

*In Search of Dignified Maternity Care:*  
**An Exploration of Childbearing Women's Experiences of Midwifery Care in  
Victoria, BC**

by

Kara Jaime Peters Taylor  
B.A., University of Victoria, 2007

A Thesis Submitted in Partial Fulfillment  
of the Requirements for the degree of

MASTER OF ARTS

in the Department of Sociology

© Kara Jamie Peters Taylor, 2009

University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without permission of the author.

*In Search of Dignified Maternity Care:*  
An Exploration of Childbearing Women's Experiences of Midwifery Care in Victoria,  
BC

by

Kara Jaime Peters Taylor  
B.A., University of Victoria, 2007

Supervisory Committee

Dr. Cecilia Benoit, Supervisor

(Department of Sociology)

Dr. Karen Kobayashi, Departmental Committee Member

(Department of Sociology)

Dr. Christine St. Peter, Committee Member

(Department of Women's Studies)

## Supervisory Committee

Dr. Cecilia Benoit, Supervisor

(Department of Sociology)

Dr. Karen Kobayashi, Departmental Committee Member

(Department of Sociology)

Dr. Christine St. Peter, Outside Committee Member

(Department of Women's Studies)

## Abstract

This thesis is based on follow-up research from a project undertaken by my supervisor, Cecilia Benoit and colleagues (2007) entitled *Social Determinants of Postpartum Depression: A Mixed-Methods Longitudinal Study* (henceforth referred to as the “postpartum and health project study” -- PPHS). The PPHS examined the prevalence of postpartum depression amongst a diverse sample of mothers in Victoria, British Columbia. The main findings illustrate that the greater a woman's satisfaction with maternity care, the lesser her likelihood of postpartum depression. The group of participants with the least satisfaction was those who were transferred from midwifery care to obstetrical care. This group also had a lower mean income than other care provider groups, such as those who retained their midwives, pointing to the connection between socio-economic status and quality of care.

In search of dignified maternity care for all women, that is care that is respectful and autonomous, my research foregrounds the narratives of women who were transferred from a midwife to an obstetrician during their labour or birth (n=11). I examine the formal and informal support they receive, and interactions between health care practitioners and reasons for satisfaction or dissatisfaction with care. I also compare the experiences of women who were transferred from a midwife to an obstetrician with those who retained their midwife in the PPHS.

My findings indicate that both sample groups' satisfaction of care and well-being was due to feeling they had autonomy over the birthing process, adequate information from health care providers about medical and technological procedures, and support. The participants' who were transferred, however, were less likely than the group who retained their midwife to experience the above elements of care. Participants who were transferred said they felt invaded by unnecessary procedures and technology, which contributed to a decreased level of autonomy. However, both sub-samples were affected by a lack of multi-disciplinary teamwork in the hospital setting. This had more of a negative impact on participants who were transferred from a midwife to an obstetrician.

## Table of contents

Supervisory Committee	ii
Abstract	iii
Table of contents	iv
List of Tables	vi
Acknowledgements	vii
Dedication	ix
<b>1) Introduction</b>	<b>1</b>
<b>2) Literature Review</b>	<b>8</b>
2.1 The History of Midwifery and the Medicalization of Childbirth	9
2.1.1 The ‘Rebirth’ of Midwifery	16
2.2 Conceptualizing Motherhood Across the Life Course	18
2.2.1 Critically Examining the Life Course Perspective	18
2.2.2 The Ideology of Motherhood/Womanhood	20
2.3 Formal Care and Maternal Well-being: Support, Autonomy and Continuity	24
2.4 Comparative Analysis of the Organization of Maternity Care: The Netherlands, Australia, Sweden and Canada	26
2.5 Socio-economic Status and Access to Social Support	40
2.6 Summary of the PPHS	43
<b>3) Research Design and Methodology</b>	<b>47</b>
3.1 The PPHS: Design, Methods and Ethical Considerations	47
3.2 My Follow-up Analysis	49
3.2.1 Sampling Strategy, Access to Data and Limitations	49
3.2.2 Social Science and the Self: A Reflexive Feminist Approach	51
3.2.3 Methods: Thematic Analysis of Birth Stories	54
3.2.4 Data Storage, Disposal, and Ethical Considerations	57

3.3	Summary	58
<b>4)</b>	<b>Research Findings</b>	<b>59</b>
4.1	Maternity Care Disruption: Centering Marginalized Experiences	59
4.1.1	Feelings of Support, Autonomy and Adequate Information	60
4.1.2	Experiencing the Medical Model of Care	68
4.2	Comparative Analysis: Contextualizing the Marginality of Maternity Care ‘Disruption’ by Situating ‘Continuity’	84
<b>5)</b>	<b>Summary and Discussion</b>	<b>96</b>
5.1	Weaving Threads and Answering Important Questions	96
<b>6)</b>	<b>Conclusions</b>	<b>102</b>
6.1	Limitations and Future Research	102
6.2	Policy Recommendations	105
6.2.1	Lending Options for Collaborative Care	108
6.3	Concluding Thoughts	112

**List of Tables**

Table 1.	Direct Maternal Deaths in Canada (excluding Ontario) per 100, 000, 1979-1999	14
Table 2.	Selected characteristics, study population compared to the Victoria Census Metropolitan Area	43
Table 3.	Mean income, maternity care provider, depression and birth outcomes	45

## Acknowledgments

First, I would like to revere the extent to which the administration staff in the Department of Sociology has made my life so much easier as a result of their extremely hard work on a daily basis. Zoe, Carol, Ronna and Tara (who is no longer in Sociology) – I couldn't handle the administrative work that goes into our department to save my life. What would we all do without you?

I would like to thank the women who participated in the PPHS and who told their countless personal stories from which this research is based. I would also like to thank the funding bodies that made it possible to do research and have a family: The Canadian Institute of Health Research, The University of Victoria, and Cecilia Benoit, who always had work waiting for me when I needed it.

Thank you, Sociology graduate student colleagues. So many of you helped through this process as counselors, editors and friends. I must extend special acknowledgements to my thesis group members, *Lisa Poole* and *Eli Manning*, who gave unwavering support and always took me to task when needed. They have taught me a lot personally and professionally, lessons I take onwards with *pride*; and *J.P. Sapinsky* who has always been a welcoming confidant and a fountain of encouragement.

I would like to thank the members of this thesis committee for their support and flexibility throughout this process. I value the contribution of each member who came at this project from diverse, yet complementary points of view. Thank you, Karen McKinnon for taking the time to be an external reviewer and, Christine St. Peter, for keeping me on track with the creativity of my writing. Thank you, Karen Kobayashi, for helping me hone my ideas from the beginning and for teaching me the value of a thesis group. Lastly, I would like to thank my supervisor, Cecilia Benoit, for lending me her influential research from which I worked; for encouraging me from the funding application process and beyond; for teaching me how to write academically; and for always understanding my familial commitments.

Thank you, Mom. You are my first taste of academia and of feminism. You have taught me strength, creativity and survival from the moment I was born. I have learned from the presence of a brilliant mother that I can be who I am today without apology. Thank you for dedicating your thesis to me as a child. I may not remember it, but it left an imprint just beneath the surface, one that continues to lead me through my studies knowing that I too can be a working mother. Dad, you are my logics and practicality. You have kept me grounded when my emotions were floating me away. Your silent encouragement through small details never goes unnoticed. Above all, I know how proud you are of me and this helps to keep me going; you cannot hide the tears in your eyes.

For my husband, I thank you for being my partner and confidant. You have always supported everything I have pursued and you continue to amaze me with the love you have for me. Without your massages, your shoulder to cry on and the constant knowledge that you could take over the house and children whenever I needed you to, I would not be where I am today. I appreciate the way at times you have put me together again, and how because of you I am accessible when I speak, regardless of being a graduate student.

Thank you for teaching me how to break through my shyness and my walls to make connections with people. Your undying kindness and friendliness has partially helped shape my brighter outlook on life.

Lastly, but certainly not least, I would like to thank the inspirations for my interest in this area of research- my children. Thank you, Lucia, for your intensity and creativity- you are a vision. Thank you, Max, for making me your other mommy and for teaching me about the logics of life. Finally, my baby Keelin, thank you for your humour and affection in every situation, no matter how tornado-like. I grow with you all.

*This thesis is dedicated to my little ones. Dare to dream big...*

*-Max, Lucia and Keelin-*

## Chapter 1: Introduction

*Birth.* Babies have been born all over the world since the beginning of humankind. Women giving birth are a constancy. For those of us who *choose* to and are able to have children, there is a thread of similarity that ties us together no matter our geographical place, race or class. When embarking on the journey of developing a topic for my MA thesis, I developed an interest in maternity care. It is this thread, this connection that drew me into this research area. My own experiences of birthing children, as well as my research interests, were inspired by my personal life, and served as an impetus to unravel the narratives of women around me who had also experienced giving birth.

On the street, in classes or coffee shops, on buses, at parties, or at my husband's place of business -- wherever I mentioned that I was interested in doing research in the field of maternity care, women who were mothers would tell me the story of their birth in relation to the care they received. Because these stories came pouring out of them without prompting, I realized that women had a great deal to say on the subject, which is something that I could not ignore. Questions began to formulate in my mind; regardless of the commonality of birthing, how does the organization of maternity care differ from place to place? How do differences within and across maternity care systems affect the women who utilize the system, such as their emotional well-being, their health or their ability to parent? Equally important, since income levels affect all aspects of our lives and because women represent a disproportionate amount of the poor in Canada and many other countries (Reid, 2008; Esping-Anderson, 2007), how does this disparity shape

women who are giving birth? How does my own home province of British Columbia fare in delivering dignified maternity care, and finally, how can we contribute to creating a system that benefits women equally?

My thesis examines the experiences of lower income women who have been transferred from the professional care of a midwife to obstetrical care due to a medical imperative, such as a C-section. I centralize these women's experiences as they are the most marginalized group of women in a larger project undertaken by my supervisor, Dr. Cecilia Benoit, entitled *Social Determinants of Postpartum Depression: A Mixed-Methods Longitudinal Study* (henceforth referred to as the "postpartum and health project study" -- PPHS), the relevant findings of which will be presented later in this thesis (Chapter 2). For now, it is useful to know that the PPHS aimed to investigate the association between women's socio-economic status, the organization of maternity care services, and women's satisfaction with the care they received across the childbearing period. The study examined maternity care from both physicians and midwives, as well as the prevalence of depression and general health among new mothers. I further build on the PPHS by drawing comparisons between participants who retained their midwives throughout their care and women who were transferred from a midwife to an obstetrician, in order to better understand the strengths and weaknesses of the current organization of maternity care in British Columbia.

Due to my experiences of meeting women who have so many vivid and rich stories to tell regarding the births of their children, I am most interested in working with birth stories. I am also interested in examining the organization of other maternity care systems whose welfare states are comparable to Canada's in order to answer the

following central question: “How can we create a more *dignified* maternity care system in British Columbia?” In other words, the rationale for my thesis is to support and illustrate what *dignified* maternity care entails. I am using Benoit and Hallgrimsdottir’s (2008) definition of dignified maternity care as a patient’s right to “receive care, high quality of care and continuity of care” (8). Quality of care then maintains that recipients have “respect, privacy, [and] autonomy” (*ibid*). Dignity in maternity care then goes beyond the biological, “locating...[women’s] bodies in the context of [their] lives” (Stewart et al., 2008: 4). While analyzing the narratives I look at how types of *formal* care (i.e., paid), such as midwifery and obstetrics, contributes to receiving quality maternity care. I also study *informal* care (i.e., unpaid); for example, how family and friends contribute to a dignified maternity care system. The interactions between the two types of care, formal and informal, are also of importance to this study.

My intention is to contribute to a body of knowledge in health research that recognizes the myriad ways in which social, political and economic structures influence the way we relate to the world, and how the world relates to us. I write my thesis with the intention and hope that it will benefit the health of birthing women, especially those marginalized by having a lower-income and experiencing midwifery care disruption. As I examine how the organization of the maternity care system in British Columbia influences women’s experiences of care I also reflect upon the questions:

- 1) How do the experiences of women who were transferred to an obstetrician compare to those who retained their midwives?

- 2) Are *formal care* and *informal care* equally salient to increasing social support for these women?
- 3) Does the structure of *formal care* in the hospital support *informal care* during the birthing process for these women?
- 4) Are women in this study affected by an over-medicalization of childbirth? If yes, how so?
- 5) How do medical practitioners work together while in the hospital setting (i.e., midwives, obstetricians and nurses)?
- 6) How can we make policy recommendations that help women to garner high rates of satisfaction with midwifery, whether there is obstetrical involvement or not?
- 7) Do findings support options for collaborative care, and if so, what would that type of care look like?

My thesis attempts to answer these questions and no doubt raises a few more for the reader in the process. In Chapter 2, I first situate my thesis within a historical context in order to better understand the research findings. This context begins with a history of traditional midwifery practices and the increased medicalization of childbirth in the modern period. It is important to understand the history that contributes to the tensions that still occur in the hospital setting between midwives and obstetricians. It is also important to draw parallels between the European witch-hunts in the 15<sup>th</sup> century, the further medicalization that occurred with Enlightenment, and the more recent disputes

between physicians and midwives. This history, as well as a more recent resurgence in midwifery, may provide insights into the integration of midwifery into the medical system in British Columbia.

In Chapter 2, I also examine how the life course perspective can contribute to my analysis by recognizing that the moment of childbirth is a complex life-changing process that is embedded in social, political, cultural and economic structures (Buchman, 1989; Treloar, 2007; Cohen, 1987). I then point to how gendered ideologies of womanhood and motherhood affect women's birthing experiences. Next I outline the dominant themes emerging from my review of the maternity care literature -- i.e., continuity, social support and autonomy over the birthing process, elements which have been deemed necessary to create the most dignified maternity care system. This is followed by a description of the organization of maternity care services in the Netherlands, Australia, Sweden and Newfoundland/Labrador. My intention in presenting this overview is to highlight alternative ways to care for pregnant women that differ from British Columbia's maternity arrangements, in an effort to recommend changes for our system. In the final section of Chapter 2, I underscore how socio-economic status affects every aspect of women's lives, and how women are affected disproportionately in terms of poverty. I connect having a lower-income to the accessibility of dignified maternity care. Finally, I will present the findings of the PPHS that are most relevant to my thesis research.

Chapter 3 describes the methodology used for the PPHS. This includes sampling, location and ethical considerations. I then describe my selection of a sub-sample of the PPHS and present my analytical techniques. The following section grapples with the theoretical lens and the methodology I employ to analyze the birth stories of women in

my sub-sample. Finally, I examine the ethical considerations for my thesis research, including storage/disposal of data and Tri Council Ethical Approval.

The research findings are detailed in Chapter 4, which includes important and recurring themes that were echoed in the literature review and the PPHS, as well as the emergence of themes that I had not anticipated prior to analysis. First, I centralize the experiences of midwifery care disruption in order to discern the voices of women who are most marginalized in the PPHS study. I also discuss the emerging themes relating to participants' experiences of birth. The themes that most contribute to positive birthing experiences are support, information, and autonomy, while an absence of this contributes to more negative birthing experiences for participants. I also examine both formal and informal support, and how they interact within the hospital setting. I discuss as well the presence of alternative health practitioners as another form of support. In the next section of Chapter 4, I discuss emerging themes that come out of participants' experiences of a medicalized childbirth. I outline the relationships between health practitioners, such as midwives, obstetricians and nurses, as articulated in the narratives of participants. I acknowledge how participants say that they both benefit from the cooperation of their health care professionals and are negatively affected by unnecessary tensions. I also point to the ways in which health practitioners work together successfully according to participants' observations. I then detail the emerging themes of participants' experiencing a medicalized childbirth such as feelings of vulnerability, invasion and fatalism. In the final section of Chapter 4, I situate the experiences of women who were transferred from midwifery care to obstetrical care by drawing comparisons to the group of participants from the PPHS who retained their midwives. My aim is to present a more balanced

approach in my analysis by cross-referencing participants' experiences of the organization of maternity care who retained their midwives and who had a higher mean income as a group than those who were transferred from a midwife to an obstetrician.

In Chapter 5, I summarize the main findings of this thesis and discuss them in light of the central themes found in the literature on the sociology of maternity care. In Chapter 6 I discuss the limitations of this thesis and implications for future research. I also make tentative suggestions for maternity care policy change in British Columbia. These suggestions are based on how other countries have organized their maternity care systems and the kind of care women want, i.e., themes that were present in the narratives of the women in PPHS, as well as the realities of economic inequalities that take into account the larger social organization of society, in order to promote healthy pregnancy and birthing from the beginning.

## Chapter 2: Literature Review

In this chapter I outline the sociological literature and theoretical underpinnings that are most relevant to my thesis findings. Situating my sociological analysis between two central arguments in the maternity care literature, I summarize a feminist analysis of the history of how the birthing process shifted from the domain of women healers to how birth became medicalized. I also acknowledge that advances in obstetrical technology have had many positive results for birthing women, and problematize the simplistic view of medicalization by presenting evidence on maternal requested C-sections. This is followed by an examination of the resurgence of midwifery concentrating mainly on Canada, and all of its key players.

In the next section of Chapter 2, I examine the theoretical framework the life course perspective (LCP), which addresses key moments in people's life trajectories that most impact their lives. I conceptualize the ideologies surrounding motherhood, womanhood and self, and how this impacts childbirth; connecting childbirth as an integral moment in the participants' life trajectories to the societal ideologies that shape them. I then outline some common themes in the literature concerning factors that promote healthy birthing experiences for women. Following this, I comparatively analyze the organization of maternity care in Europe and Canada to explore what other countries with similar welfare states to Canada are doing.

In the final section of Chapter 2, I focus on British Columbia and discuss how income affects women's ability to access social support and to receive dignified

maternity care. Finally, I present a summary of the *Post Partum Health Study* (PPHS) findings that I have used for my thesis in order to best contextualize my research.

## **2.1 The History of Midwifery and the Medicalization of Childbirth**

The history of midwifery and the rise of the medicalization of childbirth are important to know given that the current relationship between midwives, the hospital and physician led obstetrics is partially steeped in the colonization of midwives' knowledge of birth and healing. I acknowledge these histories, to inform the present interdisciplinary rivalries that exist in the hospital setting. It is important to point out from the outset that it is not medicine per se that is being critiqued in the following sections, but the *medicalization* of the processes of pregnancy and childbirth.

Scott and Marshall (2005) define medicalization as:

[T]he spread of the medical profession's activities, such as their increasing involvement in the processes of birth... Greater power is usually assumed to follow increased pervasiveness. For that reason, the term may also be used to imply expansionist, imperialist strategies (400).

Medicine has, and will always have, a valuable role to play in pregnancy and childbirth, especially for women who have more complications during their childbearing period. However, the over-use of medicine and technology inherent in medicalization has had effects both historically and contemporarily, and it is this that is of sociological interest.

In most past and many contemporary societies, the midwife has played a valuable care role in pregnancy and childbirth. For thousands of years women were the only non-familial birth attendants. Lay healers, women who had no formal university education in medicine, learned about birth and illness by sharing information with other women as

they traveled from community to community (Ehrenreich et al., 1979). This apprenticeship model of learning was integral to traditional practices (Benoit, 1991). Midwife-healers were also more likely to know the languages of immigrant women, and were often paid with food and services (Ehrenreich et al., 1979; Benoit, 1991). The knowledge of herbs and physiology was also very central to the practice of lay midwifery. This differed from the introduction of the physician “who hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity” (Ehrenreich et al., 1979: 34).

Beginning in the 15<sup>th</sup> century, the Catholic Church led witch-hunts across Europe, from Germany to England (Ehrenreich et al., 1979; Patel et al., 1997). The witch-hunts claimed approximately 50,000 European lives, most of whom were women, eradicating many forms of knowledge (Lemieux, 2007). Of the thousands of women to be burned at the stake as witches, many practiced as midwives to the women in their local communities (Ehrenreich et al., 1979; Patel et al., 1997). One of the aims of creating the myth of the witch-midwife was to control women’s role in medicine and allow university trained male physicians to monopolize childbirth attendance (Oakley, 2000; Ehrenreich et al., 1979; Ehrenreich et al., 1973; Cassidy, 2006). Adding to an attempt to control women’s autonomy in general, the witch-hunts were used as a vehicle to erode the power of individual women over the birth of their children.

The Enlightenment period, characterized as the time in which reason and science replaced the Church’s held values of faith and morality, further expanded the role of medicine in childbirth (Patel et al., 1997). The body was no longer seen as organic but as machine, and this metaphor pervaded maternity care (ibid). However, regardless of

attempts to eradicate midwifery throughout the witch-hunts or Enlightenment, midwives still continued to attend the births of those without financial means. Physicians became the norm for higher-income women, while midwives tended to immigrant and poor women (Ehrenreich et al., 1979). This illustrates both a class and cultural component of the expansion of physician-led childbirth attendance. Midwifery was never completely eroded, however it was eroded as the *norm* in many places. The extent to which physicians expanded their reach was largely dependent on geography; indeed, midwifery still flourishes as a cultural practice in many European countries today (Declercq et al., 2001; McKay, 2000; Van Teijlingen et al., 2000; De Vries, 2004; Benoit et al., 2005).

