An Icelandic Midwifery Saga - Coming to Light, "With woman" and connective ways of knowing.

An Icelandic Midwifery Saga
- Coming to Light –

"With Woman" and Connective Ways of Knowing

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ABSTRACT

The aim of this thesis was to explore storytelling of Icelandic midwives' working lives, in the period from the mid twentieth century to the present time. This ethnographic narrative study was designed with a broad perspective looking at birth stories of midwives as a mine full of their knowledge to identify and uncover. Interviews were conducted with twenty midwives to collect birth-stories that represent the social and cultural world of childbirth and midwifery in Iceland, and theory was to arise inductively from the midwives' own telling. Furthermore, one focus group interview with six midwives was conducted and field notes were used to gather more stories. The narrative analysis was designed by means of identifying the plot of the midwives´ birth stories, which was identified as being "with woman" leading the focus towards midwives' relationship with women and their inner ways of knowing.

The findings suggest that Icelandic midwives have a common philosophy of care that is associated with a midwifery partnership model, incorporated in the ideological statements of the Icelandic midwifery education in Iceland. Yet, in a diverse culture of changing childbirth, the birth stories illustrated the complexity of maintaining balance being pressed to base their work on conflicting models of care, including the social narrative of medical dominance.

The research adds information and a deeper understanding of inner knowing of midwives, intuition and spiritual awareness in practice. The "act of being with" or *yfirseta* "sitting over" at birth was identified as being crucial for preserving and developing this kind of midwifery knowledge integrated with other kinds of knowledge systems. The midwives' storyline demonstrated three different types; one developed by learning from practice experience and the second was of more spiritual nature, even transcendence. The third type referred to the connective knowing where the two other types overlap based on a reciprocal relationship with the woman – their connective way of knowing, which needs to be explored further.

It is imperative to develop further narrative methodologies in different cultural context, to identify the central concepts of the midwife-with-woman relationship. Furthermore, research is needed on how that relationship affects development of midwifery knowledge, including the intuitive and spiritual, which provides safety of childbirth.

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Socrates compared teaching to the midwifery role. In this sense, "the mother of light" i.e. midwife in Icelandic, in her teaching role awaits the birthing of ideas and knowledge. I have many people to thank for being so good in this role at my side while this thesis "came to light".

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This first chapter explains the aims and structure of this thesis about midwives' birth stories, developments of midwifery knowledge through relationships with women, the context, backgrounds, and methodology. It also outlines why this research is important for midwifery and childbirth care and how it is an original piece of work, which contributes to a growing body of midwifery knowledge.

Aims and Methods of the Study

It is my belief that through birth-stories it is possible to uncover and identify midwifery knowledge. Storytelling is a part of individual life or biography and a part of midwifery practice. Birth stories are all around us and have influence on how we think about childbirth. We live in multiple stories that represent different experiences, knowledge and views about childbirth and midwifery care. Thus, in this qualitative narrative study I have, within a midwifery empirical paradigm, in terms of midwifery ideologies and in an Icelandic context, paid attention to birth stories of midwives.

The study was designed with a broad perspective looking at birth stories of midwives as a mine full of their knowledge. Interviews were conducted to collect different types of birth-stories that represent the social and cultural world of childbirth and midwifery in Iceland, to identify their structures and look at the context within which midwives have worked, in the period of the latter half of the 20th century to present time. Interview design was based on storytelling of individual's working life story or biography (Fetterman, 1998, Wengraf, 2001, Letherby, 2003, Kristmundsdottir, 2006).

An ethnographic narrative approach was used as a step to building a body of midwifery knowledge because, as has been pointed out (Frank, 2000, Frid et al, 2000), stories and narratives are understood to be repositories of wisdom and knowledge that reflect the standpoint of their creators, in this case the midwives of this study.

Approvals for conducting the study were received from the Women Department of the Landspitali - University Hospital in Reykjavik. Application for ethical approvals and evaluations were sent to the National Bioethics Committiee in Iceland, which concluded that the study did not require a specific ethical approval. A notification about the study was sent to the Data Protection Authority in Iceland (For further discussions about ethical considerations and approvals, see page 102).

