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Women's perceptions of birth centre care: A qualitative approach

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WOMEN'S PERCEPTIONS OF BIRTH CENTRE CARE: A QUALITATIVE APPROACH

by

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Abstract

The purpose of this exploratory study was to describe women's perceptions of the care they received in a birth centre, compared to their previous experiences in a hospital. Australian statistics indicate that five percent of childbearing women now choose to receive care in a birth centre setting. Clinical outcomes of birth centre care are now well documented, but there is limited empirical data about women's experiences of this model of care. Seventeen women, who had recently given birth in a birth centre, and had previously experienced care in a hospital setting, were interviewed about their care experiences. Using content analysis, the primary patterns in the data were coded and categorised into the four key themes of: Beliefs about Pregnancy and Birth, Nature of the Care Relationship, Care Interactions and Care Structures. The underlying clinical issues were those relating to philosophies of care, control over childbirth, and continuity of carer. Women wanted carers who viewed birth as a natural process rather than as an illness, and who engaged in a sharing, rather than a controlling, relationship. Finally women preferred to know, and be known by their carers. These findings are important for midwives, in terms of their education and practice. They also have implications for hospital administrators, health planning agencies, and the medical profession.

Declaration

"I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

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CHAPTER ONE

Introduction

This study investigated women's perception of the care they received in a birth centre compared to the care they had previously experienced in the hospital setting. Australian statistics indicate that an increasing number of women and their families are obtaining care in settings other than hospital (Day, Lancaster & Huang, 1997). However, to date there is limited empirical data about women's perceptions of these models of care, considered by most to be an alternative to mainstream medical services. The first part of this chapter will provide some background information about the emergence of birth centres in Australia and some of the reasons why they have proliferated at a vast rate during the 1990s. The remainder of the chapter will identify the significance and purpose of this study, definition of terms and thesis overview.

Background to the Study

Emergence of Birth Centres

During 1996, over nine hundred Perth women chose to receive pregnancy care at a birth centre (McDonald & Evans, 1996). Five years ago, no birth centres existed in Western Australia. The only alternative to hospital birth available to women in Western Australia at that time was a homebirth. In 1992, King Edward Memorial Hospital (KEMH)

established the first birth centre in this state. This was in response to recommendations from the Ministerial Review into Obstetric Services, released in 1990 (Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). The Family Birth Centre at KEMH is now in its sixth year of operation and currently provides care to 800 women per annum. A further two birth centres were established in Western Australia in 1996, facilitated by funding from the federal government through the Alternative Birthing Services Program. The second birth centre in Perth is located at Swan Districts Hospital (SDH). The third birth centre has been established in the city of Mandurah, approximately a one hour drive from Perth. All three birth centres are situated within hospital grounds and offer women midwife led care. The birth centres at KEMH and Swan Districts both offer a small team approach, with women being cared for by a maximum of three midwives. Mandurah Birth Centre offers all women a primary midwife carer for all of their care throughout the childbearing continuum.

The increase in number of birth centres is not restricted to Western Australia. A recent survey to determine birth centre practices in Australia revealed that prior to 1990 there were only three birth centres operating in Australia, compared to twenty four in 1997 (Waldenstrom & Lawson, 1997). Data collated in this survey from 22 birth centres demonstrate that the number of women choosing birth centre care increased by approximately 1000 women per annum from

1991 to 1995. During 1995, the total number of Australian women who received birth centre care was 7495. Of these women, 4328 (57.7%) birthed in the birth centre setting (Waldenstrom & Lawson, 1997). This figure indicates that approximately 2 to 3% of all Australian births occur in birth centres. This corresponds with the figures for 1994 published by the Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit. These national statistics indicate that of the states who report birth centre births separately through the Midwives Notification System, 2.6% of births in 1994 occurred in birth centres (Day et al., 1997).

Models of Maternity Care

A birth centre is defined as "a unit located in separate premises within or outside a hospital in which comprehensive care during pregnancy, labour and the early postnatal period is provided by a team of midwives" (Waldenstrom & Lawson, 1997, p3). The birth centre model of care was developed as an alternative to standard hospital care.

The emergence of birth centres has occurred largely in response to increasing consumer dissatisfaction with mainstream hospital services. Since 1989, three states in Australia have conducted ministerial reviews of obstetric services. These reviews have been in response to discontent with current maternity services and concerns over high obstetric intervention rates (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services

in New South Wales, 1989; and Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). All of these reviews indicated that consumers were seeking a more holistic approach to care provision, and that the range of birthing options available to women needed to be expanded. The concept of birth centres as an option for low risk women with normal pregnancies was endorsed by these state reviews, with the recommendation that more birth centres be developed to allow more women access to this model of care (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; and Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990).

Published statistics of birth outcomes in Australia reveal that Australia has some of the highest intervention rates in the developed world (Day et al., 1997). In 1994, over one third of Australian women required an assisted delivery, with 20% of births being performed by caesarean section (Day et al., 1997). During 1991, in response to high intervention rates, the National Health and Medical Research Council (NHMRC) was commissioned to establish a working party to examine maternity services in Australia (National Health & Medical Research Council, 1996), The report, titled Options for Effective Care in Childbirth for effective care in childbirth, indicated that the "culture" of obstetrics in Australia required review.

For the most part, Australian maternity services are currently provided in obstetric units within hospitals. Within these units, care is based on the traditional medical model, with the majority of women being cared for by a general practitioner (GP) or a specialist obstetrician (National Health & Medical Research Council, 1996). In the public health system, care provision is fragmented, with women being exposed to multiple carers throughout pregnancy, birth and the postpartum period. Numerous consumer surveys have identified that women are dissatisfied with this form of care (Brown & Lumley, 1994). All state reviews have identified that lack of continuity of care across the pregnancy continuum is a problem which needs to be addressed (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990).

The degree of medical involvement in childbirth is now being questioned in many developed countries. Some have argued that high intervention rates are a direct result of most women being cared for within the medical model (Wagner, 1994). Medicalisation of childbirth has culminated in a broad use of medical technology for most women, even though this technology was originally developed for a minority of women who develop complications (Page, 1995; Tew, 1995; Wagner, 1994). There is little evidence to support that this broad use of technology has improved maternal or neonatal outcomes (Tew, 1995;

Wagner, 1994). Many technologies currently in use have not been adequately evaluated and their routine use is now being challenged (Enkin, Keirse, & Chalmers, 1989; Tew, 1995; Wagner, 1994). There is now a worldwide move in all fields of medicine towards evidence based practice (Enkin, et al., 1989). It is hoped that this initiative will result in new technologies being adequately evaluated prior to implementation, and that treatments and policies will be based on evidence rather than tradition.

The question now being debated throughout the obstetric world is: who are the most appropriate carers for childbearing women? Should obstetricians, who are trained to care for women with complications be caring for women with normal pregnancy (Enkin et al., 1989)? The profession of midwifery is oriented to the care of women with normal pregnancies. The role of the midwife as the primary caregiver for women with normal pregnancies is currently being investigated in many developed countries.

A number of midwife led schemes have been implemented and evaluated in the last decade both in Australia and overseas. Published data of three randomised controlled trials from the United Kingdom concluded that midwife led care is as safe as traditional care and also results in increased maternal satisfaction (Giles, Collins, Ong & MacDonald, 1992; Hundley et al., 1994; Turnbull et al., 1996).

In Australia, midwife led schemes within mainstream maternity services are small in number. Some maternity units have implemented

'team midwifery' projects (Rowley, Hensley, Brinsmead & Wlodarczyk, 1995; Waldenstrom, Brennecke & Brown, 1995). This form of care provides women with continuity of midwife carers within mainstream maternity services. The first randomised trial to be published on team midwifery in Australia concluded that team care is as effective as standard care and was associated with higher levels of satisfaction (Rowley et al., 1995). Results of other projects are yet to be published.

The forerunner to team midwifery in Australia has been the birth centre model of care. Within the birth centre setting, a more holistic approach to care is usually adopted, the underlying philosophy based on a social model of birth. Childbirth is not regarded as an illness, it is viewed as a biosocial process that is part of daily life (Wagner, 1994). This model also identifies that the social and psychological outcomes are just as important as the biological ones. The social model focuses on the appropriate use of technology. For healthy women with normal pregnancies, technology that is non invasive and acceptable to the woman is considered appropriate. Most birth centres adopt a "low technology" approach to birth.

In Australia birth centres offer consumers who are categorised as 'low risk' an opportunity to be cared for by a small team of midwives. Medical review is mandatory in some centres when clients present for their first visit and again at 36 and 41 weeks gestation (Waldenstrom & Lawson, 1997). Most birth centres have developed strict protocols for

the transfer of women to mainstream services when complications develop at any time during the pregnancy, labour or birth.

In addition, numerous birth centres in Australia have now published data on clinical outcomes (Biro & Lumley, 1991; McDonald & Evans, 1996; Morris et al., 1986; Stern et al., 1992). Evaluations from a number of centres using comparisons with non randomised control groups have been undertaken (Eggers, Kloss, Neil, & Robinson, 1985; Linder-Pelz, Webster, Martins & Greenwell, 1990; Wood, 1997). These studies reveal that birth centre care results in less medical intervention, similar perinatal mortality rates, and increased maternal satisfaction when compared to standard care. These findings are similar to those published in overseas evaluations of birth centres (Feldman & Hurst, 1987; Rooks et al., 1989; Scupholme, McLeod, & Robertson, 1986). One of the major criticisms of these types of comparisons is selection bias. Women who choose alternative birth settings have been identified as being more committed to natural birth (Waldenstrom & Nilsson, 1993b).

The only randomised controlled trial of birth centre care published anywhere in the world to date is the Stockholm birth centre Trial (Waldenstrom & Nilsson, 1993a, 1993b, 1994; Waldenstrom, Nilsson & Winbladh, 1997). This large trial (n=1860 women) compared birth centre care to standard obstetric care in Sweden. Outcomes assessed included perinatal mortality and morbidity, maternal morbidity, birth outcomes and interventions, and women's satisfaction

with care. No differences were found in the operative delivery rates between the two groups. However, women in the birth centre group were significantly less likely to have interventions such as induction of labour, augmentation of labour, electronic fetal monitoring or the use of obstetric analgesia (Waldenstrom et al., 1997). In this study, birth centre women expressed greater satisfaction with both physical and psychological aspects of care, compared to standard care (Waldenstrom & Nilsson, 1993a).

Satisfaction with Maternity Care

Assessing women's satisfaction with maternity care has proven to be a difficult task. Many studies have identified that women's satisfaction with care differs from satisfaction with their birth experiences (Seguin, Therrien, Champagne, & Larouche, 1989; Waldenstrom & Nilsson, 1993a, 1994; Waldenstrom, Borg, Olssen, Skold, & Wall, 1996). The birth experience consists of many components and is very individual; women often measure it by their own expectations prior to the experience (Bramadat & Driedger, 1993; Sequin et al., 1989; Waldenstrom et al., 1996). Women are often more satisfied with the care provided than with the birth experience (Sequin, et al., 1989; Waldenstrom et al., 1996). Therefore, although the care received from health professionals may affect women's perceptions of the birth experience, women's satisfaction with care should be assessed separately.

Women's satisfaction with care, in a variety of birth settings, has been well reported in the literature (Bramadat & Driedger, 1993; Lomas, Dore, Enkin, & Mitchell, 1987; Sequin et al., 1989; Sullivan & Beeman, 1982; Waldenstrom et al., 1996). This assessment of satisfaction is largely based on forced response questionnaires. Generally high scores have been documented when measuring overall satisfaction with care in all birth settings (Bramadat & Driedger, 1993; Lomas et al., 1987; Waldenstrom et al., 1996). However, many authors have suggested that overall satisfaction scores may not be a good indicator of satisfaction with individual aspects of care (Bramadat & Driedger, 1993; Lumley, 1985). Bramadat and Driedger (1993) suggest that high scores may be a result of the type of measurement tool used. This observation emerged based on a large study by Sullivan and Beeman (1982) which revealed that unsolicited comments from many women indicated negative experiences had occurred. However, these negative experiences were not captured by the forced response questionnaire used in the same study. These authors suggest that a forced choice questionnaire may result in an overestimation of satisfaction with care.

Another limitation of instruments developed to assess satisfaction is that the importance of different aspects of care to women has not been measured and weighted accordingly (Bramadat & Driedger, 1993). One way to avoid superficial responses to questionnaires is to perform indepth interviews, which allow the investigator to probe the importance of different aspects of care (Bramadat & Driedger, 1993; Gutek, 1978).

The findings from studies that assess satisfaction with care have been inconsistent and comparisons are difficult to make because of differences in the selection of subjects, instruments used, and vast variations in timing of studies, in relation to the birth (Waldenstrom et al., 1996). The timing of satisfaction studies has been identified as crucial (Bramadat & Driedger, 1993; Sequin et al., 1989). Asking women to assess satisfaction in the days following birth may be influenced by what many describe as the "Halo effect" (Bramadat & Driedger, 1993; Lumley, 1985). It may not be possible at this time for women to be able to discriminate between the happy experience of birth and the care they received (Shearer, 1983). A study by Simkin (1992) identified that women's recall of events regarding birth were accurate years later, but some events were viewed more negatively than they had been immediately following the birth. The small number of studies which have assessed satisfaction with birth centre care have been limited to questionnaire style assessment of different aspects of care (Cunningham, 1993; Waldenstrom & Nilsson, 1993a; Wood, 1997).

One exploratory Australian study has been published which addressed how different medical procedures impacted on women's first experiences of childbirth (Bradley, Tashevska & Selby, 1990). This study involved a matched comparison between women who birthed in a birth centre and women who had birthed in a conventional delivery suite. In-depth interviews were performed. Findings revealed that birth centre mothers experienced more control, less interventions and were

more satisfied with their experiences than well women receiving conventional care. This study also found that the orientation of women towards birth was different for birth centre mothers. Birth centre mothers actively sought more information and expressed an interest in having control over the birth process compared to women who received conventional care. The authors concluded that the policies of the unit within which women birth have a major impact on their experiences of birth.

In summary, birth centres have emerged as a safe and viable option for low risk women and statistics indicate this option is being chosen by increasing numbers of Australian women. This low technological approach to care has resulted in women being exposed to less obstetric interventions. Satisfaction with maternity services has proven difficult to assess from the use of forced response questionnaires. Finally, there has been limited qualitative data published on women's perceptions of different models of maternity care, particularly in the birth centre setting.

Significance of the Study

The emergence of birth centre care has been rapid and is viewed by many as a sign of discontent with mainstream maternity services in Australia. Birth centre care offers women continuity of midwife care, within the social model of health. To date, there is limited empirical data available about women's perceptions of the care they receive in the

birth centre setting in Australia. Published research on birth centres in Australia and throughout the world has focused largely on clinical outcomes, which indicate safe outcomes for both mother and baby when compared to traditional birth settings (Biro & Lumley, 1991; Eggers et al., 1985; Linder-Pelz et al., 1990; Waldenstrom & Nilsson, 1994; Waldenstrom et al., 1997). Maternal satisfaction with care has also been investigated in many comparative studies, with birth centre care resulting in higher levels of satisfaction (Bradley et al., 1990; Waldenstrom & Nilsson, 1993a; Wood, 1997). The assessment of satisfaction has been limited to closed response questionnaires to investigate different aspects of care.

Women's experiences of the care they receive in the birth centre setting within Australia, from an emic perspective, have never been investigated. Therefore, it was a broad mandate of this study to provide a qualitative analysis of women's perceptions of care in this setting. Findings from this study should assist health professionals to gain a more detailed insight into the birth centre model of care, and how it compares to traditional care.

Purpose

The purpose of this study was to describe women's perceptions of birth centre care following previous experiences in a traditional hospital setting.

Research Questions

This study was guided by the following questions:

1) What are women's perceptions of the care they received in the birth centre setting?
2) How do these women's perceptions of care differ from their perceptions of care previously received in a hospital setting?

Definition of Terms

Birth Centre Care: A unit located in separate premises within or outside a hospital in which comprehensive care during pregnancy, labour and the early postnatal period is provided by a team of midwives.

Low Risk Women: Women who meet the criteria for admission to a birth centre based on their previous medical and obstetric history. Women are booked for birth centre care on the premise that they have no major health problems which could affect their pregnancy, and have had no previous obstetric complications which would classify them as high risk. Exclusion criteria are outlined in Appendix A.

Continuity of Care: Care received from a small team of carers with whom women are familiar, which is consistent, reliable and non conflicting.

Continuity of Carer: Guaranteed care from a specific carer with whom the woman has developed a special relationship, at crucial times such as labour.

Thesis Overview

Chapter one introduces the research topic and discusses the relevant background information and significance of this study. Chapter two presents a review of the literature which considers studies of both birth centres and mainstream services. Chapter three will outline the choice of research methodology; sample selection and setting; data collection method; recruitment procedure and data collection protocol; a description of the data analysis process; trustworthiness of research process and findings; and ethical considerations. Chapter four will present the findings of the study. In chapter five clinical issues arising from the findings will be discussed. The relationship of the study findings to theory and methodological strengths and limitations will also be addressed in this chapter. Finally, recommendations for future studies will also be considered.

CHAPTER TWO

Literature Review

The birth centre model of care is now well established in Australia, with twenty four centres operating throughout the country (Waldenstrom & Lawson, 1997). A review of the literature reveals an abundance of quantitative data that assesses birth centre outcomes such as intervention rates, perinatal mortality and morbidity rates, and satisfaction with care. Women's experiences of care within the birth centre setting have received limited attention. The following literature review will explore the current status of maternity services in Australia. It will identify the changing face of these services and the underlying reasons for these changes. Numerous studies have now been reported on midwife led models of care, the findings of which will provide a valuable background in terms of the evaluation of alternative models of care. The following literature review has been organised into five sections: The Medicalisation of Childbirth, Organisation of Maternity Services, Midwifery Models of Care, Birth Centre Care, and Satisfaction with Maternity Care.

The Medicalisation of Childbirth

In the majority of economically developed countries, it has become accepted by society that childbirth takes place in a medical institution (Tew, 1995; Wagner, 1994). Australia is no exception. Childbirth statistics for 1994 indicated that only 1% of babies were

born at home (Day et al., 1997). This is in contrast to less than a century ago when the family home was the traditional birth place for nearly all births.

The revolution in the move of maternity care to the hospital setting has been largely attributed to the establishment of a vigorous medical profession (Tew, 1995). Professional medical organisations now promote hospitals as the only safe place for women to birth (Wagner, 1994). Since World War II there has been a proliferation of obstetric technology and by the 1960s, childbirth had become a medical procedure (Rothman, 1982). The majority of pregnant women now receive care within the biomedical scientific model of health (Wagner, 1994).

The medical profession have justified the extensive use of birth technology and the medicalisation of the birth process by the reduction in perinatal and maternal mortality rates throughout this century, which have fallen as hospitalisation of childbirth increased (Tew, 1995). This has now been challenged by a number of researchers. Epidemiological studies suggest that the most important factors in reducing neonatal and maternal mortality rates in the early part of this century have been social, not medical (Lancaster, 1956; McKeown, 1965; Richmond, 1990; Tew, 1995). Public health measures such as sanitation, better housing, better nutrition and changing fertility patterns have resulted in less disease and improved birth outcomes (Tew, 1995; Wagner, 1994).

Furthermore, the debate about where babies should be born is not necessarily informed by scientific evidence. The safety of planned home births in several developed countries has been clearly demonstrated in a number of studies (Campbell & MacFarlane, 1987; Wagner, 1994). Epidemiological analysis of perinatal mortality rates in Holland, the only economically developed country where over 35% of births still occur at home, has also demonstrated safety of home births. (Tew, 1995). Holland has experienced, as have other countries, a steady fall in perinatal mortality rates since the 1950s. In 1986, national statistics from this country demonstrated that the perinatal mortality rate in hospitals in Holland was six times that of babies born at home (Tew, 1995). Tew argues that it is not possible for 64% of all women to be high risk, so higher perinatal mortality rates in hospitals have to be attributed to hospital care. It is even suggested that hospitalisation has prevented rates from falling even further (Tew, 1995). A large number of clients in Holland have private midwife care which allows analysis of perinatal mortality rate in terms of birth attendant. This analysis demonstrates a striking contrast between doctor and midwife care. Doctors in hospital have a perinatal mortality rate of 8.9 per 1,000 compared to doctors at home, 4.5 per 1,000. This is compared to the perinatal mortality rates of midwives, which are 2.1 per 1,000 in hospital and 1.0 per 1,000 at home. These differences remained significant, even after accounting for level of risk due to parity and maternal age (Tew, 1995).

Medicalisation of the birth process is now being challenged by many feminist groups and women as consumers of health care. During the 1960s, the women's health movement arose from what many describe as the second wave of feminism (Rowland & Klein, 1990). It was during this time that women began to challenge the medical management of their health and the inappropriate mainstream medical services on offer (Pascall, 1986). During the 1980s, ministerial reviews into maternity services in several Australian states identified much consumer discontent with current services (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). These reviews have highlighted the need for hospitals to review the models of maternity care they offer and have resulted in alternative models being developed.

In summary, the care of healthy pregnant women within the medical model of health is now been challenged as inappropriate and not able to meet consumer demands. There is mounting evidence to suggest that hospital is not the safest place to birth for low risk women (World Health Organisation, 1985) and consumers are now demanding alternatives to mainstream services.

Organisation of Maternity Services

Maternity Services in Australia are based upon a medical model. Care is fragmented and there is a clear division between antenatal,

intrapartum and past-partum care (National Health & Medical Research Council, 1996). In 1994, approximately 75% of pregnant women received care in the public health system (Day et al., 1997). This reflects national data which indicates that about 34% of the Australian population possess private health insurance. In the public health system, the majority of women received antenatal care in public antenatal clinics from both doctors and midwives. Some women choose to share care with their family general practitioner (GP), if the doctor is prepared to offer obstetric services. Care in the labour ward is provided by another set of midwives and doctors, and hospital post-partum care is provided by yet another team of staff. The average patient stay in public hospitals is 3.9 days (Day et al., 1997). These women receive follow up care by the hospital domiciliary service after discharge until the fifth postnatal day.

Patients insured privately usually consult a specialist obstetrician for routine pregnancy care, regardless of "risk" status. These women have continuity of doctor in the antenatal period but with the exception of antenatal classes, have no midwife contact. Labour and post-natal care in the private hospital system is structured much the same as the public hospital system, with different teams of midwives staffing each area. The average post-natal stay in private hospitals is 5.7 days (Day et al., 1997).

The utilisation of private midwifery services is low. This is related to the fact that the cost of private midwife services is not refundable under the Medicare system. Most public and private hospitals do not

allow midwives in private practice to care for private patients; the majority of women who access private midwifery services choosing home birth. Rates of reported homebirth in Australia are about 1% (Day et al., 1997).

Review of maternity services in many states in Australia has taken place through Government Ministerial Reviews (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; and Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). Submissions from both health professionals and consumers were received in all of these reviews. As part of the Victorian review, a postal survey was commissioned to assess satisfaction with childbirth services. The objective of this survey was to confirm if concerns expressed about maternity services in submissions to the review panel were representative of the views of all women (Brown & Lumley, 1994). Findings from this survey indicated a high rate of dissatisfaction with intrapartum care, with as many as one in three women expressing dissatisfaction with labour care. This confirmed anecdotal information gathered by the review panel, that current services were not meeting the needs of women.

Other major issues identified as contributing to dissatisfaction with services were the lack of continuity of care and the limited number of birth options available to women (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; Report of the Ministerial Task Force to

Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). The role of the midwife in the care of women with normal pregnancy was identified as being under utilised and the development of models of care which incorporate midwives as primary carers was recommended. Governments have been slow to respond to the recommendations from state reviews; the committees in each state having no authority to enforce recommendations. Observable changes have been limited.

The United Kingdom has also undergone extensive reviews of maternity services. The Winterton Report (House of Commons Health Committee, 1992) expressed high levels of dissatisfaction with maternity services throughout the United Kingdom. The committee identified that the evidence provided did not support the universal adoption of the medical model to ensure safe birth outcomes. This report recognised the midwife as the specialist in normal childbirth, with the emphasis being social support rather than medical treatment (House of Commons Health Committee, 1992). Recommendations to improve services from the committee were extensive and indicated a radical restructuring of maternity services was required. In response to the Winterton Report, the Department of Health set up the Expert Maternity Group to determine future policy (Tew, 1995). The report of the Expert Maternity Group is known as "Changing Childbirth" (Department of Health, 1993). This report is now policy for England's maternity services and has set up a political mandate to ensure change within the Nation Health Service in Britain within a five year period. The primary principal of

this report is: "that women must be the focus of maternity care" (Department of Health, 1993, p 8).

In summary, maternity services which offer fragmented care have been identified as a source of discontent for consumers. In the United Kingdom, extensive reforms are taking place to ensure services are more consumer oriented. In Australia, changes within mainstream services have been slow, but increasing consumer pressure has seen new models being developed in some maternity units.

Midwifery Models of Care

To overcome fragmented models of care, continuity of care has become the key issue to new model development. In the early 1980s, the concept of team midwifery was introduced to provide women with continuity of midwife carers throughout the childbirth continuum (Walton & Hamilton, 1995). The aim of this model of care was to reduce the number of midwife carers women would be exposed to throughout pregnancy and childbirth.

The first randomised control trial to assess continuity of care by a team of four midwives was carried out at St George's Hospital in London in 1983 and was known as the "Know your Midwife" scheme (Flint, Polengeris, & Grant, 1989). This trial was restricted to low risk women, who were randomly allocated to either standard care or Know your Midwife scheme care. The findings from this trial showed that the trial group had fewer care givers than the standard care group. In the trial group, 98% of women had met their care giver in labour during their

antenatal period compared to 20% who received standard care, however the importance of this to the women was not assessed. The women in the trial group were found to have significantly fewer obstetric interventions such as augmentation, epidural, intramuscular analgesia, and episiotomy than the standard group. Women in the experimental group were more satisfied with their care. Satisfaction was accessed in terms of reduced waiting times in clinic, ability to discuss anxieties, feelings of control during labour, and whether staff were viewed as caring.

As a result of Flint's work, many variations of team midwifery were implemented during the 1980s. In 1993, the Institute of Manpower Studies compiled a survey to assess the status of team midwifery in the United Kingdom (Walton & Hamilton, 1995). This survey found a large variation in the interpretation of "team" with the average team consisting of 11 to 13 midwives. Because of the large number of midwives and the fact that most women did not have a named midwife caring for her, some clients were being exposed to more care givers than the previous models of care. Many of these schemes have now been abandoned (Secombe & Stock, 1995).

In the United Kingdom, the Changing Childbirth Report has provided clear direction for the modification of maternity services, one of the key elements being continuity of carer (Department of Health, 1993). New models of maternity care are now emerging throughout the United Kingdom, with a focus on providing women with continuity of

midwife carer across the childbirth continuum. Many midwife led schemes are now being based in the community.

In the United Kingdom, three randomised control trials to assess the efficacy of midwife led care, compared to more traditional doctor or consultant led models, have been recently reported (Hundley et al., 1994; MacVicar et al., 1993; Turnbull et al., 1996). All these trials were for women classified as 'low risk' of complications at booking and transfer rates varied from 32% to 50% (Hundley et al., 1994; Turnbull et al., 1996). These reported transfer rates indicate that antenatal criteria of low risk at booking is not capable of determining risk status throughout pregnancy. Analysis in all studies was by intention to treat. Findings in all three studies indicated that there was no difference in birth outcomes or perinatal mortality rates between experimental and control groups. However, midwife led care resulted in reduced interventions such as continuous electronic foetal monitoring, episiotomy, and epidural analgesia (Hundley et al., 1994; MacVicar et al., 1993; Turnbull et al., 1996). Two of the studies (MacVicar et al., 1993; Turnbull et al., 1996) assessed maternal satisfaction, which was significantly higher in both studies in the midwife led groups. Findings from these studies support the conclusion that midwife led care offers a safe alternative for healthy women and enhances women's satisfaction with care.

The experiences of women receiving midwife led care have been recently examined in an exploratory study in the United Kingdom (Walker, Hall & Thomas, 1995). In this study, indepth focused

interviews were used to generate data, which were analysed using a grounded theory approach. Thirty two women and six partners were interviewed during the study. One third of these women were transferred to consultant care either during the antenatal or intrapartum period, providing an important comparison group for analysis. Timing for interviews varied between the immediate post partum period (in hospital) to 3-5 months post delivery. The central category to emerge from data analysis was the importance to women of perceived control and support during labour. Factors which influenced women's perception of control were: feeling informed, having options and choices, having a supportive environment, and the development of trust in caregivers. This study identified the importance to woman of one on one care throughout labour, which was facilitated within the midwife led scheme.

Recent models developed in the United Kingdom are now focusing more on continuity of carer. This provides women with a named midwife to provide the majority of care. One such scheme developed is the one-to-one midwifery practice implemented at the Hammersmith Hospital Trust (McCourt & Page, 1996). This scheme was devised in response to the Changing Childbirth Report (Department of Health, 1993) and provides women centred care. Within this model, all women are provided with a primary midwife carer, regardless of risk, to follow them throughout the child bearing continuum. One-to-one care was implemented in two postal areas of London and extensive evaluation was based on both clinical and psychosocial outcomes. Evaluation

included comparisons to the conventional system of care operating in other postal districts. Results demonstrated that the one-to-one scheme had no significant impact on rates of normal delivery, but as with other midwife led schemes, there were reductions in the use of electronic foetal monitoring, induction of labour, episiotomy and use of epidural analgesia.

Evaluation of the one-to-one scheme included assessment of women's responses to care. All participants in this scheme were asked to complete postal questionnaires during the antenatal and postpartum periods. Questionnaires incorporated both closed responses and open ended responses (McCourt & Page, 1996). Analysis of questionnaires demonstrated one-to-one women had more positive views about their care than women who received standard care. Additional assessment through in depth interviews were undertaken to address some of the limitations of the postal survey. Comparison of responses across the three aspects of the survey demonstrated considerable coherence but also highlighted differences in quality of responses (McCourt & Page, 1996). Open ended questionnaires and interviews generated a broader range of feelings expressed, compared to the neutral responses to closed questionnaires. The evaluation of this scheme indicates that it exceeds the indicators for success outlined in the Changing Childbirth Report (Department of Health, 1993), and the scheme is now being expanded throughout other postal districts within the London area.

In Australia, the concept of team midwifery, encompassing continuity of carers across the pregnancy continuum, has been slower

to develop than in the United Kingdom. Team midwifery has been widely adopted within the birth centre setting (Biro & Lumley, 1991; Eggers et al., 1985; Stern et al., 1992). However, this model of care is limited to low risk women who chose to access this type of care.

Within mainstream maternity services in Australia, midwife led schemes are uncommon. Giles et al. (1992) reported a randomised control trial comparing antenatal care for low risk women by midwives compared to standard care. Continuity provided in the antenatal periods did not encompass intrapartum care. Outcomes assessed in this trial were salary costs and client satisfaction. The study findings demonstrated that midwife clinics were cheaper to run than doctor clinics and in addition, women expressed a higher level of confidence with care givers.

The first Australian trial on team midwifery, within mainstream maternity services, was conducted at John Hunter Hospital, in New South Wales during 1991 (Rowley et al., 1995). This randomised controlled trial was designed to assess a team midwifery model of care versus routine hospital care. The team model consisted of six midwives who provided antenatal, intrapartum and post-natal care for women in the trial group. The study was not restricted to low risk women, therefore high risk women were included. High risk women saw a team midwife at each visit and also had medical consultation according to their individual risk status. Results from this trial were similar to the midwife led schemes outlined above. There was no demonstrated difference between team care and standard care in terms of birth and

perinatal outcomes. Again, team women utilised less analgesia and expressed higher levels of satisfaction than women receiving standard care. Significant cost savings in the team model were also demonstrated (Rowley et al., 1995).

In summary, assessment of midwife led care in overseas trials has demonstrated benefits to consumers in terms of reduced intervention rates and improved satisfaction with care. Overall, models of care which focus on continuity of midwife care, such as team midwifery, have been slow to be implemented in Australia. Until recently, the team concept has been more widely adopted within the birth centre setting. However, this model of care is only available to low risk women and is an alternative to main stream maternity care in Australia.

Birth Centre Care

The proliferation of birth centres in Australia reflects the pattern which emerged in the United States during the 1980s (Mathews & Zudak, 1991). By 1987, there were 160 free standing birth centres in the United States (Rooks et al., 1989). Free standing birth centres are structurally and administratively separate from the hospital, women being transferred to main stream facilities should complications arise (Mathews & Zudak, 1991). Birth centres in Australia have developed along different lines with the majority of centres located in hospital grounds, under the control of the hospital administration (Waldenstrom & Lawson, 1997). The underlying philosophy of birth centres is that childbirth is a natural physiological process which is

seen as a largely social event rather than a medical one (Mathews and Zudak, 1991). The care provided in birth centres reflects this attitude with the limited use of technology and a client centred focus, involving women and their families in the decision making process. Continuity of care throughout the child bearing continuum from a small team of midwives is a predominant feature.

During the 1980s, the safety of free standing birth centres in the United States was been q' ..stioned by medical profession (Rooks et al., 1989). The difficulty in establishing safety from published studies has been largely due to the retrospective design and small sample sizes. The national birth centre study, conducted in the United States during 1986, was designed to obtain information on the safety and efficacy of free standing birth centres (Rooks et al., 1989). This prospective study incorporated 84 out of the 163 free standing birth centres in the United States at that time. Of the 11,814 women admitted in labour in these centres, 15.8% were transferred to hospital intrapartum and the rate of caesarean section was 4.4%. There were no reported maternal deaths and the neonatal mortality rate was 1.3 per 1,000 births. It was concluded from this study that free standing birth centres provide safe care for low risk women.

In Australia, a number of individual birth centres have now published statistics for public scrutiny (Biro & Lumley, 1991; Morris, Campbell, Brown, Lumley and Spencely, 1986; Stern et al., 1992). The good safety record reported from most centres is based on the existence of conventional obstetric back up. Transfer rates antenatally and

intrapartum of 30% to 50% are reported by most birth centres (Eggers et al., 1985; McDonald & Evans, 1996; Morris et al., 1986; Waldenstrom & Nilsson, 1993a). These transfer rates are linked to strict criteria for transfer and are considered a trade off for safety and good perinatal mortality rates (Child, 1986).

A number of matched studies have been carried out to compare care in birth centres with care received by low risk women in a hospital setting in terms of birth outcomes and intervention rates. One such study was performed at the Royal Women's Hospital, Melbourne (Eggers et al., 1985). No significant differences between the two groups were found when comparing mode of delivery. Birth centre clients were found to have longer labours but they required less analgesia. Neonatal morbidity was assessed by apgar score, and was not found to be significantly different.

A similar prospective matched study was also performed at the King Edward Memorial Hospital Family Birth Centre during 1995 (Wood, 1997). Findings from this study indicated that birth centre women had significantly lower rates of interventions in terms of electronic foetal monitoring, induction of labour, augmentation of labour, pain relief, and episiotomy. birth centre women also expressed higher rates of satisfaction with care. Outcomes in terms of perinatal mortality and morbidity were difficult to assess due to the low numbers in this study.

A retrospective matched study to compare obstetric risk and outcomes between birth centre and conventional labour ward care was

published in 1990 (Linder-Pelz et al.). This Australian study found that women who received birth centre care had outcomes at least as good as those of women receiving standard obstetric care. This study also concluded that women who received traditional labour ward care had substantially higher rates of intervention after controlling for prenatal and intrapartum risk.

The only randomised controlled trial on birth centre care to date, undertaken in Sweden, confirms the findings of many Australian birth centre studies. In the Swedish trial, birth centre care resulted in significantly lower rates of intervention, such as obstetric analgesia, induction and augmentation of labour and electronic fetal monitoring, when compared to standard care (Waldenstrom et al., 1997). Higher levels of satisfaction were also expressed for both physical and psychological aspects of care, in the birth centre group (Waldenstrom & Nilsson, 1994). Direct comparison with Australian birth centre outcomes is difficult because of different inclusion and transfer criteria. Operative delivery rates reported in the Swedish trial were substantially lower than the rates of assisted delivery reported in birth centre outcomes in Australia (Biro & Lumley, 1991; Morris et al., 1986; Stern et al., 1992; Wood, 1997). It is reasoned that these low intervention rates reflect the general obstetric culture in Sweden, which has much lower rates of intervention than Australia (Waldenstrom et al., 1997).

In Australia, in-hospital birth centres are available in nearly all states, but continue to be restricted to large urban populations. The safety of birth centre care is now well established, although it is

acknowledged that a larger data base to compare outcomes from all centres would be useful to assess rare perinatal outcomes.

Satisfaction with Maternity Care

Pregnancy outcomes have been well evaluated in terms of mortality and to a lesser extent, morbidity. However, the psychosocial outcomes of pregnancy, often referred to as the "soft outcomes", have had more limited investigation (Lumley, 1985; Oakley, 1983). These latter outcomes have proven to be difficult to assess, so are often ignored. If satisfaction was based on hard outcomes, such as the birth of a healthy baby, then all consumers would be satisfied with maternity care (Sullivan & Beeman, 1982). However, investigation into women's satisfaction with maternity care reveals that not all women are satisfied and this indicates the importance of the process, not just the end result.

A number of population based studies have now been reported, both in Australia and overseas, to determine women's satisfaction with care (Brown & Lumley, 1994; Seguin et al., 1989; Sullivan & Beeman, 1982). During 1989, an Australian survey was conducted to assess women's satisfaction with care during labour and birth (Brown & Lumley, 1994). All women who birthed in Victoria during one week in 1989 were mailed a questionnaire 8 - 9 months after birth. The response rate was 71%. This survey revealed that one in three women were dissatisfied with intrapartum care. Regression analysis demonstrated the following factors were highly related to dissatisfaction:

lack of involvement in decision making; insufficient information; a higher score for obstetric intervention; and a perception that caregivers were unhelpful. These findings suggest that there are many factors that determine women's satisfaction with care.

In the United States (Sullivan & Beeman, 1982) and Canada (Seguin et al., 1989), similar population based surveys were conducted in the late '70s and early 1980s, to assess women's satisfaction with maternity care. The American findings revealed very high levels of satisfaction with both prenatal and intrapartum care. The level of consumer satisfaction was related to both the quality of communication with carers and the extent to which preferences were. The Canadian survey results also demonstrated high levels of satisfaction with care. Satisfaction with maternity services in this latter survey were again linked to participation in decision making as well as satisfaction with explanations by carers.

Satisfaction with care in the birth centre context was also investigated in a randomised controlled trial of birth centre care, in Sweden (Waldenstrom & Nilsson, 1993a). In this study, satisfaction with birth centre care was compared to satisfaction with standard care. Women were asked to assess antenatal care one month prior to delivery and assessment of care during birth and the postpartum period were assessed two months after birth. Assessment was by questionnaire, using a seven point Likert-type scale. The return rate for all questionnaires was over 92% in both groups. Findings from this study demonstrated that women who received birth centre care expressed

greater satisfaction with both physical and psychological aspects of antenatal, intrapartum and postpartum care, than women who received standard care.

In summary, satisfaction with maternity care has been shown to be multidimensional. Some studies have identified overestimations of satisfaction levels when forced response questionnaires are used. Higher levels of satisfaction have been reported in many midwife led models of care, compared to standard care.

Summary and Conclusions

In the majority of developed countries, childbirth takes place in the hospital setting, within the medical model. This model of care is now being challenged as inappropriate for the care of healthy pregnant women. Alternative models of care, with the midwife as the lead health professional, have been developed in the United Kingdom. In Australia, dissatisfaction with mainstream maternity services has resulted in the development of many new birth centres, as an alternative to mainstream care. Satisfaction with maternity care has proven difficult to measure, and the assessment of satisfaction in most studies has been limited to forced response questionnaires.

Research to date, on the birth centre model of care, has focused largely on clinical outcomes to establish safety. Assessment of satisfaction with this model of care has had more limited investigation. Satisfaction has been assessed quantitatively in a number of studies, indicating women are more satisfied with birth centre care compared to

standard care. Womens' experiences of care in the Australian birth centre setting has never been studied from an emic perspective and requires further investigation.

CHAPTER THREE

Methodology

An exploratory descriptive design was adopted for this study. This chapter outlines the rationale for the qualitative methodology used. The design of the study and the research sample are detailed. The technique utilised during data analysis and measures to enhance rigor in the study are described. Ethical considerations underpinning the study are also outlined.

Selection of the Research Methodology

An exploratory design was chosen for this study to enable the researcher to explore women's perceptions of the care they experienced in the birth centre setting. This study was planned to complement a larger research study entitled: 'The antenatal, birth and postnatal experiences of women who gave birth in hospitals and birth centres in the Perth region'. The principle investigator on this study was Dr Patricia Percival. The larger study was carried out in twelve hospitals and two birth centres in the Perth region. The six hundred women who participated in this study completed an extensive questionnaire which assessed Women's experiences such as numbers of carers, birth gratification, satisfaction with care and postnatal depression. The current study was designed to complement the quantitative design of the larger study, by exploring women's birth centre experiences from a

qualitative paradigm. Qualitative research is described as "modes of systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings" (Benoliel, 1984, p. 3).

The combination of two methodologies should provide a more complete picture of women's experiences, in the birth centre setting. The larger study provided facts and figures about number of carers and broad levels of satisfaction, whilst the qualitative approach of this study explored what women's experiences of having a limited number of midwife carers was like. The use of multiple methods is supported by Bockman (1987), who suggests "that qualitative methodologies which address the whole, and quantitative methodologies, which analyze the pieces, should be considered together to form the whole of nursing research" (p. 72).

A review of the literature demonstrated that there had been limited investigation into women's perceptions of the birth centre model of care. To ascertain the women's perspective of their care, it was determined that an exploratory design was the most appropriate method to elicit this information. A qualitative approach has been identified as useful when the researcher wishes to document and interpret the phenomena being studied from an emic perspective (Field & Morse, 1985; Patton, 1990; Strauss & Corbin, 1990). Qualitative data allows the researcher to gain insight into the human experience.

The qualitative approach is often referred to as naturalistic inquiry (Field & Morse, 1990; Lincoln & Guba, 1985; Polit & Hungler 1995). The investigator does not attempt to control variables, manipulate the data or predict outcomes. This form of inquiry also allows the investigator to explore similarities and differences in individual experiences.

The qualitative method informing this study was grounded theory. A modified grounded theory approach was adopted to guide this study, a full grounded theory methodology not being possible due to time limitations at the Masters level. Grounded theory is described by Burns & Grove as an "inductive research technique" (1987, p. 85). An inductive approach to analysis of the data allows the important categories to emerge from the data, without making prior assumptions (Patton, 1990).

Sample Selection and Setting

Women who had received their antenatal, intrapartum and postpartum care in three Perth area birth centres were interviewed in this study. It was anticipated that all three birth centres in Perth would be involved in the larger study, as outlined above. However, it was not possible for the chief investigator of the larger study to access women who birthed at the King Edward Memorial Hospital Family Birth Centre, due to the hospitals prior research commitments. The hospital was willing to allow the researcher of the current study to access a smaller

sample of women, to be involved in Interviews. As a result of this, women at the Mandurah Birth Centre and the Swan Districts Family Birth Centre were recruited through the larger research study as planned. Women who birthed at the King Edward Memorial Hospital (KEMH) Family Birth Centre, were recruited directly from the birth centre and had not participated in the larger study.

Women were invited to participate in the study if they met the following criteria:

* had attended a minimum of five antenatal visits by birth centre midwives during their pregnancy;
* had a midwife care for them in labour who they had met at least twice during the antenatal period;
* had a normal birth;
* had been discharged home within 24 hours of the birth;
* had previously given birth to a baby in a hospital setting;
* were available for interview 2 - 4 months after the birth of their baby;
* had not had any part of their pregnancy care provided by the researcher.

Seventeen women were recruited and interviewed between November, 1996 and April, 1997. Nine women were interviewed from Mandurah and Swan Districts Family Birth Centres and eight from KEMH Family Birth Centre. As suggested by Patton (1990) and Morse (1991), interviews continued until redundancy and saturation of information was reached. After the seventeenth interview was analysed,

it was determined that no new themes were emerging from the data, so no further interviews were performed.

Data Collection Method

This study explored women's perceptions of the care they received in the birth centre setting. The data collection method chosen by the researcher was face to face interviews. It was decided that this method would allow women to describe their experiences in depth. Women who were willing to participate were interviewed in their own homes. The reason for this was twofold. Firstly, women are often more comfortable in their own environment and it was felt that the relaxed atmosphere would enhance the interviews. Secondly, all participants had a new baby and at least one other child, so it was easier for the researcher to travel to the mother than to expect her to travel to a different location. Interviews were audiotaped with permission.

A semi structured interview guide was developed to provide a general outline for questioning. This guide was not rigidly adhered to, allowing the investigator to explore issues as they emerged (Appendix B). Open ended questions were used, with a list of probes should they be necessary. A rigid interview structure were avoided, as this would have limited the experiences that were explored (Polit & Hungler, 1995). The interview questions evolved through the review of the literature and consultation with a number of midwives with research expertise. The focus of the interview was on women's perceptions of the care they

received, not on their actual birth experience. It was the intent of the interview to explore women's perceptions of both their most recent care experiences and their previous experiences. The researcher conducted pilot interviews with two women who met the selection criteria and were willing to participate. This led to minor modifications and refinement of the interview guide. This was mainly the addition of probes that could be used to elicit more depth from participant. The pilot interviews also gave the researcher the opportunity to reflect on strategies to enhance rapport, active listening and questioning techniques.

The timing of interviews was also considered during the pilot interviews. The immediate postnatal period was avoided to reduce the 'halo effect' (Bramadat & Driedger, 1993; Lumley, 1985) on the woman's most recent birth experience. Pilot interviews were performed at one and two months postnatal respectively. It was decided by the researcher that two months postnatal was the more appropriate time. By two months, women were more likely to have recovered from the birth physically, and should have overcome early postnatal problems, such as breast feeding difficulties and sleep deprivation. Demographic data as outlined in Appendix C were obtained from each participant after each interview. This enabled the investigator to compile a profile of the women interviewed.

Recruitment Procedure and Data Collection Protocol

Midwives in the KEMH Family birth centre were given a half hour presentation by the researcher that covered the objectives of the study, selection criteria for the study and recruitment procedure. All staff in the centre were willing to provide information about the study to eligible clients. All women who met the selection criteria were approached about the study prior to discharge from the Family Birth Centre. Consenting women were informed that the researcher would phone them when their baby was about two months old. During this phone call the researcher confirmed that the clients were willing to participate in the study. An appointment was then made to conduct the interview.

Recruitment of women from Mandurah birth centre and Swan Districts Family birth centre was through the larger study outlined above. Women who participated in the larger study were aware that they may be approached for an interview. The names and phone numbers of women who met the selection criteria were provided to the researcher by the chief investigator of the larger study. These women were then contacted by phone. During this phone contact the researcher explained the purpose of the interview, estimated time involvement and the fact that the interview would be audiotaped. Participation was entirely voluntary. Appointments were made to conduct interviews with women who expressed a willingness to participate. A total of nineteen women were approached for interview, two declined because they did not feel comfortable about being tape

recorded. Recruitment through the Family Birth Centre at King Edward Memorial Hospital was slower than anticipated. The main reason for this was the selection criteria excluded all primiparous clients, who account for 55 to 60% of all birth centre bookings in this centre (McDonald & Evans, 1996). It was also identified that many multiparous clients had previously attended a birth centre for care during their first pregnancy, and had never experienced hospital care.

Interviews were all held in the participants home at a time and date convenient to them, two to four months after the birth of their baby. Women were given the opportunity to read the information sheet about the study (Appendix D) and ask the researcher any questions. They were then asked to sign a written consent (Appendix E). All participants were aware that the researcher was a midwife who worked in a birth centre. Women were advised that if they did not feel comfortable with any question, they could decline to answer it. Interviews were audiotaped and ranged from between twenty minutes to one hour. The semistructured interview guide was utilised by the researcher in each interview. Probes were only used if this information was not elicited by the initial question. During each interview, the researcher tried to enhance the communication process by maintaining appropriate eye contact, maintaining an open posture, responding to comments with non verbal cues such as a nod of the head and reflective listening skills where appropriate. At the end of each interview participants were asked to complete the demographic data form

(Appendix C). Each interview was then transcribed verbatim from the tape by a professional audiotypist. The issue of confidentiality of the data was discussed with the typist and she was asked not to discuss the content of the interviews with anyone. The typist was asked to insert pseudonyms for all names of places and people throughout the transcript.

Data Analysis

Data analysed in this study was from written narrative communication transcribed from interviews. The method of data analysis utilised was content analysis. This is defined as "the process of identifying, coding and categorising the primary patterns in the data" (Patton, 1990, p381). The units of analysis identified by the investigator were phrases, sentences or paragraphs (Polit & Hungler, 1995). The significant meanings of these units were then coded and categorised into groups. This form of analysis is often referred to as latent content analysis as it allows for the underlying meanings within the communication to be identified within the context of the entire interview (Field & Morse, 1990).

Data analysis began after the first five interviews were completed and transcribed. Subsequently, each interview was transcribed as soon as possible after the interview and coded throughout the data collection period. The data were categorised through a process identified by Strauss and Corbin (1990) as open coding. "During open coding the

data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena as reflected in the data" (p. 62).

The steps used for data analysis in this study were based on the method outlined by Burnard (1991), to analyse interview transcripts. This method has been modified slightly and is outlined below:

1. The audiotapes were transcribed verbatim by a professional audiotypist.
2. Each typed transcript was checked against the audiotape by the researcher.
3. The written transcript from each interview were read and keywords and significant statements were highlighted throughout the transcript.
4. Transcripts were read again and emerging themes were listed in the margins of the recorded data to describe all aspects of the content. This allowed the researcher to become immersed in the data.
5. The identified themes that emerged from each interview were then considered by the researcher and similar themes were grouped together.
6. This theme was then named to reflect the contents.
7. Transcripts were then re-read alongside the final list of themes, identifying which theme each significant statement belonged to.

Throughout this study women were asked to discuss their birth centre care experiences in relation to their care experiences in the hospital setting. This resulted in each identified theme having a number of dimensions and features, which encompassed women's experiences in both care settings.

Trustworthiness of the Research Process and Findings

Evaluating the rigor of qualitative research is an important aspect of the research process. Qualitative inquiry is based on completely different assumptions from quantitative inquiry and the criteria used to judge validity needs to reflect this difference (Beck, 1993; Guba & Lincoln, 1985; Sandelowski, 1986). Quantitative data are generally judged in terms of internal and external validity as well as reliability. Guba and Lincoln (1985) suggest that the criterion used to evaluate rigor in qualitative inquiry should be credibility (truth value), fittingness (applicability), auditability (consistency) and confirmability (neutrality). Trustworthiness of the research process in this study was assessed using these criteria.

Creditability and Fittingness

Creditability and fittingness in this study were confirmed in a number of ways. Firstly, the validity of the categorisation process in this study was confirmed by asking a fellow research student who was not involved in the study, to read through two of the interview transcripts and identify a category system. These categories were then

discussed with the fellow research student and compared with the researcher's own category system. Secondly, the researcher's two supervisors, who were both familiar with the raw data, were consulted throughout the categorisation process. Finally, validation of the findings was achieved by returning to two of the participants interviewed. After data analysis was completed by the researcher, two participants were contacted by phone and asked if they would be willing to be involved in the validation process. Participants were sent a transcript of their interviews with categories identified and were invited to make comments on the interpretation and categorisation of the data. This ensured that the researcher's interpretation of data was correct. Feedback from these participants confirmed that the researcher had interpreted the data correctly and they indicated that the major themes were a true reflection of their experiences.

Auditability

Auditability is seen to be achieved when any reader can follow the progression of events the researcher used from beginning to end of the research process (Sandelowski, 1986). To enhance the auditability of this study a sample of a coded transcript has been included (see Appendix F), after identifying details have been eliminated. This should help the reader to clarify how the researcher derived the themes. The researcher also documented an audit trail throughout the data analysis, so it was clear how categorisation was determined. This has been confirmed by the researcher's supervisors.

Confirmability

Guba and Lincoln (1985) suggest that confirmability (neutrality) is achieved when credability (the truth value), fittingness (applicability), and auditability (consistency) are established.

Limitations

The researcher acknowledges that the sample is self selecting, clients eligible for the study chose birth centre care. Findings from this study may not be generalised to all child bearing women. However, they have the potential to be transferable to women who give birth in similar birth settings. Midwives who practice in similar care settings may be able to use the findings from this study to assist in care planning and delivery.

Ethical Considerations

Written permission to undertake this study was obtained from the Committee for Conduct of Ethical Research at Edith Cowan University. Approval to carry out this research at King Edward Memorial Hospital was obtained by the researcher, through the Research and Ethics Sub-committee at this hospital. Ethical approval at Swan Districts Hospital and Mandurah Hospital had already been obtained through the larger study. All participants in the study were involved on a strictly voluntary basis with the unconditional option to withdraw at any time. Each participant was given a letter of explanation and an informed consent to

sign prior to interview (Appendix E). All participants kept a copy of the information sheet, which contained contact numbers of the researcher and her immediate supervisor should the participant have any queries or concerns.

All research participants were guaranteed confidentiality. Participants were informed that no names would be identified on records, and that pseudonyms and a coding system would be used. A master list of participants was kept separate from the coded tapes. Only the researcher and supervisors had access to the raw data, transcripts and computer discs which are secured in a locked cupboard in the home of the researcher, and will be destroyed after a five year period.

CHAPTER FOUR

Findings

This chapter presents the findings of this study. It begins with a description of the study sample. The second section of the chapter consists of results of analysis of the interviews undertaken, focusing on women's perceptions of the care they received from health professionals, in both the birth centre and hospital environments. Each theme is illustrated throughout by including excerpts of interviews.

Description of the Sample

Seventeen women were interviewed for this study. All participants met the selection criteria, and had experienced care within the hospital setting with at least one of their previous pregnancies, their most recent experience of care being in the birth centre context. One participant reported having a previous homebirth experience. All participants were Caucasian with the exception of one woman who was a Maori. All participants reported being either married or living in a defacto relationship. The age of the participants ranged from 22 years to 34 years, and the parity ranged from between 2 and 5 children. The educational background, qualifications, usual occupation and combined family income of participants are outlined in Table 1.

Table 1. Demographic Profile of Participants

Characteristics	Women n = 17
Current Age	
22 - 25	5
26 - 30	6
31 - 34	6
Parity	
2	12
3	2
4	2
5	1
School Education	
Achievement Certificate (year 10)	9
Tertiary Entrance (year 12)	8
Highest Qualification	
None	8
Trade	3
Diploma	3
Degree (Undergraduate)	3
Usual Occupation	
Home duties	4
Service Industry	7
Professional	5
Other	1
Combined Family Income	
less than - $ 20 000	2
$ 20 001 - $ 30 000	2
$ 30 001 - $ 40 000	4
$ 40 001 - $ 50 000	4
$ 50 001 and over	5

Women's Perceptions of Birth Centre Care

Women interviewed in this study shared their experiences of care in both the hospital and birth centre settings. This provided a wealth of data about two different models of care. Final analysis of the data resulted in the identification of four key themes: Beliefs about Pregnancy and Birth; Nature of the Care Relationship; Care Interactions; and Care Structures. Each one of these themes was comprised of two dimensions at either end of a continuum, as outlined in Figure 1. Each theme is discussed separately below.

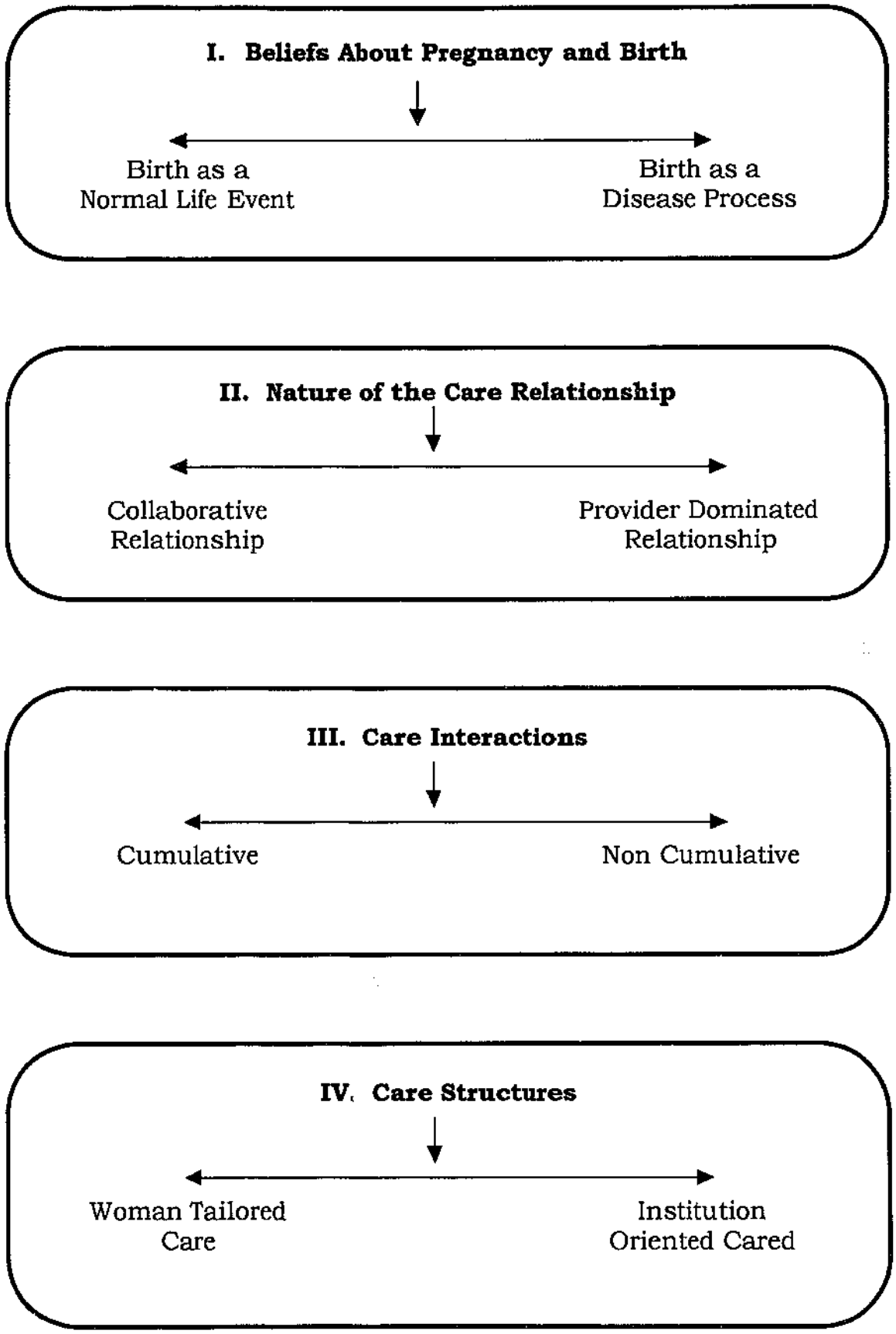

Figure 1: Overview of Themes

Beliefs about Pregnancy and Birth

The first theme to emerge from the data was Beliefs about Pregnancy and Birth. This theme captured the attitudes and beliefs about the pregnancy and birth process held by both women and their carers. The philosophical ideologies identified within the data varied along a continuum from birth being perceived as a normal life event, to birth being viewed as a disease process. The features of each of these ideologies are outlined below. Exemplars of this theme are presented in Table 2.

Birth as a Normal Life Event

The belief that birth is a normal life event was the view articulated by many women. The carers philosophical beliefs were also evident in women's descriptions of the care they received. This ideology was comprised of two features. These were: (a) Birth as a natural process, and (b) Carers non-interventionist approach. These features are described below.

Birth as a natural process. Birth as a natural process was defined as the belief that pregnancy and labour are normal physiological processes. Many participants verbalised their belief that birth was not an illness and therefore should not be treated as such.

> "Giving birth is not an illness, it is not a medical procedure, it is life, it is a miracle and each and every one is different and I think people have lost that, or had lost, I feel it is coming back now, I think women are coming into their own about how they want to give birth..." [Interview 6]

Table 2. Exemplars of Theme One: Beliefs about Pregnancy and Birth.

Beliefs about Pregnancy and Birth
This theme captures the attitudes and beliefs about the pregnancy and birth process held by both women and their carers

Dimension: Birth as a Normal Life Event		
Birth perceived as a normal life event.		
Features	**Definition**	**Exemplar**
1. Birth as a natural process	The belief that pregnancy and birth are normal life experiences.	"..the way they (midwives) just seemed to treat birth as being a natural process instead of a medical process."
2. Carer's non-interventionist approach	The lack of physical interference with the birth process.	"But I wasn't touched when I came in and I was in labour, I wasn't examined at all which I really appreciated. They seemed to know where I was at and not interfere with me in any way."

Dimension: Birth as a Disease Process		
Birth viewed as a disease process.		
Features	**Definition**	**Exemplar**
1. Birth viewed as an illness	The belief that pregnancy and birth are pathological processes.	"Doctors don't talk about things you can do during labour. When you see a doctor they talk about what problems you may have and what might go wrong. They don't talk about what is normal and how you can make things be normal."
2. Carer's interventionist approach	The physical interference with the birth process	"...with the doctors they wanted to do internals and check me all the time."

Women revealed a confidence in their bodies ability to birth normally, based on the fact that they had birthed before. This is demonstrated in participants' comments below.

> "I knew with my first baby I had a normal birth so I knew it wouldn't be a difficult birth this time around." [Interview 7]

> "The knowledge I learned after she *[first baby]* was born. I knew I could do it. It's one of those things women have done for thousands of years." [Interview 12]

Women's prior birth experiences instilled trust in the natural birth process.

The midwives in the birth centre were perceived by participants to treat pregnancy and birth as a natural life process. As one participant outlined: "..the way they *[midwives]* just seemed to treat birth as being a natural process instead of a medical process." [Interview 12]. Midwives in the birth centre were perceived to actively encourage women to trust in their body's ability to birth naturally. Many participants described how the birth centre midwives encouraged them to listen to their bodies, as demonstrated below.

> "I asked the midwife when do I know when to push? She said your body will tell you. And I said, no it won't, it didn't the last two times, the doctors told me. She said your body will tell you when you are ready to push. So I walked around a little longer then I had the urge to push. I was leaning up against the bed on the floor and moved out a bit then. Then my body told me what to do. My waters broke at that time. A couple of contractions happened - I was waiting for them to happen. Then the baby came out." [Interview 3]

> "...she *[midwife]* said you know how to do it, your body knows how to do it. The baby is going to come out. She gave me the confidence to know it was going to be fine." [Interview 12]

The midwives practicing in the birth centre context were identified by women to display trust in the birth process and encourage women to be instinctive.

Carer's non-interventionist approach. The midwives approach to care during pregnancy and labour was perceived as one of non-interference, when they adopted the philosophy that birth was a normal life process.

Participants' experiences revealed that the birth centre midwives did not interfere with their bodies in a physical sense. Procedures such as vaginal examinations were kept to a minimum and utilised when required rather than routinely; as one participant explained.

> "I wasn't touched when I came in and I was in labour, I wasn't examined at all which I really appreciated. They seemed to know where I was at and not interfere with me in any way." [Interview 15]

The non-invasive approach to care was also described by another participant. She described her perceptions of the care provided by the birth centre midwives during routine antenatal visits.

> "...the midwives would feel my stomach and that was it. They put the monitor *[doptone]* on and listened to the baby. They did not want to interfere in any way." [Interview 3]

During labour, the birth centre midwives non-interventionist approach and support of natural childbirth was enhanced by the fact that technology such as epidurals and continuous electronic fetal monitoring were not readily available in the birth centre. Women often chose the birth centre option for this reason, as one participant related.

> "...the fact if I said in labour I wanted an epidural there wouldn't be a doctor there straight away to say, OK let's give you an epidural, don't worry you shouldn't have to have pain. Just to have someone there to say, No let's go a bit longer, you can do this." [Interview 10]

Non-intervention was positively received by women and reinforced birth as a normal life process.

Birth as a Disease Process

The belief that birth is a disease process was the ideology perceived to be held by many health professionals working in the hospital setting. This belief was comprised of the following features: (a) Birth is viewed as an illness and (b) Carer's interventionist approach. These features will be further explored below.

Birth viewed as an illness. The belief that pregnancy and labour are pathological processes was evident in Women's descriptions of interactions with carers in the hospital setting. The majority of participants had previously experienced involvement of doctors during routine antenatal and intrapartum care. Women perceived that doctor's attitudes reflected their medical background; Pregnancy and birth were viewed as a disease with many potential dangers. As one woman described.

> "Doctors don't talk about things you can do during labour. When you see a doctor they talk about what problems you may have and what might go wrong. They don't talk about what is normal and how you can make things be normal." [Interview 4]

The same participant also indicated that midwives within the hospital system also adopted this ideology, preparing women for intervention.

As she outlined:

> "Actually I found the first time we went to antenatal classes it was like that. My husband and I walked out in shock, just the problems and intervention. For example, they talked about drugs but they didn't talk about how you can control your pain without this. They focused on intervention, what would happen if you had to have a caesarean, what would happen if you needed stitches. I think it is important to say these things may happen but they shouldn't be the focus." [Interview 4]

One participant in the study was having her fourth child and had previously experienced a homebirth. This option was not available to her during her most recent pregnancy. She believed that society has socialised women into thinking that birth is dangerous and the only safe place to give birth is in a hospital.

> "I think with all this programming over the years, that women believe the only way they can give birth is to go into a hospital." [Interview 6]

The belief that birth was safer in hospital, and preparing women for interventions resulted in women perceiving that carers believed intervention was routine and 'normal', indicating a distrust of the birth process.

Carer's interventionist approach. The carers orientation to pregnancy and labour was characterised by interference when they adopted the ideology that birth is a disease process. Most participants had experienced the involvement of doctors during routine care in the hospital setting. The perception that doctors did not view birth as a normal life event was endorsed by the fact that the doctor was often seen to adopt an invasive approach. Procedures such as vaginal examinations were often performed in pregnancy as a routine. As one

participant identified: "...with the doctors, they wanted to do internals and check me all the time." [Interview 3]. Another participant indicated that the only discussion about the birth focused on the participants feelings about the use of epidural analgesia during labour.

> "She *[obstetrician]* never really spoke about the actual birth. She did mention epidurals and how I would feel about having one. I said I'd prefer not to have one. But as far as the birth itself that was all that was done." [Interview 5]

The focus on possible interventions reflected the doctor's medical philosophy and did not reinforce normal birth.

In the hospital environment, the use of technology was an accepted part of the birth process. Many participants perceived that in the hospital setting, there was an assumption that women would want to use analgesia such as epidurals. One participant described how in labour, she felt that she was coping well, when she heard the midwives discussing her.

> "When I was in the hospital, when I was actually in labour, someone said "it is too late to give her an epidural" and I thought "well, did someone ask for one?" I never mentioned anything you know, and just that sort of thing, because I was in a hospital." [Interview 15].

Experiences such as this resulted in women perceiving that technology was an integral part of the birth process in the hospital setting.

In summary, the carer's philosophy of birth varied in each care setting. In the birth centre setting, the midwives approach was seen as non-interventionist, based on the belief that birth is a normal life event. In contrast, carers in the hospital setting adopted an interventionist approach, based on the belief that birth is a illness which requires medical management.

Nature of the Care Relationship

The second theme to emerge from the data was the Nature of the Care Relationship. This is defined as women's perceptions of the type of relationships they have with care providers. Women identified that the relationship with health providers varied from one of collaboration, to a provider dominated relationship. The nature of the relationship between women and carers was identified as having a direct impact on the degree of control women experienced over their birth and the degree of satisfaction women expressed. The features of each end of this continuum will be explored separately in the following section. Table 3 provides exemplars of this theme.

Collaborative Relationship

A collaborative relationship is defined as a partnership between the woman and her carer. The relationship with midwives in the birth centre was more often described by participants as one of collaboration. This relationship was characterised by two features: (a) Equality with carers, and (b) Women as primary decision makers. These features are elaborated below.

Equality with carers. The feature of equality with carers is defined as an egalitarian relationship between the women and carer.

Table 3. Exemplars of Theme Two: Nature of the Care Relationship

Nature of the Care Relationship
How women perceive their role in the relationship with the health professionals that provide care.

Dimension: Collaborative Relationship		
The collaborative relationship between the women and her carer.		
Features	**Definition**	**Exemplar**
1. Equality with carer	An egalitarian relationship between the women and carer.	"She *[midwife]* would come to my house, give me my checks. We would talk on an even. There was no superiority there..."
2. Women as primary decision makers	Women taking responsibility for decisions related to their care.	"She *[midwife]* would ask me a question and say we could do it this way and that way and gave me suggestions but ultimately it was my decision."

Dimension: Provider Dominated Relationship		
The paternalistic relationship between the woman and her carer		
Features	**Definition**	**Exemplar**
1. Health professional superiority	The authoritarian stance carers adopt when interacting with pregnant women.	"I found the males *[doctors]*, although they were very nice people and could be great at other things, but when it comes to something like giving birth. I found their attitudes very 'they know better'. That offended me as a woman and mother..."
2. Women as passive participants	Women's lack of involvement in decisions related to their care.	"And they didn't seem to take any consideration for my feelings or what I wanted or asked me what I wanted, they just went ahead and did it. They said this is what we have to do, this is what we are doing. It wasn't, this is what we could do, we have other options. They didn't give me any options."

The relationship with the midwife carers in the birth centre was perceived by women to be one of equal status. As one participant described.

> "She *[midwife]* would come to my house, give me my checks. We would talk on an even. There was no superiority there and she actually taught me how to give birth." [Interview 6]

Many women cared for in the birth centre identified that discussions during pregnancy revolved around their wishes and preferences for birth. As another participant stated: "She *[the midwife]* spent a lot of time just talking and deciding how we were going to handle things." [Interview 8]. Most women perceived that they were encouraged to play an active role in planning the birth.

> "They encouraged me to express whatever I felt I would like. They put a lot of care into what I would like for the birth, who I would like to be there...even the very small details and that really meant a lot to me." [Interview 1]

Many participants also acknowledged that their choices were respected by the birth centre midwives.

> "The birth centre births were the more positive two experiences in that I really felt my choices would be respected, what I wanted to do would be listened to and would be supported." [Interview 10]

The midwife was not perceived by women to have the authority in the relationship to make decisions for them. The outcome of perceived equality between women and their carers culminated in women having a sense of control over their care during pregnancy and birth.

Women as primary decision makers. The feature of women as primary decision makers is defined as woman taking responsibility for decisions related to their care. Women who accessed birth centre care

felt that they were treated as autonomous individuals. Many participants identified that the midwife provided them with information, enabling them to make informed decisions. As one participant outlined: "She *[midwife]* would ask me a question and say we could do it this way and that way and gave me suggestions but ultimately it was my decision." [Interview 8]. Another woman identified that the midwife did not allow her own personal viewpoint to influence the decision to be made. Rather, the midwife ensured that the participant felt that she was the one making the decision.

> "She*[midwife]* was the one who had no personal statement, she was objective. She could see we were getting a lot of pressure and she was the one that kept bringing it back and saying hold on, you have two options." [Interview 4]

Women acknowledged that they were able to make decisions that were appropriate for them. One participant outlined how she had been advised by the birth centre midwife to be transferred into the hospital for a longer postpartum stay. This was based on the fact that she had experienced a large post partum haemorrhage after her birth in the centre. This women considered this advice but opted to go home to recover. As she explained:

> "I chose to go home and that was respected as well. I wasn't made to go into hospital. As it turned out that was totally appropriate for me, I recovered quickly." [Interview 15]

Women identified that within a collaborative relationship, their right to make decisions was acknowledged and supported. Womens ability to make decisions resulted in a sense of control over their birth experiences.

Provider Dominated Relationship

A provider dominated relationship is defined as the paternalistic relationship between the woman and her carer. Many participants, when describing their interactions with health professionals in the hospital setting, described a sense of medical domination in the relationship. This type of relationship was composed of two features: (a) Health professional superiority, and (b) Women as passive participants. These are detailed below.

Health professional superiority. The feature of health professional superiority is defined as the authoritarian stance carers adopt when interacting with pregnant women. Medical practitioners and midwives in the hospital setting were perceived by many participants to have a superior attitude, based on an assumption that they are experts.

> "I found the males *[doctors]*, although they were very nice people and could be great at other things, but when it comes to something like giving birth I found their attitudes very 'they know better'. That offended me as a woman and mother..." [Interview 6]

One woman related her experience after birthing in the birth centre and then being transferred into the hospital as her baby required phototherapy. The nature of relations with carers changed from one of equality to one of feeling dominated.

> "I ended up being admitted to the main unit for a day with him *[baby]*.... There wasn't that respect that I knew my body and I knew what I needed and didn't need. It was back to more of "we know what's best for you" sort of attitude and "we know what's best for baby". It was very different." [Interview 10]

Many women felt they had no say when they had doctor care, resulting in a feeling of lack of control over their experiences. As one woman

shared: "When I had a doctor it was his baby, we weren't allowed to talk and I had to do it his way." [Interview 3]. Many participants did not perceive doctors to be very approachable, their knowledge and expertise were not to be questioned. As another woman described.

> "I don't think you can talk to them *[doctors]* like you can a midwife. Being doctors, I know you take it for granted you don't ask questions." [Interview 9].

Carers who functioned within the hospital framework were perceived to impose their own beliefs onto women. When participants did not choose to follow medical advice, they often felt pressured to conform to the carer's view, rather than the carer respecting their choice. One woman felt strongly about her baby not being given a Vitamin K injection after birth and had discussed this with the doctor at a routine antenatal visit. This woman described how immediately after birth, in the birth centre, the doctor continued to pressure her to consent to Vitamin K.

> "The doctor hovered up and down the hallway and when he heard the baby cry, he came in. But once again, as soon as he came in I got the Vitamin K issue all over again, and we were still attached to the umbilical cord and then it happened again and it was like, hang on a minute, let me complete my birth, my child is beautiful, he is healthy and happy, you even said that - don't start telling me I have to start putting something artificial, synthetic in his little body already." [Interview 6]

There was no acceptance by the doctor that the woman had the right to decline treatment based on her own belief system.

Women as passive participants. The feature of women as passive participants is defined as women's lack of involvement in decisions related to their care. In the hospital system women did not perceive

that they were to be involved in decisions affecting their care. Women often indicated they were not given any choice in terms of what care they would receive, they were simply told what would happen.

> "And they didn't seem to take any consideration for my feelings or what I wanted or asked me what I wanted, they just went ahead and did it. They said this is what we have to do, this is what we are doing. It wasn't, this is what we could do, we have other options. They didn't give me any options." [Interview 13]

Some women were subjected to procedures they did not want; their wishes specifically ignored.

> "They insisted on an examination *[vaginal]* which was something I really objected to, but they did it anyway. Then she was born less than an hour later." [Interview 4]

Women's lack of input into their care often resulted in dissatisfaction with care.

It was also the experience of many women that their preferences were not accommodated. This was in contrast to what they had expected.

> "At the hospital, when they had their antenatal classes, they said you could basically have the baby any way you wanted and I was in the actual position I wanted but then they wouldn't allow me to do it." [Interview 7].

When preferences were denied, this resulted in women expressing a loss of control over their birth experiences.

Many women described that the involvement of doctors in pregnancy care often resulted in the doctor having total control over any decisions which needed to be made. As one participant described.

> "The only time we had problems was towards the end when our obstetrician was concerned with the baby's weight. I felt the control got taken away from us a bit by everybody... The midwives then said if the obstetrician won't agree to it we won't let you into the birth centre, we shall throw you out. It then really became an issue for me because we were seeing him only if an emergency arose...So we decided to say we were wrong with the dates. So we felt our control had been taken away and it was not a decision for us at all. They weren't saying we will talk about this and decide together, it was whatever the obstetrician says is what goes." [Interview 4]

The lack of involvement in the decision making process resulted in this woman feeling a lack of control over the decision which was to directly affect her and her baby.

Some participants felt that the medical staff did not provide full information so that they could make an informed choice. One woman was advised to be induced after her waters had broken. She indicated that the doctor failed to explain what this would entail. As she describes: "But I was never really sat down and said that when we induce this is what is going to happen." [Interview 12]. The failure to provide women with enough information also resulted in women sensing a lack of involvement in the decision making process.

In summary, the nature of the care relationship varied from one of collaboration through to provider dominated. This was identified as one of the key influencing factors in women's sense of control over their care throughout pregnancy, birth and the postnatal period.

Care Interactions

The third theme to emerge from the data was Care Interactions. This is defined as the opportunities that women have to develop a rapport with carers. Interactions with health care providers were determined as either: (a) Cumulative interactions, or (b) Non Cumulative interactions. These are discussed below. Table 4 provides exemplars of this theme.

Cumulative Interactions

Cumulative interactions were defined as women being provided with the opportunity to develop an ongoing relationship with the midwife. Participants in this study were all given the opportunity to be cared for by the same midwife, or group of midwives, during their pregnancy and birth. The cumulative contact resulted in: (a) Women comfortable with carers, and (b) Women being known. These are discussed below.

Women comfortable with carers. This feature is defined as women feeling at ease with carers with whom they have had the opportunity to become familiar. In the birth centre model of care, multiple exposures to the same midwives throughout pregnancy and birth enabled a rapport to develop between women and their carers. This resulted in woman feeling at ease with the midwife.

> "...it was important to have someone I knew even though she *[midwife]* wasn't a close friend. It was someone for me to make contact with and feel comfortable with." [Interview 1]

Table 4. Exemplars of Theme Three: Care Interactions

Care Interactions
The opportunities that women have to develop a rapport with carers.

Dimensions: Cumulative Interactions		
Women being provided with the opportunity to develop an ongoing relationship with the midwife.		
Features	**Definition**	**Exemplar**
1. Women comfortable with carers.	Women feeling at ease with carers with whom they have had the opportunity to become familiar.	"...it was important to have someone I knew even though she *[midwife]* wasn't a close friend. It was someone for me to make contact with and feel comfortable with."
2. Women being known	Women's perceptions that they were understood by the midwife and that their preferences and past experiences were considered in the care relationship.	"It was someone who knew me, knew my previous experience. When I was delivering in second stage, she *[midwife]* kept saying it is not going to be the same as the last one because she knew how much that bothered me."

Dimension: Non Cumulative interactions		
Interactions with carers throughout pregnancy which do not result in an ongoing relationship.		
Features	**Definition**	**Exemplar**
1. Lack of rapport with carers	Women being unable to feel at ease with unfamiliar carers.	"...there seemed to be two people around. I wasn't that interested in looking to be honest. But there seemed to be people around but I couldn't identify with anybody."
2. Women being unknown	Carer's lack of knowledge about women's past experiences and birth preferences.	"I had written a birthplan for when my baby was born and quite a few things I had written on the birthplan weren't even really looked at...and there were little things that maybe would have run differently with the birth..."

The degree of comfort expressed was perceived by women to be directly linked to the number of contacts they had with the midwife.

> "The first *[contact with one midwife]* I was nervous. The second time I was a lot more relaxed and then the third time it was like, hi how are you going, it was a lot more comfortable and I was able to open up a lot more to her." [Interview 11]

Participants identified that they disclosed more information to carers once they felt comfortable with them. Another participant suggested that one contact was not enough to feel comfortable with a midwife.

> "I met two midwives only once, quite near the end and I remember once walking out and thinking "I didn't feel too good about that". Just because it was kind of getting near the end, and she had a whole different manner, she was nice but it was getting "who's going to be there in the end". So I was pleased when it was *[the midwife]*, who I had seen the most..." [Interview 15]

Most women expressed that the midwife they felt the most comfortable with was the one whom they had had the most contacts.

When women were cared for by a midwife with whom they had a rapport they were more likely to feel comfortable to discuss concerns.

> "You feel a lot more relaxed and comfortable and I think if you had things you want to talk about at that time you can speak more about what you want to or you feel more comfortable than just meeting a stranger walking in." [Interview 9]

Some participants described that being cared for by a familiar midwife, helped them to feel uninhibited and consequently they were able to be themselves. As one woman described.

> "It made it easier and shorter because you can come out of yourself more. You could express yourself more. You are more comfortable with them." [Interview 7]

Communication was facilitated as a result of being cared for by a familiar midwife carer.

Many participants indicated that they did not mind having intimate procedures performed on them by a midwife with whom they had rapport. As one participant outlined.

> "It was good because I knew her and I was comfortable with her and it didn't bother me if I had to have certain tests done, or if she had to break my water or come in and check me..." [Interview 13]

Care provision by a midwife with whom the woman was familiar and comfortable resulted in the woman being able to focus her attention and energy on the birth process, instead of having to spend time developing a relationship with an unknown carer.

> "... with the last two babies I knew the midwives and all I had to do was concentrate on myself and the labour. I think that is what causes a lot of pain during labour, your mind is elsewhere thinking about other things rather than what you are actually doing." [Interview 6]

Trust was often the result of women being cared for by a familiar midwife. Many participants identified that they were more likely to listen to someone that they felt knew them.

> "...and having in labour "yes you can do it", and it is like "I can't go on anymore" and it is "yes you can, you're almost there" and having someone that you know *[midwife]* telling you that, you think oh well I can do it, all right." [Interview 16]

The midwife's encouragement was perceived to have more impact when she knew the woman.

Many participants identified that being cared for by known carers resulted in the development of a special relationship, which had a positive impact on the woman's birth experiences. As one woman described.

> "So I just think that besides having your mum and your husband there who you can lean on, you also feel like a closeness with the midwife as well. It is a bond. You can't explain what that feels like. I really like it I think that is the way it should be comparing with the other births." [Interview 9]

Having the opportunity to be cared for by a known carer throughout labour was highly valued by those who experienced it.

Women being known. The feature of women being known is described as women's perceptions that they were understood by the midwife and that their preferences and past experiences were considered in the care relationship. All participants interviewed had experienced continuity of carer in the birth centre setting; being cared for in labour by a midwife that they had met at least twice during their pregnancy. Women found it beneficial to be cared for by someone who already knew their history and past experiences. As one participant explained.

> "It was someone who knew me, knew my previous experience. When I was delivering in second stage, she *[midwife]* kept saying it is not going to be the same as the last one because she knew how much that bothered me. Or how long I had second stage and how difficult it was." [Interview 12]

Many women also expressed that when the midwife knew them, they did not have to spend time conveying their fears.

> "She *[midwife]* knew what I had been going through with the first pregnancy and the birth. She knew everything, what I was scared of and all of those things. She knew exactly what I wanted. I didn't have to tell her then." [Interview 14]

Women also felt midwives who knew them understood their perspective.

> "she *[midwife]* knew how we felt about intervention and drugs...that was a direct benefit of her having had so much interaction with us along the way." [Interview 4].

Discussion of birth preferences with the midwife prior to the birth allowed women an opportunity to inform the midwife of their wishes and discuss options.

> "...she *[midwife]* knew exactly what I wanted before I even went in there so when I was in labour she knew exactly what I wanted. She made quite sure how things worked so I knew, I could have whoever I wanted there and she made things very easy." [Interview 13]

Many participants identified that discussions about their impending birth, during the pregnancy, allowed them to let the midwife know how they would act in labour and what they felt they would require from her. One participant described how she was able to let the midwife know that during labour, it was normal for her to be very vocal and that she would probably ask for an epidural, but felt with good support she should not need one.

> "I remembered we had discussed it a lot in the antenatal, that I would ask for an epidural and that I would make a lot of noise and that I would need lots of encouragement and support." [Interview 10]

The woman actually being known by the midwife resulted in her perceiving she received the support she required. As she described: "I actually didn't ask for an epidural this time. I just really felt the support was there." [Interview 10].

Many participants demonstrated a desire to have their primary midwife carer present at the birth. As this woman identified. "I really did want my own midwife to be there because she knew me and she knew how I wanted to give birth." [Interview 6]. The knowledge that the midwife present at the birth would know the woman and her wishes

resulted in most participants not actually writing a birthplan. As another woman described: "I didn't write a birthplan but it went exactly how I wanted it to." [Interview 16]. Women expressed confidence that their preferences for labour would be honoured by the midwives.

> "I was asked what way I would like to have my labour and I said I was more comfortable standing up most of the time...they said it was no problem and to do what I felt comfortable with and they would go with the flow. I was pleased about that." [Interview 11]

The woman being known by the midwife resulted in the midwife understanding the woman's needs. Some women required minimal physical input from the midwife as they had their own support team for this. As this woman outlined.

> "*[The midwife]* very much played the outer circle but coming in as required. But, not like doing lots of encouragement, I had people for that and really appreciated that." [Interview 15].

Other women needed a large amount of physical and psychological support from the midwife. Another participant described how the birth centre midwife provided this for her.

> "...she *[midwife]* was talking me through and very often during the contractions I had to hug her, to hold her, and she would look right at me and say "you can do it, you can get through it"..... she was like my tower, when I look back on the birth, that was where my strength was. My husband was not able to provide that for me. He knew that." [Interview 12]

Being known by the midwife was also perceived by women to facilitate their ability to be in control of their birth experience.

> "Having met her (midwife) beforehand and discussing what we would like to have happen and the feeling she was putting me back in control, that really made a big difference. Rather than the doctor being in charge." [Interview 1]

Being cared for in labour by a midwife who knew them, enhanced women's confidence that they would achieve the birth experience they had planned.

Non-cumulative Interactions

Non cumulative interactions are defined as interactions with carers throughout pregnancy which do not result in an ongoing relationship. For many participants, previous care in the hospital system resulted in them meeting different carers at every antenatal visit. In labour, they were cared for by midwives they had never met prior to admission. Non cumulative contacts resulted in: (a) Lack of rapport, and (b) Women being unknown. These are further illustrated below.

Lack of rapport. The lack of rapport, as a result of non cumulative interactions, is defined as women being unable to feel at ease with unfamiliar carers. Having care provided by many different carers throughout pregnancy and labour culminated in woman not having the opportunity to develop a rapport with carers. For one participant, the lack of rapport with carers in her first pregnancy whilst attending the hospital antenatal clinic resulted in her being unable to address her psychological concerns.

> "I think I was a bit scared ...with this pregnancy the talks with the midwife helped me so much...I think going somewhere like the hospital and talking to different people you don't even get into these things, you talk about the pregnancy and what is important in the pregnancy." [Interview 14]

When women receive care from different carers every time they come into the health care system, participants perceive that much time is spent covering old ground.

> "I seem to remember, when you see different people you always have to start the whole story. You always have to talk your medical history. And then they ask about the previous deliveries, were they normal? You end up doing that a lot." [Interview 15].

Many participants received labour care from unfamiliar carers during their previous hospital experiences. The lack of rapport resulted in the woman not being able to relate to carers.

> "...there seemed to be two people *[staff]* around. I wasn't that interested in looking to be honest. But there seemed to be people around but I couldn't identify with anybody." [Interview 5]

Some women also described carers they didn't know as strangers.

> "It would have been nice to have everyone around you that you knew, not just your family...rather than all these strangers around and then they change and you get more strangers coming in. It is a bit scary..." [Interview 16]

The presence of carers that women did not know was identified by many participants as a source of anxiety. As one participant described: "I think I honestly felt more tense the first time because I didn't know the people in the room..." [Interview 11]. There was also a lack of trust verbalised by some women when care was provided by unfamiliar carers. As another woman outlined.

> "...with the main hospital, when I had my first baby and the people I didn't know, I was thinking to myself: Did I really want to listen to them? I wanted to do my own thing but then again they were saying no, no, no, you have to do this and I really didn't want to do that..." [Interview 11]

Control over the birth experience was directly linked to the presence of known carers by many women. One participant described

her feelings when she was facing transfer to the main hospital for induction, after having all her pregnancy care in the birth centre.

> "...it was an absolutely enormous issue for me that I would be transferred out...I would lose control from people I hadn't met and didn't know." [Interview 10]

Participants in this study identified that being cared for by unknown carers, particularly in labour, had a negative impact on their care experiences.

Woman being unknown. The feature of women being unknown was defined as carer's lack of knowledge about women's previous history and birth preferences. In the hospital system women were exposed to multiple carers throughout pregnancy and birth. When reflecting on these experiences, many participants identified the fact that they felt unknown by carers.

> "It was really hard...they don't know you. I think at the birth centre because they knew a little about you and your life, so of course everything was different..." [Interview 14].

For this same participant, different carers at every antenatal visit resulted in a failure to recognise her anxiety related to an early pregnancy loss in her prior pregnancy.

> "It was seven months last time and I hadn't got one thing ready for the baby...it was like I didn't want to believe I was going to have a baby...that is how I felt during the pregnancy...I think if I had someone to reassure me that nothing is wrong, they said to me that things were fine, but that was different people every time...I think I needed someone to talk to." [Interview 14]

In the hospital setting, being cared for by midwives who had no knowledge of the woman resulted in many women writing a birthplan.

However, many participants felt their birthplan was not used to capacity. As one woman explained.

> "I had written a birthplan for when my baby was born and quite a few things I had written on the birthplan weren't even really looked at...and there were little things that maybe would have run differently with the birth..." [Interview 12].

Some women said in the hospital system they had been encouraged to write down their birth preferences, but that in labour this written birthplan was not referred to or considered by the staff involved in their care.

> "Actually, they sent out a questionnaire to your home and you filled it out and that allowed you to list all the choices and preferences you wanted. But when I actually went in it was never referred to and I remember thinking later, I can't remember specifically what happened, but I remember going home and thinking that they didn't even look at the care plan that I had written." [Interview 10]

The written birthplan, as a tool to assist women to inform unfamiliar carers of their birth preferences, seemed to have minimal impact on the care they received.

In summary, participants in this study identified that in the birth centre setting, they were given the opportunity to develop an ongoing relationship with midwife carers across the childbearing continuum. This was in contrast to the non cumulative interactions they experienced in the hospital setting. Cumulative interactions were perceived by women to have a positive impact on their birth experiences.

Care Structures

The last theme to emerge from the data was Care Structures. This is defined as the organisational framework through which care is delivered. Two organisational dimensions to the delivery of maternity care were identified: (1) Women tailored care, and (2) Institution oriented care. Women's experiences revealed that birth centre care was more likely to be women tailored, in contrast to care in the hospital setting, which was interpreted as institution oriented. These dimensions are elaborated further below, and a summary is provided in Table 5.

Women Tailored Care

Woman tailored care is defined as the assistance and attention provided to women during their pregnancy and birth that focuses on their unique concerns, preferences and needs. This dimension was characterised by three features: (a) Personalised care, (b) Genuine caring, and (c) Seeing-me-through.

Personalised care. Personalised care is defined as attention and assistance provided by midwives that revolves around women. When women perceived they were the focus of care, this resulted in them feeling they had received individualised care. Care delivery in the birth centre was perceived to be woman focused by many participants.

> "But when they *[midwives]* talk to you, they talk to you, not talk to you about something else or someone else or what someone else did, it was always your experience and what you want and if you aren't happy with that then they change it because as far as they are concerned you are the one having the baby not them... " [Interview 13]

Table 5. Exemplars of Theme Four: Care Structures

Care Structures
Defined as the organisational framework through which maternity care is delivered.

Dimension: Women Tailored Care		
This is defined as assistance and attention provided to women during their pregnancy and birth that focuses on their unique concerns, preferences and needs.		
Features	**Definition**	**Exemplar**
1. Personalised care	The attention and assistance provided by midwives that revolves around women.	"But when they *[midwives]* talk to you, they talk to you, not talk to you about something else or someone else or what someone else did, it was always your experience and what you want and if you aren't happy with that then they change it because as far as they are concerned you are the one having the baby not them..."
2. Genuine caring	Women's perceptions that midwives provide attention and assistance that was regarded as sincere.	"I was wondering maybe they do care a different way when they know someone."
3. Seeing-me-through	An assurance that the same midwife would provide all care throughout labour and birth.	"...that was what she *[midwife]* said to me at my visits "whoever is with you will be with you that entire time. We are not going to leave you, there will be that same person there the whole time". Like I say, when I look at it that made all the difference in being able to concentrate..."

Dimension: Institution Oriented Care		
Defined as the assistance and attention provided to women during pregnancy and birth that focus on the requirements of the care setting.		
Features	**Definition**	**Exemplar**
1. Systemised care	The attention and assistance provided to women by carers which revolves around the routines and usual practices of the care setting.	"I know with my first two sons *[hospital births]* there were so many people popping in and out, and students, and all that stuff and you are a slab on that table and you are bringing a life into this world..."
2. Fragmented labour care	The inability of the care setting to assure one carer for women throughout labour.	"But I think the main thing was I had like five different people looking after me all at once..."

Many participants described that they felt the care they received was adjusted to suit them individually.

> "Everything went at its own pace. I didn't feel things were pushed on us...it was very very nurturing care...there was no such thing as the system taking over." [Interview 15]

Women's birth centre experiences revealed that their preferences were accommodated by the midwives caring for them. As one participant explained:

> "It was all up to me. I could do whatever I wanted, lay where I wanted to and *[the midwife]* was quite happy to go along with me. She just followed me around." [Interview 3]

One participant was surprised the midwife was able to facilitate her delivery in an unusual position, just so she was comfortable.

> "...we tried a few different positions where I could feel comfortable and I ended up leaning on the bed on my knees, that felt really good. And then when it came to giving birth. I thought I would just stay like this. I didn't think it was possible because the bed was quite low. She *[midwife]* just wanted me to be comfortable." [Interview 14]

Many participants expressed the view that in the birth centre they felt they were recognised as individuals, and that their care was individualised. As the following participants outlined:

> "I had the impression that people actually read my file. There was still that individualised care." [Interview 10].

> "I felt at least they *[midwives]* took my measure and let me be what I needed to be, does that make sense rather than treating people routinely. Or I need to tell you this because that's the policy." [Interview 15].

Individualised care often resulted in participants being given some time on their own during labour, which many women really appreciated.

> "Everyone left me alone, left me to it which is great, you know. It was really what I wanted. Yeh. I didn't want to be poked and bothered, and told to lay here and do this." [Interview 17].

When women perceived that their specific needs were met by carers, then care was interpreted as being personalised.

Genuine caring. Genuine caring is defined as women's perceptions that midwives provide attention and assistance that was regarded as sincere. The birth centre environment allowed women to be cared for by midwives with whom women had developed a relationship. This relationship was perceived to result in genuine caring. As one participant identified: "I was wondering maybe they do care a different way when they know someone." [Interview 14]. Many participants described the assistance midwives gave them as caring, in a personal way. As one women described.

> "...she *[midwife]* fitted in and really cared, it wasn't just a service, she was there to help." [Interview 2].

Midwives in the birth centre were perceived to have more time available to spend with women. Time equated to caring, which resulted in women feeling they were provided with care which met their needs.

> "She *[midwife]* actually came here *[home]* and it was just so relaxed. We had a cup of coffee and she had time for my worries." [Interview 14].

> "while they *[midwives]* were here, that was your time. It wasn't looking at the watch all the time..." [Interview 13].

The birth centre structure allowed midwives the time to interact with women without being rushed. The result of this was women felt that carers were genuine and interested in them as individuals.

Seeing-me-through. The feature of seeing-me-through was defined as an assurance that the same midwife would provide all care throughout labour and birth. The birth centre framework was perceived as being able to accommodate providing women with one midwife carer for the duration of labour. Labour was identified as an important time for most participants. Many participants felt that continuous care by one midwife only during labour had a positive effect on their birth experiences. As one participant stated: "...if you had just one midwife throughout that just makes a huge difference, it really does." [Interview 8]. Women felt positive about the assurance of one carer during labour.

> "..that was what she *[midwife]* said to me at my visits "whoever is with you will be with you that entire time. We are not going to leave you, there will be that same person there the whole time". Like I say, when I look at it that made all the difference in being able to concentrate..." [Interview 12].

The assurance of one carer for the duration of labour was highly valued by women, and impacted on their birth experiences.

Institution Oriented Care

Institution oriented care is defined as the assistance and attention provided to women during pregnancy and birth that focuses on the requirements of the institution. Care delivery in the hospital was experienced as institution oriented by many participants in this study. This dimension was characterised by two features: (a) Systemised care, and (b) Fragmented labour care. These are discussed below.

Systemised care. Systemised care is defined as the attention and assistance provided to women by carers which revolves around the

routines and usual practices of the care setting. Many women perceived that the organisational structure of the hospital setting dictated the type of care they received. Participants expressed the view that they were just a number in a large system. As one participant described: "I was sitting there...no one to talk to, no-one really cares, you are just a patient." [Interview 13]. The hospital system did not allow women to become familiar with carers. Having intimate procedures performed by unknown carers resulted in a perception of impersonal care. As one participant identified:

> "...the doctor who actually examined me *[vaginal examination]* ...I had never met him. I found it very impersonal." [Interview 8]

The hospital system involved many different care providers as part of routine care, not only throughout pregnancy, but also in labour.

> I know with my first two sons *[hospital births]* there were so many people popping in and out, and students, and all that stuff and you are a slab on that table and you are bringing a life into this world..." [Interview 6]

Lack of privacy was perceived as having an extremely negative impact on women's experiences.

Hospital care often involved a doctor being called in for the birth of the baby, at the end of labour. One participant described how she felt when her doctor attended the birth of her first child. The doctor's lack of involvement in the labour care led to the woman perceiving that he did not have any understanding of what she had been through up to that point. The conversations going on around the woman resulted in her feeling that she was unimportant.

> "I thought, well you haven't been with me the past 20 hours... he *[doctor]* just walks in and I remember him talking to one of the nurses and she asked what he had been doing and he said he had just had some friends for dinner and his dinner party had been interrupted or something and that has stayed on my mind. It seemed he was feeling "oh she is just another woman in labour, she's in another world, she doesn't really know what's going on"." [Interview 1].

Another participant, when discussing her hospital birth experience, felt the hospital system was very inflexible. As she explained:

> "With my first child that is what I had. This is what we've got, this is what you get. I didn't like that because I didn't have a choice. I just turned up for the experience." [Interview 13].

The hospitals' inability to offer choices resulted in women perceiving care as not personalised.

In the hospital system, women were expected to endure long waits prior to being seen in the antenatal clinics. Carers often had little time available to discuss concerns with the women.

> "...at the hospital I was sitting there waiting for 2 or 3 hours and never saw the same doctor twice... I felt like no-one really cared. I didn't have one person I could turn to if I had worries and they didn't have time to talk. There was only 10 minutes. You waited 3 hours and then you were given 10 minutes and then you were out." [Interview 14].

The hospital structure, which allowed little time for carers to address women's concerns, resulted in women perceiving a lack of empathy by carers.

Fragmented labour care. The feature of fragmented labour care is defined as the inability of the care setting to assure one carer for women throughout labour. The hospital shift system often prevented midwives from being able to commit to staying with a client throughout their entire labour. This often resulted in women being exposed to multiple

carers in a short time frame. Woman would just start to become familiar with their carers and then there would be a shift change and new staff would come on.

> "I liked the first lot and I was just starting to get used to them and then all of a sudden, I had an epidural, went to sleep a bit, woke up and I had different ones, and it was like, oh OK." [Interview 16]

Women were aware midwives were due off shift, but as one participant reported, this caused her much anxiety and culminated in a very negative experience.

> "...one of the comments from the first midwife, I know it was good intentions, but it was "come on, you have to push that baby out I have to leave". And then I started to panic Oh my God I am not going to have it - and I didn't have it. I should have been able to push her out. ... And that midwife was with me until her shift went off at 9.30 pm. Now I started my second stage at 8.45 pm at night. When she left everything stopped. Then they had someone else come in for a while and she left, then I had a third midwife. So during second stage I had three midwives and my second stage was 2 hours and 45 minutes and it was awful." [Interview 12]

Some participants did not feel it was appropriate for carers to leave them halfway through labour.

> "I think, me myself if I was a midwife and I came in to somebody who was going into labour I would stay with them through to the end instead of OK I have to clock off now, run out and another lady come in and it is OK right what are we doing. For myself I would want to see it through to the end and that is what I felt they should have done instead of half way through." [Interview 11]

The lack of continuity of carer throughout labour was perceived to have a negative impact on many women's birth experiences.

Some participants also expressed concern about the fact there were too many carers involved in caring for them, in the hospital setting. As one participant described:

> "But I think the main thing was I had like five different people looking after me all at once..." [interview 8].

In summary, the care setting governed the type of care women received. Institution oriented care resulted in care being perceived as impersonal. Birth centre care was described as women tailored. When women were the focus of care, then care was perceived as being individualised, which impacted positively on women's birth experiences.

Summary

This study enabled women to share their experiences of care in both the hospital and birth centre settings. The four key themes to emerge from the data were: Beliefs about Pregnancy and Birth, Nature of the Care Relationship, Care Interactions, and Care Structures. Each theme was comprised of two dimensions at either end of a continuum. The following chapter will now discuss the clinical issues arising from these findings.

CHAPTER FIVE

Discussion

This chapter presents a discussion of the research findings. The interpretation of findings and clinical issues arising from the study, relationship of the study findings to theory, and methodological strengths and limitations will be examined. Implications for practice and recommendations for future research will also be outlined in the final section of the chapter.

Interpretation of Findings and Clinical Issues Arising From the Study

This study was designed to provide descriptive data about women's perceptions of care experiences in the birth centre setting, compared with their experiences previously in the traditional hospital setting. A number of factors that affect women's experiences with carers were identified in this study. The four key themes arising from the study findings were: Beliefs about Pregnancy and Birth, Nature of the Care Relationship, Care Interactions, and Care Structures. Three underlying clinical issues arose from these themes: Philosophy of Care, Control over Childbirth, and Continuity of Carer. The following discussion will address these issues and integrate relevant work of other researchers.

Philosophy of Care

The findings from this study identified that the philosophy of carers was perceived to be very different between the hospital and birth centre settings. To women, the carers philosophy was demonstrated by their approach to care. In the hospital setting, both midwives and doctors were viewed as interventionist in their approach to care. The conduct of invasive procedures, use of technology, and a focus on potential problems implied that childbirth was an illness that requires medical management. These findings confirm that care delivery within mainstream maternity services is embedded in the medical model (Bennett, 1997; Wagner, 1994).

Women identified a different approach to care in the birth centre context. Midwives were perceived to treat pregnancy and birth as normal life events. This was demonstrated by a non intervention approach to care, by actively supporting natural childbirth and encouraging women to behave instinctively, and by providing psychological support. This approach was perceived by women to promote the 'normality' of birth and often reinforced their own beliefs about birth. Care provision in birth centres is based on the philosophy that birth is a normal life event (Mathews & Zudak, 1991). The findings from the present study indicate that women did perceive this philosophy to be evident in the care they received from birth centre midwives.

The finding from this study also suggest that the carers philosophy is determined largely by the health care organisation in which care is provided. The majority of midwives have spent most of their education and practice in the hospital setting. How much does the institution's philosophy of care influence individual midwives practice? Bryar (1995) suggests that the care context has a great impact on the type of care midwives are able to deliver. Midwifery practice is often influenced by the needs of the organisation, which in the hospital setting revolves around the medical model. Bryar argues that the midwife's role has developed in a medical way because of the organisational setting. Findings from the current study provide further evidence to support Bryar's argument. Midwifery care in the two care settings was perceived very differently by women which suggests that the midwife's behaviour may be shaped by the social forces and policies of the institution in which they practice.

The belief in birth centres that birth is a normal life event is a philosophy also identified in other alternative birth settings. A recent Western Australian study into women's homebirth experiences highlighted this issue (Morison, 1996). This phenomenological study of couples homebirth experiences revealed a strong belief by both parents that birth is a normal process and that women are capable of giving birth naturally at home. Women who had experienced a homebirth reported that they actively sought a midwife who shared their philosophy of birth.

The effects of alternative models of care are now clearly demonstrated in published clinical outcomes. Reduced medical interventions are a common feature of the birth centre model of care (Eggers et al., 1985; Linder-Pelz et al., 1990; Stern et al., 1992; Waldenstrom & Nilsson, 1994; Wood, 1997).

Findings from the only randomised controlled trial on birth centre care, carried out in Sweden, also suggest that birth centre philosophy and policies not only impact on carers but also on women's behaviour (Waldenstrom & Nilsson, 1994). Prior to this trial, the low rates of intervention reported in the birth centre setting were attributed largely to selection bias, that is women who chose birth centre care were more committed to natural birth than women who chose hospital care. The Swedish trial addressed this selection bias limitation. All women who participated in the study expressed an interest in natural childbirth and were keen to receive birth centre care. Results from this trial revealed that women who received birth centre care utilised significantly less pain relief than women in the mainstream system. These results raise questions about other aspects of care that influence women's experiences and suggest that the philosophy of carers and birth centre policies may play a major part in influencing women's behaviour.

The constraints of the institution on midwives practice has also been questioned by other researchers who have evaluated midwifery models of care. McCourt and Page (1996), in their evaluation of one-to-one midwifery practice, question whether midwifery led care is possible

within an obstetric led unit. Evaluation of the one-to-one scheme, when compared to traditional obstetric care did not result in a large increase in rates of normal birth as anticipated. The researchers concluded that the midwife's practice in the hospital settings, is constrained by obstetric biased policies and practices, which do not support the physiological processes of labour and birth.

However, a recent randomised controlled trial of a midwifery model of care for low risk women, that operated within the tertiary care setting in Canada, resulted in significantly lower rates of intervention when women received midwife care (Harvey, Jarrell, Brant, Stainton, & Rach, 1996). This study indicated that although care delivery continued within the hospital system, midwives were more selective in their use of technology, without compromising safety (Harvey, et al. 1996). These findings suggest that the midwives were able to practice from a midwifery philosophy, within the hospital environment.

Comparisons of the success of midwifery models of care in different countries is difficult. The obstetric culture in Canada varies greatly to that in the United Kingdom, in terms of the involvement of midwives in mainstream care and the rates of intervention. The impact of midwifery care in Canada may be greater because of the limited involvement of midwives in the mainstream health care system in that country. The degree of autonomy of the midwives in each scheme is also difficult to compare.

In summary, there was strong evidence in this study to indicate that carers behaviours vary according to the care context within which they practice. The carer's underlying philosophy was perceived to impact on their approaches to care, which ultimately impacted on the woman's experience.

Control over Childbirth

Control over birth has been linked to the availability of information, choice and participation in decision making in numerous studies which have investigated women's birth experiences (Brown & Lumley, 1994; Sequin et al., 1989; Walker et al., 1995). In this study, women clearly articulated that their sense of control was directly linked to the nature of their relationship with carers. The relationships experienced by women with birth centre midwives were described differently compared to previous relationships women had experienced with health professionals in the hospital setting.

The collaborative relationships between women and midwives described in this study confirm findings from earlier studies, concerning women's interactions with midwives. A study by Berg, Lundgren, Hermansson and Wahlberg (1996) described the encounter between birthing women and the midwife during childbirth. This phenomenological study of eighteen women was set in an alternative birth care centre in Sweden. The essential structure of the woman/midwife encounter during childbirth was formulated into three

themes: to be an individual, to have a trusting relationship, and to be supported and guided on one's own terms. Being seen as an individual in this study was to identify the significance of the woman within the relationship. Women expressed the importance of being treated as an equal and with respect.

Findings in the current study demonstrated that within the collaborative relationship, the midwife was utilised as a resource during interactions, providing information to give women options and choices about the direction of their care. Women perceived that within this relationship they took responsibility for making decisions related to their care, which resulted in a feeling of control over their pregnancy and birth. Berg and colleagues (1996) drew similar conclusions from their study. In this study women articulated the need to be the authority at the birth. Control was achieved by being involved in decision making, which was facilitated by the midwives' support and guidance.

In the study by Berg et al. (1996), many multiparous women recounted negative experiences from previous births. Many women reported how they perceived that staff were in control. Women's loss of control was described as a consequence of lack of involvement in decision making, poor communication and lack of explanations. These findings are supported by this study, with women reporting numerous provider dominated encounters when describing previous birth experiences. These experiences revealed that women perceived a lack of

control when their preferences were not accommodated, and when there were no options provided.

A grounded theory study by Walker et al. (1995), that explored women's experiences of midwife led care, also reported control as an important issue for women. The core category to emerge in this study was the balance of personal control and support. Personal control was dependent on women having options that allowed choice, adequate information and involvement in the decision making process. McCourt and Page (1996), in the one-to-one midwifery evaluation, also identified the importance of the nature of contact between women and health professionals. The way information is given or withheld was identified by women as crucial to their experiences.

The nature of the relationship between women and health care providers as an issue of control was also raised in a study by Green et al. (1990). This study assessed the relationship between women's preferences, expectations, experiences, and women's subsequent feelings. Findings from this study suggested that the issue of control is not limited to involvement in decision making, but is much more broadly related to the type of relationships that women believed they have with staff. Loss of control was linked to factors such as lack of information and perceptions of staff as unsupportive.

A phenomenological study by Fenwick (1997), which investigated the meaning of midwifery care, also identified the nature of the relationship between the woman and midwife. Women in this study

had received care throughout the pregnancy continuum from one primary midwife carer and the place of birth varied from home through to hospital. Participants in Fenwick's (1997) study reported that "care took place within a shared equal relationship between mother and midwife" (p. 207). The collaborative nature of women's relationships with carers facilitated information sharing, choices and control.

The working relationship between midwife and woman has been identified as an important component of the homebirth experience (Morison, 1997). Women in Morison's (1997) study reported that their relationship with carers was based on mutual respect. Within this relationship, women identified that the midwife was utilised as a resource, information was shared, concerns discussed and decisions negotiated. This type of relationship facilitated empowerment, enabling women to control their own health.

It is postulated from the findings of the current study that one of the major factors influencing women's perceptions of control over their pregnancy and birth experience may be the nature of the relationship between the woman and her carers. Participants identified that the collaborative nature of the relationship with midwife carers in the birth centre facilitated information sharing, which results in an availability of choices for women. The care provided in the birth centre context has clearly moved away from the medical model, many authors now describing a partnership between women and midwives (Bennett, 1997; Guilliland & Pairman, 1995). The midwifery partnership, as a model for

practice, will be considered further in the section on relationship of the study findings to theory.

Continuity of Carer

Continuity of carer has become one of the major issues facing midwives in the 90s (Page, 1995; Walton & Hamilton, 1995). Many consumer surveys of childbearing women undertaken in the last decade in the United Kingdom have identified women want continuity of carer (Garcia, 1995). In Australia, many women have expressed similar views in submissions to various ministerial reviews into obstetric services in three different states (Ministerial Review of Birthing Services in Victoria, 1990; Ministerial Task Force on Obstetric Services in New South Wales, 1989; Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, 1990). Continuity of midwife carer across the childbearing continuum is one of the central aims of new models of care being developed in the United Kingdom and Australia (Page, 1995; Rowley et al., 1995; Walton & Hamilton, 1995).

In Western Australia, the birth centre model of care facilitates continuity of a small number of midwife carers, usually three or less, across the pregnancy continuum. Participants in this study were able to compare continuity of midwife carer in the birth centre setting, with their previous experiences in the hospital setting, which did not provide continuity of midwife carer.

Findings from the current study highlight a number of important issues in the area of continuity of carer. Not only did women identify the benefits of continuity of carer across the pregnancy continuum, but women also emphasised the impact of having a single midwife carer throughout labour. Women perceived negatively, care in a system which resulted in multiple carers throughout labour. In the hospital setting, structured rostering systems for midwives resulted in many women being exposed to many staff shift changes and multiple carers throughout labour. This type of care was perceived to be institution oriented and resulted in what many women described as impersonal care.

In contrast, the organisational structure of the birth centre was perceived to be oriented towards women. Midwives did not have to work within organisational constraints such as a rigid shiftwork system, but organised their workload around the needs of women. Although continuity of carer across the pregnancy continuum is a key feature of the birth centre model, women acknowledged that the assurance of one carer throughout labour had an extremely positive impact on their birth experiences. Woman tailored care within the birth centre context, as identified in this study, resulted in women perceiving that care was individualised and personal.

Women in the current study clearly articulated the benefits of being cared for throughout pregnancy and birth by a small number of known carers. This was particularly important at crucial times such as

labour. Women revealed that cumulative contacts with birth centre midwives resulted in feelings of comfort with carers. The rapport that developed with carers throughout pregnancy was perceived to enhance the quality of communication. Women indicated they communicated more easily with familiar carers and disclosed concerns more readily. Trust and confidence in carers developed as the relationship with birth centre midwives developed. Women also expressed the importance of being known as individuals. The midwife who was familiar with the woman was aware of her previous experiences and had a knowledge of her aspirations for this birth. Women often expressed a feeling of being uninhibited when being cared for during labour by a known midwife carer.

These findings are supported by other exploratory research studies which have assessed women's experiences of midwife led care. In Fenwick's study of the meaning of midwifery care, continuity of midwife carer for women facilitated the development of an intimate relationship with a specific midwife (1997). Features of this relationship were described by the women as mutual trust, respect, empathy and truth.

A grounded theory study of midwife led care by Walker et al. (1995) also identified that perceived support was enhanced when the woman received care from a known carer; someone she trusted and with whom she had confidence. Many women who participated in Walker's study were transferred out of the midwife program, into the

mainstream system of care when they became high risk. This enabled the researchers to compare the experiences of women who received continuity of carer with those who did not. Women who received continuity of midwife carer valued it. In contrast, many women who did not experience continuity were unable to comment on something they had not experienced. Women in this study who were transferred during labour were often not provided with continuity upon transfer. During interviews these latter women expressed a desire to be provided with continuity of midwife carer from one birth setting to another.

The issue of continuity of carer was highlighted in another grounded theory study which considered women's experiences of transfer from community based to consultant based community care (Creasy, 1997). Continuity of carer was identified as one of the main reasons women chose community based care. The negative impact of transfer on women's experiences was reduced by the maintenance of midwife continuity from one care setting to another. This study identified that continuity enhanced women's experiences in a number of ways. When carers knew the women they were able to tailor explanations to meet the woman's needs. Women also reported that they trusted the familiar carer above others. Care was perceived by woman as 'personalised' when a midwife with whom she had a relationship continued her care.

Many large trials of continuity of carer schemes have now been reported in the literature (Hundley et al., 1994; MacVicar et al., 1993;

Rowley et al., 1995; Turnbull et al., 1996). The focus of analysis of the continuity of care model in these trials has been largely based on clinical outcomes. Women's assessment of continuity in these trials has been limited to a broad rating of satisfaction with different aspects of care by questionnaire. All trials, where satisfaction was assessed, reported higher levels of satisfaction with 'continuity of care' models, when compared to standard care. Similar assessments of satisfaction with care have been undertaken in many birth centre trials (Linder-Pelz et al., 1990; Waldenstrom et al., 1997; Wood, 1997).

Continuity of carer was the focus of the one-to-one midwifery practice implemented in a number of postal districts in London in 1994 (McCourt & Page, 1996). All women in this project were provided with continuity of midwife carer across the pregnancy continuum. In comparison to standard care, qualitative analysis revealed that one-to-one women were more positive about their care than women who received standard care. Women who received one-to-one care identified that the major benefit of continuity of midwife carer was being known and followed through by a familiar midwife who understood their needs. In contrast, women in this evaluation who received conventional care, identified a need for greater continuity of carer.

Based on evaluation of the one-to-one scheme, the researchers concluded that the midwife's role, within a continuity of carer scheme, may have extended past conventional boundaries (McCourt & Page, 1996). In particular, midwives were perceived to be providing women

with more generalised pregnancy related support. Similar conclusions could be drawn from the findings of this study reported here. Participants of this study identified that a special relationship with the midwife was able to develop because of the cumulative contacts with them. The close bond and availability of the midwife resulted in women feeling supported. Participant's in Fenwick's study also reported that an intimate relationship developed with their primary midwife (1997). These women perceived that the midwife was genuinely interested in their experiences.

In summary, the current study has been able to provide a detailed description of how women perceive continuity of midwife carer, in the birth centre context. The benefits of continuity of carer identified by women in this study are well supported by other empirical findings. The team midwifery model has been well developed in the birth centre context and is now being trialed in a number of mainstream maternity units. The perceived success of this model has been the removal of the organisation barriers which, in the traditional medical model, have inhibited continuity of midwife carer both across the childbearing continuum and throughout labour.

Relationship of the Study Findings to Theory

The limited amount of empirical data available on women's perceptions of birth centre care resulted in an inductive approach being adopted for this study. This study was therefore a factor seeking exercise, to generate baseline data in this area. No theoretical assumptions were made prior to data collection, therefore a theoretical framework was not adopted for this study.

However, once the findings had emerged, a review of the theoretical literature was undertaken to identify a nursing/midwifery model which would support the findings. The findings from this study indicate that midwifery practice, within the birth centre model of care, needs to be redefined within the social context of birth. The development of the birth centre model of care has resulted in an increasing number of midwives being able to take on the responsibility of the care of low risk pregnant women without direct medical supervision. This has resulted in midwives being able to practice autonomously, within a social model of health.

Midwifery practice has undergone a similar transition in many other countries. In New Zealand, sweeping legislative changes during 1990, have enabled midwives to practice autonomously, independent from the medical profession (Guilliland & Pairman, 1994).
New models of midwifery practice have now evolved in New Zealand, based on the recognition that "midwifery care takes place in partnership with women" (New Zealand College of Midwives, 1993, p. 10). 'The

Midwifery Partnership' has been identified as a model for practice in the New Zealand context (Guilliland & Pairman, 1994).

In light of the findings of this study, the Midwifery Partnership, as a model for practice, is relevant to the practice identified within the birth centre model of care. This model is further explored below, and study findings discussed in relation to this framework.

The Midwifery Partnership

Guilliland and Pairman (1994) identify that a successful midwifery partnership can be achieved, when the midwife's sphere of practice encompasses essential philosophical underpinnings. These philosophical underpinnings include: birth is perceived as a normal life event, midwifery provides care to women across the childbearing continuum, midwifery is identified as a profession in its own right, and midwifery care is woman centred.

The findings of the current study indicate that the organisational structure and philosophy of care in the birth centre meet all of the criteria for a successful midwifery partnership. Midwives practicing in the Perth birth centres were perceived by women to view pregnancy and birth as a normal life event. The organisational structure of these birth centres allowed midwives to provide care across the pregnancy continuum, and enabled midwives to practice autonomously within the birth centre setting. The findings also indicated that the care provided

in these birth centres was women centred, as opposed to institution oriented.

The theoretical concepts underpinning the midwifery partnership are outlined in Figure 2. These will be discussed further below.

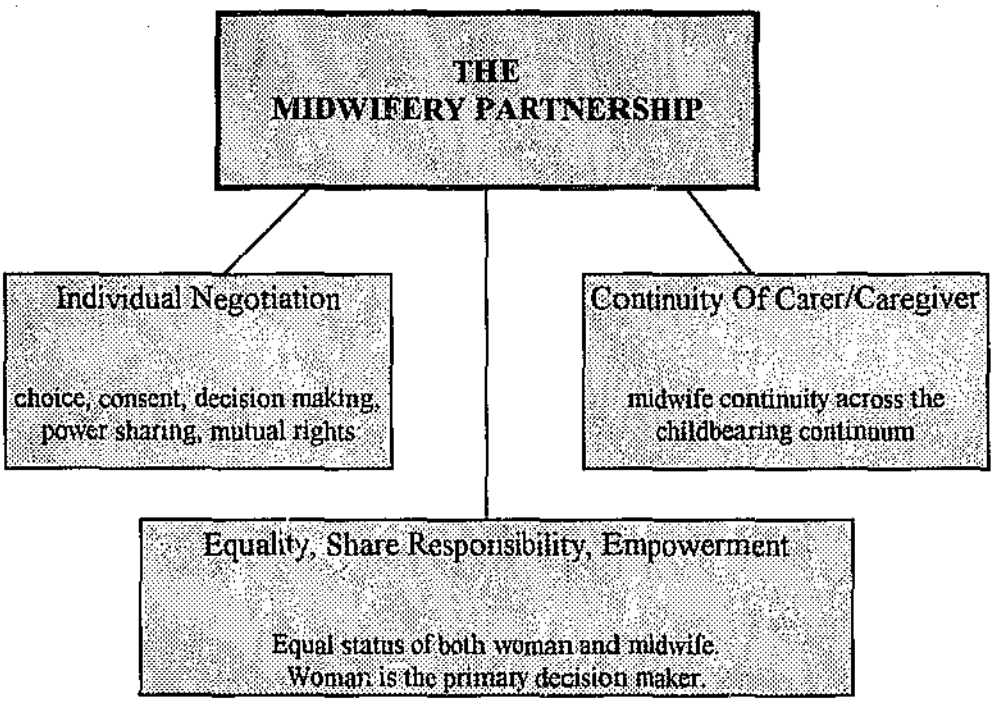

Figure 2. Theoretical Concepts of the Midwifery Partnership

Individual negotiation. The concept of individual negotiation is the underlying premise of the midwifery partnership. Guilliland and Pairman (1994) identify that within the partnership with women "individual negotiation is the method by which the woman and the midwife work through issues of choice, consent, decision making, power

sharing, mutual rights and responsibilities as these arise" (p. 7). Negotiation is the vehicle through which women maintain control over their experiences.

Findings from this study indicate that in the birth centre context, the nature of the relationship with midwives was perceived as one of equality. The collaborative nature of this relationship resulted in women being in a position to negotiate care based on their individual needs. Participants identified that birth centre midwives acknowledged women's right to choice by making options available and respecting women's decisions.

Equality, shared responsibility and empowerment. The concepts of equality, shared responsibility and empowerment support equal status of both the woman and the midwife within the relationship (Guilliland & Pairman, 1994). The midwife provides information to enable informed choice, with the woman being recognised as the primary decision maker. This relationship results in empowerment for women.

In the present study, women reported that midwives in the 3 birth centres shared information with them and the midwife was utilised as a resource; they did not 'tell' women what to do, as was perceived to have happened in the hospital environment. Guilliland and Pairman (1994) identify that within the partnership, the midwife does not hold the only authority in the relationship, but provides knowledge and support to the woman. Within the partnership, "control of the experience and

responsibility for decision making remains with the woman" (Guilliland & Pairman, 1994, p. 7). Participants in this study reported that within the collaborative relationship with the birth centre midwives, they felt they were the primary decision makers. This resulted in many participants expressing that they felt in control over the decisions related to their care.

Shared responsibility is a component of the midwifery partnership (Guilliland & Pairman, 1994). Midwives are accountable to women for the professional knowledge and skills they provide. Responsibility is also placed on women to share information that may impinge on their care. Women are also accountable for their decisions within this balanced partnership (Guilliland & Pairman, 1994). In this study, women perceived that midwives had a degree of expertise in normal midwifery care. The maintenance of professional knowledge and skills was not able to be assessed from these study findings. Women who participated in this study acknowledged that cumulative interactions with carers allowed a relationship to develop that enhanced the communication process. This resulted in woman being more likely to disclose information to carers whom they knew.

Informed choice and informed consent have also been identified as important mechanisms for empowerment (Guilliland & Pairman, 1994). The midwife has a role to play in facilitating informed choice within the partnership. Guilliland and Pairman (1994) identify that, "if the women is to be an effective partner within the relationship, she must make her

own choices" (p. 8). Participants in this study perceived that the birth centre midwives provided them with choices and encouraged them to make the decisions which were appropriate for them. By facilitating informed choice in this way, the midwife's practice is supporting women's control over their childbirth experiences.

Continuity of care/caregiver. Fundamental to the midwifery partnership is the concept of continuity of caregiver (Guilliland & Pairman, 1994). This is the opportunity to develop a trusting relationship between the women and midwife. Continuity also allows the midwife to access the women's experience. Care giver numbers should be restricted to allow a relationship to develop. Women should be central to care, rather than the midwife.

The birth centre model of care facilitated the continuity of carer concept. Women in this study identified that cumulative interactions with the same midwife carers culminated in the development of rapport and trust in carers. Participants in this study also acknowledged the benefits of the midwife knowing them. The midwife had an understanding of the women's previous and current experiences and this facilitated appropriate care for that women.

The midwifery partnership, as a model for practice, places woman at the centre of care (Guilliland & Pairman, 1994). Participants in this study reported that their care in the birth centre was focused on them, rather than the institution, resulting in a perception of personalised care.

In summary, the midwifery partnership, as a model for practice, was developed in the New Zealand context. This model provides a standard for practice which has gained recognition and acceptance within the midwifery profession (Guilliland & Pairman, 1994). Findings from this study support the application of this model of care to midwifery practice in the Australian birth centre context. The theoretical concepts of the partnership model support the fundamental basis of midwifery care, the aim of which is to meet the needs of women, their babies and families (Bryar, 1995). The application of this model at an organisational level would support midwifery practice and provide the stimulus for fundamental reforms within the mainstream maternity care system.

Methodological Strengths and Limitations

There were a number of study limitations which need to be acknowledged. Women in this study deliberately chose to have their second or subsequent child in a birth centre, after previously experiencing care in the hospital setting. The motivation for this choice was not investigated in this study. It is acknowledged that some participants may not have been satisfied with their previous hospital care experiences. Therefore, these women do not represent all women who choose birth centre care.

Data collection in this study was limited to interviews, and did not include other qualitative data collection methods. The use of

participant observation may have been useful to support the interviews in this study. The observation of interactions between women and carers in both birth centre and hospital contexts, may have been helpful in further defining the relationship between women and their carers.

The selection criteria for this study excluded women who had been transferred out of the birth centre program during the antenatal and intrapartum periods. Current statistics reveal that between 30 to 50% of women who choose birth centre care are transferred to the hospital setting for ongoing medical management (Waldenstrom & Lawson, 1997). This study did not explore the experiences of these women, and it is acknowledged that this is an area that warrants future investigation.

Not withstanding these limitations, the study was built on a number of strengths. The boundaries of this study were clearly articulated. One of the major strengths of the study design was the decision to interview multiparous women who had previously experienced at least one hospital birth, prior to their birth centre experience. This design allowed women to compare two different model of care, which provided a copious amount of rich data. The density of the data set enabled analysis of both models of care, allowing identification of major features of each.

Key informants in this study had experienced care in a number of different birth settings and were able to articulate the phenomenon under investigation. The interview guide used during interviews

facilitated indepth discussion of women's experiences. Use of open ended questions allowed informants to respond in their own words and elicited useful and interpretable data.

A number of strategies were adopted throughout this study to ensure trustworthiness of the data. Credibility was enhanced by ensuring that sufficient time was spent in the field to recognise and overcome distortions in the data (Lincoln & Guba, 1985). Interviews were continued until there was evidence of saturation. Repetition of themes was evident by the completion of the fifteenth interview. A further two interviews were undertaken to ensure no new themes emerged.

Another measure taken to enhance credibility was regular and active use of peer debriefing. To avoid bias such as 'going native' (Miles & Huberman, 1984), the researcher had frequent meetings, every two weeks throughout data collection and analysis, with thesis supervisors. During meetings, analysis was discussed and also the feelings and emotions that emerged in relation to these. Acknowledgment and discussion of these feelings and emotions allowed the researcher to prevent them from clouding her judgement. Validation of the study findings were achieved by returning to a number of participants to ensure interpretation of the data was correct.

This report provides a detailed description of the study method and findings. The detail provided would enable another researcher to replicate this study, resulting in 'auditability' (Sandelowski, 1986). The

findings are well supported with excerpts from the data, which allows the reader to judge the 'fittingness' of the results to describe the phenomenon outside of the context of the study situation (Sandelowski, 1986). As well, confirmation of study findings was evident through a re-examination of the literature, revealing links to theory and support from other empirical findings.

Conclusion

Women's experiences of maternity care are varied and there are many factors which affect these experiences. In this study 17 women who had experienced two different models of care shared their experiences. The findings suggest that the nature of the care relationship and the carers approach have a strong impact on women's childbirth experiences. The birth centre model of care allows midwives to practice outside the traditional constraints of the hospital organisation. Women in this study clearly articulated the positive benefits of this model of care, which was perceived to be woman centred.

Women also spoke of their previous hospital experiences where birth was viewed as an illness, where their birth was controlled by (often unknown) others, and where their needs must fit in with the needs of an (often rigid) organisation.

Birth, then, is an important event in a woman's life. Health professionals should not underestimate the impact that their actions

have on women at this time. In listening to the voices of the women in the study it was clear to me that they not only wanted a healthy baby, they also wanted a positive birth experience - to quote -

> "Having a baby is such a special time. You only get to do it two or three times in your whole life and it needs to be right!" [Interview 4]

Implications for Health Care

This study was designed to ascertain women's perceptions of care they had received in the birth centre setting following previous hospital experiences. There is mounting empirical evidence that women are more satisfied with models of care that provide continuity of midwife carer, than they are with standard care. The findings of this study have assisted in identifying aspects of care which women perceive as impacting on their care experiences. These findings also have implications for health care planning, and the practice of midwives and other health professionals involved in the care of childbearing women.

Recommendations

The following recommendations are made based on the findings of this study:

1) Expansion of midwifery models of care into mainstream services.

   The model of care offered in birth centres is restricted to 'low risk' women who chose to access this form of care. However, the majority of women continue to receive care in the hospital

environment. It is clear from this study that some aspects of care in the hospital setting impact negatively on some women's experiences. Models of care which provide continuity of midwife carer across the childbearing continuum clearly have many positive benefits for women. Organisational barriers to more effective models of care within mainstream maternity care require review. Hospital administrators now need to facilitate and support the implementation of midwifery models of care such as team midwifery, to ensure services provision which is consumer focused and can meet the needs of women.

2) Recruitment and education of midwives. Findings from this study suggest that midwifery practice within the hospital environment is perceived to be grounded within the medical model of health. This has implications for the recruitment and education of midwives. Currently in Australia, an undergraduate nursing qualification is required prior to undertaking a midwifery course. The transition from nursing to midwifery may have some impact on the carer's philosophy. This requires a transition from caring for clients who are often unwell, in the hospital environment, to caring for childbearing women who in the main are healthy. Training institutions need to more closely consider the socialisation process of students into the midwifery profession. Midwifery students often experience a gap between theory and practice. Clinical experiences for students continue to be based mainly in

the hospital setting, within the medical model. Ideally, students should have some of their clinical placements working with midwives who practice within alternative models of care, such as birth centres, continuity of carer schemes and community based practice. This may provide students with a more solid grounding in 'normal' midwifery practice.

3) Implications for Clinical Practice. The findings of this study should be of interest to all health professionals involved in the care of pregnant women. The positive experiences of women who have received midwife continuity should not be ignored. This study has emphasised the importance of the involvement of midwives in antenatal care. This involvement allows a relationship between women and midwife to develop prior to labour. This relationship is recognised to enhance communication both throughout pregnancy, during labour and the postnatal period. The other findings of this study have important implications for midwives working in mainstream maternity care. The nature of the relationship between woman and carer has a major impact on women's experiences. Although all midwives may not have the opportunity to work within a 'continuity of carer' scheme, they can still adopt a collaborative approach to care, working with women. Information sharing, the provision of options and acknowledging women's right to make

decisions, all keys components to women's sense of control over their birth experience.

Future Research

A number of recommendations are offered for future midwifery research:

1) This study identified the nature of the care relationship as one of the key elements which affects women's experiences of care. Future studies should be designed to further explore this concept and should be combined with participant observation of the interactions between women and their carers, in the hospital and birth centre settings.

2) This study considered the experiences of multiparous participants, who had experienced both mainstream and birth centre care. Future studies should consider the experiences of Primigravid women, who have not experienced mainstream maternity services, to validate the findings of this study.

3) Future studies also need to give consideration to whether women's perceptions of birth centre care changes over the course of their pregnancy experiences.

4) The benefits of continuity of midwife carer to women were clearly articulated by women in this study and supported by empirical evidence from many other evaluations of continuity of midwifery care. Further research is required to explore the experience of

women who are transferred from the birth centre environment into the hospital environment, and the impact ongoing continuity of carer has on this transition.

5) The impact of the care context on midwifery practice remains an unresearched area that would be worthy of further investigation. Findings from this study to suggest that midwives practicing within the hospital environment may not be able to adopt a midwifery philosophy of birth. The socialisation process of midwives who work within mainstream services requires further investigated.

6) The importance of the relationship between women and midwife, emphasised in this study, has enormous implications for the practice of midwifery. Further research into the experiences of midwives working with women in a more collaborative way, would provide a more complete picture of these caregiving interactions.

REFERENCES

Bennett, M. J. (1997). The more things change, the more they stay the same: Whither Midwifery. Australian College of Midwives Incorporated Journal, 10 (4), 4-14.

Benoliel, J. Q. (1984) Advancing nursing science: Qualitative approaches. Western Journal of Nursing Research, 6, 1-8.

Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. Western Journal of Nursing Research, 15 (2), 263-266.

Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women' s experience of the encounter with the midwife during childbirth. Midwifery, 12, 11-15.

Biro, M., & Lumley, J. (1991). The safety of team midwifery: the first decade of the Monash Birth Centre. The Medical Journal of Australia, 155, 478-480.

Bockman, D. L. (1987). Qualitative versus qualitative nursing research. Holistic Nursing Practice, 2 (1), 71-75.

Bradley, B. S., Tashevska, M., & Selby, J. M. (1990). Women's first experiences of childbirth: Two hospital settings compared. British Journal of Psychology, 63, 227-237.

Bramadat, I. J., & Driedger, M. (1993). Satisfaction with childbirth: Theories and methods of measurement. Birth, 20, 22-29.

Brown, S., & Lumley, J. (1994). Satisfaction with care in labour: A survey of 790 Australian women. BIRTH, 21 (1), 4-13.

Bryar, R. M. (1995). Theory for midwifery practice. London: Macmillan Press Ltd.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. Nurse Education Today, 11, 461-466.

Burns, N., & Grove, S. K. (1987). The practice of nursing research. Conduct, critique and utilisation. Philadelphia: W. B. Saunders Company.

Campbell, R., & MacFarlane, A. (1987). Where to be born? The debate and the evidence. National Perinatal Epidemiology Unit: Oxford.

Child, A. (1986). The concept of birth centres. The Medical Journal of Australia,144, 620.

Creasy, J. M. (1997). Women's experience of transfer from community -based to consultant-based maternity care. Midwifery, 13, 32-39.

Cunningham, J. D. (1993). Experiences of Australian mothers who gave birth either at home, at a birth centre, or in a hospital labour wards. Social Science Medicine, 36, 475-483.

Day, P., Lancaster, P., & Huang, J. (1997). Australia's mothers and babies. AIHW National Statistics Unit: Sydney.

Department of Health. (1993). Changing childbirth. Part 1: Report of the expert maternity group. London: OHMS.

Eggers, T.R., Kloss, M., Neil, J., & Robinson, H.P. (1985). Family births at the Royal Women's Hospital, Melbourne. Australian and New Zealand Journal of Obstetrics and Gynaecology, 25, 255-258.

Enkin, M., Keirse, M. J., & Chalmers, I. (1989). A guide to effective care in pregnancy and childbirth. Oxford: Oxford University Press.

Feldman, E., & Hurst, M. (1987). Outcomes and procedures in low risk birth: A comparison of hospital and birth centre settings. BIRTH, 14 (1), 18-23.

Fenwick, J. (1997). The meaning of midwifery care: A hermeneutic inquiry. Proceedings of the Australian College of Midwives 10th Biennial National Conference. (pp. 205-211). Melbourne.

Field, A. F., & Morse, J. M. (1990). Nursing research: The application of qualitative approaches. New York: Chapman and Hall.

Flint, C., Poulengeris, P., & Grant, A. (1989). The 'Know Your Midwife' scheme - a randomised trial of continuity of care by a team of midwives. Midwifery, 5, 11-16.

Garcia, J. (1995). Continuity of carer in context: What matters to women? In L. Page (Ed.), Effective group practice in midwifery: Working with women (pp. 96-105). Oxford: Blackwell Science.

Giles, W., Collins, J., Ong, F., & MacDonald, R. (1992). Antenatal care of low risk obstetric patients by midwives. A randomised controlled trial. The Medical Journal of Australia, 157, 158-161.

Green, J. M., Coupland, B.A., & Kitzinger, J. (1990). Expectations, experiences & Psychological outcomes of childbirth: A prospective study of 825 women. Birth, 17, 15-24.

Guilliland, K., & Pairman, S. (1994). The midwifery partnership - A model for practice. New Zealand College of Midwives Journal, October, 5-9.

Gutek, B. (1978). Strategies for assessing client satisfaction. Journal of Social Issues, 34, 44-56.

Harvey, S., Jarrell, J., Brant, R., Stainton, C., & Rach, D. (1996). A randomised controlled trial of Nurse-Midwifery care. Birth, 23 (3), 128-135.

House of Commons Health Committee (1992). Maternity Services. Vol. I (The Winterton Report). London: HMSO.

Hundley, V.A., Cruikshank, F. M., Lang, G.D., Glazener, C.M.A., Milne, J.M., Turner, M., Blyth, D., Mollison, J., & Donaldson, C. (1994). Midwife managed delivery unit: a randomised controlled comparison with consultant led care. British Medical Journal, 309, 1400-1404.

Lancaster, H. O. (1956). Infant mortality rates in Australia. Medical Journal of Australia, 2, 100-108.

Lewis, P. (1995). Refining the model: Group practice midwifery. MIDIRS Midwifery Digest, 5, (2), 219-223.

Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. London: Sage.

Linder-Pelz, S., Webster, M.A., Martins, J., & Greenwell, J. (1990). Obstetric risks and outcomes: Birth centre compared with conventional labour ward. Community Health Studies, XIV, (1), 39-46.

Lomas, J., Dore, S., Enkin, M., & Mitchell, A. (1987). The labour and delivery satisfaction index: The development and evaluation of a soft outcome measure. Birth, 14, 141-145.

Lumley, J. (1985). Assessing satisfaction with childbirth. Birth, 12, 141-145.

MacVicar, J., Dobbie, G., Owen-Johnstone, L., Jagger, C., Hopkins, M., & Kennedy, J. (1993). Simulated home delivery in hospital: a randomised controlled trial. British Journal of Obstetrics and Gynaecology, 100, 316-323.

Mathews, J. J., & Zadak, K. (1991). The alternative birth movement in the United States: History and current status. Women & Health, 17, 39-56.

McCourt, C., & Page, L. (Eds.). (1996). Report on the evaluation of One-to-One midwifery. London: TVU.

McDonald, S. & Evans, S. (1996). Annual statistics for the King Edward Memorial Hospital Family Birth Centre 1995 - 1996. Unpublished report. King Edward Memorial Hospital. Perth.

McKeown, T. (1965). Medicine in society. George Allen and Unwin: London.

Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis. A sourcebook of new methods. Sage: Newbury Park.

Ministerial Review of Birthing Services in Victoria. (1990). Having a Baby in Victoria. Melbourne: Department of Health Victoria.

Ministerial Task Force on Obstetric Services in New South Wales. (1989). Maternity Services in New South Wales. Sydney: New South Wales Department of Health.

Morison, S. (1996). A phenomenological study of the homebirth experience: The couples perspective. Unpublished master's thesis, Edith Cowan University, Perth, Western Australia.

Morris, N., Campbell, J., Biro, M., Lumley, J., Rao, J., & Spensley, J. (1986). Birth centre confinement at the Queen Victoria Medical Centre: Four years' experience. The Medical Journal of Australia, 144, 628-630.

Morse, J. (1991). Strategies for sampling. In J. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (rev. ed.) (pp127-145). Newbury Park: Sage.

National Health and Medical Research Council. (1996). Options for Effective Care in Childbirth for effective care in childbirth. Canberra: Australian Government Publishing Service.

New Zealand College of Midwives. (1993). Midwives handbook for practice. Dunedin: New Zealand College of Midwives.

Oakley, M. A. (1983). Social consequences of obstetric technology: The importance of measuring "soft" outcomes. BIRTH, 10 (2), 1983.

Page, L. (1995). Redefining the midwife's role: changes needed in practice. British Journal of Midwifery, 1 (1), 21-24.

Pascall, G. (1986). Social Policy Analysis. London: Tavistock.

Patton, M. (1990). Qualitative evaluation and research methods. (2nd. Ed.) Newbury Park: Sage.

Polit, D. F., & Hungler, B. P. (1995). Nursing research. Principles and methods. Philadelphia: J.B. Lippincott Company.

Report of the Ministerial Task Force to Review Obstetric Neonatal and Gynaecological Services in Western Australia. (1990). Volume 1. Summary and Recommendations. Perth: Health Department of Western Australia.

Richmond, J. (1990). Keynote address, American Academy of Pediatric Conference on cross national comparisons of child health, Washington DC, March, 1990.

Rooks, J.P., Weatherby, N.L., Ernst, E.K.M., Stapleton, S., Rosen, D., & Rosenfield, A. (1989). Outcomes of care in birth centres: The national birth centre study. The New England Journal of Medicine, 321, 1804-1811.

Rothman, B. K. (1982). In labour: Women and power in the birthplace. New York: W. W. Norton & Company.

Rowland, R., & Klein, R. P. (1990). Radical Feminism: Critque and construct. In S. Gunew. (Ed.). Feminist Knowledge. Critique and construct (pp 271-303). London: Rutledge.

Rowley, M.J., Hensley, M.J., Brinstead, M.W., & Wlodarczyk, J.H. (1995). Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. The Medical Journal of Australia, 163, 289-293.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8, (3), 27-37.

Scupholme, A., McLeod, A.W.G., & Robertson, E. G. (1986). A birth centre affiliated with the tertiary care centre: Comparison of outcomes. Obstetrics & Gynecology, 67 (4), 598-603.

Secombe, I. & Stock, J. (1995). Team Midwifery. In L. Page (Ed), Effective group practice in midwifery. Working with women. (pp 106-116). Oxford: Blackwell Science.

Seguin, L., Therrien, R., Champagne, F., & Larouche, D. (1989). The components of women's satisfaction with maternity care. Birth, 16, 109-113.

Shearer, M. H. (1983). The difficulty of defining and measuring satisfaction with perinatal care. Birth, 2, 10.

Simkin, P. (1992). Just another day in a woman's life? Part II: Nature and consistency of Women's long term memories of their first birth experience. Birth, 19, 2.

Stern, C., Permezel, M., Petterson, C., Lawson, J., Eggers, T., & Kloss, M. (1992). The Royal Women's Hospital Family Birth Centre: The first 10 years reviewed. The Australian and New Zealand Journal of Obstetrics and Gynaecology, 32 (4), 291-295.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. London: Sage Publications.

Sullivan, B. A., & Beeman, R. (1982). Satisfaction with maternity care: A matter of communication and choice. Medical Care, 20, 321-330.

Tew, M. (1995). Safer Childbirth. A critical history of maternity care. Melbourne: Chapman & Hall.

Turnbull, D., Holmes, A., Shields, N., Cheyne, H., Twaddle, S., Harper Gilmore, W., McGinley, M., Reid, M., Johnstone, I., Geer, I., McIlwaine, G., & Burnett Lunan, C. (1996). Randomised controlled trial of efficacy of midwife managed care. The Lancet, 348, 213-218.

Wagner, M. (1994). Pursuing the birth machine. The appropriate search for birth technology. Sydney: ACE Graphics.

Waldenstrom, U., Borg, I., Olsson, B., Skold, M., & Wall, S. (1996). The childbirth experience: A study of 295 new mothers. Birth, 23, 144-153.

Waldenstrom, U., Brennecke, S., & Brown. S. (1995). Project: Team maternity care for women at low risk of medical complications. Unpublished research proposal, La Trobe university.

Waldenstrom, U., & Lawson, J. (1997). Birth Centre Practices in Australia. Unpublished Report. Royal Women's Hospital: Melbourne

Waldenstrom, U., & Nilsson, C. (1993a). Women's satisfaction with birth centre care: A randomised controlled study. Birth, 20, (1), 3-12.

Waldenstrom, U., & Nilsson, C. (1993b). Characteristics of women choosing birth centre care. Acta Obstetricia et Gynecologica Scandinavica, 72, 181-188.

Waldenstrom, U., & Nilsson, C. (1994). Experience of childbirth in birth centre care: A randomised controlled study. Acta Obstetricia et Gynecologica Scandinavica, 73, 547-554.

Waldenstrom, U., Nilsson, C., & Winbladh, B. (1997). The Stockholm birth centre trial: Maternal and infant outcomes. British Journal of Obstetrics and Gynaecology, 104, 410-418.

Walker, J. M., Hall, S., & Thomas, M. (1995). The experience of labour: a perspective from those receiving care in a midwife-led unit. Midwifery, 11, 120-129.

Walton, I., & Hamilton, M. (1995). Midwives and changing childbirth. Cheshire: Books for Midwives Press.

Wood, J. (1997). An evaluation of the Family Birth Centre at King Edward Memorial Hospital. Proceedings of the Australian College of Midwives Tenth Biennial National Conference. (pp. 519-529). Sydney.

World Health Organisation. (1985). Having a baby in Europe, public health in Europe No 26, Copenhagen.

Appendix A

Exclusion Criteria for King Edward Memorial Hospital

Family Birth Centre

Medical

* cardiac disease except uncomplicated mitral Valve prolapse
* renal disease
* psychiatric disorder including puerperal psychosis
* haematological including bleeding disorders
* essential hypertension
* pulmonary embolism or deep vein thrombosis
* epilepsy or seizures or use of anticonvulsant drugs
* malignant disease
* asthma requiring hospitalisation or steroid therapy other than inhaled steroid therapy in the previous five years
* chemical dependency
* known bony pelvic deformity
* H.I.V positive (with evidence of immunodeficiency)
* systemic lupus erythematosis
* diabetes mellitus

Obstetric

* Parity 5 or more
* previous severe pre eclampsia or eclampsia in most recent pregnancy
* previous abdominal uterine surgery including caesarean section
* previous poor obstetric outcome such as stillbirth, birth asphyxia, shoulder dystocia.

Factors to be assessed individually by Obstetrician/FBC General Practitioner

* three or more first trimester spontaneous or induced abortions without subsequent term delivery or midtrimester abortion.
* previous third stage problems including postpartum haemorrhage
* infertility requiring surgery of fertility drugs
* previous cone biopsy
* thyroid disease
* previous infant with major congenital anomaly and/or inherited disorder (subject to genetic consultation)
* atypical red cell antibodies
* previous caesarean section
* difficult vaginal delivery

Appendix B

SEMI STRUCTURED INTERVIEW GUIDE

1. Why did you choose to have your baby in a birth centre?

2. Can you describe the type of care you had during your previous pregnancy/s and birth/s in the hospital environment?

   Prompts
   - How may caregivers?
   - Type of relationship with care givers?
   - Opportunity to discuss birth preferences?
   - Involvement in decisions making?

3. Could you describe the type of care you received during your pregnancy and birth in the birth centre environment?

   Prompts
   - How may caregivers?
   - Type of relationship with care givers?
   - Opportunity to discuss birth preferences?
   - Involvement in decisions making?

4. How did this experience compare to your previous birth experience?

5. Could you tell me about your care after the birth of your baby?

6. Tell me about the followup provided for you after discharge in each care setting?

   Prompts
   - Number of carers?
   - Were they known to you?

Appendix C

Demographic Data

1. What is your age? _____

2. What is your usual occupation? _____

3. What is your highest level of education? (Please circle one under each heading).

School Education	**Other Qualifications**
Less than Achievement Certificate. 1	None..... 1
Achievement Certificate.....2	Trade/Apprentice/certificate..... 2
TEE (Leaving)/Year 12 3	Diploma..... 3
	Under Graduate Degree 4
	Post Graduate Degree 5

4. What is your combined family annual income?

Last Financial Year			**This Financial Year (Anticipated)**		
$0	-	$10,000 1	$0	-	$10,000..... 1
$10,001	-	$20,000 2	$10,001	-	$20,000..... 2
$20,001	-	$30,000 3	$20,001	-	$30,000..... 3
$30,001	-	$40,000 4	$30,001	-	$40,000..... 4
$40,001	-	$50,000 5	$40,001	-	$50,000..... 5
$50,001	-	and over.....6	$50,001	-	and over 6

5. What is your Marital status?

Appendix D

INFORMATION SHEET

Study Title: Women's Perception of Birth Centre Care

My name is Karen Coyle and I am a Midwife who works full time in a Birth Centre. I am currently researching women's experiences of care in the birth centre setting. The information gained from this study will assist in the future planning of models of health care.

If you agree to participate in this study it will involve being interviewed by myself about 3 months after the birth of your baby. This interview will be audiotaped so that I can carefully analyse it at a later date. The interview will take approximately one hour of your time and I would be happy to come to your home to do this, at a time convenient to you. Your identity will remain confidential as the interview will be coded by number and no names will be used.

Your participation in this study is strictly voluntary and you have the right to withdraw at any time. You also have the right not to answer any questions you may be uncomfortable with.

If you have any questions about the study or being a participant, please do not hesitate to call me on 9402 1402. You may also contact the Head of Postgraduate Nursing Studies at Edith Cowan University, Patricia Percival, on 9273 8591.

Approval for this study has been given by the Ethics Committee's at Edith Cowan University.

Appendix E

CONSENT FORM

Study Title: Women's Perception of Birth Centre Care

I have read the information sheet about the above study and my questions have been answered to my satisfaction.

I understand that I am agreeing to be contacted by Ms Karen Coyle and will be interviewed about three months after the birth of my baby. I understand the interview will be audiotaped.

I agree that the information gained through this study may be published providing that my name is not used.

I am aware I have the right to withdraw from the study at any time after I have given consent and that withdrawal will not interfere with routine care.

I, _____ have been asked to participate in the above research study, which has been explained to me by _____. I understand it's aims and how I will be involved and hereby give my written consent.

Name: _____
Signature: _____
Date: _____
Witnessed by: _____
Signature of Witness: _____
Date: _____

Appendix F

Coded Transcripts

Interview Transcript	Code/theme
Interview 10	
The Birth Centre births were definitely the more positive two experiences in that I really felt my choices would be respected, what I wanted to do would be listed to and would be supported. Whereas with the other two, I remember with the first it wasn't an issue of what I wanted or didn't want. The second looking back on it now, at the time I felt a bit cheeky, but looking back at it now I realise it wasn't as bad a birth as I thought.	Positive experience Choices respected & supported hospital - lack client focus negative hospital experience
But with the third and fourth, the Birth Centre made a choice. The midwives and the philosophy made a difference and also my experience and knowing myself and knowing my body. But also respect for the midwives I knew. Especially the last time. There was an acceptance that I knew my body and I knew how it would react and that was something quite specific to the birth Centre. Because afterwards when I ended up being admitted to the main unit for a day with him was totally different. There wasn't that respect that I knew my body and I knew what I needed and didn't need. It was back to more of "we know what's best for you" sort of attitude and "we know what's best for baby". It was very different. Perhaps actually I had really forgotten and it was highlighted by that.	PHILOSOPHY carers Knew own needs birth centre - respect clients knowledge Hospital - lack respect Patronising/Provider dominated
Interview 12	
They put the drip in at 1.00 pm and by 1.30 pm it was like I started labouring and I think at about 3.00 pm they said to me "you really should have something for the pain" and during the birthing classes they said they wouldn't encourage you to do it unless they felt it was necessary so I said "I don't want it, I don't want it" and she said "you really have a long way to go I think you better take it" - so I gave in.	Actively encouraged to use analgesia expectations and actual experience different Gave in to carers
And that midwife was with me until her shift went off at 9.30 pm. Now I started my second stage at 8.45 pm at night. When she left everything stopped. Then they had someone else come in for a while and she left, then I had a third midwife. So during second stage I had three midwives and my second stage was 2 hours and 45 minutes and it was awful. I mean it was really awful, not just in pain, but just in the ....even on husband, it was like "when is this baby going to come out". It just kept coming down and going back up, coming down going back up. I was on my back. I had a midwife holding my hand and my husband holding my hand and my feet on their hips. But they had tried to get me to turn over and go on all fours at one point and I couldn't do it. I think I was so tired. I did it with my second baby, I went on all fours and it took just a while for him to turn down the birth canal, and then it was it was the right thing to do. But when I had my first baby I just couldn't do it and I just had a real hard time pushing her out. I don't know if I had the same midwife the whole time I don't know if it would have taken so long.	shift change at crucial stage multiple carers in 2nd stage - negative impact Tired - unable to reposition perceived difficult labour strong impact/change of carers