In fact, the history of the erosion of midwifery and the medicalization of childbirth has its roots largely in the United Kingdom, the USA and Canada. According to Shroff (1997), “it is estimated that midwives deliver approximately 80% of the world’s babies” (15). Canada lags behind in respecting midwifery and publicly acknowledging its importance (*ibid*). Although the medicalization of women’s bodies in general is intertwined with western imperialism, it follows that many countries around the world with traditional birthing practices are still affected by the dominance of the medical model of childbirth. However, in many poor areas of the world, doctors are reserved for rich and urban women. The entanglement of race, class and location in the world largely makes an impact on an analysis of birth, something I do not have space for in this thesis, but is more than noteworthy.

When examining the history of midwifery in Canada it is important to acknowledge ancient beginnings. Indigenous midwifery practices, in the territories we now call Canada, have existed since the beginning of human inhabitation. European

midwives also brought their own traditional ways to this land during colonization (Shroff, 1997; Malik, 2004; Davies, 2000). According to Davies (2000), colonizers saw medicine as “a heroic and masculine enterprise and one closely linked to the spread of European culture and values” (*ibid*, 74-75). The colonization and erosion of Indigenous ways, including midwifery, are also of vital importance for research in Canada. Unfortunately, space does not allow me to deal with the topic in detail. Please see *A Path Towards Reclaiming Nishnawbe Birth Culture* (Couchie et al., 1997) as an example of this scholarship.

*Two Sides of the Same Coin: The Complexities of Obstetrics in Women’s Lives*

In order for physicians to corner the “market of childbirth” and spread their cultural values of medicine and Enlightenment, they had to systematically instill the image of the witch in every person’s consciousness. This was something that was transferred from early modern Europe to North America and still, “the witch hunts left a lasting effect: an aspect of the female has ever since been associated with witch, and an aura of contamination has remained, especially around the midwife...” (Ehrenreich et al., 1973:4). Pregnancy and childbirth were pathologized by medicine and as a result medicine began to take over, which consequently rendered pregnancy and birth more dangerous. In other words, as obstetricians eroded the practices of midwifery as the norm for all women in North America, childbirth became medicalized, actually increasing illness and death through its practices. For example, the introduction of the forceps, touted as the greatest obstetrical advance, actually increased maternal mortality rates in countries such as Britain (Oakley, 2000: 322). In the early 1900s in New York City, doctors’ mortality rates were 3.5 higher than midwives, a trend that was echoed across

North America and Europe (Oakley, 2000: 322).

According to Oakley (2000) the field of obstetrics has often lacked a scientific basis for its practices and/or for its opposition to midwives, regardless of their arguments that obstetrics was based on scientific research. Rice (1997) echoes this claim, asserting that this is still the case today. She argues that obstetrics is “the least scientific of the medical specialties and the least likely to abandon practices which have not been shown to be of benefit” (174). According to Busfield (1987), research concerning the medicalization of maternity care has also:

[E]mphasized the negative aspects of women’s experiences of being pregnant and giving birth: their sense of alienation and distress when faced with the bureaucratic structures of the hospital and an impersonal, interventionist medical profession which makes frequent use of strategies as inductions, [C-sections], and episiotomies (77).

Medicalization has made women doubtful of their own knowledge because of the authority of the male “expert”. According to Ann Oakley (2000), women have become fractured bodies characterized by illness and medical functioning. In short,

The rise of obstetrics and its eventual dominance over midwifery was thus achieved in part by the argument that those who care for childbearing women can only do so properly by viewing the female body as a machine to be supervised, controlled and interfered with by technical means, science, or reason... (Oakley, 2000: 323).

On the other hand, research has illustrated that access to medical technologies during childbirth have contributed positive outcomes for women and their families. For example, when Medicare was adopted in Canada in the early 1970s, women gained

access to free hospital and physician care, which contributed to some degree to reduced mortality and morbidity rates (Benoit et al., *forthcoming*) (see Table 1).

**Table 1: Direct Maternal Deaths in Canada (excluding Ontario) per 100, 000, 1979-1999**

**Source: Canadian Perinatal Health Report. 2003.**

<b>Cause</b>	<b>1979-1981</b>	<b>1985-1990</b>	<b>1991-1996</b>	<b>1997-1999</b>
Complications in labour and delivery	9.5	1.4	3.5	1.6
Hypertension	6.1	8.9	4.9	1.6
Interpartum hemorrhage	3.4	2.7	4.9	1.6
Postpartum hemorrhage	4.1	3.4	1.4	1.6
Pulmonary embolism	6.8	3.4	9.1	6.3

The use of C-sections is also a complex issue. The most common reason for a C-section is ‘failure to progress’, which means that the fetus is taking too long to emerge, risking brain damage due to lack of oxygen (Cassidy, 2006). Another more controversial reason is because of the use of electronic fetal monitors (EFM). Fifteen percent of all C-sections are performed because of EFM readings (Cassidy, 2006: 120-121). Borrowing from technology developed by NASA, the EFM replaced the simple hand-held fetal stethoscope to monitor the fetus in the hopes of preventing birth-related brain injuries

(Cassidy, 2006: 120). Many critics of this technology, including many doctors, remark the EFM is often inaccurate. Contrary to the original hypothesis, evidence is mounting that incidents of brain injuries such as cerebral palsy have not been reduced with the use of EFMs (Busfield, 1987; Oakley, 2000; Rice, 1997).

Although it can seem straightforward, the use of the C-section gets further complicated in recent history. According to research by Bourgeault et al. (2008), the same rhetoric of the alternative health movement that lobbied for the demedicalization of childbirth (i.e., choice) is now being used to support the ‘choice’ of medical interventions such as the C-section. Women are becoming ‘consumers’ in childbirth; especially higher-income women who are choosing to have C-sections rather than go through the natural process of birth (*ibid*). This cannot be seen as an individual choice entirely. Bourgeault et al. use Frank’s (2002) framework for understanding health and illness to take into account micro, macro and meso levels of maternity care consumerism and maternal requested C-sections (Bourgeault et al., 2008: 107). In other words, women are making a ‘choice’ that is based on societal expectations - i.e., the lasting effects of the medicalization of childbirth.

In cases where C-sections are warranted, the procedure no doubt saves the lives of women and infants. However, with the increased uses of unnecessary technology, there are many C-sections performed without clear cause, and it is sometimes difficult to disentangle whether the procedure is warranted or not. Beyond the potential dangerous effects of the C-section during childbirth, the regular post-surgery needs of women can lead to an increased rate of postpartum depression (Benoit et al., 2007) and bonding with their new babies (Atkins, 1998). I return to this topic in Chapter 4.

Before moving onto the next section I feel that in examining the history of midwifery and the medicalization of childbirth, it is very important to not forget that although all women suffered, and continue to suffer, from the medicalization of childbirth, poor women have suffered disproportionately. Such procedures and technologies such as obstetrical forceps and C-section techniques were honed through obstetrical experimentation on poor and slave women, many of who lost their lives (Cassidy, 2006). Also, although there is a rise in maternal requested C-sections for higher-income women, obstetrical intervention is still overwhelmingly a poor women's problem (Benoit et al., 2007).

### ***2.1.2 The 'Rebirth' of Midwifery***

Even though there were many forms of knowledge that were eradicated by the witch-hunts and the expansion of medicine into childbirth as outlined above, midwifery has never been completely eroded. There has always been, and continues to be, lay midwifery practices around the world, including North America. What did occur, as outlined in the previous section, was that the medicalization of childbirth became the norm in general throughout North America. The agency of women must be keenly recognized, however, in reclaiming birth as a natural process and a healthy event generally in Canada as well. Partly due to a demand for more humane birthing experiences, "midwifery is experiencing a rebirth" (Shroff, 1997: 17). Midwives, along with consumers' demands for healthy birthing practices, have used the women's movement to lobby the government for the regulations and recognitions mentioned above, with important successes in some provinces and territories.

Along with women's growing disillusionment with obstetrics, there has also been some erosion of the power of Western medicine (Shroff, 1997: 17). Aboriginal peoples of Canada are reclaiming their ancient practices in contemporary initiatives all over the country (Benoit, 2006; National Aboriginal Health Organization, 2008). This not only questions the power of Western medicine, but challenges frameworks of colonization as well.

In combination, many Aboriginal and non-Aboriginal birthing women and midwives are in search of more natural ways to give birth and to limit problems of over-medicalization. This has led to an expansion of other health practitioners in Canada that support the proponents of a less interventionist style of childbirth, such as traditional Chinese medical practitioners (TCM), doulas, chiropractors and traditional Aboriginal midwifery. A few of these so-called 'alternative' health practitioners have emerged in the narratives for this thesis as an important part of the birthing experience for many participants (see Chapter 4).

This has also led to the regulation and integration of midwifery in many provinces across Canada. Although Canada has a publicly funded universal health care system (Medicare), Canadian maternity care differs greatly across the country, especially concerning the access of non-medical health professionals, such as certified midwives. The legislation and regulation of midwifery varies from place to place. In Ontario, British Columbia, Alberta, Quebec, Manitoba and Saskatchewan and the Northwest Territories, legislation for midwives' integration into the health care system exists (Benoit et al., *forthcoming*; Wrede et al., 2001:44). Although Saskatchewan has legalized midwifery practice, there has been no public funding provided to utilize such services.

Currently, Ontario, Quebec, Manitoba, British Columbia, Alberta and the Northwest Territories publicly fund midwives (Benoit et al., *forthcoming*); however, the Manitoba system differs in that midwives can be either funded publicly or they can choose to practice privately and charge a fee for course of care (Wrede et al., 2001:44). Quebec has also introduced another birth setting choice for women. In Quebec, midwives mostly practice in a birthing centre, while the province does not fund home births (Benoit et al., *forthcoming*).

## **2.2 Conceptualizing Motherhood Across the Life Course**

From the history of midwifery and the medicalization of childbirth, the ideologies that contributed to how *midwifery* is viewed today become apparent. Let us now look to the ideologies that inform the way we look at the birthing woman; the *mother*. To aid in this shift from the midwife to the birthing woman, I outline how the conceptual framework of the life course perspective (LCP) can be used in a critically engaged way to examine women's experiences of the resurgence of midwifery, and the 'new' midwifery's relationship to medicine. I also make clear the social, political, economic, and cultural institutions that come into play during the important, life changing moment of birth.

### **2.2.1 Critically Examining the Life Course Perspective**

The LCP is a mode of social inquiry that takes into account the impact of meaningful moments over a person's life trajectory. It is important to note that people have more than one trajectory (i.e., health, relationship, family, work and so forth). Buchman (1989) describes the life course as "consisting of institutionalized sequences of

events, positions and roles which shape the individual's progression in time and space" (43). In other words, cultural expectations incorporate a social identity that underlies each life stage. The LCP can be used longitudinally, but for the purposes of this study, I will use it to look at a specific point in time that holds meaning for participants -- the processes of pregnancy and childbirth. Within this short-term application of the LCP, "transition is explored with primary attention given to the course of the transition itself" (Treloar, 2007: 8).

It is important to examine the life course in a critical way, given that the life course itself is socially constructed. Therefore life course stages have not been, nor will they ever, remain fixed in terms of length or meaning. As a theory, social scientists are constantly changing their definitions of what a life course entails (Cohen, 1987). Using the LCP as a tool is very useful in examining specific contexts and stages in people's lives, but it must be situated within unequal and ever changing social systems. Viewing a person's life course trajectory as programmatically laid out due to social patterns can often erase the differences and marginalities in people's lived experiences. Doing so also assumes a fixed social system and glosses over the "more flexible biographical patterns within a continually changing social system" (Cohen, 1987: 1). As a social scientist, I intend to use conceptual frameworks, as Cohen (1987) has, in complex and context specific ways. I do so to better understand that a person's socio-economic status, among other things, greatly affects the way he/she moves through life and the length of their life stages because "[the] impact of extreme material inequalities influence experience throughout the life course" (Cohen, 1987: 5).

Therefore, I must take into account the ever-present social, political, economic, and cultural contexts that interact with people's experiences and subjectivities when using the LCP as a guiding tool. Integral to the practice of critically negotiating the LCP within the context of people's lives is the recognition that gender, for example, is created and perpetuated through everyday interaction (Goffman, 1987). Gendered ideologies affect the way participants navigate their lives, including for many women ideologies of motherhood (Cohen, 1987; Hammer, 1996; Bailey, 2001; Bailey, 1999; McMahon, 1995), as will be discussed in the following section.

### ***2.2.2 The Ideology of Motherhood/Womanhood***

Even though paid employment is important for many women's independence and identity, motherhood remains also a pivotal point of gender identity for most women, in the same way as paid employment is for men. Both are viewed as a point of entrance into adulthood (Cohen, 1987; Hammer, 1996; Bailey, 2001; Bailey, 1999; McMahon, 1995). In Bailey's (1999) study on motherhood, "motherhood acted as a narrative pivot in the construction of a reflexive biography" (Bailey, 1999: 351). Participants in her study connected becoming a mother not just with adulthood but also with womanliness and viewed it as an achievement (Bailey, 2001: 116). Furthermore, Bailey's study (1999) found motherhood to be linked to increasing feelings of self-worth for women. The ideologies of womanhood and motherhood are often so intertwined that women are not seen as complete adults unless they become a mother. Woman's primary responsibility is still seen as 'mothering'; even those who are childfree are actively defined against this role (Bailey, 1999: 337).

McMahon's (1995) study on first-time motherhood of middle and working class white women illustrated similar patterns of the entanglement of motherhood, womanhood and self. The process of gendering based on biological difference that has shifted throughout history (McMahon, 1995) has a particular impact on women's bodies:

The biologization of bodies (and gender identities) was particularly coercive in its application to women, as their reproductive capacity became defined as the essence of their personhood and nature. Motherhood was constructed as the expression of women's natural, social and moral identity (McMahon, 1995: 24).

Motherhood became a dominant cultural script that affects all women through what McMahon (1995) deems the "cult of true womanhood" which is closely associated with domesticity (28). While the failure to become a mother is relegated to incompleteness as a woman, those who become mothers are always haunted by the "shadow images" of bad mothering (McMahon, 1995: 29). In McMahon's study (1995), participants saw motherhood as a catalyst for transformation, revealing their "real self" (158). In other words, one does not merely give birth to babies, but to themselves as well.

Similarly, Bailey (2001) notes, "...both [the body and woman] are constituted through discourses and practices of which gender is a part, although certain practices may be facilitated or discouraged by certain material realities" (111). Discourses of motherhood contribute to identity formation for women, which put pressure on women to succeed at the onset. Why, then, are gendered ideologies and discourses of motherhood and womanhood important for this thesis? Taking my cues from the LCP and the research detailed above, childbirth is a self-defining, life changing moment; the aforementioned pressure of gendered discourses and ideologies occurs through motherhood, which for

many women is introduced through childbirth. Women are often positioned within competing discourses (Bailey, 1999: 335) of motherhood, femininity, and womanhood. For pregnant women, the discourse of passivity as a feminine virtue is often irreconcilable with the expectations of autonomous decision-making and control over their birthing experiences. In other words, in North America, discourses of individualism and choice are prevalent (McMahon, 1995), yet the expectation of selflessness as conceptualized within the ideology of “good motherhood” (*ibid*) is in direct conflict with the rhetoric of individualism.

Childbirth is a specific moment in time when women can enter motherhood, which makes it a “significant life transition” (Busfield, 1987; Burgoyne, 1987). For women who experience a negative birthing experience this is “exacerbated by other problems generated by poverty, poor housing, and social isolation” (Burgoyne, 1987: 50). It is easier to have agency and resist the impact of contrasting discourses when you have relative power due to a higher socio-economic status (Bailey, 1999: 347).

Especially for first-time mothers, motherhood is like entering a new world (Bailey, 1999: 347; Fox and Worts, 1999). If birth is a porthole to a whole new world, what happens when one’s first experience of this world is tainted by negative experiences? How does having a lower-income further impact these experiences? If motherhood is constructed as the way to become an adult, a complete woman, and a way of achieving self-worth, we can only speculate the amount of pressure it places on women. If birth is the moment in which women enter this ‘new world’ of motherhood, and this world incorporates discourses of “good” and “bad” mothering and femininity, this would certainly add to the pressure. The “shadow image” of failure as a mother seeps

into women's experiences, then, from the beginning. This may limit autonomy in the birthing process by planting a seed of doubt in one's own abilities to make informed choices concerning medical technologies and procedures. To have a birth experience synonymous with previously held ideologies such as self-sacrifice, individualism, completeness and achievement is hard to live up to.

To summarize, when utilizing the LCP to analyze experiences of childbirth, it is important to be careful that one does not perpetuate gendered ideologies that attribute incompleteness to women who do not follow a trajectory that includes motherhood. It is also important to be aware of the discourses that influence the way that women view themselves at this pivotal point in time of becoming a mother. This occurs also for women at the point in their lives when they do *not* become a mother, whether by choice or situation. There are numerous biographical experiences and contexts, as well as dominant societal discourses and ideologies, and these impact life transitions such as birth. Women navigate their way through a web of their own history and socialization to claim their own experiences. Women experience phenomena "in terms of their own situated but interactive relationship with their social worlds and the material and cultural resources available to them...they engage, rather than merely express, the circumstances of their existence" (McMahon, 1995: 29). It is fruitful then to seek out moments in which women's agency within childbirth is always present- whether this presence is fighting or merely lingering.

In the following section I explore the elements that may need to be in place for women to have positive birthing experiences in order to promote a better introduction to motherhood, as well as for women to exercise agency in the child birthing process.

### **2.3 Formal Care and Maternal Well-being: Support, Autonomy and Continuity**

According to the literature on childbirth, women's well-being is closely connected to satisfaction with their maternity care. An "ethos of care" (Morgan et al., 1998: 82) contributes to feelings of satisfaction – i.e., encouragement and friendliness, therefore, interpersonal formal support is integral to the well being of women. Tinkler et al. (1998) state that the nature of a positive midwife-woman relationship has central importance in influencing autonomy, support, and satisfaction and that this importance has gone unrecognized in the literature. In other words, "positive relationships [with caregivers] facilitated conditions which influenced satisfaction with care" (Tinkler et al., 1998: 32), and those without the opportunity to see a midwife several times were unable to build a good relationship with their caregiver.

Midwives, compared to physicians, are more likely to foster a more adequate client-caregiver relationship, including partner-caregiver relationships (Tinkler et al., 1998). This is due in part to the structure of maternity care in Canada and the contention that midwives' practices include a more client-centred approach with more time allotted to each person. The type of care that fosters an environment in which a positive relationship can form between the women and her health practitioner is one that is continuous – i.e., care throughout the pregnancy, childbirth and postpartum periods (Benoit et al., 2007; Tinkler et al., 1998; Sandall, 1995; Morgan et al., 1998).

Another recurring theme in the maternity literature is how women's feelings of having a "sense of control" is related to maternal satisfaction (Benoit et al., 2007; Tinkler et al., 1998; Sandall, 1995; Morgan et al., 1998). Having a sense of control is lost when

maternity care disruptions occur (Benoit et al., 2007). Therefore, a sense of empowerment that builds on the assets women already have to help them feel like they have the autonomy to create their own desired outcomes, encourages them to feel like they have control over their own bodies and their own birthing process. This is imperative to maternal well-being, especially in critical times. Empowerment can increase feelings of control which can be achieved for women through the fostering of autonomy and choice within pregnancy and birth, as well as the presence of a strong social support network (Morgan et al., 1998; Sandall, 1995). Midwifery garners the highest levels of satisfaction as long as a transfer of care to a physician does not occur (Benoit et al., 2007). However, given that medical emergencies sometimes occur, it is important to examine the ways in which stronger maternity care support networks can be developed in the face of disruptions in the continuity of care.

What is most clear in the literature is the importance that women place on having a caregiver who is ‘known’ to them throughout their pregnancy but especially during the birth of their child. The concept of ‘knowing’ can be defined as a caregiver who is present at the birth in which the childbearing woman has “formed a trusting relationship” (Rice, 1997:151). What appears to be of paramount importance, then, is the fostering of a relationship by foreseeing who will be present at the birth; and it would follow that care from a familiar care giver at *crucial* times, such as birth or a health crisis, are vital for maternal satisfaction.

With these central themes in mind, I will now examine the organization of maternity care in Europe and Canada for the practice of woman-centred care as outlined in the concepts above. In doing so I am attempting to show that an interrelation of

cultural values and the state shape maternity care systems differently from country to country, including the roles of maternity care providers and the quality of care available to birthing women and their families.

#### **2.4 Comparative Analysis of the Organization of Maternity Care: The Netherlands, Australia, Sweden and Canada**

It is important to know what works for birthing women within other examples of care. Each country offers unique options of care that differ greatly from the present-day Canadian case, which can be useful in providing a context to search for dignified maternity care in Victoria, British Columbia. The regions surveyed include the Netherlands, Australia, and Sweden, and Newfoundland/Labrador as an exceptional case in the historical organization of maternity care in the Canadian context. I will outline the basic tenets of these maternity care systems before briefly examining the unique situation British Columbia currently faces with regard to the integration and public funding of midwives.

##### **The Netherlands**

The case of the Netherlands is unique in that the percentages of home births that occur are unparalleled in any other high-income country; 30-34% of all births in the Netherlands take place at home (Declercq et al., 2001:16; McKay, 2000: 160). Even though the Netherlands has the same access to obstetrical technology as other high-income countries, there is not the same level of reliance on such technologies. This country places an emphasis on the beauty of the “old ways” of birth, which has had a positive bearing on rates of infant mortality and maternal morbidity in that the rates are

some of the lowest in the world (Declercq et al., 2001:16). The Dutch perinatal mortality rates are actually lower for home births than for hospital births (McKay, 2000: 160).

Home births are prevalent because they are encouraged and supported by the Dutch state and measures have been put into place to preserve this cultural phenomenon. For instance, for low-risk pregnancies and births, public insurance only covers midwifery services since a law was passed in 1941 that gave preferential treatment to professionally-trained midwives, guaranteeing them to be paid first through the public or private system for low-risk pregnancy and childbirth (McKay, 2000: 160). Although the ruling of 1941 still holds today, women have the choice of whether they deliver in hospital or at home; however, those who do choose the former and have low-risk pregnancies tend to have a hospital stay of less than 24 hours even though they are still accompanied by midwives (Declercq et al., 2001: 17; McKay, 2000: 161). The Dutch government's official aim is to move low-risk birth from the hospital and into the home entirely (Van Teijlingen et al., 2000: 167).

Dutch midwives have attained prestige and autonomy partially through the measures outlined above but also through their regulation since 1818 at which time they were deemed legitimate health practitioners and the most appropriate maternity care practitioners to care for Dutch women with unproblematic pregnancies (Declercq et al., 2001: 17; Van Teijlingen et al., 2000: 167). Another reason midwives have achieved this type of recognition and extensive scope of practice is the way in which the Netherlands structures its health care system. The Dutch do not revere science to the extent that other high-income countries do (DeVries, 2004). The Dutch also adopt a logical approach when it comes to technological advances and health policies through a negotiation

process that includes all parties that have vested interests in health (Declerq et al., 2001: 18). Midwives, similar to other health and medical practitioners, have official voting capabilities in the creation of their countries health policies. This occurs through elected members who are responsible for their collective interests at the bargaining table.

The prestige and autonomy of midwifery is surely in existence largely as a reflection of Dutch cultural ideologies, which have largely shaped the country's structure of maternity care. Low-risk pregnancy and childbirth are seen as natural life events. Women are not treated as "patients"; medical intervention is reserved for true emergencies and both health professionals and the public at large consider home birth to be safe (McKay, 2000: 161; Van Teijlingen et al., 2000: 163-64). According to Van Teijlingen et al.'s (2000) writings on the Dutch methods of maternity care, the Dutch believe that women's bodies know best. Therefore, pregnancy and childbirth are natural processes and women need practical, not just medical help (164).

The ideology of practicality in maternity care, and the encouragement of home birth have given rise to the Dutch homecare worker called *kraamverzorgster*. Dutch homecare workers give roughly one week of postpartum care to new mothers. This package of care includes: recognizing health deviations in mother/baby and contacting the midwife if such health deviations occur; newborn care; breastfeeding support; advice about caring for a newborn; and domestic duties including care for older children and housework (Declerq et al., 2001: 17; Van Teijlingen et al., 2000: 164). The duties of the homecare worker also include assisting the midwife or physician during labour and birth, in either the hospital or the home (Van Teijlingen et al., 2000: 164).

Research findings on the use of the homecare workers indicate they are an important component of the maternity care services available to Dutch women. First, roughly 73% of childbearing women use the homecare workers service, indicating that it is central to the Dutch postpartum experience (McKay, 2000: 160). Second, the high usage of homecare support is correlated with low rates of postpartum depression and perinatal deaths, as well as increased breastfeeding rates compared to women who did not utilize the services of a *kraamverzorgster* (McKay, 2000: 160; Van Teijlingen et al., 2000: 168).

The success of Dutch maternity care is an amalgamation of the factors stated above, but it also largely has to do with the Dutch philosophy of *continuity of care*, defined in the previous section as seeing the same caregiver/team of caregivers prenatally for labour/birth and during the postpartum period. This type of care is considered to be a major component of high quality care in the Netherlands (McKay et al., 2000: 160; Van Teijlingen et al., 2000: 167). It is common for the childbearing woman to see the same midwife throughout her course of care, but also to meet her *kraamverzorgster* prenatally, who will aid the woman during her labour/birth, as well as spend time with her during the postnatal period alongside the midwife.

Next I will examine the Australian organization of maternity care, which is similar in the form of postnatal support, but differs considerably from the Netherlands in that maternity care is embedded in a very different type of health care system, reflecting a distinct set of cultural ideologies about childbirth. The example of how Australia modeled a postnatal homecare system after the Dutch *kraamverzorgster* is especially noteworthy. We can learn from their less successful attempt at providing such services.

## Australia

Australia's maternity care system diverges from that of the Netherlands in many ways, particularly with regard to Australia's parallel public/private care option. This system creates a two-tiered system favouring those with private insurance. For example, women with private insurance can choose the care of an obstetrician in a private hospital, providing continuity of care through the childbearing experience. Women who are covered publically see various health practitioners at a hospital clinic, resulting in little or no continuity of care (Benoit et al., *forthcoming*). As a result of the higher public costs associated with hospital stays, women in the public system face a shorter hospital stay following the birth of their child, significantly affecting lower income women (Benoit et al., *forthcoming*).

Due to the recognition that social class affects the outcome of postnatal support accessibility, in 2002 a pilot project was launched to introduce a new postpartum homecare worker program in Australia. The women who participated in the pilot tended to be younger, have less formal education, lower incomes, and tended to be discharged earlier from the hospital following the birth of their children than the general public (Zadoroznyi, 2006: 36). Following the Netherlands' model, Australia has modeled a postpartum home care worker, the *mothercarer*, after the Dutch *kraamverzorgster*, a project that has been launched in only one region as of yet.

The introduction of *mothercarers* into the Australian maternity care system had a two-fold purpose: more adequate support for all postpartum women and increased employment opportunities for young women aged 18-25 in an underemployed area of

Australia (Zadoroznyi, 2006: 37). The program was especially designed to provide support for women who opt for a hospital stay of less than 24 hours postnatal. The homecare worker was available to provide women and their babies who were discharged early with social care, education, and domestic services for 6 days postnatal (Zadoroznyi, 2006: 37).

However, compared to the Netherlands the Australian program has not been hugely successful. Roughly 30% of childbearing women have opted into the homecare program (Zadoroznyi, 2006: 37) compared to 73% in the Netherlands (McKay, 2000: 160). Several factors contributed to these differences: there was a perception that the Australian homecare program was only for “at risk” women, including those without social support and those with lower-incomes. As a result the women who opted into the program generally had fewer social, cultural, and economic resources (Zadoroznyi, 2006: 40). Also women perceived the workers as young and minimally trained, most of the workers not being mothers themselves (Zadoroznyi et al., 2007: 234). The training program the *mothercarers* complete is in fact minimal when compared to their Dutch counterparts - 6 months compared to 3 years, respectively (Zadoroznyi, 2006:37). As a result of training the homecare workers, Australian midwives have been required to increase their workload without the equivalent increase in pay, and have no opportunity to give input into the program (Zadoroznyi et al., 2007:236-237). These factors have created tensions among these groups of postpartum health practitioners.

On the other hand, there have been important successes with the Australian *mothercarer* program. The women who received services from a *mothercarer* reported high levels of satisfaction, psychological well-being, and comparatively higher levels of

breastfeeding, despite the fact that they had lower education and income as a group, which typically accounts for lower rates of breastfeeding and higher rates of postpartum depression (Zadoroznyi, 2006; Benoit et al., 2007).

Australia's two-tiered public/private system then has greatly affected access to non-medicalized maternity care for birthing women. Medicare does not reimburse midwives, nor are they allowed to order medical tests or prescribe medication (Benoit et al., *forthcoming*). More than that, it has created obvious inequality in the delivery of dignified maternity care based on socio-economic status. According to Benoit et al. (*forthcoming*):

Women living in outer regional, rural and remote areas of Australia experience higher levels of maternal, neonatal and foetal death, have poorer access to maternity care services and reduced availability of maternity providers, including general practitioners and obstetricians (20).

It is important to keep in mind the result of the expansion of the private system when evaluating our own practices.

I will now turn to a maternity system in Sweden that mixes a natural approach to pregnancy and childbirth with a more medicalized model of care. Due to the transfer of care of the participants in this study that resulted in hospital births, the following section is especially important in order to learn from a country that has dignified hospital births. Taking into account that some women will inevitably need or want to give birth in a hospital setting, we need to examine how best to serve these women.

## Sweden

Midwives in Sweden are responsible for all low risk pregnancies and childbirths; however, almost all women give birth in the hospital (McKay, 2000: 158). Nurse-midwives care for the vast majority of birthing women in Sweden. While advanced obstetrical technology is available, the Swedish maternity care system is non-interventionist. This pragmatic approach to childbirth includes natural pain relief techniques such as massage, acupuncture, and hot water baths in hospital settings (Nelson et al., 2001:89).

Sweden also has a relatively low C-section rate, which has fluctuated between 11-13.5% since the 1980s (Nelson et al., 2001:88). I would like to put this number into context by acknowledging the C-section rate of 26% in Canada (Bourgeault et al., 2008). Sweden also has the 3<sup>rd</sup> lowest infant mortality rate in the world (Nelson et al., 2001:88; McKay, 2000:158). The Swedish organization of maternity care cannot be isolated from the larger social organization of the state that reflects women-centred policies such as paid sick leave during pregnancy and one year paid maternity leave at 80% of the original salary (Nelson et al., 2001:88). Maternity care is also universal and free for all women, funded through general taxes (McKay, 2000:158).

The Swedish maternity care system reflects the country's spirit of 'state feminism' (Benoit, 1997:98) and a developed welfare state based on social democratic principles. As illustrated above by the relatively low C-section and infant mortality rates, the best perinatal outcome is central to Swedish maternity care, which is achieved through interdisciplinary teamwork. Midwives are valued in Sweden as autonomous.

They collaborate with other care providers during the course of pregnancy, childbirth and the postpartum period (McKay, 2000:158). Women start their prenatal visits with nurse-midwives in a maternity centre at 12 weeks gestation; however it is common to see a physician twice in the prenatal period, even for a low-risk pregnancy and an open dialogue between practitioners for childbirth is common (Nelson et al., 2001:89).

Because maternity care clinics and birthing hospitals are separate, midwives burn out less because they work set hours (Nelson et al., 2001:89). Midwives are also paid health benefits, which also contributes to good working environments (Benoit, 1997:100). Swedish midwives have manageable hours with a salary and benefits for their contributions, however as a result of separating maternity clinics and birthing hospitals, women do not receive continuous care from one (or a group) of health practitioners during their maternity care. Women do, however, have continuity in their general health care because midwives provide services related to sexual health, family planning and gynecological care (Benoit, 1997:99). The Swedish health care system does not separate women's lifetime health care from their maternity care; therefore, birth is not considered a pathology that should be fractured from the natural processes of women's lives.

This continuity of care over a woman's lifetime has also been found in another place that historically organized a maternity system in a way that provided interdisciplinary care. Newfoundland and Labrador are the exception to the rest of Canada in this regard (Benoit, 2000).

## **Canada**

### *Newfoundland and Labrador*

In the 1940s the Cottage Hospital Plan (CHP) was implemented across the province. This plan provided free maternity care coordinated by midwives in a cottage hospital setting with physician backup in case of obstetrical emergency (Benoit, 2000:198). The cottage hospitals had 30-50 beds and were attended to by midwives, nurses, a few physicians and a small support staff. Midwives worked autonomously; physicians were only called upon when medical complications occurred (Benoit, 2000:198-199). Midwives provided care from the prenatal to the postpartum period for women who were geographically isolated from larger hospitals, while the structure of the cottage hospital provided women with a safe place to give birth. Obstetrical technology and physicians were available but did not dominate the birthing process. The cottage hospital also gave women repose from the demands of their home life. For women who were the primary caregivers in their families, the cottage hospital provided postpartum care that allowed them to rest until fully recovered, sometimes for a period up to a week, before returning to care for other children and their homes (Benoit, 2000:198).

Similar to the lifetime continuity of care from Swedish midwives, midwives in Newfoundland and Labrador offered support to women for their general health concerns (Benoit, 2000). This approach created health care that was woman-centred, as well as intergenerational in which mothers and daughters would often see the same midwife in their area throughout their lifetime, creating a generational flow of care that is unparalleled today.

By the 1980s, the autonomous midwifery system had been eroded due to the closing of the cottage hospitals, forcing women to travel to birth their babies in more

distant regional hospitals. There are only a few cottage hospitals that survive today in the more isolated northern regions of Newfoundland and Labrador (Benoit, 2000:199).

The demise of the cottage hospital system in Newfoundland and Labrador indicates a different historical path in regard to maternity care provision in Canada compared to the other countries examined. In other words, while many European countries saw the consistent value of autonomous midwifery, Canada has been a rollercoaster from eroding midwifery traditions, to the integration of midwifery into the public health care system. This will be further detailed in the following section. Next I examine how British Columbia organizes its maternity care, to better situate the research for this thesis in the experiences of women in Victoria, BC.

### *British Columbia*

In British Columbia, midwives are publically funded per client's course of care and are permitted to practice in hospital or home (Benoit, 2008: 520). With the integration of midwifery, British Columbia has adopted a woman-centred approach to maternity care in which the following major elements of the 'spirit' of early systems of midwifery are supported (Benoit, 2008: 520; Rice, 1997:151; Shroff, 1997):

1. Continuity of care - Women receive care from one, or a group of, midwife(s) from the prenatal through the postpartum period.
2. Informed choice - Women receive information about medical tests and procedures that are available to them and make the decision of whether to utilize them or not.
3. Choice of birth place - Women can choose where to give birth including hospital or home.

4. Appropriate technology - Women will not be subjected to unnecessary medical invasiveness, especially through technological means.
5. Time with women - Women are given the time for counseling and education during the childbearing period, because time is considered important in fostering a trusting relationship with a caregiver and integral to a positive birthing experience.

The integration and public funding of a woman-centred midwifery practice in British Columbia creates a culture of choice for women; however, the transition has not been a smooth one. On January 1<sup>st</sup>, 1998 midwives were legalized in British Columbia and a split occurred between the midwives who wanted integration and those who wanted to practice outside state intervention. According to Benoit (1997: 94), there were both pros and cons to midwifery integration reflected in this debate. The professionalization of midwifery promised standards of practice, accessibility of care to vulnerable populations, employment security and better working conditions for midwives. However, professionalization was troubled by the threat of co-optation by medicine and the greater monitoring of midwives' work since they would henceforth be required to follow state and hospital policies. This kind of bureaucratization of birth surfaced throughout the narratives in this study (Chapter 4). Certification also required already practicing midwives to return to school for a four year Bachelor of Science educational program, one that is still not accessible to all practicing midwives because many are unable to pay the required tuition fees and other educational expenses (Benoit, 1997: 96), not to mention taking the time out of their lives, the ability to move to Vancouver where the

only program in British Columbia exists, or the highly competitive nature of the application process.

Tensions also increased between nurses and midwives. Midwives felt compelled to distance themselves from nurses in order to secure their position as autonomous maternity practitioners (Kornelsen et al., 2004:111). Because of an overlap in scope of care between midwives and nurses when attending hospital births, some nurses feel they have been relegated to administration and emergency maternity care, negatively affecting both their job security and job satisfaction (Kornelsen et al., 2004:122).

At the point of midwifery integration most physicians fought to limit the autonomy of midwives and called into question their credibility. As a result of the limitations placed on the autonomy of midwifery due to such ‘questions’, midwives have strict limitations on prescriptions (including birth control) that fall within a course of care. One could argue that there is a distinct parallel between the type of medical authority obstetricians have over midwives now, and the erosion of midwifery throughout history, leaving us to wonder if enough lessons were learned from the witch-hunts. After the integration of midwives, the earlier apprentice model of education was abolished and replaced by an undergraduate university degree located at the University of British Columbia (UBC) (Kornelsen et al., 2004:116-117). In September 2002, the first midwifery students began their training at UBC in order to create consistency across midwifery practice and to be more accepted by the medical community. The “ghost of the witch” however still influenced the ways in which midwives were allowed to (partially) reclaim their legitimacy as childbirth attendants.

Remuneration has also been a source of conflict between physicians and midwives in British Columbia. At a time when physicians who practice maternity care felt under-paid, the funding model was announced for midwives causing more personal and professional rifts between midwives and physicians (Kornelsen et al., 2004:119). The official position of the College of Physicians and Surgeons did not help this matter. The institution claimed that British Columbia is no place for home births and that nurse-midwifery is the only acceptable practice (Rice, 1997:152-153). As illustrated above, the interprofessional conflicts in maternity care in British Columbia are not between individual midwives and physicians per se, but are a result of poor planning on behalf of professional organizations and colleges and riddled with imperialist practices against midwives. Poor planning, the reluctance to change the College of Physicians and Surgeons' official stance on midwifery/home births, and the history of the erosion of midwifery, now affect care for women by fostering a lack of interdisciplinary management in this province. This will be discussed further in Chapter 4.

Interprofessional rivalries have somewhat dissipated in the recent decade yet problems still remain. As a result of lingering tensions among health practitioners, there is a reluctance to form multidisciplinary professional teams, as well as an ongoing reluctance to work with midwives in the case of emergency transfers of care (Kornelsen et al., 2004:122). With the integration of midwifery in British Columbia, a medical transfer of care system was implemented to increase effectiveness of medical transfers and safety of care for mother and newborn during a home birth (Home Birth Demonstration Project, 2001). While it is rare for physicians to refuse a medical transfer, because they could be held liable for any injury that would occur as a result, physicians

have often instead accepted transfers with reluctance while blaming the midwives for the emergency (Kornelsen et al., 2004:122).

However, there is more at stake than merely accepting transfers. The event of medical transfer is based on a list that takes into account risk factors that are constructed by the medical community and have been known to change over time (Rice, 1997:173).

Protocols that state that a transfer of care is necessary are outside the control of both the midwife and the birthing woman. Once the transfer to the hospital is in place the woman becomes part of the institution of medicine, which includes strict policies that are adhered to. However, 'risk' is not an equal concept for all women, as I illustrate in the following section. Socio-economic status can have a negative bearing on access to social supports, as well as increasing the medicalization of childbirth.

## **2.5 Socio-economic Status and Access to Social Support**

Social support is a key social determinant of health for childbearing women and what women want as central to good maternity care services (Benoit, 2008:507). Therefore low-income women could greatly benefit in terms of special support from the 'spirit' of midwifery as outlined in the previous section. As was noted in both my international and national overviews, pregnant women who are low-risk have greatly benefited from midwifery care. The spirit of midwifery also embraces equality between the health care professional and the woman, avoidance of technology whenever possible, collaborative knowledge sharing and adherence to the natural processes of childbirth (Rice, 1997:151). This kind of formal social support can help women feel strong and powerful, especially women who have felt disempowered by their socio-economic status. However, this can

change to feelings of loss and abandonment if a transfer of care to another kind of provider occurs, including the loss of the basic tenets of a natural, empowering birth (Shroff, 1997:357).

According to Reid (2008), those who live in poverty in Canada are disproportionately women, and they have the highest rates of morbidity and mortality (199). Lower-income women are more susceptible to stress, depression, anger and low self-esteem; they also have less access to health promoting resources, quality health care and informal social support (Reid, 2008). Due to these confounding factors, women with lower-income who are transferred during labour/birth are especially vulnerable to ill health in the postpartum period (Benoit et al., 2007).

Jomeen's (2007) research also supports the above findings that lower income levels do not only negatively affect access to maternity care, but also serve to increase the risk of medical intervention and consequently decrease choice for poor women. Due to poor housing, nutrition and informal support, lower-income women are also more likely to have complications during their labour and childbirth, and are more likely to be transferred to obstetricians than middle/upper income women (Jomeen, 2007). Also, because of a woman's possible removal of choice, "tensions inherent between a woman's notion of birth as normal and natural and medicalized interventionist approaches can generate more damaging emotional consequences...[and it must be recognized that] choice is not an equitable concept for women" (Jomeen, 2007:490). In other words, social inequality constrains women's choices in maternity care attendance, which is further exacerbated by someone else deciding the need of transferring care from a midwife to an obstetrician.

Therefore it is important, especially for lower-income women, to have dignified maternity care. However, these women have fewer resources to advocate for themselves. The Inverse Case Law (Hart, 1971) stipulates that those who need quality health care the most are the least likely to receive it (Kirkham et al., 2002: 510). Factors such as stigma and low literacy skills, as well as the patient's inability to question the kind of formal care they receive may be reasons for the discrepancy. As Kirkham et al. (2002) observe, women, especially those who are young and with low incomes, tend to be treated differently by their maternity care providers than higher income counterparts. Lower-income women are more likely to be subject to discriminatory treatment by health care professionals in the form of disrespectful interpersonal relations and the feeling of 'rushed' care (Reid, 2008:209; Shroff, 1997).

Many social researchers agree that lower-income women experience a greater loss of control than their higher income counterparts (Benoit et al., 2007; Tinkler et al., 1998; Sandall, 1995; Morgan et al., 1998). Medical transfer further contributes to this loss of control. Shroff (1997) states that "some women have likened their hospital birth experiences to rape; they have been degraded, humiliated and violated by disrespectful personnel and invasive technology" (357); this is a problem in which "working class women...have often felt furthered punished by medical staff" (*ibid*, 358). Therefore, it could be argued that women have actually experienced a form of violence within their medicalized maternity care, which is further confounded by a lack of respect and autonomy for women with lower-income.

## 2.6 Summary of the PPHS

For my thesis I have utilized data from Dr. Benoit et al.'s PPHS, which aimed to investigate the association between the social determinants of health, including women's socio-economic status, the organization of maternity care services, and satisfaction with the care received across the childbearing period. The PPHS also sought to examine the prevalence of depression and general health among a *diverse* sample of new mothers at 6-7 months of pregnancy, 3-4 weeks postpartum and 4-6 months postpartum (Benoit et al., 2007). The characteristics of the sample as compared to women in the Victoria Census Metropolitan Area (CMA) are detailed below (see Table 2).

Table 2. Selected characteristics, study population compared to the Victoria Census Metropolitan Area (CMA) (Benoit et al., 2007: 721)

Measure	Sample population (n = 90)	CMA (n = 337 411)
Aboriginal background	5.0%	2.8% (females)
Visible minorities	12.5%	9.0% (females)
Less than high school graduation	7.5%	9.9% (female age 20 – 34)
Average (mean) annual gross household income	\$54,126 (CAD) \$57,000 (median)	\$66,594 (CAD) \$59,015 (median)
Own home	42.5%	61.8% (by household, not specific for age or gender)
Employed	72.2%	56.2%

Quantitative findings from the PPHS suggested that socio-economic status is closely linked to birth dissatisfaction and being transferred from a midwife to an obstetrician in the course of labour and birth. Further, the qualitative interview data revealed two main sources of dissatisfaction: disruption of birth plans and inadequate support from maternity care providers. One of the key reasons for disruption was the need for obstetrical intervention, such as a C-section.

It is noteworthy that the women in the PPHS who chose midwives had lower-income generally than those women who chose physicians. Although low income is typically a predictor of higher incidences of postpartum depression, the women in this study who had continuous midwifery care had the highest satisfaction with their birthing experience. They also had lower rates of postpartum depression comparable to the higher-income women who chose a physician. This occurred *despite* their lower-incomes. However, it also followed that women who were transferred from midwifery to obstetrical care also had lower-incomes and suffered the most in terms of the highest rates of dissatisfaction with their birth experiences and the highest reports of postpartum depression (see Table 3).

Table 3. Mean income, maternity care provider, depression and birth outcomes (Benoit et al., 2007: 726).

Maternity care provider	Mean income	Wave 2- BDI	Wave 3- BDI	%Vaginal delivery	Birth satisfaction Wave 2*
Midwife only (n = 42)	47,056	8.3	8.2	100%	1.32
Midwife & physician (n = 11)	44,667	10.1	8.0	8.3%	3.08
Physician only (n = 37)	60,877	7.7	6.0	60.5%	1.91

\*1 = highly satisfied.

The researchers in the PPHS found that women were less satisfied if their birth experience was in direct conflict with previously held expectations about how their birth would unfold. Those who had a planned C-section felt that their plans had not been suddenly changed and were more satisfied than those who had an emergency C-section. Echoing the literature review in Chapter 2, social support was of utmost importance for women's satisfaction with their formal care and positive health outcomes following the births of their children. Social support from a care provider was more likely found in continuous midwifery and physician care, leaving the women who were transferred to feel the least supported by their maternity care providers.

The PPHS illustrated a link between socio-economic status, the organization of maternity care and birth satisfaction, but how did this unfold according to the experiences of women? My thesis attempts to respond to this question. From the PPHS findings, I know that the group of women who were transferred had a higher incidence of

postpartum depression, which was also linked to their income, as outlined in Table 3. My thesis examines the experiences of this sub-sample of women and the negative impacts of both poverty and maternity care disruption on them.

In the next chapter, I outline the methodological and ethical considerations from the PPHS as well as my own follow-up analysis. I will also discuss the sample, broken down into two groups of birthing women, and my positionality as a feminist and a mother.

### **Chapter 3: Research Design and Methodology**

In this chapter I will first discuss the postpartum health study (PPHS), including its research rationale, study design and methods used, as well as ethical considerations. Next I will describe my follow-up analysis including my sampling strategy, access to data and the limitations of my analysis. I will also outline the ethical process I undertook to have my study approved at the University of Victoria, the data I drew from the PPHS to attempt to answer my research questions, the techniques I utilized to analyze the data, and the reflexive feminist lens I adopted to interpret my findings. I will not only speak of such reflexivity, but will also actively practice reflexivity by sharing some of my own experiences of birth, my positionality, and how these impact my research.

#### **3.1 The PPHS: Design, Methods and Ethical Considerations**

The researchers in the PPHS employed a non-random purposive sampling strategy to select a diverse sample of pregnant women from different socio-economic and educational backgrounds from the Victoria Census Metropolitan Area (CMA). This was done to represent an adequate picture of the styles of maternity care available within the British Columbian maternity care system and the diversity of backgrounds of women who live in the CMA. That is to say the sample was “selected on the basis of known characteristics...relevant to the research topic” (Ritchie et al., 2003: 108). Other significant experiences in the PPHS included women who had received continuous care from a midwife, a maternity physician, or an obstetrician, or those who were transferred from a midwife to an obstetrician. While the women who chose a midwife in the PPHS sample represented roughly one half of the participants, this is relatively high compared to the 15-20% midwifery rate in the CMA (Benoit et al., 2007: 721).

One of the main goals of the PPHS was to recruit participants from different social backgrounds. Characteristics of diversity were based on a range of “ages, ethnicities, educational levels, parity and economic status” (Benoit et al., 2007). Of importance to my thesis findings given my sub-sample is the measure used for income. Income was measured in the PPHS by taking the median of gross annual income of the whole sample. Lower-income women in this study are those whose household income falls below \$7,000 per annum, which is \$2,000 below the CMA median for income. The sample characteristics compared to those of the general CMA population were previously summarized in Chapter 2 (see Table 2).

The sample was located through the distribution of posters and flyers to places where the researchers’ expected pregnant women would frequent, including physicians and midwives offices, pre-natal classes, ultrasound offices, and maternity programs for lower income women.

Four interviewers collaborated in creating the research instruments. The interviewers were trained to ensure consistency in the interviews across the different points in time. As noted above, in-depth interviews were performed in three separate waves; each stage involved the use of both closed and open-ended questions. The close-ended questions also used ‘probes’ to elicit more depth within the data collection. The Beck Depression Inventory (BDI) was also used at each interview to assess the state of the participants’ emotional well being at each stage. How the participants’ BDI score relates to both income and style of maternity care provider is central to my thesis, the summary of which was displayed in Chapter 2 (see Table 3).

The quantitative data in the PPH were analyzed using SPSS 12.0 software, while

the qualitative data was transcribed verbatim. The transcripts were then coded for emergent themes by several researchers and QSR NVivo 2.0 was utilized to aid the researchers in the qualitative analysis.

The PPHS researchers gained Tri Council Ethics Approval, as well as free and informed consent from participants who were competent adults; i.e., individuals over the age of 19 years old without any mental impairment that would prevent them from comprehending the details of the research, potential risk, confidentiality and anonymity (see Appendix 1).

## **3.2 My Follow-up Analysis**

### ***3.2.1 Sampling Strategy, Access to Data and Limitations***

My sampling strategy was a convenient one given that I am interested in the sub-sample of participants who chose midwifery for their style of maternity care (n=42). Although I had access to all of the data from the PPHS (including narratives of women who chose a physician), in discussion with my thesis committee and in consideration of the limits of time for an MA thesis, I have decided to considerably narrow my scope. Further, my rationale for focusing on this sub-sample is based on a critical review of the literature and the preliminary findings from the PPHS, which indicate that midwifery care elicits the highest client satisfaction. Therefore, I believe examining the maternity care practices that elicit highest client satisfaction and finding ways to best support such practices, helps to create a more dignified maternity care system in British Columbia. To enable the interpretation of the richness of the women's narratives, and to foreground the stories of those who are most marginalized in the PPHS, I focused on the experiences of

the participants' that were transferred from the care of a midwife to an obstetrician (n=11). As noted above, the PPHS found that these women also had a lower mean income than women in other participant categories. I compared these participants with the other participants who were able to retain their midwives across the childbearing period (n=31).

I gained access to the birth narratives of women who chose midwives in the PPHS directly from my supervisor, Dr. Cecilia Benoit. To ensure respect for the participants, as well as their complete anonymity, I received transcripts labeled only by participant number. I had no access to data that tied any personal information such as name, background, or contact information to the participants' numbers. In other words, my data analysis was done using general findings from the PPH study, paired with anonymous birth narratives.

Given my relatively small sample size and the fact that the PPHS itself is based on primary data gathered from a non-random sample of pregnant women in the study region, there are limitations in terms of diversity. Also, although my small sample size preserves the integrity of the qualitative data (internal validity), as a small, non-random sample there are limitations as to the external validity of the findings. In other words "the potential for drawing inferences from a single study to wider populations, contexts or social theory" (Ritchie et al., 2003: 285). A larger qualitative study of the same kind with more diversity would serve to increase what researchers can infer from the findings. Despite this shortcoming, I believe this study is an important step in better understanding the experiences of women who are transferred from one type of maternity care provider to another as it compares women to their higher income counterparts who retained

continuity of midwifery care, in order to recommend policy changes to promote dignified maternity care.

### **3.2.2 *Social Science and the Self: A Reflexive Feminist Approach***

I have chosen to use a critical feminist approach to conduct my follow-up analysis of the PPHS. I begin with the view that gender-based inequality is a current problem in our society (Eiseinstein, 1983; Reinhartz, 1992; Kleinman, 2007; Lorber, 2007). This approach has allowed me to examine lower-income women's birth stories and their suggestions for how care could be better organized to meet their personal needs and that of their children and families. The birth story is an event that serves to illustrate the relationship between women's lived experiences and larger structures and institutions in our society. It also points to a specific point in time that is life changing for women who become mothers.

I used an interpretive framework, which is to say I interpreted the narratives guided by a combination of themes found in the maternity care literature, relevant findings from the PPHS, and my own experiences. I explored how the organization of maternity care, as well as unequal structures of gender and class, in our society influence how women experience birth.

Taking from Susan Krieger's (1991) *Social Science and the Self: Personal Essays on an Art Form*, I conducted and will disseminate this research without using the "contaminant view of the self" (1). Seeing *myself* not as an object that contaminates my research but as a subject that recognizes that my experiences are there to guide and are present as sociological insight (Krieger, 1991: 181). Although I do not centre my own

experiences of birthing children in this study because its purpose is to centralize the experiences of others, I also do not shy away from the use of the first person in my writing. It is important to make myself visible in my research and to guide it with my own experiences, because to “ignore the continuity between maker and made is to describe a world of objects where the individual is not seen, where the presence of an artist is not recognized in her work, the presence of a scientist not acknowledged in a study” (Krieger, 1991: 89).

From a feminist-researcher perspective, bias exists only insofar as one’s standpoint is not acknowledged and the researcher has not attempted to grapple with “her own previous experiences, intentions, hopes, [and] prejudices” (Reinharz, 1983). It is important to explore my own experiences and position in society while interpreting women’s birth narratives, given that I carry my own birth stories and positions in life, something that is worth doing at this juncture. I have given birth in a hospital and at home, and have been under the care of a midwife and a physician. I must be completely transparent in my predisposition to midwifery. This preference for midwifery care began as a result of personal experience. However, as this study illustrates, the literature and data both concur that midwifery care offers more woman-centred maternity care. Therefore, although I may have a personal “bias”, it is also based in evidence. Such evidence, however, does not preclude that many women are satisfied with physician care as well (Benoit et al., 2007).

I have also been transferred from one care provider to another twice, although I have only had vaginal births with no medical intervention or medications. I lived below the poverty line when I gave birth to my first child, and I also know what it is like to be a

single mother. Regardless of my ability to empathize with the women whose narratives I read because I can draw from past experiences, the reality is that I have considerably more income now. My position as a graduate student also awards me more power in our society and I am now a partnered parent. I am a white woman and a Queer woman, and this also influences how I see both the world and the data I am utilizing for my thesis.

On the other hand, I also aim to show “as much as is possible of the procedures that have led to a particular set of conclusions” (Seale, 1999). I want to make apparent the rigour of my analysis and lessen the impact of my subjective positions. I also engaged in *reflexivity* while interpreting the women’s narratives through the coding of emerging themes. I believe that my personal position as a mother allows me the opportunity to relate to the material in a way that gives depth to the subject matter. This is also how I ensured greater credibility of my findings. I attempt to portray the experiences of birth in a way that is sensitive to the subject, drawing upon my own birth experiences. Credibility is used in qualitative research in place of the natural sciences conception of validity, which measures the ‘correctness’ of the data (Lincoln et al., 1985). Credibility, then, means adequately representing the views of the participants, and by doing this I hope to illustrate that I am ‘investigating what [I] claim to be investigating’ (Ritchie et al., 2003: 273).

To stay attuned to my reflexive feminist lens, I must also reflect upon the fact that I do not know the sexuality of the participants whose narratives I have analyzed. Similarly, I do not know the racial or cultural background of each participant, although I have given an overview of the characteristics of the entire PPHS sample in Chapter 2 (see Table 2). This is important to acknowledge because without the explicit discussion of

sexuality or race in my thesis, I worry that assumptions could be made that are steeped in the invisibility of heteronormativity and whiteness (Bonnet, 1996; Carter, 2007; McIntosh, 1989). In other words, I would like to counterbalance the potential assumptions that all the participants are ‘straight’ or ‘white’ because I have not directly and individually identified them as anything else. Each participant in this study could occupy an intersectionality of positions and identities, but for the purposes of this study, the variable that I focus on is that of class (i.e., income). At the same time, class cannot be separated from gender, race, sexuality or anything that has been deemed a ‘variance’ from the norm (Acker, 2006; Bannerji, 2005). For example, many of the participants in this study may have a lower-income due their material experiences of racism. However, the participants within their birthing narratives did not directly speak to these experiences, nor did they speak directly to many other experiences they might have had. What I attempt to make clear here is that just because the *narratives* do not reflect these important elements of people’s lives directly, it does not mean that many forms of inequalities are not present in their larger *stories*.

### **3.2.3 Methods: Thematic Analysis of Birth Stories**

I used a qualitative research approach for my thesis because of the nature of the data that I analyze for the project. It is important that I examined the phenomena from the point of view of those involved in its occurrence (Ritchie et al., 2003) in order to better understand the connection between the social organization of maternity care and women’s experiences of care, and recommendations for change, especially as it pertains to social support and the medicalization of childbirth. My qualitative approach built on the mixed-methods used in the PPHS; I essentially picked up where the PPHS left off in

terms of this subject; the information was assiduously collected and had not yet been analyzed.

For my investigation, I reviewed the pre-existing data from the PPHS. By reading these women's narratives, I gained insight into the world of maternity care through other women who have experienced it. To increase *dignity* in maternity care, I must contribute to uncovering the 'problems' of maternity care. By examining low-income women's personal experiences of childbirth, I am a collaborator with these women in understanding their experiences and defining what maternity care would serve best them.

Relevant PPHS findings and themes from my literature review were used to triangulate my findings; that is to say, "the use of different methods and sources to check the integrity of, or extend, inferences drawn from the data" (Ritchie et al., 2003: 46). This served to give multiple perspectives and infer the best findings possible.

More specifically, for my data analysis I used various grounded theory procedures (Charmaz, 2000). To begin, I narrowed my scope on the second interview wave of three interviews in the PPHS. I have concentrated on wave two (W2) because the participants' birth stories were recorded during this wave. After dividing the transcripts into two categories, those who retained their midwife and those who were transferred, I used open coding to start my analysis of each group individually. That is to say, I coded my data from my first examination of the data, staying open to emerging themes while reading the transcripts.

I have concentrated my analysis mainly on the birth story of each participant, following W2, question 6 (Q6) "*Please tell me about your baby's birth*". However, I

have also made use of examining questions that show personal reflection of the participants' looking back on labour, birth, social support and interaction with medical practitioners such as, *“Overall, how satisfied were you with the care you received from each paid care provider involved in your labour and delivery?”* (Q11); *“How would you rate your overall satisfaction with the birth itself, based on your own expectations, and compared to past births if you have other children?”* (Q7); and *“Is there anything you would do differently, another time?”* (Q8).

To uncover possible policy implications I also reviewed responses to the questions, *“Would you have wanted any of these types of care, but they were not accessible to you? If so, what were the barriers to your accessing this care?”* (Q13); and *“Is there anything we haven't discussed yet that you'd like to bring up, with regards to the birth, your health or your baby's health, and the level of support you receive from the people around you?”* (Q97). Finally, to further triangulate the findings from the PPHS that illustrated a connection between having a lower-income and being transferred from midwifery to obstetrical care, I took into account the questions concerning possible financial hardship including ability to pay for necessities such as rent and access to adequate nutrition and housing (Q66- 69b and Q93- 95).

As I read the transcribed narratives, I practiced constant comparative analysis (Charmaz, 2000) between participants to recognize common themes as well as deviant instances. I then examined the data for a second time, employing axial coding. That is to say, I read all of the written stories from the participants in each group at once, in order to gain an overall picture of possible similarity of themes. I then took my time to read and code each narrative. Likewise, I made sure not to let too much time lapse between coding

each transcript. I allowed sufficient time for reflection, while keeping them close enough so that the common themes became apparent. As I analyzed the narratives I kept a reflexive memo of the process to sort through emergent themes, to acknowledge some of the emotive reactions I had, and to give space to my own experiences as they might surface.

Reading the interview transcripts consecutively and several times helped me to continue to tag common themes within each sample group (Ritchie et al., 2003). In the third stage of coding, I used my own experiences, as well as the narratives of my participants in conjunction with each other to guide my interpretation. I employed selective coding, that is, “initial codes that reappear[ed] frequently to sort large amounts of data” (Charmaz, 2007: 516). After detailing the themes into codes, I grouped them into categories and cut and paste the relevant narrative passages. I remained as flexible as possible throughout the process and changed codes and categories as I began to ‘get to know’ my findings. Finally, in order to make a more substantial argument, I compared the centralized experiences of women who were transferred to those who retained their midwife by identifying common themes as well as those that differed.

#### ***3.2.4 Data Storage, Disposal, and Ethical Considerations***

After receiving Tri Council Ethics Approval to analyze the raw data from the PPHS, I was given access to the transcripts from all completed PPHS Waves (1-3) from Dr. Cecilia Benoit. To ensure confidentiality and to safeguard the privacy of the data, the transcripts and coded data were stored in my personal laptop computer, protected under a password that is known only to me. The transcripts, coded data, and all other electronic

records (computer files) will be erased after a period of 10 years. During the maintenance period, the data was used to write my Master of Arts thesis as well as to disseminate it in other forms, including peer-reviewed academic journal and conference presentation submissions.

### **3.3 *Summary***

In this chapter I have outlined the rationale, study design and methods used in the postpartum health study (PPHS). I also described my follow-up analysis, including the lens and methods used for this thesis. Finally the ethical considerations for both studies were described.

In the next chapter I present my findings. Specifically, I outline the recurring themes found within the narratives of the participants who chose midwifery for their maternity care from the PPHS.

## Chapter 4: Research Findings

### 4.1 Maternity Care Disruption: Centering Marginalized Experiences

As noted in Chapter 3, the central focus of my analysis is in regard to the experiences of the sub-group of participants who chose midwives for their maternity care but ultimately received care from an obstetrician during their birth. While this is my central focus, I also compare the experiences of participants who chose midwives but received obstetrical care, to the experiences of participants who retained their midwives.

For the participants who were transferred, they were transferred because they were deemed in need of a C-section, whether planned ( $n=3$ ) or emergency ( $n=6$ ). One participant had a forceps assisted delivery, and another required an obstetrician due to uncontrolled uterine bleeding, immediately postpartum. By focusing on the experiences of this group of participants, I am writing my thesis around hearing the stories of women who are most marginalized within the larger PPHS sample. As discussed in Chapter 3, these women fall below the mean income of the larger sample and are further marginalized by being transferred to an unknown caregiver typically for major abdominal surgery at a time in their lives that is a 'new beginning' (Bailey, 1999: 347; Fox and Worts, 1999). These participants, as noted in Chapter 2, also had higher postpartum depression rates on the BDI scale than those who were able to retain midwifery care across the birthing period.

For these reasons, I am retelling the transferred participants' stories in terms of their views on the formal support they received from midwives, obstetricians, nurses and alternative practitioners, the informal support they received from their communities at

large, and observations of how medical practitioners worked together (or not) in the hospital setting. I do so in hopes of mapping out the sequences of events that contribute to birthing experiences, so as to better understand what *dignified* maternity care entails in practice from the viewpoints of this small group of disadvantaged participants.

#### ***4.1.1 Feelings of Support, Autonomy and Adequate Information (or lack of)***

At my first glance of the quantitative overview of the data from the PPHS, I was confused at the preliminary findings presented by my spreadsheet of women who were transferred from midwife to obstetrician. At that juncture I was grappling with some predispositions towards thinking that all the participants who were transferred would rate their birth as unsatisfactory. This is largely due to the overview of the PPHS data that illustrated that the women who were transferred had the highest rates of postpartum depression and the lowest rates of satisfaction. However, more than one half of the participants (n=6) rated their overall birth satisfaction as ‘satisfied’ and 5 of them rated their overall birth satisfaction as ‘highly satisfied’. I wondered how to make sense of this and searched for patterns to explain it, such as a connection between expectations of place of birth and satisfaction, formal care satisfaction rates and birth satisfaction rates, the presence of alternative practitioners, the concerns of first-time motherhood, and so forth. In other words, I examined the raw data to see if being a first-time mother, giving birth in a hospital compared to at home, and certain kinds of social support contributed to how participants’ rated their levels of satisfaction.

It was not until I really examined what the women were *saying* that the data began to make sense. In my deeper reading of the transcripts, it seemed to me that many participants rated their birth as satisfactory because in the end they had a healthy baby.

However, in reading the details of their experiences with each paid support person they came into contact with, I realized participants were far from satisfied with many elements of their labour and birthing process.

The qualitative data revealed many themes that are supported in the maternity care literature in terms of the importance of support, which incorporated autonomy and adequate information (Benoit et al., 2007; Tinkler et al., 1998; Sandall, 1995; Morgan et al., 1998). Although the literature illustrates that these elements are most likely found in continuous maternity care, especially continuous midwifery care, for our purposes it is interesting that the data revealed similar patterns for women who have experienced midwifery care disruption. It is social support, especially formal support, that proved to be the deciding factor for women in this participant group as to whether their birth experiences were traumatic or neutral. As one participant stated, it “all comes down to support. Need to help women get more support” (PP11-W2: p. 8).

#### *Formal Support: Midwives, Nurses and Alternative Practitioners*

As echoed in the literature, participants found the greatest social support within the practice of midwifery. High satisfaction with social support from a midwife still occurred for most women, even some of the women who were transferred to an obstetrician. Upon reflection, the participants who spoke positively of their midwives consistently attributed their satisfaction to the type of support they received. There is a link to what participants view as ‘support’ and the *spirit of midwifery* (Shroff, 1997); in other words, these participants seem to be saying they felt the most supported by midwives who provided informed choice, appropriate use of technology, and a

willingness to spend time with them. Even though two elements within the spirit of midwifery could not be satisfied - choice of birthplace and continuity of care - those participants who said they felt like they were given enough information regarding medical procedures and were able to understand why certain choices had to be made, felt more supported. As one of the participants stated:

My midwife came in, talked, and went through the schedule. [Y]ou know how it works, Ken (participant's partner), that he would get dressed when the nurse came in said it was time. [T]hey would come in and give me a little thing for indigestion for your stomach and then give you some gravol cuz I tend to be nauseous after. [W]e talked about everything that was gonna happen, you know how the surgery would work. (PP15-W2: p. 1-2)

Also, when the participants perceived medical technologies as necessary, they were highly satisfied with their midwives. Instead of seeing the technology as invasive, they appreciated that it was there because they felt they truly needed it. One participant reiterated her trust in her midwife to make the right decisions regarding surgical options:

You know I was, we tried everything right. [The midwife] didn't try to push me...I could totally trust that that was the best option and I knew she had the best interests for me. (PP55-W2: p. 4-5)

Women also really valued the time midwives spent with them in terms of availability or actual presence. It was important for women to have access to their midwives whenever they felt they needed them, and that their midwives were physically present for their labour and birth. This expectation carried into the operating room during C-sections. Participants often made reference to accessibility or presence of their midwife in their narrative:

Um, just the quality of the [midwife's] care and her availability and I could call her anytime. (PP28-W2: p. 2)

I was definitely satisfied with the fact that she was there with me the whole time. (PP39-W2: 5-6)

I knew I was in good hands. (PP55-W2: p. 2-3)

Feelings of autonomy are also central to making difficult experiences in childbirth more positive. One participant viewed her birthing experience as 'empowering' and attributed her feelings of being powerful to the ability to choose pain relief and to be informed of the medical procedures ahead.

Nurses also played a vital role in contributing to feelings of support for those women who had more favourable birth experiences. This is not a surprise given that labour and delivery nurses have experience in providing that kind of support, especially before the recent changes in the maternity care system in the study region with the legalization and public funding of midwifery services (Kornelsen et al., 2004). Nurses still provide this kind of active support today as illustrated in the narratives, as long as they view their role as supportive to women's emotional and medical needs in cooperation with the midwife. This garnered high ratings of satisfaction from participants. This kind of support was also intertwined with the ability to give adequate information to labouring and birthing women:

She [the nurse] was good and she was really supportive and 'course, once the drip was in, she stayed there. [S]he was, you know, just the cheerleader by my side. 'Come on!' and in a really nice way so she was nice to have around (PP39-W2: p. 6)

They [the nurses] were very understanding and they supported you emotionally as well as physically and medically. [They] would come at any minute for any problem or any question they were completely at your beck and call. (PP88-W2: p. 5)

[Q: What made some nurses care more satisfying than others?] [It was being] willing to actually show me how to do things and talk to me about the problems [I was]having with the baby, whereas some of them [would] come in and do it for you and they don't really try to help you. (PP28-W2: p.3)

Another important player in helping women achieve more positive experiences in the face of disruption is the *doula*. A doula is a trained birthing professional who is paid for privately (i.e., not covered by medical insurance) and is knowledgeable in natural pain relief techniques (Campbell et al., 2007). One of the doula's roles is to provide emotional support for birthing women, as well as working in a supportive role with the midwife and partner (if there is one). If the woman does not have a partner, the doula can take on a similar role. She does not have the training to deliver babies or to provide internal exams but can play a pivotal role in assisting the midwife and the woman in reading external cues of labour progression and is usually with the birthing woman during the early stages of labour, before the midwife is required (*ibid*). This is similar to the homecare workers in the Netherlands and Australia. Just like abroad, these types of support in Canada are vitally important in the childbearing process to increase maternal health (Campbell et al., 2007).

Unfortunately, because doulas are an added expense and this participant group had limited disposable income, only two participants utilized doula services. Although several participants expressed an interest in having one, the cost of a doula was a deterring factor:

I would have liked a doula but they're very expensive. I saw that it was like four hundred, five hundred dollars and my midwife was always like... sometimes they do, they'll lower the fees. [B]ut it takes, it hurts her pride a lot too, like I would – I didn't want to [go to] Mothering Touch and be

like ‘hi ah can’t afford to pay five, five hundred dollars for a doula, can you please take pity on me?’ (PP103-W2: p.21)

The participant’s words, ‘take pity on me’, serves to illustrate the complex emotions that surface when discussing the inaccessibility of services due to income, especially as it pertains to increasing social support at a vulnerable moment in a woman’s life.

Even participants able to find the money for a doula expressed concern over the cost:

It would have been nice if the you know the doula like we paid quite a bit for the doula so um, we chose to do that. [Y]ou know it’s expensive uh, anyway it would be nice if there was um...[I– public health care?] Yeah, but I think they’re worth it, it just like, it was something that we paid for and we knew wanted the support so but definitely it was expensive. (PP11-W2: p. 5)

The participants who could afford a doula only had positive things to say in terms of their care:

[The doula] came uh, right at five in the morning with the midwife and she stayed all the way until 11:15 pm. [S]o she came to the hospital, she didn’t do any service at the hospital, she just came with me. I did acupuncture with her through my whole pregnancy as well. I knew her quite well and she just came to support me. (PP11-W2: p. 5)

[The doula] was great. She provided exactly the right level of care. She wasn’t too in my face, she was there when I needed her and was happy to back off when the midwife was around and I just wanted to be alone. (PP105-W2: 4)

Although some women who were transferred from a midwife to an obstetrician said they felt as though they received support in terms of autonomy, adequate information and time spent with them from some health practitioners, the majority of the participants who experienced disruptions did not have such positive experiences of care. The data

indicated that there were participants who did not receive enough support, who said health practitioners did not give them information regarding procedures and technologies kept them in the dark, and who mentioned feeling disempowered and lonely. Although in most instances these feelings seemed to go hand in hand with coming into contact with medical practitioners outside of midwifery. One participant located the problem with a lessening presence of her midwife: “she wouldn’t stay there with me. [S]he’d stop by, check me, leave, stop by, check me, leave” (PP103-W2: p.17). Another participant talked about feeling like she was ‘out of the loop’ when it came to her midwife:

I did feel a little bit out of the loop sometimes or I don’t know. Not out of the loop in that she’d surprise me with procedures or anything like that just... sometimes like I wasn’t being told everything. (PP103-W2: p.17)

Midwives who did not reflect the themes of the *spirit of midwifery* (i.e., autonomy, time spent with women, adequate delivery of information) were considered by participants as failing to give adequate support during the birthing process. This may have occurred as a result of their lessening scope of care as the participants were transferred increasingly to obstetricians, although the participants held midwives personally accountable. These expectations differed for other health care professionals, most notably the obstetrician, which I detail in the upcoming section, *Gendered Expectations of Care*.

#### *Informal Support: Partners, Friends and Family*

Although informal support, defined in the PPHS as care from partner, family and friends, who are not paid, is not as central in participants’ narratives as formal care, informal support was still important to them. Participants who had a partner, friends or family supporting them through the process were very grateful:

[I was] really happy my mum was there because she really helped with the pain during contractions. And I can say, I've never loved her more. (PP103-W2: p.7)

My husband was really, really good in coaching me through the whole thing. He was there; he talked me through everything. He was just great. (PP60-W2: p. 2)

Most apparent in the narratives were the moments in which informal support was infringed upon. It was particularly upsetting for participants to be separated from loved ones, especially during times of medical intervention, such as when having a C-section. In numerous transcripts, loved ones were either not allowed in the operating room at all, or were delayed considerably from being present. Two participants spoke of being prepped for an emergency C-section, at which time their partners were not allowed in the room, and then there was a surgical delay. One participant waited for 2 hours in the operating room, body frozen, her arms strapped down to the metal table, without the comfort of her partner who was not permitted into the room. Other participants also had similar experiences:

I was too freaked out about the surgery. I was looking for Tony the entire time; I was searching for him. I didn't understand why he wasn't there at that point. Why isn't my husband right here next to me and why won't they let him in? And they said that they were talking to him about something but I couldn't understand what it was. It seems like a long time. (PP70-W2: p. 3)

[During the C-section] my mom wasn't there. I'm sure they didn't let her come in. She was there immediately before and immediately after but she wasn't in the room. [During] the caesarean they don't let... more than one person [in]. (PP103-W2: p. 9-10)

#### ***4.1.2 Experiencing the Medical Model of Care***

Similar to PPHS findings, I also discovered that expectations of care, i.e., what women want versus what they got, factored into having certain kinds of birth experiences. However, expectations of care were not the only elements that contributed to such experiences. Even those who had experiences contrary to their expectations and were not happy with the birth event per se acknowledged how it could have gone better or worse based on the formal support they received from a variety of health practitioners involved. In the following section, I highlight the findings that have to do primarily with the participants' experiences of the medicalization of childbirth when participants have chosen to attempt to have a 'natural' birth with a midwife. I will also explore the elements that make for more pleasant birthing experiences once someone is transferred to the care of an obstetrician, and nurses. As part of this exploration, I will examine how practitioners interact with each other, and what impact these interactions have on labouring or birthing women.

##### *Gendered Expectations of Care*

The participants looked for the same elements characteristics in an obstetrician as they did in a midwife; however the expectation of how health practitioners demonstrated these elements of care, differed greatly. All of the midwives in the PPHS study were women while all but one of the obstetricians who provided services to the mixed provider group of participants were men. First, it is important to note that I do not attempt here to essentialize women and men, nor midwives as female and obstetricians as male. Even obstetricians who are women work within a medicalized system based on traditional aspects of masculinity such as distance and objectivity. Further, categories of masculinity

and femininity are not based on the biological differences of *sex*, but the learned characteristics associated with gender (Butler, 1991). According to Connell et al. (2005), masculinities and femininities “are configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular social setting” (836). In other words, biological males can have feminine traits, just as females have masculine traits.

As my analysis of the participants’ transcripts revealed, gender plays an integral role in participants’ expectations of care. This makes sense since gender is an integral part of people’s lives and, for women more than men, relations of gender typically result in inequality (Eiseinstein, 1983; Reinhartz, 1992; Kleinman, 2007; Lorber, 2007). Gendered expectations of masculinity and femininity are the cornerstones of gender inequality, and such notions pervade all of our lives as we actively reproduce these differences through discourses (Foucault, 1979; Foucault, 1981). How women say they wish to consume maternity care in this study illustrates how the discourses of femininity are associated with midwifery, and discourses of masculinity are associated with obstetrics. Among other things, traditional notions of femininity entail caring and sacrifice, often associated with subordination, while traditional notions of masculinity are associated with knowledge and power (Connell, 1987; Connell et al., 2005).

While participants were most satisfied with care that incorporated their feelings of *autonomy*, acquiring sufficient *information* and *time* spent with them, they expected midwives to satisfy these factors differently than obstetricians. Midwives were expected to spend considerable time with the participants, including the entire labour and birthing process. Participants also expressed a wish to exercise complete autonomy under the care

of a midwife and said they wanted the midwife to sufficiently relay information.

Midwives were expected to have ‘typical’ feminine traits of support and friendship, especially as it pertained to the time devoted to their care, and to be a competent medical professional simultaneously:

[The midwife’s] just very professional as well, very friendly, caring. [She] knew what she was talkin’ about. (PP55-W2: p. 4)

I was definitely satisfied with the fact that she was there with me the whole time. (PP39-W2: 5-6)

[Participant discussing medical procedures with the midwife] I don’t know like you go ask the doctor, like you figure that out, like that I thought that’s what your job is, not mine (PP88-W2: p. 4).

On the other hand, the participants expected obstetricians to spend very little time with them. Instead, obstetricians were expected to be efficient with their time, to answer the participants’ questions and supply information and that was it. The participants appeared to be less concerned with autonomy and being in control when under the care of an obstetrician:

It was like I was able to participate even though I had this big cloth in front of me strapped to a table and frozen. [The obstetrician said] okay we’re...cutting open the first layer, cuz he asked me {---} do you want to know what I’m doing, you know. I said well not graphically but I wanna know, and he said okay we can see the sac, the placenta sac,. [U]m, kay we’re cutting now and okay oh I can see a foot! You know so, it was like I was there [and the obstetrician] was...asking how are you doing? How are you doing? You know, I wasn’t just this body like on the table. Like my other surgeons didn’t even talk to me, you know, I was just this carcass lying on the table. (PP15-W2: p. 3)

In other words, this participant was satisfied because she felt as if the obstetrician knew she was there; all she wanted was to be treated like a living, human being and not a ‘carcass lying on the table’.

Women’s expectations of obstetricians were also considerably less in terms of support. While midwives were expected to be supportive friends, and stay by the side of the labouring women through the whole process, obstetricians were expected to take a few minutes to explain the procedures that the women were about to undergo.

Participants also expected more medical competence from obstetricians, illustrating another element of gender inequality within a general devaluation of women and ‘non-physician healers’. Although all of the participants from both sample groups chose midwives, their expectations of medical competence favoured obstetricians. This indicates how the medical hierarchy created from the erosion of midwifery still lingers in women’s consciousness. Similarly, the expectation that they would have less autonomy with an obstetrician and viewing the obstetrician as more of an authority, points again to the value that participants placed on typically masculine traits, such as power and authority.

#### *Cooperation and Information vs Interdisciplinary Tensions*

Participants also pointed out the importance of cooperation between all of the professionals involved. Women in this study who felt as if they were being taken care of by a team of medical professionals who respected each other were more trusting and more willing to undergo medical procedures such as a C-section. This resulted in more positive experiences for the participants and their families:

It was incredible...[the doctors]...discussed what was going on and it was very good. (PP88-W2: p. 5)

Well the team of people that were there was very good...[M]y anxiety was relieved...just because I had confidence in who was there, you know, uh, it makes a really big difference...I mean you're going into surgery. (PP15-W2: p. 3)

[The obstetricians] just stepped in...there [was] no barrier...[S]ometimes they're not so prejudiced that you started with the midwife and now you need a doctor...[T]hey were great...just like okay, she needs help, I got in just as soon as anybody else would have and that was impressive cuz I thought I might be...second priority I guess. (PP88-W2: p. 4)

However, the opposite was true of many participants' experiences; tensions between midwives and nurses or midwives and obstetricians were more likely to occur than not, and this affected the quality of care that some women received. Because of the relatively new legalization and public funding of midwives, tensions between professionals in the hospital setting are still prevalent. As midwives entered the hospital, nurses' scope of care shrunk as midwives became more responsible for low-risk labour care, previously a nurse's domain (Kornelsen et al., 2004). For example, one participant spoke of feeling as if nurses treated her unfairly because she had a midwife:

Um, some of them [nurses] I was quite happy with, some of them I did not like at all... Some of them don't like having midwives work in the hospital and they're quite obvious in how they treat you very differently (PP28-W2: p. 2-3).

Participants also spoke of tensions between obstetricians and midwives. This appeared not to be because of a perceived overlap in scope of care, but because some participants perceived their midwives to have less power and authority than obstetricians. As one participant remembered:

I guess...[the midwife] had tried to talk to the obstetrician about possibly trying forceps or whatever and he just said no it's too dangerous. (PP39-W2: p. 3)

Other participants felt as though having a midwife put them at a disadvantage in terms of being listened to by obstetricians. One of them wondered if having a doctor would have awarded her more autonomy over her birthing experience:

That's the other thing that I would do differently. I would have had a family doctor at the time because so much of the care that nurses and other doctors are willing to provide for you, is done on the basis of other care providers...I felt that I wasn't heard and I wasn't listened the way that I could have been if I had had a family doctor vouching for me. (PP70-W2: p. 8)

Due to the unlikelihood of having her family physician present at the birth, and the limited time physicians spend at the hospital during a woman's labour, this quote is very interesting.

Participants identified the most important issue as the lack of communication that exists between midwives and obstetricians in the hospital. They felt as though they had to relay messages back and forth between their care providers. This role of 'go between' at a time when the participants were at their most vulnerable was exhausting and problematized the trusting relationship they had with their midwives, resulting in more confusing and negative birthing experiences:

[The midwife was] sort of...haphazard with information that was being passed through the doctors like I felt that I was the go-between...I wanted her to check in with the doctors not me having to keep her updated with what was happening with the doctors. (PP88-W2: p. 4)

Yeah, like I don't know what the medical terms were for things and, she [the baby] ended up having a little bit of a heart thing that they were checking out...[The midwife was] trying to probe me well what was this

what was that what did they give her? I don't know like you go ask the doctor, like you figure that out, like that I thought that's what your job is, not mine. (PP88-W2: p. 4)

One participant took a more diplomatic approach, pointing less to the personal tensions between midwives and obstetricians, and more to the structure of the hospital. This includes how the structure of the hospital setting contributed to inadequate practitioner relationships, stating, “the hospital isn't set up well to deal with I'm not really sure, just lack of communication between doctors and midwives” (PP88-W2: p. 4).

How the maternity care system in British Columbia is organized around compartmentalized services also creates tension for the women who utilize them. Those who experience the exhaustion of going back and forth between a midwife and a doctor, would rather opt to have a doctor and forgo the specialized care and support of a midwife. One participant said that she would strongly consider that option in the future just in case she needed medical intervention, pointing to the need for continuity in the birthing process:

I think a midwife is great when everything goes naturally and it's fine but when all of a sudden you need medical intervention, they don't have that knowledge, so it's somewhat irrelevant in a way...I would just do a C-section another time because what I've been having to do is double time, like, having to go to my midwife, and then go to the doctor, go to the midwife keep everybody up to date and it's kind of like 'why?' I should just be going to a doctor in the end. (PP88-W2: p. 3)

### *Bureaucratization, the Politics of Risk and the Impact on the Birthing Process*

There is a debate in the narratives about the source of the communication problems between health practitioners during a hospital labour and birth. It may be

partially personally driven, but also encouraged by our current organization of maternity care that compartmentalizes services. This results in further division between midwifery and obstetrical care. Regardless of where these problems come from, bureaucracy was a theme in the participants' narratives. Hospital policies had a negative impact on the birthing process for many participants, usually regarding making decisions about whether to allow a woman to labour longer than medical protocols. As discussed earlier, once a participant presented with a factor that was on the hospital's 'risk list', a set of medical procedures were set in motion (Rice, 1997). Sometimes this occurred at the outset of the pregnancy, with the participant losing her ability to choose her place of birth. One participant spoke of why she had planned a hospital birth rather than a home birth, "because I had a C-section before I had to – I had to go to the hospital" (PP14-W2: p. 3).

According to this participant the ability to choose to have a vaginal birth after a C-section (VBAC) was limited to giving birth in the hospital. Current data from the Canadian Institutes of Health Research also illustrate that VBAC rates are decreasing, especially for women with low-incomes (Benoit et al., *forthcoming*). Roughly, 81.9% of women in 2005-2006 had a repeat C-section (*ibid*). This begs the question of how the decreasing rates of VBACs are affected by the bureaucratization that informs the decision-making process of whether or not to opt for a subsequent C-section. Midwives have the ability to assess the risk-factors that make a pregnancy high or low risk and can make recommendations for having a safe home birth or not. However, midwives must turn their client over to the authority of an obstetrician once she enters the hospital and obstetricians can 'override' the decisions of the midwife. Concerns over midwifery autonomy are one of the factors that contributed to the debate between midwives

regarding integration. There is a potential loss of autonomy for both women and their midwives once midwives are no longer outside the medical system (Benoit, 1997). This situation was apparent in the PPHS, rendering both the participant and her midwife less autonomy - the woman over her own body, and the midwife over her own profession.

Other times, the ‘risk-list’ can haunt a woman’s labouring experiences and restrict her ability to give birth vaginally without any signs of fetal distress. One participant recounts a birth story that illustrates this point:

I was in labour for about six hours and nothing was progressing. I was still one centimetre, and they said they wouldn’t let me progress so –so far into it because I had a C-section with my first... [S]o I went in for um, a C-section. (PP14-W2: p. 2-3)

Even for one participant who had a more positive birthing experience, the structure of the hospital and how the maternity system is organized around C-sections, was a lingering concern that was often on her mind:

It’s really early you know...I better not go into labour, cuz you know, cuz then I’ll be in the hospital for emergency C-section...[Y]ou want to try to avoid that, cuz then you don’t get the surgeon you want. (PP15-W2: p.2)

Although this participant’s birth worked out well, the constant fear about scheduling practices at the hospital was stressful right up until the time she had her baby. This situation leads me to ask the question *why can a woman choose her midwife, but not her obstetrician?* Although I will not address this question in this thesis, it is a question to ponder, and perhaps to ask it again when thinking of future research.

Sometimes hospital policy is so strict that it places the health of pregnant women in jeopardy. One participant was having her pregnancy closely monitored via ultrasound near the end because of concern for the lack of fetal growth. After being confined to bed rest in the hospital, she went in for an ultrasound that was ordered one day too early. The participant's interactions with the ultrasound technician were as follows:

I said well, they're supposed to monitor his growth today and she said no, because two weeks have to pass in order for that to happen and I'm going to inform the nurses that they can't send people and blah, blah, blah. So all this bureaucracy type thing that was behind it...[S]he was pushing how it had to be on the 14<sup>th</sup> day. I said well it's only one day away. (PP70-W2: p. 1)

As a result of the technician's refusal to measure the growth of the fetus, the woman was sent for an additional ultrasound the following day. The results indicated some concerns; she had to have an immediate emergency C-section. The extra day increased the obstetrician's concern for the fetus, illustrating how an arbitrary policy could have led to potential complications.

#### *Vulnerability, Feelings of Invasion and Unnecessary Interventions*

Roughly one half of the women who were transferred reported that they felt physically invaded due to what they did not believe were necessary medical interventions. At a time when the majority of the participants had been in prolonged labour and had just been told that they must have a C-section, they were feeling extremely vulnerable and were less able to advocate for themselves. As one participant stated, "I do think that after you've been in active labour for that long you're not able to think 100% clearly and make...solid decisions" (PP39-W2: p. 4).

Some participants felt as though inexperienced medical personnel were practicing on them. One woman spoke of how uncomfortable she was to have a young ‘good looking’ male doctor give her a vaginal exam when she felt the procedure was unnecessary. For someone who appeared to be very shy about her body, she said she felt humiliated to have numerous nurses and doctors in the room while she was undergoing this procedure. She expressed frustration that there was not room for her to decline the exam.

[T]his young good-looking guy...just stuck his hand up there...I could tell it was just for practice ...[I]t was so awkward...Especially ‘cause they ask and what am I gonna do go like, “no”? ...I was just like “fine you’re the sixth person today...All the nurses did it too and – it’s funny...how kind of humiliating is to...go through that. Especially if you’re at all uptight about your body...I avoided getting a pap smear ‘til I was twenty-one...I didn’t want strangers looking down there. (PP103-W2: p. 13)

Reid (1997) wrote of how some women compared their hospital experiences to that of rape; while this is a very strong word and was not present in the data, there were many instances such as these in which women felt like they were physically invaded and felt powerless to say no.

Another participant recounted a story about not receiving the information she felt she was entitled to. When a student nurse began to prep her for a C-section, the participant pointed out she had not given permission to be prepped for surgery by a student and was upset by the omission:

She was taking a long time, but mostly it just bothered me that...the nurse came in and she came with a student... [T]his nurse, who I’d had previous experiences with, she was a very nice nurse and everything but she was one of those nurses that’s like...she just does things her way. She didn’t

tell me that it was a student nurse until she was already in there and had already started prepping me. I'd already shown her pretty much all of my private parts. (PP70W2: p. 2)

This participant experienced a second moment of invasion when another medical practitioner came into the room without her permission during her C-section prep, at a time when she said she felt physically exposed and very vulnerable:

[The student nurse] put in the catheter and shaved me and everything. While she was shaving me the resident came in, male resident came in, which bothered me because I felt there was no need for him to look at me. (PP70-W2: p. 2)

Some participants said the use of technological interventions by nurses and/or obstetricians were not always necessary. One participant looked to her midwife when she was feeling vulnerable due to her long labour and strong contractions, hoping that her midwife would take on the role of making the decisions that would most benefit her and her baby. While C-sections are most commonly performed due to 'failure to progress', another 15% or so occur because of the electronic fetal monitor (EFM) reading (Cassidy, 2006). One participant described her experience with an EFM related C-section:

Every time we tried to move they lost her heart rate...I had a drip they had the fetal monitors on her so if she tried to put me on my side they lost her heart rate... [T]hey couldn't tell see it on the monitor or whatever. (PP39-W2: p. 2)

Due to her movements, the EFM could not accurately read fetal movement and as a result this participant was told she needed a C-section. Even though the use of EFM technology has been criticized for its unreliable and inconsistent measures, (Cassidy, 2006), it remains a means of assessment used by obstetricians; this is illustrated by the data. When

the participant described hearing that she was to receive a C-section that she deemed unnecessary, she felt as though her midwife did not sufficiently advocate on her behalf when she was feeling vulnerable:

The obstetrician came in and said ‘o let’s just give her a C-section’ and so that’s what they did! ... I freaked out...I told them all ahead of time that I didn’t want that so I remember yelling and screaming and then I don’t know if it was shock or fatigue, [but] I actually blacked out and then woke up screaming again... “[Where am I? What’s happening to me? What’s going on? (PP39-W2: p.2)

This illustration of what can be described as a traumatic moment begs the question of why EFM’s are still utilized so frequently and relied upon when they have been proven to be unreliable.

#### *Did I have a baby?*

After many participants from this study got through the unsatisfactory interactions with medical practitioners, the feelings of invasion and the C-section itself, it was all supposed to be worth it for one thing: a healthy baby. However, in the moments following the birth, many participants expressed their distress about not being able to see or hold their baby anywhere from several minutes to sometimes several hours. From my own experience of midwives’ teachings and numerous books on birthing that I read in preparation for my own first birth, it is important for a mother to see and feel her baby in order to process what has just occurred (Atkins, 1998).

The first time I gave birth I was shocked at the sight of a baby. It is a strange concept to think through that although I understood intellectually that I was going to have a baby, I still was unprepared for the birth of a real human being. Due to this kind of shock, to

begin to associate oneself with the strange being that just came from one's body, it is imperative to begin bonding right away. It is the moment after birth when an infant is placed in our arms that we work towards. It's how we survive it all.

It is important to ask what happens to women who are robbed of this moment. How does that affect them in the days and months to come in terms of their postpartum health? One participant expresses how she felt by asking the question, "did I have a baby?" (PP70-W2: p. 6). She recounted a story in which she had lost so much control over her birth that she no longer saw it as her birth, but as a birth that belonged to the doctors at the hospital:

It just felt like I didn't have the baby. I wasn't the one who had the baby. It was the doctors who gave birth to the baby. It just felt like that. I know that's not what actually happened and I know...I still had the baby for eight months inside of me and that should count for something. But it just didn't feel that way. It felt...like I said it was such a weird feeling because even after I had had the baby, it just felt like where's my baby? (PP70-W2: p. 6).

Not only was she unable to be with her baby immediately following the birth, but her newborn was taken away for more tests after a brief moment with the child. During this period, the nurses instructed her to rest and heal when instead the participant said she wished to be with her child. At one point, the participant made her way to the floor where her baby was being monitored despite the pain from her surgery, only to find out that she still wasn't able to hold him:

What made me even more angry was that I actually made the extra effort to get out of the bed, to go all the way to the special care unit, only to find out that I couldn't hold my baby because he had to be at exactly 30.5 degrees Celsius in the incubator and if they took him out then his blood sugars would drop. I was so mad. (PP70-W2: p. 6)

Some participants also expressed frustration about not having their baby near them after the birth. This was meaningful enough to surface again and again in the data:

You don't see the baby which is like it's about ten minutes fifteen minutes before you see the baby but... I mean normally if you have a natural birth you'd see it right away...[W]hatever [after a C-section] they don't let you see it. (PP88-W2: p. 2)

They needed to do something else with her so they wheeled me into the recovery room for an hour [without the child]. (PP103-W2: p.10)

They didn't bring the baby to me right away. Like they brought the baby over so that I could see him but I couldn't hold him and I can't remember why. (PP70-W2: p. 4)

While there may be many reasons why women must be separated from their babies, what is most noteworthy is the distinct lack of information that health practitioners gave the participants about why they had to be separated, and the stress this caused them.

### *Fatalism*

The discontinuity of going back and forth between health practitioners due to a transfer of care can persuade women to opt for a C-section in subsequent births. Three of the participants who had negative experiences of transfer said they had decided they did not want to risk losing their midwives or end up with an emergency C-section again next time for which they were ill prepared. When asked the question "*Is there anything you would do differently, another time?*" they stated:

I could say next time I would fully consider a planned caesarean. (PP103-W2: p.16)

I would sign up for a C-section. (PP88-W2: p. 3)

Um, I don't think I'd have a midwife... Yeah. I'd stick with just having a doctor. That's the only difference. And I might just go in for a C-section... Just because I know I can't – I can't do it [again]. (PP14-W2: p. 5)

Even though midwives can and do deliver VBACs successfully, many participants would rather opt for major abdominal surgery and avoid transfer, than attempt a VBAC and potentially have a positive birthing experience with a midwife. Not only does this illustrate how traumatic the experiences of transfer were for the participants, but it is also indicative of their agency, to the extent they want retain some control over their own fate during future pregnancies.

Sometimes fatalism crept up during the birthing process itself. Some participants said they had wanted to speak up against specific medical procedures during the labour and delivery but were so tired or in so much pain, they gave up:

[T]he whole pregnancy I'd always wanted to really avoid a caesarean 'cause my mother had had four and... I had wanted to have a normal labour. But at that point I really didn't care anymore. (PP103- W2: p.8)

[Re: vaginal examinations] I was just like 'fine you're the sixth person today'. (PP103-W2: p.13)

Again, it seems that participants were attempting to hold onto some form of agency in a situation that strips them of so much of their autonomy. By actively choosing to relinquish control, they implicitly gave their permission for something to occur that was going to happen no matter what they said.

In the next section I will briefly compare the experiences of the transferred group to those of participants who were able to retain their midwife throughout the labour and

delivery process. It is important to examine whether or not women who were transferred had negative experiences due to the transfer only, or if the organization of maternity care in British Columbia also negatively affects those who give birth.

#### **4.2 Comparative Analysis: Contextualizing the Marginality of Maternity Care ‘Disruption’ by Situating ‘Continuity’**

In the previous section women pointed out the importance of having autonomy, accurate information and adequate time spent with them as central to high quality maternity care. The same themes held true for the group of women who retained their midwives. By the same token, there was a minority of participants in the latter group (two women) who had negative birth experiences in this sample because they felt as though those important elements were not met by their primary caregiver.

Although I am not studying a sub-sample of participants who chose physician care, the women in the PPHS who had continuous midwifery care and those who had continuous physician care were highly satisfied with their experiences and had the best postpartum health. This illustrates that it is actually better to have *a good doctor than a bad midwife*. Although such a saying is rather binary and colloquial, it seems to ring true for the two participants who mentioned that their midwives did not listen to them or were not supportive to their family members. One participant recounted how her midwife, causing anxiety for the participant during the labour and birth, treated her husband in a rude and disrespectful way:

[The midwife], was in my opinion, rude and denigrating to my partner... So it just seemed like one thing after the other like she had a sort of list or litany of problems with him and I felt very discouraged... So it was this sort of tempest [in a] teapot, and in the meantime my relationship with my

mum and my partner was getting very strained because they didn't believe what the midwife was saying. [B]ut I was investing in her that she was in authority and putting my belief in her which turned out to be very misguided. And that's when I was really fucking angry. So I felt a sort of betrayal of trust. (PP68-W2: pp. 4-5)

Another participant felt as though she did not get what she needed in terms of formal care because her midwife was “very, very conservative and more medical model” (PP81-W2: pp. 7). This led her to the decision of changing midwives after the birth of her baby to another midwife in the same practice. When she was asked to rate her satisfaction with her midwife's care she responded:

Somewhat dissatisfied. I hate to say that because I'm really on the midwife's side compared to a doctor's side, generally. Just because of the time and the training etc., etc. But this woman was...making some calls that... I have now asked not see her and I'm seeing the other partner. (PP81-W2: pp.9)

This illustrates that even someone who believes in the practice of midwifery can be dissatisfied with care from a particular midwife, resulting in more negative birthing experiences. The examples above serve to demonstrate that both participants would have been better off with more supportive care that reflected their beliefs about childbirth, regardless if the care was received from a midwife or a physician.

Participants in this sample were also affected negatively by the organization of maternity care in British Columbia. However, interactions with medical practitioners from the hospital were less frequent and therefore less invasive for women who retained their midwives. The participants who retained their midwives had higher levels of education and income compared to participants who were transferred to obstetrical care.

They also had continuous maternity care that the groups of women who lost their midwives did not. Therefore women who retained their midwives had a midwife able to advocate for them throughout the process, as well as more cultural resources through higher education and income to advocate on behalf of themselves. Nevertheless, a poor team atmosphere affected a few participants in this sample based on observations of interactions between midwives, nurses and obstetricians. One participant spoke about the tensions between midwives and nurses she experienced: “all the nurses weren’t on the same page; they didn’t like midwives and they made that well known” (PP81-W2: pp. 6).

Participants who retained their midwives described mainly positive interactions between obstetricians and midwives. This is not surprising because they were low-risk and did not need emergency care from an obstetrician. However, one participant did choose to seek written permission to have a VBAC from an obstetrician, just in case the obstetrician at the hospital had a different opinion:

It was recommended to go to an obstetrician uh, so that we can get confirmation in writing that VBAC would be appropriate for my situation so that if another obstetrician were scheduled...when I happened to go into the hospital, there was a discrepancy whether I should have a VBAC or not...[W]e would have something in writing saying that there was no issues surrounding me having a VBAC. (PP38-W2: pp.2)

The following narrative was the most revealing in terms of the politics of hospital births. Because she had a traumatic experience with an obstetrician for her first child, this woman and her midwife sought written permission for a vaginal birth as a source of protection. They also induced her birth based on which obstetrician was scheduled at the hospital so that she would not have the same obstetrician as she had previously in the event of another C-section:

I: So what made you decided to break the water – did they tell you that the outcome could be or did you decide to...

R : The number one reason was, and it's gonna sound um, kind of bizarre, but the number one reason was politics. Politics within the hospital and...who was scheduled when... [T]he pressures of who was being scheduled every day was getting closer... I was starting to feel a little discouraged and somewhat pressured and, thinking about who was scheduled all the time. (PP38-W2: pp.1-2)

Inducing births based on scheduling practices is a symptom of the problems that occur within our current organization of maternity care. This can potentially affect the physical health of both mother and child, and in addition increase emotional distress that accompanies this set of decisions. The induction of labour can contribute to other medically invasive practices and can ultimately lead to a C-section (Atkins, 1998). In this particular case, it worked out well for everyone involved. However, the potential for complications because of such a strong desire to avoid certain practitioners is a dangerous effect of a poorly designed maternity care system that does not include autonomous decision making for women surrounding the selection of a specialist.

Women who retained their midwives still reported feelings of vulnerability due to pain and exhaustion. However, the positive outcome of a vaginal birth rendered the decision-making process regarding medical interventions a moot point. In situations where there was reason for concern, participants who had continuous care from a midwife fared best when they felt as though the obstetrician respected the midwife's expertise. In other words, obstetricians were given high marks when they presented themselves as consultants, gave adequate information to the participants, and did not intervene in the birthing process:

[The obstetrician] basically just presented himself as a consultant. [He] didn't try and intervene. He wasn't overbearing. [He] wanted to know what we wanted to do. And basically just said 'yep, I'm fine with that and hopefully you won't see me again' which was exactly what I was looking for in an obstetrician...[S]o I thought he was very good. (PP59-W2: pp. 7)

[The obstetrician] was just gentle, and he talked to me and he explained whatever he was doing. My husband and I were pretty touched by...the way he handled everything. He didn't cut me you know. He was very gentle... He said this is all about you. (PP60-W2: pp. 4)

As we can see above, if the health practitioners involved make the concerns of the birthing woman central, it results in a more positive birthing experience. As with the group of women that were transferred, women from this sample also felt that having a team of professionals best served their interests and the interests of their family.

Although there were similarities between both groups of participants who chose a midwife as their primary care giver, there were also marked differences that contributed to a higher satisfaction for the women who were able to retain their midwives. First, the majority of these women felt as though all of their hopes for a positive birth were satisfied. Participants overwhelmingly used the word 'supportive' or 'support' to describe the care they received from their midwife:

She's a great support, and really encouraging and really honest with me I think 'cause things were taking a long time at the beginning and then she was right there at the end, very vocal with me, helping me through the end part 'cause that was pretty difficult. [S]he's just overall, and she was really supportive. (PP18-W2: pp.4)

I don't really have a sense of comparison, because I've never had a baby under the care of a physician before, but I...just felt...[the midwife] was really like, supportive and encouraging and... knowledgeable. (PP71-W2: pp.4)

Also their practice has four midwives in it and it's in the community and they are a really great support for one another...I feel that they have a home base. (PP26-W2: pp.3)

I chose to wait it out [breaking waters in hospital], when I discussed it with my midwife...[S]he was very supportive [with] my decision and anything that I decided to do she was going to back me up. (PP38-W2: pp. 2)

This kind of support rendered midwives the status of a good friend:

Through the process I'd say...[the midwife] became... somewhat of a friend...[W]e had a really good relationship with her. (PP83-W2: pp. 8)

Support was only one element that came though overwhelmingly in the data.

Women were also very pleased with the autonomy they had over their own birthing experiences:

[Both the midwives]...understood what I had wanted too...I explained to both of them what I wanted in the birth and I mean... they both would have been great either way. I think they knew. I mean I was actually able to pull ah, Hayden out of me. With my own hands and put him on top of me. (PP05-W2: pp. 7)

Everything was very up to me. She'd say do you want this, do you want that, giving me options and letting me kind of chose what I wanted to do. (PP06-W2: pp.3)

[The midwife's] very like, she was attentive...[W]e had discussed what I wanted and how I wanted things to go and she was kind of on the ball with that. (PP85-W2: pp. 4)

Midwives were also described in terms of the time they spent with these participants, pointing to the importance of continuity within the birthing experience, as well as surrounding it:

Just the individual care...[W]ith normal doctors they kind of come in and out and they come and check on you and then they leave. She was just there the whole time and whatever I needed. Basically just being there. (PP06-W2: pp.3)

I don't know it's just basically everything about her care was awesome. And she didn't leave the whole time. She didn't leave me in anybody's strange hands. (PP60-W2: pp. 4)

I just think she did her job very well...They're consistent. You see the same person or the same two people all the time. (PP59-W2: pp. 7)

Most midwives were also deemed to be encouraging. Participants said that when they were feeling as though they could not go on due to pain or exhaustion, the encouragement they received from their midwives was vital:

[The midwife]...even when...it was taking a long time she never used words like 'failure to progress' or 'you're not moving fast, things aren't, you're not dilating'. (PP85-W2: pp. 6)

She was really supportive and really positive and there was a few times where I would say like 'oh I can't do this, I can't' and she would just say, 'you're doing it, you're doing it!' And that would just stop me from going to that defeated place and that place where I was getting scared of the pain. And she would really, really talk me through it, and that helped so much. (PP85-W2: pp. 7)

Another important factor for women who retained their midwife is having adequate information. The participants who specifically mentioned information spoke about the open communication they had with their midwives about the process of childbirth, medical procedures and so forth. In the words of one participant who had received continuous care from a midwife:

[The midwife] allowed me to focus on what she was telling me to do...[I]t just helped so much because, her instructions were just so accurate, what I needed to do and what I needed to prepare for, for like what was coming

next. And I just think that allowed me to relax and I didn't have any tearing or anything. (PP21-W2: pp.3)

Not only was fatalism absent from the narratives of the women who retained their midwife, an additional theme was present that did not show up with the previous group. Many participants who received continuous care from a midwife said they felt confident in their abilities to birth a child, and how that largely contributed to a more relaxed birthing atmosphere. They attributed this to the presence of a midwife in almost every case. Because women in this sample generally had more feelings of being supported, they were more likely to feel empowered, painting a very different picture of birth:

I just felt like she was so much more involved that I had a lot more confidence in the whole birthing process...because of having [the midwife]. (PP05-W2: pp. 18)

[The midwife] made me feel confident about what I was doing so I'd um, yeah I was very satisfied. (PP76-W2: pp. 3)

We had that confidence that if anything did go wrong...[the midwife] was more than capable of taking care of whatever situation might arise...[K]nowing that just really puts our minds at ease cuz we know that everything is going to be just fine. (PP83-W2: pp. 8)

Feelings of maternal confidence were also increased due to the presence of alternative health practitioners as additional sources of support for the birthing women who retained their midwife. As noted above, the group that retained their midwife across the child-birthing period had an income that was higher than the mean income of the larger PPHS sample. Therefore women in this group had more accessibility to a doula, for instance, than many of the lower-income women from the transfer group who could

not afford to pay for one out of pocket. For all the women who had the services of a doula, she was described as an integral member of the team:

I felt very secure and comfortable knowing that...[the doula] was there...[The doula] knew what I wanted and how I wanted the birth to be and even if I couldn't articulate that to someone, I knew that she would be able to. And she could calm me down. (PP46-W2: pp.5)

And [the midwife] sort of let the doula be more the like loving member of the team. (PP48-W2: pp.7)

Some women indicated that they did not feel as though they could have 'done it' without the help, trust and caring of their doula:

Our doula – if you guys have babies – get a doula, they're fantastic. Even if you have a midwife – it wouldn't have been the same without her. She was just... sort of like having your mum there without having to deal with your mother [laughs]. She was just perfect and just – everybody just did a really good job. (PP48-W2: pp.6)

I can't imagine going into labour without a doula, because I was hyperventilating at one point, at a couple of points actually, and I don't know how you would get yourself out of hyperventilating. You need someone there to refocus you and bring you back and help you out, cuz it was just so intense. (PP68-W2: pp. 3)

[The doula]-wonderful, excellent. Couldn't have done it without her...[W]e had established a relationship before the labour itself and so I knew how she would be with me and I thought it was really effective. Little bit of tough love every now and then, which was really good. And I just SO trusted her and feel that trust was well placed. (PP68-W2: pp. 7)

### ***Summary***

In this chapter I have provided qualitative data that focuses on the experiences of women marginalized by their lower-incomes and by the experience of being transferred from a midwife to an obstetrician. Women had the highest satisfaction within a transfer of care when they had adequate support and information and felt as

though they had some autonomy in the process. The formal support of midwives, nurses and doulas seemed to be extremely important, followed by the informal support of family and friends. When women did not receive adequate support, information or did not feel as though they had sufficient autonomy, their experiences of birth were not as positive.

The participants also had similar expectations about obstetricians, such as having an obstetrician that answers question patiently, and so forth. Midwives, however, were expected to spend more time with their patients in order to be supportive, while obstetricians were only expected to pass on sufficient information. The gendered implication in this is inescapable; midwives (who were all women in this study) are expected to be competent friends and obstetricians (who were all men in this study) are supposed to be informative.

Participants were also most satisfied when midwives, nurses and obstetricians were perceived to work well together, providing a united team for birthing women. It was all too common, however for tensions to exist between health practitioners, and women suffered as a result, especially participants who were transferred from a midwife to an obstetrician. Those participants felt vulnerable and invaded by the bureaucratization of hospital guidelines as well as by medical procedures and technologies. The participants in the second sample had less interaction with other health practitioners due to the continuity of their midwifery care, and therefore were not as affected by the tensions. Participants in both groups held those obstetricians who respected the autonomy of the birthing woman and her midwife in very high regard.

Being separated from their babies at birth further contributed to the negative experiences of women who were transferred from a midwife to an obstetrician and left them feeling as though they had not in fact delivered a baby at all. In the end, many women who experienced transfer illustrated fatalistic attitudes towards their birth and potential subsequent births by not caring or opting to skip the whole process next time and get a C-section on their own terms.

The participants who retained their midwives experienced more autonomy, information and support than the participants who were transferred to obstetrical care. This was largely due to the continuity of the care they received. Participants in this sample also had more confidence in the birthing process and in their own abilities, due to the trust they had in their midwives, as well as the added support of alternative health practitioners, most notably doulas. This no doubt has contributed to the lower BDI (mean depression scores) of this group in the postpartum period, illustrating the importance of continuity in maternal well-being.

Regardless of the continuity and level of support, participants who experienced maternity care disruption and continuity were also affected by the bureaucratization of the hospital due to regulations regarding 'risk factors' and the politics of scheduling. Women who had continuous midwifery care, however, also had higher incomes and generally more support, giving them more tools and advocacy to work with than the lower-income women who were transferred to obstetrics.

Overall, women who retained their midwives across the childbearing period experienced a more positive birth due to the factors above. The experiences of women

who were transferred to obstetrics are now more contextualized. Although all women are affected by the problems in the health care system in British Columbia due to the organization of our maternity care system, women who are marginalized by having a lower income, as well as being transferred to obstetrics and therefore experiencing a disruption in care, are more at risk for postpartum depression.

In the next chapter I discuss my qualitative findings in light of the main themes identified in the research literature in Chapter 2. I also conclude the thesis by answering my research questions.

## Chapter 5: Summary and Discussion

In this chapter I build on the existing literature that concerns maternity care with the qualitative findings from my thesis. I do so by summarizing the findings and answering the questions I posed in this study in order to clearly state what my contributions are to the advancement of knowledge in this area.

### 5.1 Weaving Threads and Answering Important Questions

On the advice of friend and colleague E. Manning, I must start at the beginning. I began this thesis with the concept of *dignified* maternity care; a concept that denotes not only the accessibility of maternity care services for all women, but respect and autonomy for all women who give birth. Why is dignified maternity care so important? The answer to this question is found in the literature and my research findings. This is more than a set of academic studies; *this is about women's lives*.

*How do the experiences of women who were transferred compare to those who retained their midwives?* Support is the most notable theme in maternity care research. Formal support is central to birthing experiences, especially that which reflects the spirit of midwifery. In other words, as is detailed in the literature, the spirit of midwifery includes feelings of autonomy over the birthing process, receipt of adequate information and time spent with birthing women. Due to having a higher-income, more education, and continuous midwifery care, women who retained their midwives in this study had better access to alternative health practitioners and more support in general. This resulted in the women saying they felt more autonomous and empowered. Increased support also

contributed to this group having more positive birthing experiences and lower mean depression scores during the postpartum period.

On the other hand, women with a lower-income in the PPHS who were transferred from a midwife to an obstetrician had different stories. They said they felt more susceptible to invasion, both from medical professionals and technology. Even though both groups of women noticed tensions between health practitioners, it was the women who experienced midwifery disruption that were most negatively affected by such tensions. This is largely due to the lack of support that women in the group who were transferred from a midwife to an obstetrician experienced. Women in the group who retained their midwives not only received more support from their midwives as a result of continuity, they were more likely than the women with a lower mean income to have additional support, such as a doula.

The presence of the doula in the literature is always positive, and as the cases of the Netherlands and Australia illustrate, this form of support helps to curb postpartum depression rates, perinatal deaths and increase breast-feeding rates. However, these services are not equitably distributed in Canada. Women in Canada represent the majority of the poor in this country, and poverty is correlated with having less social support (Reid, 2008). This exacerbates an already difficult and ill-health promoting situation. Childbearing women already face a major life changing process when giving birth, one that is riddled with societal expectations of become a complete woman and a good mother. There is even more pressure for women who face additional barriers and stigma due to having a lower-income. Further, because women with low-income may have less informal support (Reid, 2008), they require more formal support in the child birthing

process to promote a healthier birth and postpartum period. Therefore the accessibility of dignified care has been further problematized by my findings.

Women, who had less support due to their transfer from a midwife to an obstetrician were fatalistic when speaking of their potential subsequent births. Many participants said they would rather opt for surgery (C-section) than face another possible transfer. This illustrates the complexities outlined by the research on C-sections regarding the availability and necessity of the C-section versus the medical dominance of them. There is a marked connection between women being deemed ‘too posh to push’ due to a maternal requested C-section, and this type of fatalism. The findings of this thesis point to uncovering at least one of the reasons women opt for a C-section, which further complicates the model that renders this phenomenon a woman’s individual ‘choice’.

I must point out at this juncture that regardless of whether midwifery care was continuous or disrupted, it was common across both groups to be affected by bureaucratization, i.e., hospital policies regarding the birthing process. The existing literature comments on low-income women and how they are affected by the politics of ‘risk’—i.e., reasons for hospital delivery or C-section due to the list of possible medical risks for mother and child (Jomeen, 2007). Research indicates that ‘risk’ is not an equitable concept in that the childbearing period for low-income women is more likely to be deemed ‘risky’ than for their higher- income counterparts (*ibid*). This can affect the likelihood of surgical intervention, as well as their choice of where to give birth. Therefore being placed on the ‘risk list’ can interfere with some of the basic tenets of dignified maternity care. My findings further contribute to this literature by illustrating that although low-income women have fewer resources to support them when these

politics occur, all women have the potential to be affected regardless of socio-economic status.

*Are formal care and informal care equally central to increasing social support?*

The literature on maternity care and the findings from this thesis both point to the distinct importance of formal care. Informal care is not as present in the narratives of participants or in the maternity care literature, however, it is very important for family and friends to be involved as added supports for birthing women. I have not adequately researched this area to be able to firmly state that one form of support is more important than another. In analyzing the data I realized that perhaps I should not attempt to do so at all. Both formal and informal care lead to increased support, and efforts should be made to secure both forms of caring.

What is of obvious importance is that there is a strong presence of formal care, which takes the pressure off family and friends to be a formal carer; midwives can care for women in ways that allow their family or friends to just “be there” for the new mother. The midwife needs to be a healer, an advocate and diplomat, in order to create the space for friends and family to love and comfort.

*Does the structure of formal care in the hospital support informal care during the birthing process?* When a birth goes as planned in the hospital and no obstetrical intervention is required, informal support was not usually infringed upon. However, participants who were transferred from a midwife to an obstetrician were more likely to say they felt that the bureaucratic structure of the hospital (i.e., hospital policies) interfered with their informal care. This was very difficult for the participants. For

example, the absence of a partner, parent or newborn during medical procedures or exams was very upsetting and confusing for many participants. This of course, is confounded by what the literature points out in regards to lower-income women; they have less autonomy and less of an ability to advocate for themselves. The transfer of care contributes to this problem even more, as the women experience vulnerability not just from their social positions in life, but due to the physical feat of labour/childbirth and the feelings associated with medical interventions. The infringement upon informal care had lasting affects for the women involved, and made an impact on the postpartum health of this participant group. This needs to be addressed in terms of maternity care that occurs in the hospital setting.

*Are women in this study affected by an over-medicalization of childbirth? If yes, how?*

Some participants felt as though they received a C-section unnecessarily. Others felt physically invaded by both medical technologies and personnel. It can be argued that participants being forced to birth in a hospital due to the politics surrounding the risk of a VBAC illustrate another form of over-medicalization. The initial push towards the hospital then increases one's odds of medical interventions. This in itself points to the over-medicalization of childbirth, in that women who give birth at home, like in the Netherlands and the PPHS, actually fare better in terms of their overall health than women who give birth in the hospital (McKay, 2000; Benoit et al., 2007).

*How do medical practitioners work together while in the hospital setting (i.e., midwives, obstetricians and nurses)?* Participants overwhelmingly agreed that it is best when all health practitioners cooperate. In some cases, obstetricians presented themselves as a consultant and the midwife retained autonomy over the birthing process alongside

the woman. All too often, however, the participants mentioned that obstetricians exercised power and authority over midwives, illustrating the undeniable reality of gender inequality between midwives and obstetricians. Also, there were many reports by participants of tensions between midwives and nurses that equally had a negative impact on their birthing experiences.

*How do we make policy recommendations that help women to garner high rates of satisfaction with midwifery, whether there is obstetrical involvement or not? Do findings support options for collaborative care, and if so, what would that type of care look like?* I will turn to these last two questions in due course, attempting to answer them in Chapter 6.

## Chapter 6: Conclusions

In this chapter I ponder the limitations of this thesis and make suggestions for future research that would benefit women's maternal health in British Columbia with the central theme of dignified maternity care in mind. I also outline the policy recommendations that emerge from models of care abroad and participants' narratives. The recommendations for policy change that came out of the participants' narratives are both directly stated, and occasionally interpreted through my analyses of their experiences of maternity care. I then examine options for collaborative care before moving on to some concluding thoughts.

### 6.1 Limitations and Future Research

Although this thesis has contributed to an important body of knowledge concerning women's health and maternity care, there were many areas of interest that came from my analysis that I did not have the scope to address within this project, as well as some limitations of the thesis itself. First, while working from a larger project undertaken by another researcher (Benoit et al.'s PPHS) has greatly benefited my research, there remain some concerns. Working from the PPHS meant that I did not collect my own data. While this helped me to pursue my MA in a timely manner, it created a distance between the participants and myself that would have been less evident than if I had collected the data. By studying participant narratives collected by another researcher, I did not have access to non-verbal cues, voice intonation and interpersonal interaction from participants. Additionally, I was unable to follow-up on statements from participants that may have contributed to more in-depth analyses of important themes. On

the other hand, by analyzing data from a larger project, I was in a better position to generalize my findings by connecting to information on “the big picture” that was readily available for comparison and triangulation.

An example of future research based on what was not covered in the scope of my thesis is a cost-benefit analysis of the policy recommendations in this thesis would perhaps help to move such policies forward; specifically, to illustrate that these recommendations are cost-effective for the province would be very useful in lobbying the government to better organize our maternity care system.

Further research should also take into account how cultural ideologies shape our current maternity care system. As DeVries et al. (2004: 231) recommend, “health care reform must attend to the cultural ideas that sustain health systems”. We need to imagine how Canadian ideologies might be changed in order to promote the state recognition of midwives as the most qualified practitioners for low-risk pregnancy and birth. As a result an increase in the number of universities that offer midwifery-training programs would logically follow a change in ideology surrounding midwifery care. Currently six Canadian universities offer a program in midwifery. However, three of the universities are located in Ontario (Laurentian, McMaster, Ryerson) and one in Quebec (Université du Québec). For the rest of Canada there is one university in British Columbia (UBC) that offers the program, and only one Aboriginal midwifery program that is located in the Pas, Manitoba.

Also, research regarding pregnant women’s lived experiences should actively engage with the reality of intersectionality (Acker, 2006; Bannerji, 2005). In other words,

similar research should be undertaken with purposeful attention made to the impact of how factors such as the race, class, gender, sexuality and other forms of inequality interact to shape maternity care experiences. Although I did not have the information needed to support such an analysis due to being 'blind' to particularities of each participant, this does not diminish the vital importance of revisiting the findings in light of the knowledge of all of the inequalities that affect the lives of these women, as well as their maternity care.

In the U.S. there is a model of care that seems to be addressing these intersections of class and race called *Centering Pregnancy*. The model of prenatal care consists of pregnant women who are grouped (8-12 people per group) by the gestational 'age' of the fetus, and who meet regularly throughout their pregnancy with the same care provider (Novick, 2004; Grady et al., 2004). This model is worth looking into as preliminary research illustrates that this form of care has greatly benefited women marginalized by the intersections of age, class and race (*ibid*).

Future research should also take into account the partners of birthing women in more central ways. I believe this to be aligned with feminist ideologies, given the findings from this thesis illustrate that partners' involvement in the birthing process is central to the positive experiences of birthing women. It is important to do research on how partners can feel included, how they can better support their birthing partners, and how health care practitioners/hospital administration can better support this involvement. This would only contribute to caring for birthing women in the best way possible.

A final line of future research concerns nurses' struggle for autonomy while working within a medically-dominated and bureaucratic maternity care system under pressure to reduce costs. This area would benefit from a nuanced analysis of qualitative research done with health care providers, including nurses, midwives and obstetricians. It would also be interesting to find the many potential commonalities between health professions numerically dominated by women, such as nursing and midwifery, in order to better build cooperative capacity that better serves the needs of birthing women.

## **6.2 Policy Recommendations**

From the larger PPHS findings, as well as the maternity care literature and the findings from my own analysis; midwifery has been illustrated to elicit the highest rates of satisfaction if it remains continuous across the childbearing period. While this was not possible for the women who ultimately need obstetrical intervention, the data recommend that the 'spirit of midwifery' should be adhered to as much as is possible across all patterns of care. Women need to feel empowered and confident and to be 'kept in the loop' regarding medical procedures. Such information needs to be adequately relayed by midwives, obstetricians and nurses. This also includes keeping families together; women need to be with their partners or other close family members or friends, and their newborn baby needs to be close by. Where this is not possible, women need to be clearly told why this has occurred and for how long they will be separated from their child. Following a C-section, women must be united with their baby immediately postpartum, as cleaning and weighing the baby is not immediately necessary. While a woman is being sutured postpartum, her partner or her midwife can hold the infant close to the

postpartum women, providing an opportunity for bonding as well as a distraction from the procedure.

Second, midwives need to be able to practice as autonomous practitioners and make decisions around ‘risk factors’, the use of technologies, and medical interventions. This includes the use of technologies that have proven to be inaccurate and unreliable, such as the EFM (Cassidy, 2006). Hospital care providers and society in general must value midwives in accordance with the level of training they have for pregnancy, labour/birth and postpartum care. We should take our cue here from the Dutch who do not let technology dominate the birthing process (Declercq et al., 2001; McKay, 2000). Dutch midwives are also autonomous and respected health practitioners with parity in the health care system (Declercq et al., 2001). Similarly, Canadian midwives need to equally share in the decision-making process; that is, they should be on par with other health care professionals when it comes to the development of health care policies in this country. We can also learn from Sweden, a country that respects their midwives as autonomous as they are largely responsible for low-risk pregnancy and birth (McKay, 2000).

Third, hospital care providers must also strive to be less invasive and more sensitive to birthing women’s needs. This means that all internal examinations must be regulated and performed by the primary attendant only. Hospital care providers must understand how gendered power affects women during their care. For example, many women are not comfortable with men examining them, or being in the room when invasive procedures are being implemented (see Chapter 4).

In addition, once a trusting relationship has formed, health care professionals should also seek out information from their clients regarding trauma due to abuse issues that may surface during labour or birth, and then provide counseling referrals if necessary. Providers should also be sensitive to women's specific needs and inform the hospital of these needs. In other words, hospital care providers must be aware that many women have experienced gender-based violence from men, including sexual abuse and rape, and therefore explicit permission must be sought from each woman for any procedures performed by male health professionals. A female physician's services should be offered as an acceptable alternative if for some reason an opinion second to the midwife is desired. The fewest number of professionals should be allowed in the room during internal exams, which should of course occur as infrequently as possible.

Finally, women from this study also recommended the following:

- 1) That there be a whirlpool installed for labouring women at the Victoria General Hospital to help manage pain without the use of medication.
- 2) That every labouring woman has a doula, covered by our Medicare, MSP; this could include an increase in doulas' post partum duties to mirror the Dutch home care worker.
- 3) That midwives' care be expanded past the 6-week postpartum time frame.

As we saw in Chapter 2, this would be achieved by increasing midwives' scope of responsibilities. In Sweden midwives are also responsible for women's sexual health, providing additional sense of continuity (Benoit, 1997). Newfoundland and Labrador's midwives historically provided more continuity of support throughout a woman's lifetime

as well (Benoit, 1991). It must be noted however, that by increasing the scope of midwifery care already over-worked midwives may suffer and feel the pressure of expanding their care to sustain their client base. The needs of birthing women must also be aligned with the needs of care providers, perhaps creating a common ground in future research.

### ***6.2.1 Lending Options for Collaborative Care***

The general findings from this thesis suggest that a model of maternity care that is collaborative is in the best interests of the physical health of mother and child, as well as the emotional well-being of all family members. Further research is necessary to see if collaboration with other care professionals may be beneficial for health practitioners.

Although home births should be supported and valued as a safe alternative to the hospital, women should have a variety of choices of *where* they give birth to their child. Given that some women feel more comfortable birthing in a hospital, the hospital should be a welcoming place. For women who choose to birth in the hospital or for women who must be transferred due to a medical emergency, such tensions between health care professionals must be adequately addressed, and perhaps alleviated by some form of collaboration.

The more people involved in the birthing process with diverse expertise and training, the better off the woman and her family will be, as long as there is cooperation among them. The Netherlands has one of the lowest infant mortality and maternal morbidity rates in the world. They also have a maternity care system that is considered successful. They have a system in which trained homecare professionals meet with women prenatally, assist the midwife or physician during labour and delivery in hospital

or in home, and provide postpartum practical care for the women and her family. I see this system as an extension of what doulas provide for women in British Columbia, and it is important in terms of accessibility that our Medicare provides coverage for their services.

We can learn from the Australian case in modeling a homecare system after the Dutch. Although Australia has a similar system modeled after the Dutch, it has not been utilized to the same degree. Although the homecare project did report positive effects, such as diminishing postpartum depression rates and increasing breastfeeding rates within vulnerable populations, the Australian system did not reach a large target population, and therefore the project did not demonstrate health benefits to a large enough group of postpartum women. We must be conscious then of the ways in which Australia did not have as much success with home support as their project anticipated. If we look into this possibility for British Columbia, first, midwives need to be involved in the training process for homecare workers. Second, there needs to be more intensive training for homecare workers. Finally, the utilization of the homecare worker in Canada needs to be framed differently than in Australia; they need to be viewed as individuals who are able to assist all new mothers, regardless of socio-economic status and access to social support. This would not only increase the number of women who utilize the services, but it would lessen the stigma attached for lower-income women, thereby promoting a healthier postpartum period for women who need it the most.

In collaborative working relationships between midwives and obstetricians or physicians, the suggestion that they work side-by-side may not be helpful or realistic given the gendered power inequalities that exist. These inequalities are entrenched in the

hierarchy of medicine and a violent and eradicating history (see Chapter 2). Instead, taking the lead from other countries as well as the findings from my thesis, midwives could be considered authorities on low-risk pregnancy, childbirth and postpartum care to counterbalance these inequalities that exist between professions.

Obstetricians need to respect the autonomy of midwives and present themselves as consultants when medical need arises; this respect needs to be based on the midwife's expertise in responsible decision-making. When a medical emergency does occur that falls outside the scope of midwifery care, midwives can present as an additional support and advocate on behalf of the birthing woman. If there was mutual respect between midwives and obstetricians supported by both state and hospital policies, the obstetrician would also see the midwife as a consultant for more natural approaches or as an advocate during a medical emergency. Further, similar to Sweden, women should meet with an obstetrician during their pregnancy, which should be her guaranteed practitioner should the need arise for obstetrical intervention. This would help to ensure that every woman has a caregiver that is known to her at birth, something that would promote continuity of care. Midwives and obstetricians should also have an open dialogue of information sharing, and that collaboration should begin in pregnancy.

The tensions between nurses and midwives must also be adequately addressed to build a collaborative initiative for maternity care. In Sweden, the hospital care providers practice non-interventionist birthing methods and all medical practitioners work collaboratively. To help alleviate pain for labouring women, hot water baths, massage and acupuncture are available by highly trained nurses. Sharing the scope of care for low-risk childbirth can minimize the tensions between nurses and midwives. Nurses should be

trained in more natural approaches as they are in Sweden. Midwives can utilize the services of nurses as added team members to care for labouring women, which could help alleviate some of the pressure midwives carry in terms of being solely responsible for labour and birth. By the same token, with the additional services nurses could provide for more natural (less interventionist) birthing, they too could increase their job satisfaction. The above could only occur if nurses also viewed midwives as valued and autonomous, and midwives respected nurses for the experience that they have to offer as well.

Collaboration between midwives, nurses and obstetricians needs to begin at the outset in order to function more smoothly. Looking into the training practices of all three professions to include a collaborative framework could potentially make the difference for future professionals likelihood of sustainable cooperative working environment. It might also be beneficial for maternity carers to learn from each other and have similar women-centred care basic training before they move into specialization.

Finally, there is still another example of how collaboration between professionals in maternity care could be implemented to provide a more dignified birthing experience for women. Examining the home and the hospital is useful, but the analysis must not stop there. Similar to Quebec's option of the birth centre, the cottage hospital in Newfoundland provided a birth experience that was run by autonomous midwives in a free standing building outside of the home and larger hospitals. A third option for place of birth then could allow women repose from the demands of their home life and provide a medical space that is not centred on illness.

Especially in rural areas, including areas with high Aboriginal populations, women could benefit across Canada from having better access to services from women in their communities. MacKinnon (2008) has studied the role of rural nursing in maternity care, illustrating the level of skill they have in actively creating community and in the care they offer in rural hospitals. Rural nurses are often the only birth attendant who is available in rural hospitals (ibid), and further research should include the way in which nurse practitioners can collaborate with other maternity health professionals in order to meet the needs of women, no matter their geographical location.

Creating a model of collaborative care needs to be done through rigorous research over a long period of time. There are many potential limitations to collaborative care that need to be adequately addressed. The medicalized and gendered hierarchies that exist within the health care system are just some of the struggles towards collaboration. With the increasing neo-liberal reforms on our health care system, many professionals experience longer hours, less job security/benefits and less pay (Benoit et al., *forthcoming*). In creating a collaborative model, the health and well being of the professionals involved must be taken into account, making the option of collaboration part of the solution of sharing a burden of work, not contributing to increased hours and the potential for “burnout”.

### **6.3 Concluding Thoughts**

Dignified maternity care is about giving dignity to women and their families. Women are not asking for much; they are merely asking to be treated like human beings and be accorded the same respect as everyone else during a vulnerable time in their lives.

Giving birth is a new beginning, already riddled with gendered ideologies and discourses that put pressure on women to be perfect - perfect women and perfect mothers. To further exacerbate this, there are many other forms of marginalities that intersect with gender such as socio-economic status and race. *This is about women's lives*. More than that, the health of birthing women filters into the rest of our lives, into the lives of our partners, our children, our family and friends.

The cost to ourselves and to our society is too steep if we do not address the problems of the current structure of maternity care in British Columbia. It is important to look outside our own systems when searching for solutions. In other words, we need to continue to comparatively examine what other countries are doing in order to learn from the strengths and weaknesses of their systems. There is no need to reinvent the wheel in order to give the best start to women possible when embarking on the journey of motherhood. Promoting dignified maternity care in British Columbia is one piece of the puzzle; equal access to quality maternity care needs to be part of a larger initiative to promote equality in our society. As long as there is inequality in health care, childcare, income distribution, housing, racial and sexually-oriented discrimination, there will continue to be inequality in maternity care. Finally, the state, along with its citizens, needs to work together to address these serious problems. While women's health over the life course may be affected by problems in maternity care, the meso and macro levels of community and society are affected as well. Solving these problems are not women's health issues alone; they are collective. *Our* health depends on it.

## References

- Acker, J. 2006. "Inequality Regimes: Gender, Class, and Race in Organizations". *Gender & Society* 20(4). Pp. 441-464.
- Armstrong, P. 2008. "Finding Dignity in Health Care and Health Work: A Foreword." Pp. 4-5 in *Canadian Journal of Public Health*, 99(2), edited by Benoit, C. and H.K. Hallgrímsson.
- Atkins, J. 1998. *It's Up to You: Your Pregnancy, Your Birth and Your New Baby*. British Columbia: HealthMates.
- Atkinson, P. 1992. "The Ethnography of a Medical Setting: Reading, Writing and Rhetoric." *Qualitative Health Research*; (2) 4. Pp. 451-474.
- Bailey, L. 1999. "Refracted selves? A study of changes in self-identity in the transition to motherhood." *Sociology*, 33(2). Pp. 335-352.
- Bailey, L. 2001. "Gender shows: First-time mothers and embodied selves." *Gender and Society*, 15(1). Pp. 110-129.
- Ballem, P.J. 1998. "The challenge of diversity in the delivery of women's health care." *Canadian Medical Association Journal* (159) 4: 336-339.
- Bannerji, H. 2005. "Building from Marx: Reflections on Class and Race". *Social Justice*; 32(4). Pp. 144-160.
- Benoit, C. 1991. *Midwives in Passage*. St. Johns, Newfoundland: Institute of Social and Economic Research.
- Benoit, C. 1997. "Professionalizing Canadian Midwifery: Sociological perspectives." Pp. 87-114 in *The New Midwifery: Reflections on Renaissance and Regulation*, edited by F.M. Shroff. Toronto, ON: Women's Press.
- Benoit, C. 2000. "An Exception to the Canadian Case: Autonomous Midwifery at the Margins." Pp. 195-203 in *Midwifery and the Medicalization of Childbirth*, edited by E.R. Van Teijlingen; G. Lowis; P. McCaffery and M. Porter. New York, NY: Nova Science Publishers.
- Benoit, C.; Wrede, S.; Bourgeault, I.; Sandall, J.; De Vries, R.; and E.R. van Teijlingen. 2005. "Understanding the social organization of maternity care systems: midwifery as a touchstone". *Sociology of Health and Illness*, 27(6). Pp. 722-737.
- Benoit, C.; Carroll, D.; and R. Eni. 2006. "To Watch, To Care": Stories of Aboriginal Midwifery in Canada." *Canadian Journal of Midwifery Research and Practice*; (5) 1: Pp. 11-17.
- Benoit, C.; Westfall, R.; Treloar, A.; Phillips, R. and S. Mikael Jansson. 2007. "Social Factors Linked to Postpartum Depression: A Mixed-Methods Longitudinal Study."

*Journal of Mental Health* (16) 6: 719-730.

Benoit, C; Carroll, D. and R. Westfall. 2008. "Women's Access to Maternity Services in Canada: Historical Developments and Contemporary Challenges." Pp. 507-527 in M. Morrow; O. Hankivsky and C. Varcoe (eds). *Women's Health in Canada: Critical Theory, Policy and Practice*. Toronto, ON: University of Toronto Press.

Benoit, C. and H.K. Hallgrímsdóttir. 2008. "Engendering Research on Care and Care Work across Different Social Contexts." *Canadian Journal of Public Health*, 99(2). Pp. 7-10.

Benoit, C.\*; Zadoroznyj, M.; Hallgrímsdóttir, H.; Treloar, A and K. Taylor. "Neo-Liberalism & Maternal Health Outcomes in Canada and Australia." *Forthcoming*.

Biró, M. A.; Waldenström, U.; Brown, S.; and J.H. Pannifex. 2003. "Satisfaction with Team Midwifery Care for Low- and High-Risk Women: A Randomized Controlled Trial." *Birth* (30) 1: 1-10.

Bonnett, A. 1996. "Whiteness Studies: The Problems and Projects of a New Research Agenda". *Theory, Culture and Society*; 13(2). Pp. 145-155.

Bourgeault, I.; Declercq, E.; Sandall, J.; Wrede, S.; Vanstone, M.; van Teijlingen, E.R.; De Vries, R.; and C. Benoit. 2008. "Too Posh to Push? Comparative Perspectives on Maternal Request Caesarean Sections in Canada, the US, the UK and Finland." Pp. 99-123 in *Patients, Consumers and Civil Society; Advances in Medical Sociology*, Volume 10, edited by Chambré, S.M.; and M. Goldner. U.K.: Emerald Group Publishing.

Burgoyne, J. 1987. "Change, gender and the life course." Pp. 33-66 in *Social Change and the Life Course*, edited by G. Cohen. New York, NY: Tavistock Publications.

Busfield, J. 1987. "Parenting and parenthood." Pp. 67-86 in *Social Change and the Life Course*, edited by G. Cohen. New York, NY: Tavistock Publications.

Butler, J. 1991. *Bodies that Matter*. New York: Routledge.

Carter, J. B. 2007. *The Heart of Whiteness: Normal Sexuality and Race in America, 1880-1940*. Durham and London: Duke University Press.

Cassidy, T. 2006. *Birth: The surprising history of how we are born*. New York: Atlantic Monthly Press.

Charmaz, K. 2000. "Grounded Theory: Objectivist and Constructivist Methods." in *Qualitative Research*, edited by N.K. Denzin and Y.S. Lincoln. London, England: Sage Publications.

Cohen, G. 1987. *Social Change and the Life Course*. New York: Tavistock Publications.

Connell, R.W. 1987. *Gender and Power*. Cambridge: Polity Press.

Connell, R.W. and J.W. Messerschmidt. 2005. "Hegemonic Masculinity: Rethinking the Concept". *Gender and Society*, 19(6). Pp. 829-856.

Declercq, E.; Devries, R.; Viisainen, K.; Salvesen, H. B. and S. Wrede. 2001. "Where to Give Birth? Politics and Place of Birth." Pp. 7-27 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by R. De Vries; C. Benoit; E.R. Van Teijlingen and S. Wrede. New York, NY: Routledge.

De Vries, R. 2004. *A Pleasing Birth: Midwives and Maternity Care in the Netherlands*. Philadelphia, PA: Temple University Press.

De Vries, R.; Wrede, S.; van Teijlingen, E.R.; Benoit, C.; and E. Declercq. 2004. "Making Maternity Care: The consequences of culture fore health care systems." Pp. 209-231 in *Comparing Culture: Dimensions of Culture in a Comparative Perspective*, edited by Vinken, H.; Soeters, J. and P. Ester. Boston: Tuta Sub Aegide Pallas Press.

Ehrenreich, B. and D. English. 1973. *Witches, Midwives and Nurses: A History of Women Healers*. New York: The Feminist Press.

Ehrenreich, B. and D. English. 1979. *For Her Own Good: 150 Years of the Experts' Advice to Women*. New York: Anchor Press.

Eisenstein, H. 1983. *Contemporary Feminist Thought*. Boston, MA: G.K. Hall & Co.

Enkin, M.W.; Glouberman, S.; Groff, P.; Jadad, A. R. and A. Stern. 2006. "Beyond Evidence: The Complexity of Maternity Care." *Birth* (33) 4: 265-269.

Esping-Anderson, G. 2007. "More Inequality and Fewer Opportunities? Structural Dterminants and Human Agency in the Dynamics of Income Distribution" in *Global Inequality*, edited by Held, D. and A. Kaya. Cambridge: Polity Press.

Foucault, Michel. 1979. "Truth and Power: Interview with Alessandro Fontano and Pasquale Pasquino" in Michel Foucault: Power, Truth, Strategy, trans. Paul Patton and Meaghan Morris; Sydney: Feral Publications, Pp. 29-48.

Foucault, Michel. 1981. The History of Sexuality, vol 1, An Introduction [1978], trans. Robert Hurley; Haronondsworth: Penguin.

Fox, B. and D. Worts. 1999. "Revisiting the critique of the medicalized childbirth: A contribution to the Sociology of Birth." *Gender and Society*, 13(3). Pp. 326-346.

Goer, H. 2004. "Humanizing Birth: A Global Grassroots Movement." *Birth* 31: 308-314.

Goffman, E. 1987. *The Presentation of Self in Everyday Life*. London: Penguin Press.

Grady, M.A. and K.C. Bloom. 2004. "Pregnancy Outcomes of Adolescents Enrolled in a CenteringPregnancy Program." *Journal of Midwifery and Women's Health*, 49 (5). Pp. 412- 420.

Gramling, L.; Hickman, K. and S. Bennett. 2004. “What Makes a Good Family-Centered Partnership Between Women and Their Practitioners? A Qualitative Study.” *Birth*, 31 (1). Pp. 43-48.

Halfon, N., & M. Hochstein. 2002. “Life course health development: An integrated framework or developing health, policy, and research.” *The Millbank Quarterly*, 80(3). Pp. 433-479.

Hammer, T. 1996. “Consequences of Unemployment in the Transition from Youth to Adulthood in a Life Course Perspective.” *Youth and Society*, 27 (4). Pp 450-468.

Jomeen, J. 2007. “Choice in childbirth: a realistic expectation?” *British Journal of Midwifery* (15) 8: 485-490.

Kimmel, M. S. 2008. *The Gendered Society Reader*. Oxford, England: Oxford University Press.

Kirkham, M.; Stapleton, H.; Curtis, P. and G. Thomas. 2002. “The inverse care law in antenatal midwifery care.” *British Journal of Midwifery* (10) 8: 509-514.

Kleinman, S. 2007. *Feminist Fieldwork Analysis*. London, England: Sage Publications.

Kornelsen, J. and E. Carty. 2004. “Challenges to Midwifery Integration: Interprofessional Relationships in British Columbia.” Pp. 111-130 in *Reconceiving Midwifery*, edited by L. Bourgeault; C. Benoit and R. Davis-Floyd. Montreal, QC: McGill-Queen’s University Press.

Krieger, S. 1991. *Social Science and the Self: Personal Essays on an Art Form*. New Jersey, NY: Rutgers University Press.

Lemieux, S. 2007. “Witch-Hunting in Early Modern Europe: the End of the 'Bloodbath of the Innocents.'” *History Review*; 57. Pp. 20-25.

Lincoln, Y.S. and G.E. Guba. 1985. *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications.

Lorber, J. 2007. *Gender Inequality: Feminist Theories and Politics 3<sup>rd</sup> ed.* NC: Roxbury Publishing Company.

MacKinnon, KA. 2008. “Labouring to nurse: the work of rural nurses who provide maternity care”. *Rural and Remote Health*, 8 (1047). Pp. 1-15.

Malik, L. 2004. “Intersections: Giving birth to new traditions”. *Herizons*. Pp 47.

Martin, E. 1989. “The cultural construction of gendered bodies: Biology and metaphors of production and destruction.” *Ethos*, 54(3-4). Pp. 143-160.

McIntosh, P. 1989. “White Privilege: Unpacking the Invisible Knapsack”. *Peace and Freedom*; 49(4). Pp. 10-12.

McKay, S. 2000. "Models of Midwifery Care: Denmark, Sweden and the Netherlands." Pp. 155-162 in *Midwifery and the Medicalization of Childbirth*, edited by E.R. Van Teijlingen; G. Lowis; P. McCaffery and M. Porter. New York, NY: Nova Science Publishers.

McMahon, M. 1995. *Engendering Motherhood: Identity and self-transformation in women's lives*. New York: The Guilford Press.

Miller, T. 2000. "Losing the plot: Narrative construction and longitudinal childbirth research." *Qualitative Health Research*, 10(3). Pp. 309-323.

Morgan, M.; Fenwick, N.; McKenzie, C. and C.D. Wolfe. 1998. "Quality of midwifery led care: assessing the effects of different models of continuity for women's satisfaction." *Quality in health care* (7) 2: 77 -82.

National Aboriginal Health Organization. 2008. *Celebrating Birth – Aboriginal Midwifery in Canada*. Ottawa: National Aboriginal Health Organization.

Nelson, M. K. and R. Popenoe. 2001. "Looking Within: Race, Class and Birth." Pp. 87-111 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by R. De Vries; C. Benoit; E.R. Van Teijlingen and S. Wrede. New York, NY: Routledge.

Novick, G. 2004. "Centering Pregnancy and the Current State of Prenatal Care." *Journal of Midwifery and Women's Health*, 49 (5). Pp. 405-411.

Oakley, A. 1981. "Interviewing women: a contradiction in terms." in *Doing Feminist Research*, edited by H. Roberts. London, England: Routledge and Kegan Paul.

Oakley, A. 2000. "Who Cares for Women? Science versus Love in Midwifery Today." Pp. 319-328 in *Midwifery and the Medicalization of Childbirth*, edited by E.R. Van Teijlingen; G. Lowis; P. McCaffery and M. Porter. New York, NY: Nova Science Publishers.

Palys, T. 2003. *Research Decisions: Quantitative and Qualitative perspectives 3<sup>rd</sup> ed.* Scarborough, ON: Thompson Nelson.

Reid, C. 2008. "Women's Health and the Politics of Poverty and Exclusion." Pp. 199-220 in *Women's Health in Canada: Critical Perspectives on Theory and Policy*, edited by M. Morrow; O. Hankivsky and C. Varcoe. Toronto, ON: University of Toronto Press.

Reinharz, S. 1992. *Feminist Methods in Social Research*. Oxford, England: Oxford University Press.

Reinharz, S. 1983. "Experiential analysis: a contribution to feminist research." in *Theories of Women's Studies*, edited by G. Bowles and R. Duelli Klein. London, England: Routledge and Kegan Paul.

- Rice, A.J. 1997. "Becoming Regulated: The Re-emergence of Midwifery in British Columbia." Pp. 149-179 in *The New Midwifery: Reflections on Renaissance and Regulation*, edited by F.M. Shroff. Toronto, ON: Women's Press.
- Ritchie, J. and J. Lewis. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London, England: Sage Publications.
- Sandall, J. 1995. "Choice, continuity and control: Changing midwifery, towards a sociological perspective." *Midwifery* (11) 4: 201 -209.
- Schneirov, M. and J. D. Geczik. 1998. "Technologies of the Self and the Aesthetic Project of Alternative Health". *The Sociological Quarterly*; 39(3). Pp. 435-451.
- Scott, J. and G. Marshall. 2005. *The Oxford Dictionary of Sociology*. New York: The Oxford University Press.
- Seale, C. 1999. *The Quality of Qualitative Research*. Oxford, England: Blackwell.
- Shroff, F.M. 1997. "Closing Questions." Pp. 357-362 in *The New Midwifery: Reflections on Renaissance and Regulation*, edited by F.M. Shroff. Toronto, ON: Women's Press.
- Tinkler, A. and D. Quinney. 1998. "Team midwifery: the influence of the midwife-woman relationship on women's experiences and perceptions of maternity care." *Journal of advanced nursing* (28) 1: 30 -35.
- Treloar, Adrienne. 2007. "Biographical 'Disruption' in First-time Mothers' Reflections on the Transition to Motherhood." MA Thesis, Department of Sociology, University of Victoria, Victoria, B.C.
- Tudor, H. J. 1971. "The inverse care law." *Lancet* (7696) 1: 405-412.
- Van Teijlingen, E. R. 2000. "Maternity Home Care Assistants in the Netherlands." Pp. 163-172 in *Midwifery and the Medicalization of Childbirth*, edited by E.R. Van Teijlingen; G. Lowis; P. McCaffery and M. Porter. New York, NY: Nova Science Publishers.
- Wharton, A. S. 1991. "Structure and Agency in Socialist-Feminist Theory." *Gender and Society* (5) 3: 373-389.
- Wrede, S.; Benoit, C.; and J. Sandall. 2001. "The State and Birth/The State of Birth: Maternal Health Policy in Three Countries." Pp. 28-50 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by R. De Vries; C. Benoit; E.R. Van Teijlingen and S. Wrede. New York, NY: Routledge.
- Zadoroznyi, M. 2006. "Postnatal care in the community: report of an evaluation of birthing women's assessments of a postnatal home-care programme." *Health and Social Care in the Community* (15) 1: 35-44.

Zadoroznyi, M. and J. Sutherland. 2007. "A New Postnatal Home Care Worker: Challenges for Training, Implementation and Policy." *Australian Journal of Social Issues* (42) 2: 227-240.

### Websites

Manitoba Health. "Midwifery Services: Regulated Midwifery in Manitoba." Manitoba, Canada: Government of Manitoba, Retrieved June 24<sup>th</sup> 2008.

(<http://www.gov.mb.ca/health/midwifery/midwifery.html>).

Canadian Association of Midwives / Association canadienne des sages-femmes (CAM/ACSF). "Midwifery in Canada-Quebec." Head Office in Montreal, QC: CAM/ACFS, Retrieved June 24<sup>th</sup> 2008.

(<http://www.canadianmidwives.org/quebec.htm>)

The Midwives Association of B.C. "Registered Midwives." B.C., Canada: The Midwives Association of B.C., Retrieved May 20<sup>th</sup> 2008.

(<http://www.bcmidwives.com>)

Health Canada. "Health Care System." Government of Canada: Health Canada, Retrieved May 20<sup>th</sup> 2008.

(<http://www.hc-sc.gc.ca/index-eng.php>)