The overall aim has been:

- To explore storytelling of midwives' working life and culture of midwifery practice in Iceland in the context of place of birth.

- To develop midwifery knowledge, describe and identify exemplars from birth stories of midwives which inform childbirth care, midwifery practice and education.

The study changed in accordance with developments of methods as new themes emerged in the field, which at the same time narrowed down the focus of the research, defined here as " the most general set of phenomena about which the study makes claims" (Hammersley, 1998, p. 31). During the research process I have been identifying the different identities of midwives' ways of knowing in their storytelling with the research interest shifting towards midwives' relationships with women and their intuitive and spiritual knowing, how this kind of inner knowing develops and what it consists of. This led to the third aim of the study:

- To explore birth stories of midwives with focus on the relationship between the midwife and the woman and midwives' inner knowing

Storytelling and Developing Midwifery Knowledge

Midwifery is a young discipline within the academic world and there is an urgent need to identify the body of knowledge that underpins the practice of midwifery (Siddiqui, 1994) and for multiple research methods that uncover answers to complex questions about the process and outcome of the midwifery model of care (Kennedy and Lowe, 2001). This study is a part of an ongoing dialogue around these fundamental issues, central concepts about what midwifery is.

Narrative research is engaged in the collection of stories. In midwifery practice there are many different stories: for example the official birth story contained in medical records or the personal stories of women and their families. There are also the unofficial stories of the working life of midwives and it is important to bring those to light. Stories in which midwives reflect on their own clinical practice and discuss effective ways of practice, their ways of knowing, which might lead to new forms of storytelling that then might shape midwifery practice.

Narratives have different aspects and dimensions and have an evaluated function and as Labov and Valetsky (1967, cited by Wengraf, 2001) stated; a story is pointless without an evaluation. This research is designed from a broad perspective, exploring storytelling and the culture of midwifery and childbirth care in Iceland. The storyteller, in this case the midwife, told about events that have been important for her and her evaluation makes a point, resulting in a midwifery narrative which provides convincing insights and opens ways for understanding and seeing the diversity of midwifery practice and epistemologies of midwifery.

Ways of Learning and Culture of Midwifery

Midwifery is one of the oldest professions in the world. Traditionally, midwives learned their art with their mothers and grandmothers, and were in intimate and direct contact with the women they attended. Midwifery was looked upon as being a natural aspect of a woman's life. This kind of knowledge was not viewed as a body of knowledge distinct from knowledge of other aspects of life (Donnison, 1988, Page, 2003, Wickham, 2004).

"Historically, culture is a particular way of being in fundamental situations: birth, death, love, work, giving birth, being embodied, growing old, speaking". (Lyotard 1962, cited by Malpas, 2003, p. 111) and cultural coherence is generated by shared storytelling in which beliefs, identities and relationships are related back to a group of people. In this sense just as in a Cashinahua tribe (Lyotard, 1984) the culture of midwives and their identity arises from shared culture constructed in their stories.

Many midwives believe that we should use birth stories in midwifery research and I think that midwives agree with Kirkham (1997) that telling stories has been a way of learning in midwifery practice, and that older midwives have been role models for younger ones, paradigm stories being passed on to give messages (Hulst and Teijlingen, 2001) as well as being a way of transmitting midwifery knowledge in order to make decisions in practice and to legitimate the practitioner (Jordan, 1993). From detailed stories, the hearers take what they find to be valuable (Riessman, 1993). This makes them a democratic means of conveying information, as is my personal experience from the labour ward at the Landspitali University Hospital in Iceland, and similar to Jordan's descriptions of how, in Maya birth in Yukatan, stories function in decision making in actual labours.

> "As difficulties of one kind or another develop, stories of similar cases are offered up by the attendants, all of whom, it should be remembered, are themselves experienced birth-givers sharing a collective expertise. In the way in which these stories are treated – elaborated, ignored, taken up as themes, characterized as typical, and so on – the collaborative work of deciding on the present case is done". (Jordan, 1993, p.195)

Until in the last decades, Western midwifery knowledge has been based on experiential learning rather than on academic learning based on scientific methods. Much of midwifery knowledge is therefore practical and taken for granted or tacit knowledge. It is challenging to access practical knowledge and to find appropriate ways to identify and uncover it. Kirkham (1997) stated that the practice of real experts has a subtlety that theoreticians or researchers strive in vain to capture. However, even though midwifery skills in practice can never be uncovered, there are ways to reveal partial as well as situated knowledge, one of them being narrative methodology where narrative knowledge (Lyotard, 1984) stands as the basis of human experience and society. Narrative knowledge is more than emotional expressions; it is in fact a legitimate form of reasoned knowing (Bruner, 1985 cited by Polkinghorne, 1995).

According to Frank (2000) the narrative is a structure underpinning a story and narrative analysis locates structures that storytellers rely on but are not fully aware of. The advantage of the narrative approach can therefore be as Wengraf (2001) points out, that it conveys tacit and unconscious assumptions and norms of the individual or of a cultural group. This can be related to the midwifery profession in different clinical situations or cultures.

In times of rapid social change and increased medicalization of childbirth, midwifery skills, for example in normal birth, may be disappearing and not passed on to new generations of midwives. It is my view that measures to prevent this loss could be taken by collecting and keeping birth stories of midwives as a way to organize the memories of the past (historical memory). This could teach future midwives what midwifery "really" is, moving forward midwifery knowledge, identifying midwifery culture and skills and know-how.

Storytelling and Access to Knowledge of Midwifery Practice

When I started on this research journey of exploring midwives' storytelling, I was interested studying midwifery practice, the skills of the midwife when she is with the woman, her interventions and what she "really" does for and with the woman and her family.

It is indeed challenging to access practical knowledge and to reveal embedded knowledge but as "stories are concerned with human attempts to progress to a solution, clarification, or unravelling of incomplete situation" (Polkinghorne, 1995, p. 7), the narratives from practice can cast a new light on what has previously been experienced as familiar (Benner, 1984) and capture the practical knowledge of midwives. Much has been written about how you learn through reflection in practice (Schön, 1983, Jarvis, 1999, Johns, 2002) and about how, with clinical experience, the practitioner recognizes clues or learns to recognize patterns which show what to do or what not, based on a gut feeling or knowledge based on intuition (Benner, 1984, Benner et al, 1996). This means that in paradigm or exemplar birth stories that are used to guide midwifery care and are also identified during narrative midwifery research, hidden knowledge can be revealed.

Nevertheless, not all knowledge is visible in the narrative form or as a discourse and there is a taken for granted knowledge which cannot be articulated (Jarvis, 1999). Intuitive or subjective knowledge can then be regarded as the embedded versus the articulated knowledge (Wengraf,

2001). Alternatively, particular narratives can contain descriptions about intuition as well as about techniques or even tips to help the mother during pregnancy and childbirth. Narrative that goes beyond concepts and academic scientific theories to illustrate the complexity of practice that

> "shows how evidence is only one form of information that is woven together with the information derived from the clinical history and examination, and the woman's preferences, values, hopes dreams and fears, to work together to reach a decision for the woman herself and her situation" (Page, 2004, p. 20).

The narrative can be recognisable to midwives and contain elements that could be a guide for midwifery practice, not necessarily in an explicit or concrete way, but more as stimulus to thought, possibly with philosophical underpinning, to change views and practices in midwifery.

Originality and Importance of Work

Traditions have been changing in midwifery as has the social and cultural context within which midwifery knowledge develops. In birth stories there is a hidden treasure of midwifery knowledge for academic work to reclaim and advance an emerging body of knowledge in midwifery. Although midwives agree on how stories contain midwifery knowledge and you often hear midwives say that they love telling and listening to birth stories, they at the same time do not take them seriously; they believe them to be for fun and a way of talking about their work. Therefore little research has been done on them. This way to explore midwives' storytelling of birth as a source to identify and develop midwifery knowledge and to theorize in a narrative way from a midwifery point of view is novel in the midwifery literature.

Narratives are persuasive because they can accommodate contradictory experiences and the complexity of experience (van Manen, 1990); hence this narrative study has been useful to receive new information about midwives' experiences and their inner knowing. Developments of different ways of inner knowing were identified which created a deeper understanding of inner knowing, intuition and spiritual awareness in relationship with the woman at birth, thus connective ways of knowing. This kind of knowing, as far as I know, has not been described

and discussed before in the midwifery literature. There, in part, lies the originality and importance of this work.

Effective midwifery relies on the relationship between the midwife and the woman as it is one of the elements that have been noted to contribute to the existing paradigms of midwifery practice (Page, 2000, 2004, Kirkham, 2000, Siddiqui, 1999, 2005). Little research has been done on how aspects of this relationship between the midwife and the woman affect development of midwifery skills and knowledge. This midwifery saga coming to light, uncovers ways of connective knowing with women, which is paramount to explore in further studies.

Midwifery is a young discipline worldwide, and particularly in Iceland, as it its only 10 years since midwifery education has been part of academia. This research is the first one of its kind in Iceland and was done as a step to fulfil a principal need to identify and build a theoretical base for midwifery research in an Icelandic culture and to explore the huge cultural and social changes in maternity services with a focus on place of birth. Both have an impact on models of childbirth care and midwifery knowledge.

By and large, I have been exploring midwives' birth stories in order to:

- Point out underlying models of care and theories in midwifery practice in Iceland.
- Identify and draw out midwives' stories which bring to light use of different ways of knowing in relationship with woman, in diverse situations of midwifery practice.
- Identify exemplary narratives which could be used to encourage and promote new forms of storytelling in order to advance midwifery knowledge.
- Identify a philosophical base, epistemologies of midwifery practice knowledge in Iceland.

In this study I have been writing my own culture about childbirth care and midwifery knowledge in Iceland, making sense through birth stories of Icelandic midwives, resulting in a storied episode, a midwifery narrative, which in later chapters are presented as the research product. This narrative research was conducted from the point of view of midwives, grounded in their empirical knowledge and life histories of practice experiences, their epistemological

position about how they as "knower" know the "known" (Harding, 1987a, p. 3) about midwifery in Iceland. The findings might then be applied to settings of midwifery practice in other countries.

Structure of Thesis Related to Methods

Literature search

This study was performed in the context of midwifery based on the life histories of the working life of midwives and was not guided by any particular theory. The method of literature search included a preliminary search which was done with library data bases to develop the research proposal, focusing mainly on narrative qualitative research and the methodology and design of the study. Then the snow ball method was extensively used to search for relevant literature and work of different authors were chosen as the research process evolved to expand my understanding of narrative knowledge about childbirth care with a focus on place of birth in the background. This process of literature search was intermittent, working both on ways of contextualizing narratives with information and information with the narratives.

When the focus of the study had become clear and main findings had emerged, an extensive search was done through a computerised literature search of databases. Main key words were; midwifery, place of birth, storytelling, social narratives, knowledge development, childbirth, models of care, relationship, support, intuition, spirituality and safety. As this research was conducted from a midwifery point of view, and narrowed down to focus on midwifery relationships with women, literature used relied a great deal on midwives' groundbreaking writings and relevant midwifery research. A huge amount of material was found in relation to aspects of the midwife-woman relationship and experiences of childbirth. Much less was found about the development of midwifery knowledge, inner knowing, intuition and the spiritual side of midwifery care.

Organization of Report

This process of literature review described above, is a part of the research method and it directs the structure of the thesis in which I hope to demonstrate an interplay between stories of midwives' relationships with women and midwives' ways of knowing on the one hand and

changes in place of birth, different models of care and social narratives around childbirth on the other. Birth stories told by the midwives of this study are therefore both presented in earlier chapters with the midwives' names all being pseudonym *(always printed in italics)* as well in the finding ones and discussed in relation to the literature to illustrate and identify the social and cultural backgrounds of place of birth in Icelandic context that can also be applied to other midwifery situations in the Western world.

Narrative ethnographies like this one, will not attempt to know the totality of a group's life (Denzin, 1997), the working life of midwives. The focus is rather on interpreted glimpses of interplay of how cultural midwifery practices, connected to structural formations and frames of narratives are experienced at a particular time and place, by people and institutions interacting around childbirth, i.e. the midwives of this study in a dialogue with a midwifery researcher.

The literature review in relation to the stories is organized and discussed both at the front before describing the research process and methods, and also towards the end in the findings' and discussions' chapters where narratives are drawn out that are considered to be exemplary for this Icelandic midwifery saga.

Chapter Two – The Icelandic Context

This chapter is about where the study took place, its background and the researcher's relationship to the field of study. The geography and history of the country and Icelandic characteristics of midwifery education and the organization of maternity services are described.

Geography and History – Setting the Scene

The study took place in Iceland, which is an island in the North Atlantic Ocean and one of the Nordic countries. It is a very small society in a country of 103, 000 km², the most sparsely populated country in Europe with 63% wasteland and people living around the coastal belt in urban centres, mostly in the South and South-West. Because of the Gulf stream Iceland enjoys a warmer climate than its name indicates with average temperature in July being 10.6 and just below freezing in January (Halldórsson, 2003). In 1960 the inhabitants were 175.000 but on the 9th of January 2006 the population of Iceland reached the 300.000 mark (Statistics Iceland, 2006).

Iceland is a country of a rough natural setting with extremes in weather, dark winters and light for 24 hours in the summer. Earthquakes, volcanic eruptions as well as snow avalanches in the winter are fairly commonplace on this island of ice and fire. It was settled during the Viking Age (ca. AD 750-1050) from Norway in the year 874 (Þorsteinsson and Jónsson, 1991). However, about 20-25% of founding males had Gaelic origin and majority of females are thought to have come from the British Isles (Halldórsson, 2003).

Until recently Icelanders have been one cultural group with low immigration, but this has been changing; foreign citizens were 1.8% of the population in 1995 and 4.6 % in 2005 (Statistics Iceland, 2006). Fishing and farming has been the main livelihood, with tourism and high technological industry growing. And in the last decade Icelanders, have in the mood of Vikings, gone abroad to invest in banking and retail; the market in Iceland is getting bigger, being a part of globalization and new economies.

In the 13th century, following the Viking –Age, the Sagas of Icelanders were written about the settling of Iceland (Þorsteinsson and Jónsson, 1991). Hallgrímur Helgason (2002), a well known contemporary author in Iceland, claims that they are the Genesis of Iceland, the Birth of a Nation and form the basis of Icelandic culture. They are the history, genealogy, geology, geography, anthropology, mythology, law and religion, all in one. Icelanders might not believe their every word, but they do believe in them, the sagas being the Bible of Icelandic people. He goes on and wonders why Icelanders decided to write historical novels when this genre did not even exist in other parts of Europe, and certainly not "back home" in Scandinavia. His explanations in relation to modern Iceland, the context of this study, are the following:

> "Many people say this was the result of Norse and Irish blood-mixing. Studies have shown that 30% of early Icelanders were of Irish decent, a fact that helps us to understand why today we feel so different from the ever-sensible Norwegians and so very much at home in Irish pubs. Icelandic literature is Hamsun gone Wilde.
>
> So:
>
> The Sagas: Celtic humour combined with Nordic pride? Maybe. (This special cocktail of genes seems to have produced a real writing-breed: the first 400 Icelanders who immigrated to Manitoba in the late 19th century immediately published their own newsletter; which is the oldest ethnic newspaper in Canadian history.) But maybe the land itself also played a part. I don't want to sound too patriotic, but still, there is something special about Iceland. It's not very user-friendly, but it gives you energy, you get inspired. It keeps you on your toes. Every ten years there is a new volcanic eruption; the landscape alters; a new mountain is created or a new island emerges from the sea and we have to come up with a name for it. The country itself is creative and forces us to be so too. When you live on the continent for a while, you get overwhelmed by the fact that the landscape around Paris hasn't changed one bit for 500.000 years. You get depressed. You miss all the exciting earthquakes and blizzards at home. And when you add to this the powerful feeling of being one of the first generations of human beings ever to live in this inspiring island, you get that historical urge which lies behind all the saga-writings: you just had to put it on paper. These stories had to be told".

Based on these views, Iceland has a strong image of being a land of stories or Sagas. In Icelandic the word *saga* means both "story" and "history" and the word is related to the Icelandic verb, *að segja* and in the English, *to say*. Icelanders love hearing and telling (saying) good *sagas*; one good reason that a narrative research method is appropriate for this study on the midwifery knowledge and culture in Iceland.

Life Expectations, Fertility and Pregnancy Rates

The last quarter of the 19th century and the first half of the 20th century was a period of intense change in Iceland, from being a medieval peasant society, colonized by Denmark for centuries until it became an independent republic in 1944, to become a modern industrial society (Kristmundsdóttir, 1997, Kjartansson, 2003). The most fundamental changes are related to the remarkably better survival rates of young children at the end of the 19th and early 20th century. Within only a few decades, infant mortality rates declined from levels that were higher than in most European countries to become among the lowest (Garðarsdóttir, 2002).

In the early 1930s Iceland with Norway and New Zealand had already achieved the UNICEF target, set in 1980, for all countries having an infant mortality rate below 70 live per 1000 births by year 2000 (Halldórsson, 2003). This was around the time when the older midwives who took part in this study were being born and growing up. Iceland was in the phase of modernization with technological developments in fisheries. The patterns of the settlement of Iceland were changing from being predominantly a rural society toward increased urbanization. Then the infant mortality (deaths by the first year per 1000 newborns) was 40 per 1000 live births and newborn females were expected to reach an age of 65 (Garðarsdóttir, 2002, Halldórsson, 2003). Today, in the period 2001-2005 the infant mortality rate was only 2.5/1000 (Statistics Iceland, 2006).

Childbearing has been highly valued in the Icelandic culture, founded in a notion of close-knit family ties and the need for people to work and support the running of this small nation. Thus, fertility rates have been high and have prevailed until recently, for a longer time in comparison with the neighbouring countries in Scandinavia and Western Europe. During the period of 1960-2000 the fertility rate of all women through the reproductive years has gone down from 4.1 in 1956-1960 to 2.0 in 1996-2000 per 1000 women (Bender, 2005).

Although after 2000 the pregnancy rate of teenagers has declined, it is considerably higher (39.9) than in the other Nordic countries (Norway 28, Denmark, 20.9, Finland 26.5, Sweden 29.4) (Bender, 2005). Consequently, teenage pregnancy rate has been high compared to the Scandinavian countries and has until the present time to a great extent been accepted in the

Icelandic culture. Unintended pregnancy by all women has not been considered a big deal in Iceland reflected in the common view or culturally in-grown phrase *Þetta reddast* which means "Things will take care of themselves". This could be a contributing factor in relation to teenage pregnancy (Bender, 2005, p 23).

Fertility rate per 1000 women younger than 20 years was about 80 and at its peak in the period 1966-70 but has since been dropping to 26 in 1990-2000. It is still high, on the same level as the Eastern European countries, Latvia, (19) Lithuania (24) Estonia (26). The UK has the rate of 28 and it is highest in the USA at 57. The lowest rates in 2002 were found to be in Sweden (7), the Netherlands (8) and Denmark (9) (Bender, 2005).

As mentioned before, a century ago Iceland was one of the poorest countries in Europe with life expectations among the lowest in the world. The health and survival chance had improved vastly during the last three decades of the 19th century, whereas in the 1840s infant mortality rate had been 240-660 per 1000 which was comparable with German speaking districts in Germany and Austria, as well as a few areas in Sweden and Finland. Most of these areas were known for lack of breastfeeding and the artificial feeding of the newborn. This was also the case in Iceland in the 18th and early 19th century (Garðarsdottir, 2002).

Since 1904 prenatal death rate (first week deaths and stillbirths by 22 weeks and 500g per 1000 live births) has been among the lowest in the world (Ólafsson, 1998, Halldórsson, 2003). It is now in the period 2001-2005, by annual means, 3.6/1000. Life expectancy in the same period was 78.9 years for males and 82.8 years for females, and is also one of the best in the world (Statistics Iceland, 2006) and it has been increasing since the 1920s from being 60 years for women and 56.2 for men (Halldórsson, 2003).

Garðarsdóttir (2002) identified two key factors behind the extraordinary decline of infant mortality during the 19th and early 20th century. Firstly, changes in epidemiological regime and consequently virulence of various epidemic diseases. Secondly, changes in feeding patterns with midwives playing a central role, also as health promoters. Improved educational opportunities for women were reflected in the increasing education of midwives after the period of 1850 especially in regard to breastfeeding and infant health and hygiene care. Huge differences in the infant mortality level have been identified between areas with high literacy

and where the best educated midwives worked and breastfeeding was common, and with those where newborns were artificially fed and midwives were less educated or did not change feeding traditions towards breastfeeding (Garðarsdóttir, 2002). Thus, more favourable conditions for educated midwives to implement knowledge about optimal infant care and breastfeeding had impact on survival chances and health outcomes.

An Historical Overview of Midwifery in Iceland

There is a lack of historical and anthropological studies on early and modern midwifery practice in Iceland. However, a number of scholars have contributed building a picture of Icelandic midwives relating to Icelandic history, their education and professionalization resulting in publications by the Icelandic Midwifery Association (Jónsson, 1959, Þórarinsdóttir, 1984, Sigurðardóttir, 1984) and about the midwives' role in the infant mortality decline in the late 19th century (Garðarsdóttir, 2002, 2005). Icelandic midwives therefore know their history and look back for their roots and ideologies.

By law, midwifery is a self-governing profession and midwives in Iceland have always been entitled to care for women on their own responsibility. At all births women have a documented midwife. Formal midwifery training within an emerging health system started as early as in 1761 under the supervision of the first Medical Director of Health, or *Landphysicus*, Bjarni Pálsson. At the time, the first educated midwife, Margarethe K.J.B. Magnússen (1718-1805) who was Danish, was called to Iceland to undertake the role of supervising and teaching midwifery in the capital of Reykjavik (Jónsson, 1959, Sigurðardóttir, 1984).

Prior to this, the first known recommendations about midwifery are found in the rules of the church in 1537 focusing on religious issues and ethical characteristics offering emotional support and mentoring for women (Sigurðardóttir, 1984, Einarsdóttir, 1993). The Danish church law from 1685 came into law in Iceland and as in many other countries (Marland, 1993) parish ministers had the responsibility to instruct and choose faithful and good-hearted women to become midwives in local communities. They were instructed about prayers to perform and about the sacrament of baptism. They could carry out an emergency baptism if a baby was unlikely to survive. Despite changes in regulations and midwives' training, parish ministers continued to play a central role in the choice of and supervision of midwives well

into the 19th century. A close relationship between the church and education of midwives continued (Guðmundsdóttir, 2006).

The country was divided into 20 medical districts and there was to be one midwife in each one but as these requirements were not met and the country sparsely populated, relatively few women had access to trained midwives (Garðarsdóttir, 2002). Thus for some time the work of midwives varied between areas in terms of practices and knowledge, not all of them having formal training and licence to practise. Gradually more and more midwives became educated, supervised by the district doctors around the country. Midwives were until the mid 19th century as a rule required to be married and to have given birth, before they were accepted for the midwifery exam.

Midwives serving in the capital Reykjavik in the late 19th century were usually educated in Copenhagen and they took care of the training of midwifery students under the supervision of the medical director of health. Apprenticeship was the way of teaching with the midwife apprentice moving to Reykjavik and accompanying the town midwives to the childbearing woman. They were also obliged to read some theory and complete an official examination. Midwifery text books, were translated and published, the first one, *Yfirsetukvennaskólinn,* by Buchvald, or "the Sitting Over Women's School", in 1749 (Jónsson, 1959, Sigurðardóttir, 1984). This name refers to an old term for the midwife in Icelandic, the "sitting over woman". In 1846 reader by Levy was published (Stadfeldt, 1886).

The capital town of Reykjavik had, already in early 19th century, low infant mortality and a strong tradition for breastfeeding which was different from other fishing villages in the neighbourhood with similar geographical backgrounds. This can be explained in part by the better education of midwives in Reykjavik compared with midwives in other parts of the country. Socio-economic conditions and knowledge are factors that limited available options, which could explain why Danish infants of better means had much better survival chance than the Icelandic ones. Furthermore, in Denmark infants were in general breastfed which, as has been said, was not the case in Iceland.

Medical reports of the district physician Jón Finsen also show that mortality rate was as early as 1859, relatively low in Þingeyjarsýslur, which is a neighbouring county to Akureyri in the

Northern medical district. During the years 1845-1859 four midwives in this medical district had "sailed" to Copenhagen to become educated as midwives. