p.142). From a rural, feminist perspective Poiner (1990), Coorey (1988, 1990), Bramston et al. (2000) and Alston (1997; 1998a, b;

[233] A data trail has been maintained to ensure the trustworthiness of these de-identified and generalised findings.

2000; 2005a, b) have raised awareness of how the rural male ethos and patriarchal ideology impact upon women and, as critical determinants in gender relations, enable the perpetration of violence against women. Focussing on small sugar and mining towns in North Queensland with similarities to those in this study, Pini cogently describes how masculine authority continues to be legitimatised and endorsed within rural communities, despite social re-structuring and re-negotiation of gender roles (2004a, b). For this reason, in the following examples I intentionally apply the terms 'wife' and 'husband' rather than 'partner', as used earlier.

Although it is a generalisation to say that women occupy a lower status position in rural and remote communities, it was evident that economically productive work and public roles were considered of greater importance than women's reproductive work and invisible roles in the domestic sphere.

Consistent with the widely acknowledged triple burden of labour[234] experienced by rural/remote childbearing women, farming women shared their experiences of juggling multiple demands early in the postnatal period. As recovering from childbirth and being a new mother was not valued as 'work', their needs were neglected and they became physically and emotionally exhausted. For rural women married to cane farmers or mill workers, their lives were greatly affected by seasonal factors. Relationships were strained as women tried to adjust their babies' routine and home duties to their husbands' activity patterns and needs. For remote pastoralists, demands included breastfeeding a newborn, managing toddlers, teaching older children via School of the Air, while also performing all domestic duties, caring for extended family, cooking and washing for fencing and mustering gangs and generally helping out as needed. Three of these women had experienced complicated births and should have been recipients of supportive care for the first six postnatal weeks. However, instead of having time for recovery, they became fatigued and depressed.

Picking up the burden for absent husbands was found to be a common experience for women in this study. Mining wives were either sole parents or, when their husbands were home on shift rotation, coped with the additional burden of a man who was drunk or exhausted. Women married to shearers, farmhands and pastoralists were isolated for extended periods while their husbands were away working. Two of the farming women had

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[234] Beyond childbirth (reproduction), 'labour' subsumes their economic contribution (production), unpaid farm work, caring tasks and domestic duties.

husbands who, for economic reasons, were earning an income off the farm and so were rarely home. As outlined in 8 B.1, this meant being left alone to bear the brunt of abusive behaviour from in-laws. Several of the itinerant women married to professionals also managed alone for periods of time and, being outsiders, found it hard to find trusted individuals with whom to share their concerns about mothering.

The lack of outreach services and unreliable transport meant that remote area women received no postnatal follow-up if they could not get into town during clinic times.[235] Three women described having difficulty accessing transport and were unable to leave their homes without it. One very isolated woman burdened with many children had no local transport when her husband was away shearing. As she was racially abused by her neighbours, she had no one locally to assist her so relied upon catching a passing coach on the highway when she needed to go to town.

Many women had periods of depression and felt that there was no one to whom they could turn. Telephone help lines were not considered a suitable option. Being unsupported, especially during the postnatal period, was especially problematic for the women who did not have family nearby and who were experiencing compounding forms of violence, such as emotional and economic abuse. Three daughters-in-law, for example, reported family abuse including behaviours such as being constantly criticised, ridiculed, neglected or ignored, having no independent income and made to feel an economic burden, having restricted access to transport and telephone calls, being expected to care for their in-laws and farm labour while visits from their own family and friends were unwelcome.

A perception of being under surveillance limited some women's sense of freedom and safety. Not only did several women comment on how their controlling husbands/families screened their mail, monitored their actions and scrutinised their social contacts, but concerns about small town gossip, loss of privacy and shame meant that women tended to conceal problems. A profound sense of social isolation and emotional deprivation resulted. Four itinerant women chose to relocate to avoid scrutiny and find the support they required. For two of them, this meant leaving their husbands. Four women described how they received no emotional support form heir husbands, nor did they assist with the children's care.

Emotional neglect was a common concern for women. The necessity and loneliness of relocating to a major centre and birthing alone was often distressing. Caring for stock, paid off-farm work, harvesting and such like were prioritised. Women described trying to plan their

[235] While no outreach services existed in my remote study sites, some Western districts have enabled health professionals to make home visits.

conception to avoid busy seasons or hoped a planned induction to ensure their husband was present. Postnatally, the burden of new mothering was widely devalued and little local support was available for women.

For some women, being local and having a good social network alleviated the domestic problems they experienced. However, for others being well known and 'everyone knowing everyone's business' increased their isolation. This was most noticeable in Mining Town and Sugar Town.

As women's roles, including childbirth, were considered less important than those of men, they were expected to suppress their personal needs and desires. Economic independence through paid work was discouraged for rural/remote women following marriage. (Nurses were an exception). This potential loss of skills, fulfilment and identity challenges the notion of a choice biography. Even women who had professional qualifications were expected to defer to less educated men/husbands. With the exception of women who had to work for economic survival, women were expected to give up paid work and notions of self-actualisation once they became mothers. Hegemonic practices, such as criticism from other mothers, discouraged attempts to maintain workforce knowledge and skills for personal 'selfish' reasons. [236]

C.2.2 Summary of violence findings

The findings in this study were consistent with the commonly identified risk factors for violence against women. These include a higher incidence of all forms of violence amongst women who are socially isolated, living in a rural or remote area, young, indigenous, and from ethnically and linguistically different backgrounds, particularly those within mining communities or living on farms and stations (Wendt, 2004; Warner-Smith & Lee, 2003; NHMRCa, b; WESNET, 2000; PADV, 2000; Quinlivan & Evans, 1999; OSW, 1997; Parker, McFarlane, Soeken, Torres & Campbell, 1994). In addition to the two women who were victims of physical violence, most women in this study described social, emotional, and/or economic forms of abuse. Hegemonic practices were found to perpetuate the masculinist and patriarchal culture of rural and remote society. Shame, fear and concerns about privacy conceal the true extent of the problem. Disclosure requires trust, and as discussed earlier, trust of health services and health providers is

[236] However, community or charity endeavours were considered suitable for women

problematic. Addressing the neglect of childbearing women's social and emotional wellbeing needs to be addressed by rural and remote health services.

8.2 Chapter summary

In exploring *Labour Relations* between and amongst birthing women and maternity care providers, the content of this chapter has been wide ranging. Relational genograms have been employed to illustrate these relationships and highlight strengths and concerns. Drawing upon participants' perceptions and field observations, a number of constraints on effective relations have been identified. Dysfunctional workplace relations have been revealed as a significant barrier to the delivery of quality care. Concepts of trust have been applied and advanced. In particular, issues have been raised about the gaps in services for childbearing women experiencing violence. Recommendations related to these findings are provided in the final chapter.

Chapter 9

Conclusions and implications

9.1 Introduction

Childbirth in rural and remote contexts is situated within a complex network of social, cultural, historical and political discourses. This significant life event takes place against an existential terrain in which global trends are actualised in local policies and practices that in turn impact upon the everyday experiences of individuals. The implications of this are expressed in social relations, social values and embedded in the local maternity setting. However, interpersonal relations at the micro-societal level also have wider consequences for both birthing women and the quality of maternity provision.

For the purpose of this study, a contemporary, feminist ethnographic approach was employed to explore the social relations surrounding childbirth within rural and remote contexts. As little was known about how childbearing women and maternity care providers in North Queensland perceived birthing experiences, this study has identified multiple, converging factors that impact upon their expectations and satisfaction with the event. These contextual factors, intertwined with contiguous notions of risk and trust, have been revealed to influence perceptions of available choices and the constraints that affected the quality of women's birth experience and their overall satisfaction. Consequently, concepts of choice, risk and trust have been threaded throughout the chapters of this thesis. This concluding chapter will summarise some of the significant discoveries made during this study and in light of the findings, suggest directions for future research and practice. These are divided into methodological contributions and substantive findings.

9.2 Revisiting the question and aims

With this project, I questioned what could be learnt from the perceptions of rural and remote childbearing women and maternity care providers that would contribute to improving the quality of birth experiences. In particular, I wanted to know if birthing women's expectations were being met, and if so, how a 'good' birth was negotiated. If not, I investigated factors that constrained satisfaction with the experience. By exploring the perceptions of both birthing women and maternity care providers I could also identify whether the relationships between and amongst them influenced the quality of the outcomes.

The general aim of this study was to explore the perceptions and experiences of childbearing women and maternity care providers in four rural and remote areas of North Queensland. Four specific aims guided the investigation. These were to explore participants' choices, expectations and satisfaction; examine factors which enabled or constrained a satisfactory birth; identify and document the perceived strengths and limitations of maternity services; and to compare and contrast the views of birthing women with those of rural and remote maternity care providers. Chapter 4 describes the four communities in which the study was situated.

To answer the question and accomplish the aims, contemporary feminist ethnographic methods were selected. As outlined in Chapter 6, these were most appropriate for eliciting the intensely personal information related to the sensitive topics of birth and social relations between and amongst birthing women and maternity care providers. During fieldwork, data collection involved participant observation, content analysis of selected documents, descriptive and reflexive field notes, and 72 in-depth interviews conducted with 27 childbearing women and 21 maternity care providers.

As discussed in Chapter 6, sections 6.2.4, 6.3 and 6.4, while this study achieved the aims, there were a number of design issues and limitations. These predominantly related to first, ethical considerations when conducting research with vulnerable participants, second, the unpredictable nature of gathering and interpreting subjective, non-standardised data and third, issues about generalisability. Concerns about face validity, trustworthiness and transferability of perspective-ridden findings have been addressed in 6.4.2 and 6.4.3. While triangulation with official accounts of birth experiences in medical records was problematic, the interview data supports the value and appropriateness of the feminist, inductive methods employed for this sensitive topic research. This study has been able to shed light on interpersonal issues in rural and remote maternity service generally

9.3 Revisiting the politics and provision of maternity care.

9.3.1 Contested relations

Recognising that elaborate discourses surround childbirth and shape models of maternity care, Chapters 2 and 3 reviewed the macro-structural influences upon birthing practices, the micro-interactive aspects of social relationships, and the social production of maternity services. Maternity care providers are pivotal actors in the delivery of health

services to birthing families yet, like birthing women, they are also situated within complex and competing discourses that influence their practice. Ongoing jurisdictional disputes and professional rivalries result validate Kent's (2000) perception that childbearing women's bodies are a contested site of social action. The problems with interpersonal violence have also been described and discussed.

Applying a feminist critique, Chapter 2 outlined the expropriation of childbirth and its subsequent medicalisation. Embedded in that discussion were concepts of patriarchy, masculine and medical hegemony, along with counter-hegemonic possibilities. However, while valuing the significant contribution that feminist critiques of obstetric ideology, medico-centric practices and the technocratic regulation of birthing bodies have made to re-appraisals of maternity care, Chapter 2 introduced a cautionary note. That is, generalist assumptions that all doctors are intransigent, self-serving men, midwives are essentially virtuous and woman-centred, and that all birthing woman are docile bodies subjected to an oppressive clinical gaze, were not supported by the findings of this study. Contradictory behaviours, reversals of power and resistance were evident at the local level, as later described in Chapters 7 and 8.

9.3.2 Quality of maternity care

Chapter 3 raised the multiple issues surrounding the provision of quality maternity services. Drawing on extensive reports, reviews and research into maternity care, the major barriers to achieving quality outcomes and consumer satisfaction are identified in Chapter 3. Table 3.0 summarised the principal themes within these maternity reviews. Commonly identified concerns about service delivery relate to diminishing maternity care options, inadequate information about available options, polarised views amongst care providers and the community, fragmented services, lack of continuity of care, limited access to appropriate care, competing models of care, the maldistribution of services and resources, rising obstetric intervention rates and the escalating cost of diagnostic procedures. Of note, is the 'inverse care law' which results in disproportionate funding being channelled towards specialist care for those at least risk, that is healthy, privately insured women. These themes were further explored when analysing the narratives of birthing women and maternity care providers in Chapters 7 and 8. While it is possible to conclude that the recommendations of the many reports and reviews are seldom actualised or the problems redressed, the findings of this study advance the recommendations from Hirst's *Rebirthing* (2005).

9.3.3 Evaluative principles

Employing Duckett (2004) and Campbell and Garcia's (1997) frameworks for evaluating health services, five key principles are described in Chapter 3 and applied to the analysis of *A good birth* (Chap. 7) and *Labour relations* (Chap. 8). Consumers and health providers' satisfaction with maternity care and quality outcomes can be linked to service delivery that is efficient, effective, acceptable, accessible and sustainable. However, differing perceptions of quality outcomes were found to differ both in the literature and between the study participants. For example, the dominant model of care has a medico-centric, legal and technical focus which views the best possible outcome for mothers, babies and the health service as one where safety is ensured and risks contained. As accountability rests with the maternity care providers, this approach tends to provide fewer options for women and yet in a health service evaluation, it would viewed as effective, allocative efficiency. Birthing women, however, found it reduced consumer choice, accessibility, affordability and acceptability; especially as related to respect and participation. Based on these evaluation principles and the research findings, I contend that a social model of maternity care, such as that advocated by the National Rural Health Alliance (NRHA 2005a, b, c), would satisfactorily meet both the diverse needs of consumers and enable rural and remote health services to achieve quality outcomes.

In order to improve maternity outcomes, greater collaboration is required between the health sector and other sectors. I endorse the NRHA's recommendations regarding the governance of health, intersectoral collaboration and seamless birthing services. Their proposals for "Making every mother and child count in rural and remote Australia" and "Sustaining wellbeing" (NRHA, 2005b, c) require that the restructuring of health services be underpinned by the principles of community participation, equity, sustainability and quality. This proposed quality initiative involves a collaborative model of governance between rural health providers and communities. Decision making about the models and mechanism of health service delivery that will best meet locally identified needs and priorities will be made in partnership with communities.

A sustainable model is required for rural and remote birthing services. The NRHA and Commonwealth working group recognises the need for credible and competent service providers, regular services and local health care professionals empowered so that they are better able to advocate for and manage their patients (NRHA, 2005c).

In response to the decreasing maternity workforce and to address the needs of women in rural areas, the NRHA (2005b, c) advocates policies that support a midwifery-

focused model of service delivery and endorses independent midwife deliveries as an important part of the solution to birthing services in the next 20 years. Rural women , especially for young mothers, require policies that integrate a gender sensitive approach and that take into consideration the need for better access to holistic care, counselling and female practitioners (NRHA, 2005c). The NRHA recommendations provide the broad context within which my recommendations, which follow, would be best facilitated.

9.4 Methodological contributions to research

9.4.1 Contemporary feminist ethnography

As a feminist researcher with an emancipatory intent, who is also mindful of gendered power differentials and the politics of representation, I developed an innovative methodology. Situated within an interpretivist paradigm, an eclectic, non-prescriptive, feminist approach was found appropriate to the sensitive topic under investigation and this enabled me to be responsive to the dynamics of the birthing experience. In contrast to the bleak assertions that feminism has become intellectually ossified, politically disabled and theoretically mired in textual analyses (Stevens, 1998; Rojek & Turner, 2000), I have built on the work of renowned feminist scholars and synthesised selected aspects of postmodernism with an emancipatory agenda. This inquiry was grounded within the material reality of the ordinary lives of rural/remote people and the everyday problems they encounter, which is consistent with the 'cultural turn' in sociology (Rojek & Turner, 2000).

Chapter 5 has discussed how this 'hybrid' methodological approach melds a feminist, realist epistemology with postmodern critique and sociological insights. Through merging a feminist agenda with an oppositional postmodernism (Kincheloe & McLaren, 1994; Fahy, 1996), it has been possible to emplace social actors into 'real' social contexts, retain a woman-centred position, while also valorising the political and moral imperatives of feminist research. Consequently, this methodology reconciled my emancipatory values, beliefs and principles with the antihumanism, decentred subject and relativism of postmodern discourses. Furthermore, it reflected the complex sociocultural and historical specificity of real lives.

9.4.2 Relational genograms

Relational genograms were developed as a strategy to conceptualise and effectively display the complex patterns of social relationships and social interactions

found in the data. Through relational modelling, social organisations are portrayed as dynamic, living systems thus creating 'diagnostic' and predictive possibilities. As the network of interpersonal relationships between and amongst birthing women and health providers were found to impact significantly upon the quality of the birth experience, relational genograms enabled me to provide visual models that illustrate the changing strengths and weaknesses in the relationships amongst participants and within health settings over a period of time. These relational genograms were based on the concept of family and practice genograms which are proven tools for assessing social interactions. When applied to complicated social interactions within rural/remote settings, the relational genograms enabled the researcher to model and interpret the relationship patterns using observation and participants' views as data sources.

In *Labour relations* (Chapter 8), relational genograms are applied first to illustrate identified workplace bonds and tensions, secondly to represent birthing woman's perceptions of the maternity care they received, and finally to promote an understanding of interpersonal dynamics. The snapshots of workforce relations in each of the health settings at the beginning and end of the fieldwork provide a diagnostic tool that is potentially useful for human resource managers and health administrators. As suggested in *Recommendation 1* (Appendix 14), this tool potentially provides a basis for early intervention. With staff retention a significant barrier to the provision of quality maternity services, relational genograms provide a means to model and identify negative occupational relations that inhibit optimal care and contribute to an unacceptable workplace environment.

As health care consumers, birthing women's perceptions of health care providers and preferences for available maternity services have also been visually portrayed with relational genograms. Together with the interview data, the genograms in Chapter 8 not only model the public and private services birthing women accessed but also their perceptions of these agencies. Furthermore, the types and strength of the relationship women had with particular maternity carers and their degree of satisfaction with the quality of care provided are revealed.

9.5 Conceptual contributions: Choice, risk and trust

The interrelated notions of choice, risk and trust are interwoven throughout this exploration of rural/remote childbirth perceptions, policies and practices. Theoretical perspectives of these concepts were outlined in Chapter 1 (section 1.4) and revisited in the

discussion of findings in Chapters 7 and 8. This study emerged from my interest in the limited childbirth options available to rural/remote women and my observation that their preferences and experiences were shaped by risk discourses and issues related to trust.

9.5.1 Choice and risk

I have argued that rural/remote women are as individually diverse as their metropolitan counterparts and that this is reflected in their varied expectations, preferences and perceptions of childbirth. The birthing women's everyday lives were embedded in complex social contexts and subject to multiple constraints. While all women would ideally like childbirth to be a gratifying, life-enhancing experience, rural and remote women are surrounded by uncertainty and risk in almost every aspect of their lives. Although it has been argued elsewhere that women, as maternity consumers, can choose between different discursive constructions of childbirth, each with concomitant risks, this is especially challenging for women from disadvantaged backgrounds and first time mothers. Supporting Zadoroznyj's (2000) findings, 'class' and parity were found to influence consumerist behaviour. Well-educated, articulate women and those who had previous experience with birth were most likely to be assertive about their preferences.

The contention that people in post-traditional society are liberated from restrictive, foundational social structures and gender roles and so are able to create individualised biographies is not well supported by this study. As illustrated in the findings, material circumstances, temporal and contextual constraints are such that rural/remote birthing women were are not able to freely shape individual life plans or a choice biography. Time, space, material circumstances, social relationships and maternity service policies were all barriers to actualising individual choice. Therefore, these findings are counter to the neoliberal expectation that individuals are able to autonomously, reflexively and rationally make decisions and informed choices from a range of options, cognisant of the attending risks. While decision-making around available childbirth options was a foremost consideration, reflexive, consumerist behaviour was not the norm for rural/remote childbearing women. Some preferred to trust their chosen doctor and adopt the role of compliant patient.

Choice was a contested notion within the health context. The politics of choice in an arena dominated by risk discourses, led to debates over modes of delivery, place of birth, protocols, practices and indemnity. It was one cause of the professional disagreements. Although the Queensland Health Patient Charter advocates the ethico-

legal benefits of informed choice, in practice support for the concept within Maternity services was limited and conditional. From a management perspective,[237] choice can be inefficient, disruptive to planning and effect quality outcomes. Concerns for physiological safety and perinatal outcomes led to defensive practices and prudential risk management strategies, which meant that even women experiencing uncomplicated pregnancies were at times, denied any options. Maternity care providers tended to assume that birthing women were not capable of making fully informed, rational decisions. When several women who prioritised their psychosocial and emotional needs and demanded a local birth, they were considered irresponsible and irrational. However, the interviews revealed that those women were aware of the potential risks when making their decisions. Usually women sought permission to make choices and doctors were endowed with the authority to allow or deny these requests. This again challenges the notion of an individual choice biography.

A number of women exercised limited choice. Having chosen their private doctor and hospital they then relinquished responsibility and entrusted their bodies to expert management. These findings lend credence to Beck's (1999) paradox and Skinners' (2002) contention that proliferating risks tend to make consumers anxious and more reliant upon the doubtful omniscience of scientific and technological expertise (such as medicine) to manage uncertainty. It also supports Lupton's (1999b) observation that as it is no longer possible for an individual, even a reflexive maternity consumer, to be fully informed about the choices and potential risks, women may respond with ambivalence, a sense of powerlessness and induced passivity. Given the current risk-laden, medico-centric culture that predominates in maternity services, the notion of childbirth choice is problematic.

9.5.2 Trust and risk

Closely meshed with issues of choice and risk, trust, distrust and mistrust emerged as a significant themes and sub-themes in participants' narratives. While theoretical conceptualisations of trust differ, in this study trust was observed to be a risk-taking procedure that increased individual vulnerability. Trust was considered in relation to interactions at interpersonal, general, institutional and global levels.

Amongst the maternity care providers, low levels of trust were observed. As shown in *Labour relations* (Chap. 8) strong, trusting relationships were formed between particular

[237] As discussed by the doctors in Mining Town and Sugar Town

health professionals, inter and intra-professional hostilities tended to create distrust. Disharmonious workplace relations, rapid turnover of staff and varying levels of competence led to mutual mistrust and distrust. Female maternity care providers who felt comfortable, competent and capable of managing rural/remote birthing were most likely to trust birthing women and adopt a woman-centred approach. Relocation for birth and the likelihood of obstetric intervention demonstrates the trend towards viewing birth as a risk-laden event.

Birthing women's expectations of trust were influenced by available options, perceived risks and previous experiences linked to educational background, knowledge, familiarity and parity. A congruence between individual expectations and the behaviour of the trustee enabled trust to be established and maintained. Rational evaluation such as overt and covert testing was commonly used as a means of establishing trustworthiness. Often trust was awarded conditionally with this evaluation leading to it being withheld or reinforced. Some women pre-reflectively reduced uncertainty by placing a willing, faith-like dependence upon another. This was likely to apply to inexperienced first-time mothers and those who had no other option. When trust was present it moderated the effects of life stressors, reduced anxiety and enabled women to cope. Experiential knowledge (such as multiparity) was fundamental for future trust.

Interpersonal trust required dependence or reliance upon another person, such as a partner, kin, neighbour or health provider, to behave or perform as expected. They conveyed concerns about privacy and shame in small communities. Outsiders, tended to be mistrusted or conditionally trusted. Birthing women's trust of maternity care providers was linked to notions of integrity, obligation, commitment, competence and confidentiality. Facework was important to forming personal judgements about who can be trusted, that is who one can confidently rely upon in time of need. There was an evaluative dimension to developing interpersonal trust and for this reason women preferred local or known carers. Familiarity over time combined with the shared impressions of family and friends ameliorated distrust of outsiders. Where face to face encounters were not possible, the opinions of trusted others were important influences on decision-making.

Justifiable concerns about the inconsistent and unreliable quality of care provided by rural/remote maternity services tended to create distrust and mistrust. Although ontological security in the health system was evident, trust in 'faceless' institutions was inhibited by media reports, scepticism, safety concerns and lack of familiarity. Trustworthy maternity care services were associated with dependability, reliability, an environment

which ensured safety and privacy along with continuity of care by culturally appropriate, knowledgeable and skilful professionals. When evaluating the trustworthiness of a maternity service, consumer considerations included the principles of quality such as efficiency, effectiveness, acceptability, accessibility, equity and sustainability. Distrust and mistrust of health services arose from experiences of poor quality care (either personal or hearsay) which involved segmented care, conflicting advice, lack of privacy, breaches of confidentiality, adverse outcomes, a rapid turnover of personnel and factionalism amongst health care providers.

Therapeutic encounters are enhanced if patients/clients are treated honestly and respectfully. Maternity care providers can promote trust through identified behaviours. These include actively listening to women, clearly communicating information, demonstrating an understanding of their individual experience, thoroughly and holistically evaluating their needs and competently providing appropriate care. The significance for maternity care outcomes for developing and maintaining childbearing women's trust is modelled in Figure 9.1, which follows.

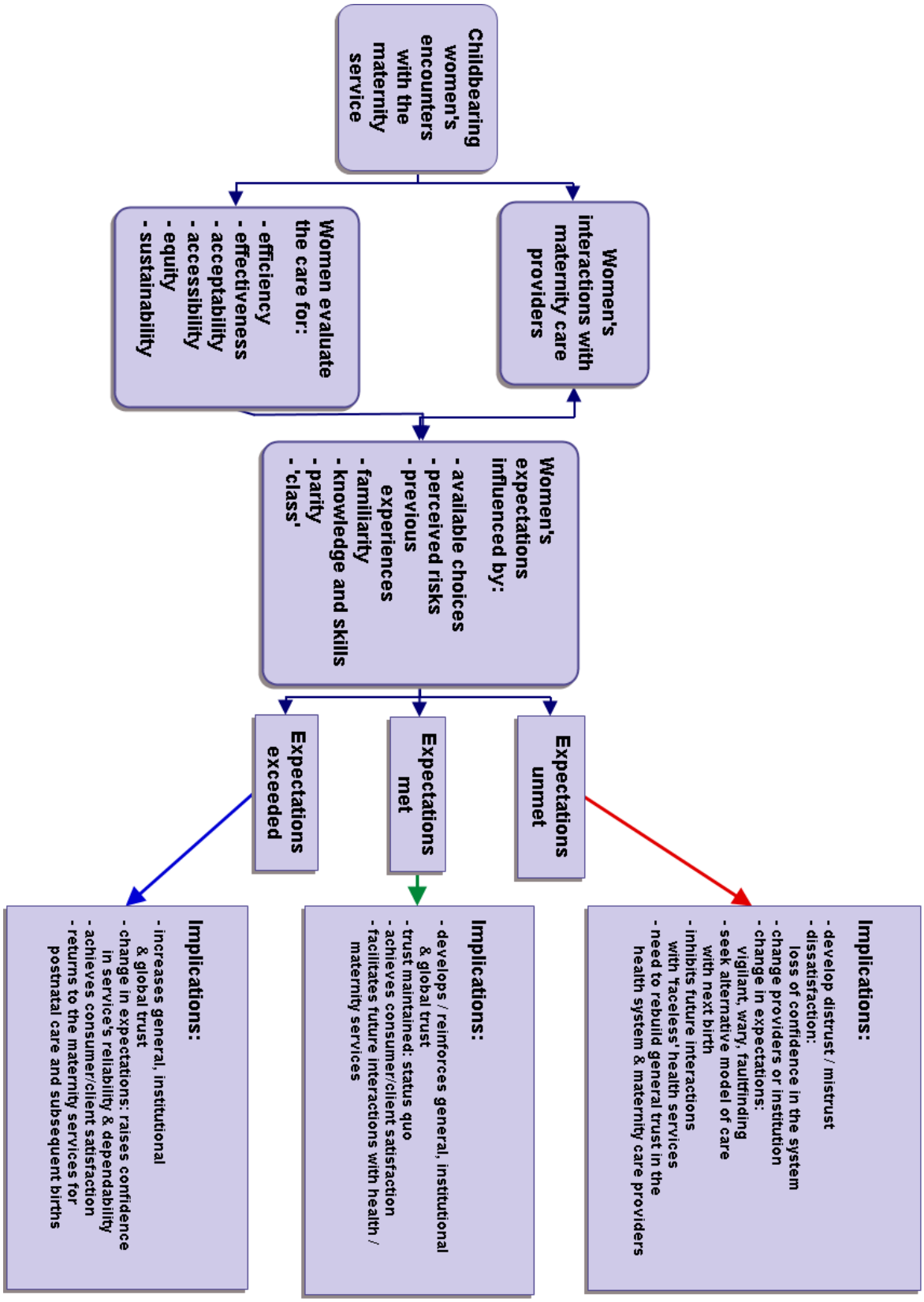

Figure 9.1 Developing and maintaining childbearing women's trust in maternity services

9.5.3 Concordance

To achieve optimum outcomes, concordance is proposed as a way forward to an effective partnership between maternity care providers and maternity consumers. Consistent with the notion of a concordant partnership is the practice of facilitating reciprocal trust to evolve by open and honest discussions between a birthing woman and (her preferred) maternity care providers about benefits, risks and concerns. Underpinning this development of a trusting is the provision of balance and unbiased information about available birthing options accompanied by non-judgmental support with decision-making and respect for women's choices. Creating a space and place where women can safely express their needs and desires, and confidently discuss sensitive matters, is required for this approach to be successful. Concordance provides a potential pathway through the contradictory expectations that childbearing women should be both compliant patients who entrust their care to 'experts' and rational, autonomous individuals capable of reflexively making well-informed decisions about maternity care.

The suggested concordant approach is outlined in *Recommendation 2* (Appendix 14). Further research with rural and remote health services is proposed to evaluate the implementation, achievability and preliminary outcomes of this strategy.

9.6 Substantive contributions and recommendations for practice

9.6.1 Perceptions of a good birth

Birthing women and maternity care providers' perceptions of a good birth were explored in Chapter 7. Choice and trust were paramount requirements for birthing women. 'Class' and parity were significant influences on their desires, expectations and requirements. As individuals, women had diverse views, which made it difficult to provide a simple answer to the query: What do rural women want? The exemplary stories represented the range of women's views on what they considered a 'good' birth. Their experiences ranged from a non-interventionist birth amongst familiar women in a remote community to a highly-interventionist delivery in a busy, hi-tech, tertiary hospital. Consequently, I assert that only the individual birthing woman herself can decide whether or not her experience was satisfactory.

While it is not possible to generalise from the birthing women's narratives, there were areas in which they overlapped and concurred. Recurring themes included the need

to make choices and retain some sense of control, a desire across the childbearing cycle for continuity of care, locally available social and professional support, concerns about privacy and confidentiality, and access to well-qualified, competent, culturally appropriate (preferably female) carers. Although there are limited available options for rural and remote women, each considered the people and places that they would entrust with their birth experience and made decisions accordingly. Women who gave birth in a small, rural/remote hospital amongst known carers were more likely enjoy a positive experience than those who relocated to a major centre for an obstetrically managed event. In addition, women who relocated for birth were more likely to experience the undesirable consequences of disjointed maternity care and separation from their support networks at time of high need.

Every woman commented on how the psychosocial and emotional aspects of childbirth tended to be neglected. As childbirth is not just a physiological event, women reflected upon the lack of consideration given to meeting their holistic needs, especially during the postnatal period. The tendency for maternity care providers to focus on the physical wellbeing of mothers and their infants (i.e. obstetric and perinatal outcomes) was a source of dissatisfaction for most childbearing women. They commonly felt challenged by early parenting and the lack of social support contributed to depression and loneliness. Even the most joyful labour and birth was tempered by the postnatal experience.

As illustrated in Chapter 7, birthing women's narratives revealed that their perceptions of the birth experience and of themselves as mothers was internalised and subsequently actualised in their identity (self-perception) and in their social practices. The discursive position of these women is evidence that the groundwork for self-perception is founded upon their experiences during this vital period of their lives. Interactions with health providers, medical 'permission' to make limited choices along with the quality of information provided to birthing women contributed to shaping these self-perceptions.

Based on these research findings, (*Recommendations 3* and *4,* Appendix 14) it is evident that rural/remote birthing women would benefit from the adoption by maternity services of a social model of care. When formulating strategies for risk management and quality improvement, consideration needs to be given to providing maternity care that is more women-centred, flexible, collaborative and inclusive. This would address the significant concerns raised by women in this study about their neglected emotional, psychosocial and cultural needs. Consistent with these findings are Hirst's recommendations to Queensland Health about ways to improve maternity practices and

experiences (2005, pp. 52-54).

Amongst the maternity care providers, perceptions of what constituted an 'ideal' birth also varied significantly between individuals and professions. The spectrum of views ranged from supporting personalised 'natural' birth in a homelike setting to defensive practice underpinned by predictability, control and the 'security' of obstetric services. Polarised opinions were expressed about the same birth event and were implicated in conflictual relations. Most maternity care providers framed their views with negative examples. These highlighted adverse factors and inherent risks that were not conducive to a good experience or a satisfactory outcome. Risk discourses predominated. While recognising that maternity care must be provided within a framework of safety and quality, risk management strategies tended to limit flexibility. Predictability and control of outcomes were valued.

Overall, the interviews with doctors, nurses and midwives revealed that a 'good' birth experience in a local rural/remote setting was one which occurred during normal office hours on a weekday in a multiparas woman who was experiencing an uncomplicated birth. Timing was widely perceived as important[238] so that the most experienced midwives and doctor(s) could be present, antenatal records could be accessed, and continuity of care possible. This enabled the required medical supervision, skilled support and, if necessary, obstetric intervention.

In contrast, Aboriginal Health Workers valued effective relations with birthing women, which required mutual respect and trust from culturally appropriate (female) carers. Important considerations for quality maternity provision were age (maturity), parity, personal privacy, gender and avoiding shame.

Diverse views between individuals were found to be related to each maternity care provider's personal and professional background, philosophy and experiences. Individual values, current knowledge and skills, level of competence combined with confidence working in a rural/remote context contributed to maternity care providers' preparedness to facilitate or disallow local birthing. Disagreements and hostility between maternity care providers were identified as a major barrier to effective service delivery and quality care; these are addressed further in the following section.

[238] As described in Chap. 7, timing also included not going into labour when the doctor was an inexperienced locum, skilled local carers were not available, or when weather conditions prevented retrieval.

9.7 Constraints

The endemic interpersonal violence identified in rural communities and maternity settings was an unanticipated finding. Within occupational and family relations, psychological, social and emotional forms of violence were observed.

9.7.1 Family and domestic violence

An unanticipated finding was the prevalence of social, emotional, psychological and economic forms of violence evident in childbearing women's stories and revealed to a `'safe outsider'. This culture of violence was evident in gender relations in the community, workplace and homes. Violence was found to contribute to postnatal dysphoria and depression. Concerns about shame and privacy were significant concerns.

Within some families, women reported both highly controlling relationships and neglect. Several new mothers were without social or emotional support while also subject to surveillance, constant criticism and neglect. Experiences included being deprived of transport, money and contact with friends and family. Mail was screened and phone calls restricted. In particular, daughters-in-law tended to be maltreated and abused.

This study supports earlier reports that the triple burden of farming work, domestic caring obligations combined with a subordinate social status, are risks to rural women's health. Farming women described their exhaustion when not only recovering from birth trauma, caring for infants, the extended family and managing the household but also being expected to carry out heavy duties caring for farm workers.

Within the townships, transient 'blow-ins' who were isolated from support networks found there was no one locally they could trust to share their experiences of an abusive partner. Amongst mining women, stressors and abuse commonly led to relationship breakdown.

The endemic interpersonal violence observed was secondary to wider structural or systemic factors including rural stressors and inequitable gender relations. The impact of rural economic depression and uncertainty was compounded by social and geographic isolation and inappropriate or inaccessible services for rural/remote women. A complex interplay of masculinist attitudes and patriarchal values were found in rural and remote communities.

Hegemonic masculinity and patriarchal relations were implicated in the domestic and family violence described by birthing women in this study. While it is simplistic to assert that male supremacy manifests as domestic violence, across settings prevalence

has been shown to increase when there is an unequal distribution of power between the genders and where patriarchy is systemic, such as in mining and farming communities. Inequitable gender relations were actively reconstituted in everyday rural life and this impacted upon women's health and well-being. Rural women tended to occupy subordinate positions and devalued roles. As hegemonic masculinity discursively constructs and shapes gender experiences, it influenced women's perceptions of childbearing and mothering in rural areas. Isolation compounded their vulnerability. Domestic labour and reproduction were widely considered 'women's business' and valued less than the farm production or paid work undertaken by men. Consequently, rural/remote women's contribution was taken for granted and largely unacknowledged.

It was evident from these findings that maternity services were having difficulty recruiting and retaining well qualified (female) health professionals who were sensitive to the complex needs of rural childbearing women and competent in advising and supporting them. Furthermore, participants' accounts revealed the need for a therapeutic environment for women experiencing all forms of violence, which invites disclosure, provides validation and supports their decision-making. *Recommendation 5* (Appendix 14) outlines strategies to meet this identified need.

9.7.2 Unhealthy workplace relations

Although concerned and caring in their relations with birthing women, health professionals tended to bully, mob and marginalise each other. Child health nurses and newcomers to the rural/remote context were most likely to be victimised; doctors were least likely to be affected. Verbal denigration and covert power games were common. For the victims, the situation was worsened by social and professional isolation from support networks and lack of action by management. Organisational factors compounded the problem. These included staff and workload issues, stress, inadequate professional development as required to competently and confidently cope with the expanded scope of practice, [mis]management of staff concerns, inadequate resources and institutional support, and backstage complaints.

Four explanations for workplace hostility and unhealthy relationships amongst maternity care providers were outlined in Chapter 2 and applied to the findings in Chapter 8, *Labour relations.* These were professionalisation, oppressed group behaviour, the vocabulary of complaints and conflicting cultures of care. All were found to be problematic Findings from this study indicate that conflictual intra and inter-professional relationships

were endemic. Creating 'otherness' through dichotomous thinking, in the form of 'them and us', not only had a significant impact on social interactions and staff retention but also had devastating consequences for individuals. Professionalisation and professional boundary maintenance explained some of the fraught relations. However, the professionalisation project alone does not explain the horizontal violence amongst midwives and nurses. An alternative explanation for the destructive behaviours amongst female carers was Freire's notion of oppressed group behaviour, yet a deconstructive analysis reveals the flaws in this justification. Conflicts arose over philosophies of care, management styles and issues of clinical competence. The perpetrators were not pre-reflective, misguided collaborators whose dysfunctional behaviours inadvertently reinforced medical hegemony and asymmetrical power relations. Midwives were observed to strategically align with the doctor for career enhancement; the doctors were not observed to be using 'divide and conquer' tactics to reinforce a dominant ideology. I have argued that the observed behaviours are consistent with Nietzsche's notion of *ressentiment*. Instead of adopting a unified approach and positive expressions of power that would advance women's position, midwives and nurses tended to focus on power as individualised control enacted through discursive and non-discursive practices.

Turner's (1986) notion of a vocabulary of complaints was explored as another explanation for the subversive discourses of discontent noted in the nurses, midwives and health workers. The 'front stage' persona of compliance and concealed disgruntlement was observed as a device to manage interpersonal differences between an authorised position and actual practices. 'Backstage' informal complaints were common within interviews. In the rural/remote context, these acted as a powerful sub-cultural ideology and as a means for de-legitimising broader institutional controls. However, by concealing the discontent and active resistance to outside directives, this culture of silence became counter-productive as it bypassed official documentation and therefore institutional recognition of the problems. Frustrations over staffing issues and concerns about the urgent need for maternity reforms contributed to backstage discontent. While the reasons for resistance (workloads, bed-rationing, budgetary controls and restrictions to scope of practice) were client-centred and commendable, the vocabulary of complaints was ineffectively employed. I contend that oppositional politics provide a potential space for resistance to hegemonic discourses. As such, the vocabulary of complaints could de-legitimise and destabilise authority. The potential remains for birthing women and midwives to effectively work together to challenge existing practices and bring about the

desired changes in maternity care.

Conflicting cultures of care is proposed by Hirst (2005) as another reason for friction in maternity environments. The opposing cultures vying for predominance are described as mechanistic and organic (Figure 2.0). While characteristics of each of these cultures within Hirst's (2005) model were exemplified by the people and practices described in *Labour relations* (Chap. 8), I have argued for a new paradigm that envisages cultures of care as a continuum within a context, thus avoiding rigid oppositional thinking. As developed in Figure 8.9, this dynamic model enables maternity care providers to respond to internal and external influences and accordingly position themselves along the continuum. In contrast to Lane's (2002) derogatory notion of indecisive hybrids, this paradigm is inclusive and responsive to contextual considerations at a given time. This paradigm is also consistent with the notion of a *modus vivendi.*

Arising from these findings is an evident need for maternity care providers to actively work towards engaging in constructive, collaborative and mutually supportive occupational relations. The paradigm depicted in the *Cultures of Care Continuum* (Figure 8.9) allows for the complexity, reality and dynamism of practice in rural/remote maternity settings and moves beyond divisive, dichotomous thinking. Through contextualising issues, reflective practice and effective communication, it is possible to find common ground and points of compromise so as to develop positive, constructive relationships. *Recommendation 6* (Appendix 14) addresses this concern.

9.8 Labour relations: The insider – outsider phenomenon

Being positioned as an outsider in a rural/remote community leads to a sense of 'otherness' and social exclusion. This study has identified this as a risk factor for staff retention. The phenomenon I observed is inadequately explained in sociological literature (Chap. 8, Section A.3.3). Combined with workplace relations, the contested culture of rural/remote society was one of tension, disharmony and anxiety. Rural settings are resistant to the constant change of transient and itinerant people ('blow-ins'), including health professionals. Amongst the health professionals, those positioned as outsiders were either new to the rural/remote context, and/or designated Maternal and Child Health nurses, who were external to the main arena occupied by midwives and doctors. They tended to become professionally and socially isolated. As shown in the genograms in Chapter 8, those most professionally advantaged were 'locals', maintained strategic alliances and/or were key insiders within the workforce. Being an outsider was not a static

position but rather a shifting, permeable social location. Therefore, given the strategies for inclusion suggested by several participants and within social welfare literature, entry and acceptance within the workplace and wider community is possible. These strategies for inclusion are detailed in *Recommendation* 7 (Appendix 14) and can be incorporated into professional development. Implementing such strategies potentially enables integration by disrupting the insider/outsider dichotomy. They provide a constructive way to reduce the undesirable professional and personal consequences of exclusion.

9.9 Summary, significance and conclusion

Childbirth was once 'women's business' and an everyday life experience. Following global trends, it is now an event that is politicised, obstetrically regulated, technocratic and medico-centric. In exploring the perceptions of rural and remote childbearing women and maternity care providers, I have identified factors at a macro and micro-societal level which enable and constrain quality birthing experiences. I have argued for a move away from oppositional narratives towards recognition of the dynamic complexities of contemporary maternity settings. While wider social trends and values impact upon local maternity polices and practices, at a local level maternity providers play a pivotal role in the quality of maternity care in small rural/remote settings. Their life experiences, individual philosophy, professional background, confidence and competence all influenced their practice, perceptions and the workplace culture. Relationships amongst maternity care providers and with birthing women have been identified as significant to staff retention and consumer satisfaction. Paramount concerns for rural/remote childbearing women were limited choice applying to access, expectations and preferences and the oversight of their social and emotional needs, especially postnatally.

This study has contributed to the theoretical understanding of discourses surrounding choice and trust in relation to childbirth and rurality. It adds to the body of knowledge about the lived experiences of rural and remote childbearing women and maternity practitioners. Gaps in the provision of quality rural and remote maternity care have been indentified. Through critically examining the social issues surrounding contemporary rural/remote birthing, together with findings from this ethnographic study, insights have been gained, spaces for resistance revealed, and ways to progress beyond oppositional thinking identified, which potentially enables maternity care providers to offer a more responsive service and thus fulfils my feminist political imperative.

Research findings from this study have contributed to recommendations for

maternity policy and practices which, if implemented and evaluated, have the potential to improve the quality of maternity care for women in rural and remote areas of North Queensland. To provide women-centred care, maternity services need to recruit and retain well-qualified [female] health professionals who are sensitive to the diverse expectations, concerns and needs of rural/remote childbearing women and competent in advising and supporting them. Through adopting a concordant approach, reciprocal trust and enhanced decision-making around birthing choices are possible.

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Appendices

Appendix 1 Classifying rurality and remoteness: A summary of the strengths and limitations of three geographic systems.

The three classification systems for measuring the degree of rurality and remoteness are the Rural, Remote and Metropolitan Area (RRMA) classification, the Accessibility/Remoteness Index of Australia (ARIA and ARIA+) and the Australian Standard Geographic Classification (ASGC) Remoteness Area Structure (RAS). This section briefly outlines the strengths and limitations of each as compared and contrasted by the Australian Institute of Health and Welfare (AIHW, 2004e), Australian Government Department of Health and Ageing (DoHA, 2005) and Royal Australian College of General Practitioners (RACGP, 2005).

For the purpose of this project, the RRMA classification system was most useful. Since 1994, its 'Index of Remoteness' has widely applied as a measure of access based on the key factors of geographic distance, population density, workforce supply, health and wellbeing. Each zone indicates differences in service and infrastructure provision, economic base, land usage, natural resources along with social and demographic structures (AHWAC, 2002; DoHA, 2005). The seven categories are ranked hierarchically with the first two applying to metropolitan areas and with the remainder as follows: RRMA 1 designates *large rural centres* as statistical local areas (SLAs) where most of the population reside in urban centres with a population between 25,000 – 100,000 and includes Queensland cities like Cairns, Mackay and Rockhampton. *Small rural centres* (RRMA 3) are zones containing SLAs with urban centres of 10,000 - 24,999 people. *Other rural areas* (RRMA 4) are the remaining SLAs in the rural zone, like the Shires of Cardwell, Hinchinbrook and the Whitsundays. According to the RRMA, the two remote zones are the least densely populated and located hundreds of kilometres from a major urban centre. *Remote centres* (RRMA 6) include an urban centre with a population over 5,000 such as Bowen and Mt Isa. Finally, at RRMA 7 are *other remote areas* which range from Cape York Aboriginal communities like Aurukun to western towns like Longreach. The towns and surrounding districts included in this study (as described in Chapter 4) are designated RRMA 4 *Other rural* and 7 *Other remote*.

Although the RRMA is a useful tool, easily understood and applied, it is currently under review by the DoHA (2005) because of its limitations. The broad generalisations of the RRMA classifications have not been updated to adequately accommodate changes, adjusted for exceptions or to reflect the differing levels of disadvantage between districts

regarding socio-economic levels, health outcomes and available health providers (DoHA 2005, p.4; RACGP, 2005). In addition, unlike ARIA, the RRMA does not measure distance to service centres by road, which for most rural and remote areas in North Queensland is a major consideration as road conditions, especially during the 'wet' season, affect accessibility.

ARIA (and ARIA+[241]) is considered conceptually simpler and "more robust" over time than the RRMA methodology (AIHW, 2004e). Developed by the Key Centre for Social Applications of Geographic Information Systems, it is a strictly geographic measure using a 0-12 point scoring system to allocate an ARIA category (University of Adelaide, 1999). As such, sociocultural considerations are excluded from the index. ARIA's strengths compared to RRMA is that it differentiates levels of accessibility in relation to remoteness and can be updated as populations change. ARIA considers proximity to service centres by road but not in relation to car ownership, access to public transport or seasonal road conditions (AIHW, 2004e). The broad categorisations are a further limitation. With 19% of the population classified as outside the most accessible areas, the small populations make statistical analyses unreliable. Consequently, highly dissimilar areas can receive the same remoteness score even though "accessibility of health professionals and other issues affecting health in each of these … areas would likely be quite different" (AIHW 2004e, p.15). According to ARIA, of the four study sites in this PhD study, one would be considered moderately accessible, one would be categorised as remote and two as very remote.

The ASGC RAS recently developed for the Australian Bureau of Statistics is a six level system which facilitates analysis of a census collection district. Following the AIHW (2004e) critique, the RACGP (2005) submission to the Australian DoHA review points out these tools are "based on gross groupings of population and do not cater for the variations in [health services], or in those required by population groups and sub-groups. This inadequacy can have a compounding effect as such variations can have maximum impact on health in a community at a much smaller level of population grouping [consequently] variation and changes can still escape prediction or identification" (RACGP 2005, p.3). The inability of ASGC RAS areas to exhibit a remote local community is evident in the broad categorisation of the study sites as Outer regional, remote and very remote.

With all three classification systems, the local context of a rural or remote health

[241] Aria+ adds a greater level of precision to measuring small remote centres. Compared to the ARIA index values, its instability enables changing and actual levels of remoteness to be reflected, however it has the same limitations (AIHW 2004e, pp.16-17).

service is too small a statistical unit for analysis and so as tools, ARIA and ASGC RAS are of limited practical use when researching the inequities and specific areas of need in this study. Accordingly, the ABS and AIHW caution that the accuracy of these geographic systems is limited at a local level. They are most valid when applied to aggregate data using large spatial markers (such as large SLAs); at the level of postcodes they can become misleading.

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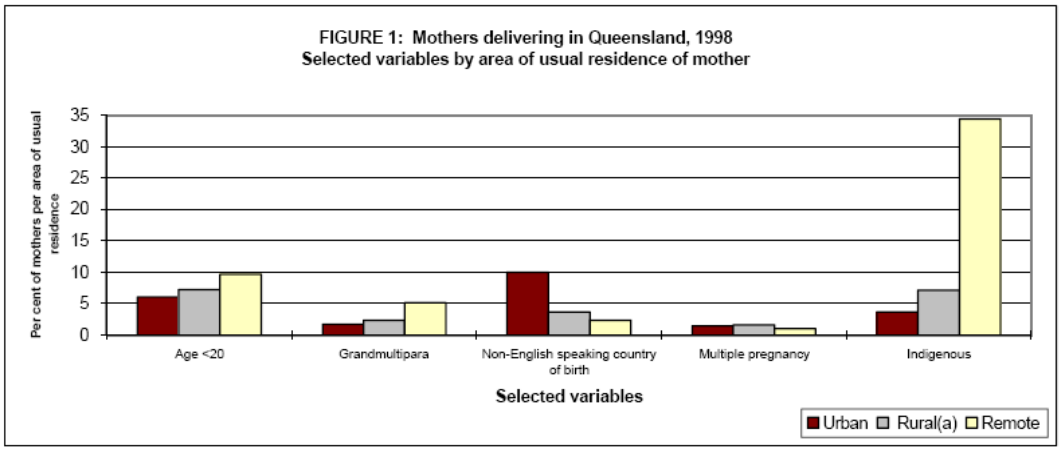
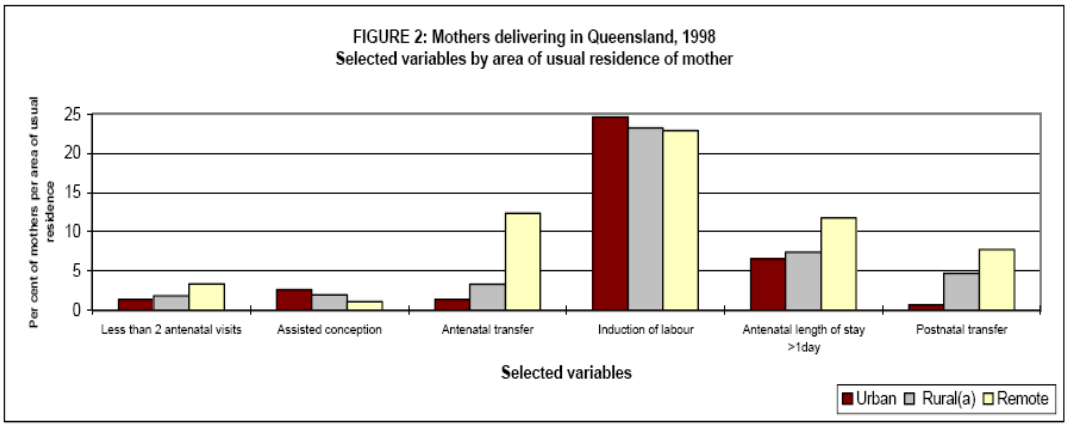
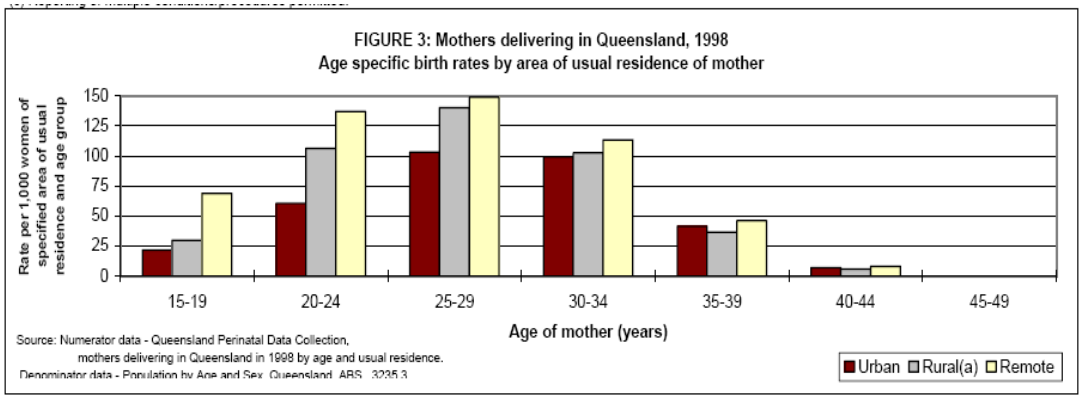
Appendix 3: Selected Queensland perinatal variables

Comparative profile of women whose usual residence was a rural* or remote area who 'delivered' in Queensland in 1998 using selected perinatal data variables (Queensland Health, Health Information Unit, 2000).

* Rural includes districts from large rural (e.g. Cairns and Mackay) to remote major i.e. Mt Isa







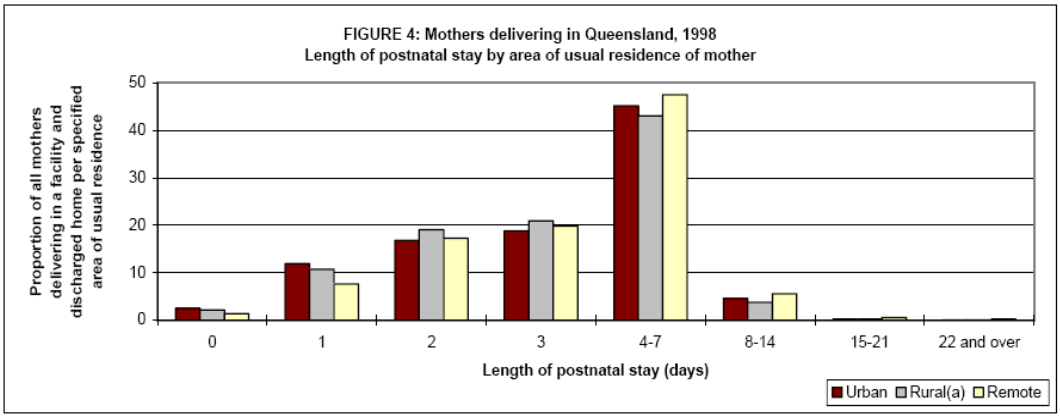


FIGURE 4: Mothers delivering in Queensland, 1998
Length of postnatal stay by area of usual residence of mother
Proportion of all mothers delivering in a facility and discharged home per specified area of usual residence
50
40
30
20
10
0
0
1
2
3
4-7
8-14
15-21
22 and over
Length of postnatal stay (days)
Urban
Rural(a)
Remote

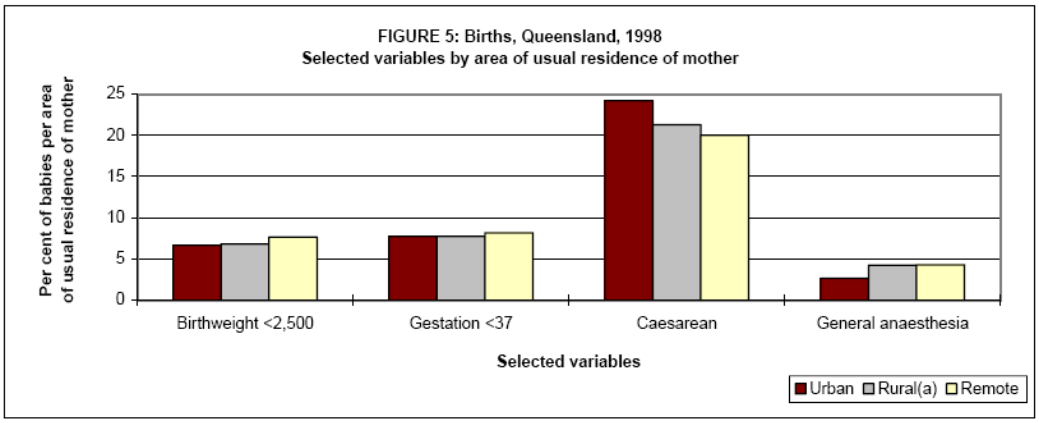


FIGURE 5: Births, Queensland, 1998
Selected variables by area of usual residence of mother
Per cent of babies per area of usual residence of mother
25
20
15
10
5
0
Birthweight <2,500
Gestation <37
Caesarean
General anaesthesia
Selected variables
Urban
Rural(a)
Remote

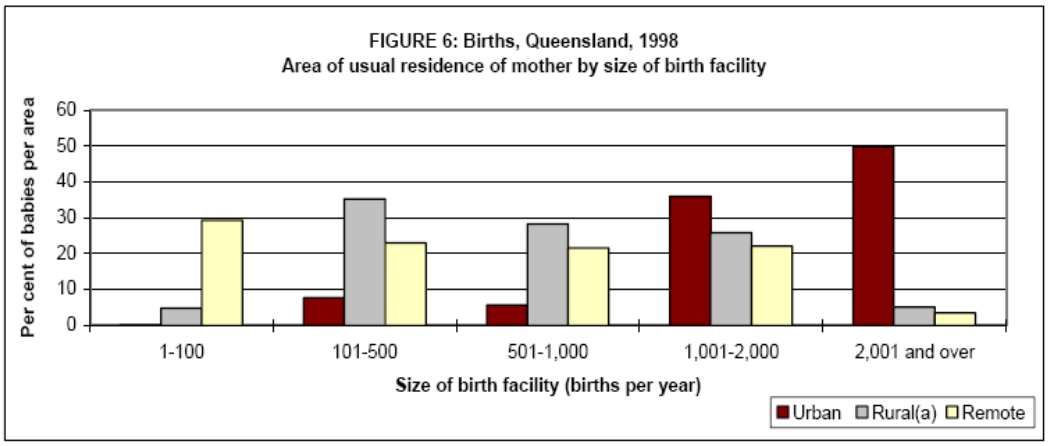


FIGURE 6: Births, Queensland, 1998
Area of usual residence of mother by size of birth facility
Per cent of babies per area
60
50
40
30
20
10
0
1-100
101-500
501-1,000
1,001-2,000
2,001 and over
Size of birth facility (births per year)
Urban
Rural(a)
Remote

Appendix 4 Defining domestic violence

The Domestic Violence Resource Service (2000) and the Office of the Status of Women and Department of the Prime Minister and Cabinet (1997) use the following categories to describe domestic violence.

Physical abuse or assault involves the use of greater physical strength to exert control. It includes pushing, shaking, forcibly holding, slapping, punching, kicking, choking, throwing her against walls, throwing objects at her, using weapons, raping, or threatening to do any of these things.

Sexual abuse or assault entails forced, non-consensual sexual acts or behaviour. Sex is used as a means of control and may involve forced or unwanted sex or sex acts such as bondage, rape and the use of foreign objects. Also included are behaviours like ignoring or ridiculing sexual feelings, committing sadistic sexual acts, physically attacking the sexual parts of her body, sexual harassment, unwanted stroking, touching or squeezing.

Verbal abuse involves threatening physical abuse, provoking fear, continuous verbal harassment, ridicule, insults and swearing.

Psychological or emotional abuse enables control through fear and intimidation. It may include refusal to communicate, 'mind games', attacks on self-esteem by withholding approval, appreciation or affection or by punishing, threatening, criticising, insulting, ridiculing, demeaning or degrading. In addition she may be blamed for the family's problems. It also may involve threatening to abduct or harm the children, threatening to kill her or himself, or harming the family pets, stalking or behaviour intended to frighten her as well damaging walls, furniture or household items. She may also be isolated by having the car disabled or the phone disconnected.

Social abuse occurs when a woman is socially isolated to increase control over her. It is achieved through deterring and insulting friends or family; preventing her from socialising; monitoring and sabotaging her social interactions; criticising, ridiculing or humiliating her in public; depriving her of outside contact by phone or use of transport.

Economic abuse involves manipulative control of family finances and resources to deny a woman the ability to meet daily needs for her and the children, or the right to live decently and make even basic financial decisions.

Spiritual abuse is one of the least recognised forms of abuse. It involves gaining control by damaging or breaking her spirit, shaming and degradation, ridiculing values and beliefs and other types of emotional abuse that resulting in loss of self-confidence and self-esteem. Religious beliefs may be used be used as a weapon to control her behaviour or she may be prevented from practicing her religious beliefs.

Appendix 5: Participant Information Sheet

VOLUNTEER INFORMATION SHEET

A study of birthing women's perceptions of health delivery services in rural and remote areas

Felicity Croker
James Cook University
Townsville

VOLUNTEER INFORMATION SHEET

Purpose of the study

I am a nurse and midwife studying for a Doctorate in Sociology at James Cook University. I wish to learn about the recent birthing experiences of women in rural and remote areas. In particular, I wish to find out where women had their babies, what choices were available to them and how this affected them and their families.

TO DO THIS, I NEED THE HELP OF WOMEN LIKE YOU WHO HAVE RECENTLY HAD A BABY.

Who is invited to participate?

I would like to talk to:

- women who have **had a baby in the past year;**
- women from a **variety of cultural backgrounds**;
- women who had their **babies in the local community**;
- women who **went away to a large hospital to have their babies**.

Benefits of participation

Information from this study:

1. will allow for the views of childbearing women in rural and remote areas to be documented and their specific needs identified.
2. may contribute to policy changes which improve the available health delivery services in rural and remote areas.
3. may contribute to women in rural and remote areas being offered a wider choice of birthing experiences.

WOULD YOU LIKE TO TAKE PART IN THIS STUDY?

Procedure

If you agree, I would be interested in interviewing you. If you belong to an ethnic minority group, I can arrange for a woman of your culture to explain the study to you and to be with you during the interview if you wish.

Before meeting, I will send you some questions to think about. These are just a guide and you should feel free to talk about other birth issues which concern you.

There will be **two interviews**. Each interview will take approximately **one hour,** but can take longer if you wish. If you feel uncomfortable being interviewed alone, you may be interviewed with a friend who has also recently had a baby.

With your permission, **each interview will be taped.** As it is important that the information I use in the study accurately reflects your views, I will send you a typed copy of the interview. You can add details or make changes to this if you wish. Later, we will meet for a second time just to make sure I am correctly reporting your views and to discuss any changes you may wish to make.

I would also like your permission to **view your birth record** at the hospital. You may participate in the interviews even if you do not give permission for your records to be viewed.

Your participation in this study is entirely voluntary. If you change your mind you can withdraw at any time without giving a reason and your information will not be used.

In about a year, you will receive a summary of the findings of the study and will be consulted before it is published.

Confidentiality

If you agree to participate, all your responses will be kept private. Your real name will not be used in any reports or publications resulting from the study. Tapes and other private information will be coded and kept in locked files at all times.

Further questions?

If you need to ask any questions before you decide I can be contacted on:
Telephone: (07) 47814909 (work) or (07) 47788373 (home). To save you the expense of a long distance call, I will call you back.

If you would like to join the study please contact me either by phone or post the answer form to the address below. I will send you a consent form and arrange a time for us to meet.

If you have decided not to participate, thank you for reading this statement and taking the time to consider joining the study.

To participate *please return this slip to:*

Felicity Croker
Department of Psychology and Sociology
James Cook University
TOWNSVILLE, Q. 4811

✂ ----------

I would like to take part in the study of birthing women's experiences in rural and remote areas.

Name: _____

Address: _____

_____

Telephone: _____

Appendix 6 Follow-up letter to participating birthing woman

Dear …

Re: Study of birthing women's perceptions of health delivery services in rural and remote areas

Thank you for agreeing to participate in this study. I have enclosed an information sheet and a copy of the consent form for you to read. Please contact me if you have any queries.

I hope to be in [redacted] again within the next few weeks and will telephone you before I come to arrange a suitable time. When we meet, I would like to discuss your recent childbearing experiences with you. To begin with, I would like to ask you some questions about your age and background. I would also like to know the number of pregnancies and children you have had and how previous experiences differed from your recent birth.

I am interested in the care you received during your last pregnancy, who performed your antenatal care, how satisfied you were with this care and whether you attended childbirth education classes. I would also like to discuss your recent birth, in particular, the decisions you made about where you gave birth, who was present, what pain relief you received and any interventions that occurred. Your perceptions of the period after the birth are also important. I would like to know which health professionals assisted you physically and emotionally during this period and how you felt about the services they provided. I am also interested in your views on motherhood.

These topics are just a guide and you should feel free to talk about other birth issues which concern you. Your birthing experiences as a women living in a rural/remote community will contribute valuable information to this study.

I look forward to meeting you.

Yours sincerely,

Felicity Croker

Appendix 7 Follow-up letter to participating maternity care provider

Dear [redacted]

RE: Birthing women's perceptions of health delivery services in rural and remote areas

Thank you for your interest in this project. After our phone conversation today, I feel that interviewing you would provide useful background information on the experiences of birthing women in your area as well as valuable insights into midwifery practice within a remote setting.

This PhD study combines a midwifery perspective with Sociology. I have received approval from the Institutional Ethics Committee at Townsville General Hospital to conduct a study into birthing women's perceptions of health delivery services in rural and remote areas of North Queensland. My research not only looks at the views of birthing women but also incorporates the perceptions of health providers of the services they offer. (I am awaiting approval from the Chief Executive Officer of the Mt Isa Health District to approach you within your workplace). By interviewing midwives, medical practitioners, health workers, child health and community nurses as well as the birthing women, I am able to reflect many perspectives on the same situation.

As we discussed, I would like to come out to [redacted] in the near future. When we meet I would like to discuss your experience as a midwife and DoN working in a remote area, as well your perceptions of the birthing and postnatal experiences of women in your district. I am also interested in the scope of the health service you provide. These topics are just a guide and, if you agree to be interviewed, you should feel free to talk about other issues which you consider significant. One of the aims of this project is to provide health providers with a "voice". You could express your views on policy issues and other matters of relevance if you wished. Your experiences as health professional living in a remote community would contribute valuable information to this study.

I would welcome assistance with contacting women in your district who have given birth in the past year. In particular, I aim to have a representative sample of women which includes country and town women; primiparas and multiparas; women with various socio-economic backgrounds; as well as those who gave birth locally and those who went to a major centre. I am happy to go out to stations to talk to women about their birth and will interview friendship pairs if they feel more comfortable having a support person. Enclosed are some Volunteer Information Sheets designed to give information about the study to birthing women. The interview process is the same for health providers.

I look forward to meeting you,

Yours sincerely,

Felicity Croker.

Appendix 8 Participant consent: Birthing women

James Cook University
Department of Psychology and Sociology

CONSENT TO PARTICIPATE IN A RESEARCH STUDY OF WOMEN'S PERCEPTIONS OF HEALTH DELIVERY SERVICES IN RURAL AND REMOTE AREAS

Purpose:

Felicity Croker, who is a nurse and midwife studying for a Doctorate in Sociology, wishes to learn about the recent birthing experiences of women in rural and remote areas. I have volunteered to take part in this study.

Procedures:

1. If I agree to be in the study I understand that I will be interviewed twice. Each interview will last about 1 hour and will be audio-taped. If I wish, a woman of my culture can also be present for the interview. During the interview I shall be asked about my birthing experiences, including where I gave birth, the choices available to me and how these affected me and my family.

2. If I agree to participate, I know that all my responses will be kept private. My real name will not be used in any reports or publications resulting from the study. I may have access to my interview data and may make changes to it if I wish. Information from the study will be kept in locked files and the interview tapes will be destroyed after 5 years. The investigator will consult me before publishing the results.

3. If I agree to take part in the study, I give permission to the investigator, Felicity Croker, to look at my medical records.

Possible discomfort:

1. In the unlikely event that a question may make me feel uncomfortable or upset, I understand that I do not have to answer the question if I prefer not to.

2. I have met the investigator, Felicity Croker. I know she is a nurse who can assist me with discomfort which may arise from the questions asked. A woman from my culture will also be present to support me if I wish. I can contact Felicity on (07) 47814909 (work) or (07) 47788373 (home) and leave a message on the answering machine if she is not there.

3. Participation in this study is voluntary. I know I am free to choose not to be part of this study. I understand that if I change my mind and withdraw, my information will not be used.

Involvement of others:

If I have a problem which is distressing me as a result of my birth, Felicity will obtain my consent before referring me to a culturally appropriate local person or an outside support group if necessary.

Benefits:

I understand that this study may not directly benefit me. However, the results will assist in identifying the specific needs of childbearing women in remote areas. This may contribute to policy changes that lead to a wider range of birthing choices for women in remote areas.

Costs:

I do not have to pay money to take part in this study and I will not be paid to take part in this study.

Questions:

I have had the opportunity to ask questions about this study and may contact Felicity Croker on (07) 47814909 or (07) 47788373 if I have any further questions.

Consent:

I have been given a copy of the consent form to keep.

I agree to participate in this study

I agree / do not agree to my medical records being viewed

……

(Date) (Participant's signature) (Name)

.....

(Date) (Investigator's signature) Felicity Croker

Appendix 9 Participant consent: Maternity care provider

James Cook University
Department of Psychology and Sociology

CONSENT BY A HEALTHCARE PROFESSIONAL TO PARTICIPATE IN A RESEARCH STUDY OF WOMEN'S PERCEPTIONS OF HEALTH DELIVERY SERVICES IN RURAL AND REMOTE AREAS

Purpose:

Felicity Croker, who is a nurse and midwife studying for a Doctorate in Sociology, wishes to learn about the recent birthing experiences of women in rural and remote areas. She is interested in the outcomes of health delivery services to Aboriginal and non-Aboriginal childbearing women in rural and remote areas. Felicity wishes to document the views of health professionals who live and work in these areas of North Queensland. I have volunteered to take part in this study.

Procedures:

1. If I agree to be in the study I understand that I will be interviewed twice. Each interview will last about 1 hour and will be audio-taped. During the interview I shall be asked about my experiences with local women who have given birth over the preceding year. This will include questions about where and how women gave birth, the choices available to them and the various roles of midwives and doctors in the care of women during the antenatal, intrapartum and postnatal period.

2. If I agree to participate, I know that all my responses will be kept as privately as possible. My real name will not be used in any reports or publications resulting from the study. I may have access to my interview data and may make changes to it if I wish. Information from the study will be kept in locked files and the interview tapes will be destroyed after 5 years.

Possible discomfort:

1. In the unlikely event that a question may make me feel uncomfortable, I understand that I can decline to answer the question I know I can contact Felicity on (07) 47814909 or (07) 47788373 if I wish to discuss the interview with her and can leave a message on the answering machine if she is not there.

2. Participation in this study is voluntary. I know I am free to choose not to be part of this study. I understand that if I change my mind and withdraw, my information will not be used.

Involvement of others:

If I have a problem which is distressing me as a result of my professional involvement with birthing women, Felicity will obtain my consent before referring me to an appropriate local person or an outside support group if necessary.

Benefits:

I understand that this study may not directly benefit me. However, the results will assist in identifying the specific needs of childbearing women in remote areas. It will also disseminate the views of healthcare professionals in these areas. This may contribute to policy changes regarding the role of the midwife and the healthcare provisions to birthing women in remote areas.

Costs:

I do not have to pay money to take part in this study and I will not be paid to take part in this study.

Questions:

I have had the opportunity to ask questions about this study and may contact Felicity Croker on (07) 47814909 or (07) 47788373 if I have any further questions.

Consent:

I have been given a copy of the consent form to keep.

I agree to participate in this study.

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(Date) (Participant's signature) (Name)

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(Date) (Investigator's signature) Felicity Croker

Appendix 10: Excluding the focus on Aboriginal women in remote areas as participants

This study was inspired by my experiences as a midwife working in a remote area, so I was keen to include Aboriginal women as research participants. Aware of the potential effects of my white, middle class background and because of exploitation by white researchers in the past, Aboriginal people were extensively consulted when I proposed and designed the study. These issues have been well addressed by the grandmothers of the Congress Alukra and in *Some good long talks* (Myles & Tarrago, 1992). Consistent with the NHMRC *Guidelines on research ethics regarding Aboriginal and Torres Strait Islander cultural, social, intellectual and spiritual property*, key Aboriginal women were invited to act as advisors and I agreed not to pry into or publish gender restricted information on traditional birthing practices. Support and approval to involve Indigenous women were sought and received from the Centre for Aboriginal and Torres Strait Islander Participation and Development at James Cook University and the prospective communities. However, although culturally appropriate protocols were followed, I reluctantly decided not to specifically recruit Aboriginal women for several reasons. First, adequate funding for research in remote areas that included the required Aboriginal 'research assistant' was not forthcoming. Second, although a widely accepted elder woman was prepared to take on this culture broking role, further cultural barriers emerged particularly in relation to 'truth' and trust.

Elder women were campaigning for birthing on the homelands. Young Aboriginal women who were potential participants were in the position whereby they were culturally bound to support the elders' views while in private conversation some talked about how they enjoyed the opportunity to go to the city for shopping, cinema and other experiences not available in their communities. This view contrasted to the disadvantage experienced by the women who were already mothers who faced separation from children and family. Issues of 'truth' emerged as it became evident that out of respect, participants would tend to say what they perceived elders wished hear. Consequently, some young women would have preferred to be interviewed by someone of their generation who understood their perspective but only an older woman was perceived as an appropriate research assistant by the community gatekeepers. In addition, within Aboriginal communities, knowledge is power. Women expressed a concern about "blabbing" if people from their own community were involved in interviewing or interpreting transcripts. Therefore, there was a possibility of limited disclosure. Finally, all information generated needed to be approved by elders in the community. Again this raised issues of confidentiality.

Community ownership of the data also meant that the findings considered private women's business may not be released. This had been the experience of a researcher studying postnatal depression in rural/remote Aboriginal women. Consequently, remote Aboriginal communities were not specifically targeted by this project. However, several Aboriginal women who were part of the general population in the selected towns volunteered to participate in the study. Their data has not been separated out from the findings to avoid creating a category of "otherness". Two Aboriginal birthing women's stories are included while two others represent the health workers.

Appendix 11Thematic lists for in-depth interviews

Thematic list: Birthing women

Clustered around a ‘P’ mnemonic

Personal:

- demographic background and relevant social history including age, cultural background, educational level, occupation and family relationships

Past:

- obstetric history including past pregnancies, parity, and previous experiences with health services

Present:

- current pregnancy (planned)
- birth – place, physical and psychosocial-emotional aspects
    - perceptions of available options (people present, pain management, positions, support …)
- post-partum experience - physical and psychosocial-emotional aspects

Perceptions of:

- maternity services,
- interpersonal relationships, and
- specific issues for rural/remote women throughout the childbearing experience

Thematic list: Maternity care providers

- Professional background
- Roles and relationships with birthing women
- Perceptions of issues identified as affecting the health and wellbeing of women of childbearing age in their rural/remote community

Appendix 12 Visual contexts: Field work photographs

12 a) Rural and remote milieu

Fieldwork images have been removed the digital version to ensure confidentiality

Fieldwork images have been removed the digital version to ensure confidentiality

Fieldwork images have been removed the digital version to ensure confidentiality

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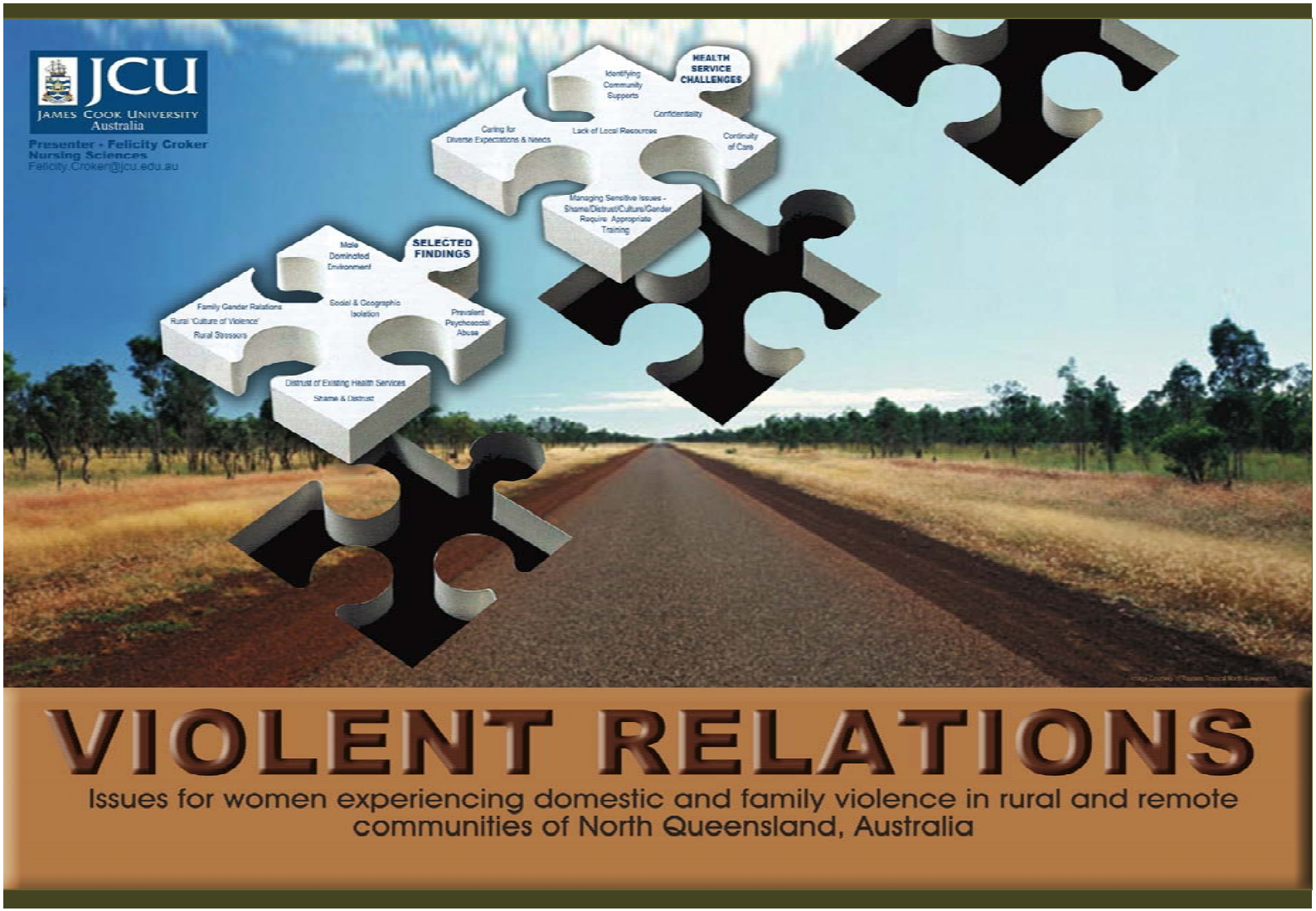
Appendix 13: Violent relations



Appendix 14: Summary of recommendations

On the basis of the research evidence, seven recommendations are made for future health policy and practices. Implementation of these recommendations potentially enables the effective and efficient delivery of quality maternity services.

Recommendation 1: Employing relational genograms

It is recommended that human resource managers and rural/remote health administrators regularly employ relational genograms as a diagnostic tool to identify and predict:

- interpersonal barriers to the provision of quality maternity services,
- consumer satisfaction, and
- negative occupational relations that potentially influence staff retention

Where problems are identified through relational modelling, early intervention and plans for resolution are then possible. Areas of strength can then be replicated and/or reinforced, thus improving the quality of maternity care.

Recommendation 2: Employing strategies that enable concordant relationships

It is recommended that maternity care providers adopt a concordant approach to their interactions with birthing women. To achieve this goal, health services should:

- provide maternity care providers with the knowledge and skills to effectively, honestly and respectfully communicate with birthing women
- ensure maternity care providers have unbiased information about the risks and benefits of available childbirth choices
- provide a safe, private environment that enables holistic assessment and confidential discussion.

Recommendation 3: Adopting a social model of maternity care

It is recommended that maternity services:

- adopt a more flexible, social model of care to enable rural/remote childbearing women to both make informed decisions and actualise their choices. Maternity care should be women-centred and decision-making both inclusive and collaborative.
- provide a model of care that also considers women's emotional, psychosocial and cultural safety when formulating strategies for risk management and quality improvement. This is a significant concern for birthing women.

Recommendation 4: Improving maternity practices and birthing experiences

Based on the research findings, the adoption of Hirst's recommendations are endorsed, as follows. Hirst (2005) recommends that Queensland Health should aim to:

4.1 improve maternity practices and build maternity services capacity by

- providing integrated, seamless and cooperative care across services
- recognising that care belongs to consumers and
- effectively engaging in a partnership model of maternity care

4.2 improve the birthing experience through new approaches to care and changes to existing approaches, including:

- reframing pregnancy education to prepare new parents for life post birth as well as for birth itself
- providing culturally safe environments (including access to women carers)
- providing environments of ease and calm for labour, birth and post birth care and
- providing post-birth care and a support network in the community that eases the transition to life as a parent.

4.3 facilitate women making decisions about their care, approaches and outcomes by:

- providing comprehensive, timely, independent and accessible information on all aspects of childbirth
- offering choices that enable a woman to give birth at ease with her environment, her attendants and herself (2005, pp. 52-54).

Recommendation 5: Providing appropriate services for women experiencing violence

It is recommended that maternity care services provide appropriate services for rural and remote childbearing women who are experiencing violence through the following strategies:

Maternity care services should

- recruit and retain well qualified (female) health professionals who are sensitive to the complex needs of rural childbearing women and competent in advising and supporting them.
- provide a therapeutic environment for women experiencing all forms of violence, which invites disclosure, provides validation and supports their decision-making.

Maternity care providers should

- receive the required professional development to enable them to effectively care for rural/remote women who experience abusive relationships
- adopt evidence based strategies for managing domestic and family violence in small communities
- provide effective communication through confidential, non-judgemental interactions and responsive caregiving. This would potentially build trust during therapeutic encounters and may facilitate women sharing their experiences of violence with a local health professional. To enable disclosure, maternity care providers need to move beyond the physiological focus and consider women's psychosocial and emotional wellbeing.
- advocate for women's issues and gender equality in rural fora rather than accepting the status quo and/or supporting hegemonic relations.

Recommendation 6: Adopting strategies that facilitate constructive professional interactions

It is recommended that maternity care providers:

- actively engage in constructive intra and inter-professional occupational relations. Within rural/remote settings, active professional 'boundary maintenance', gender violence and a spirit of *ressentiment* tends to be disruptive to care and destructive for individuals. Through employing a collaborative approach and positive expressions of power (enacted through discursive and non-discursive practices), it is possible to advance women's professional position.
- adopt a paradigm, such as the *Cultures of Care Continuum* (Figure 8.9), which allows for the complexity, reality and dynamism of practice in rural/remote maternity settings.
- avoid oppositional thinking in social and workplace interactions. Dichotomies and otherness are not constructive positions. Through contextualising issues, reflective practice and effective communication, it is possible to find common ground and develop positive relations.
- adopt a *modus vivendi* that will enable rival professionals with conflicting philosophies to work together for the greater good. Being prepared to compromise (even temporarily) allows time for disagreements to be managed in the short term while and constructive solutions to issues are explored.

Recommendation 7: Implementing strategies for inclusion

It is recommended that the professional education of rural/remote maternity care providers includes strategies for inclusion.

When entering a new context, maternity care providers should assume “otherness” and be aware of the social rules, which have been found to facilitate ‘belonging’. These include:

- Developing a community profile;
- Carefully assessing one’s personal and professional position;
- Networking
  - accepting social invitations from locals;
  - forming strategic relationships with decision-makers who may see a newcomer as a threat;
- Actively observing
  - corroborating information and forming one’s own assessments;
- Effectively communicating
  - actively listening;
  - conveying interest, awareness and empathy for people who perceive one as a threat;
- Being visible and familiar
  - informally engaging with locals in everyday situations;
  - volunteering with community groups (but not taking positions of leadership or control);
- Establishing credibility and competence but never positioning oneself as ‘superior’ or the ‘expert’;
- Reflecting on the impression made on others;
- Adopting a strengths-based approach;
- Pragmatically incorporating local ways (until evidence-based practices can be tactfully introduced);
- Developing reflective practice skills through journaling.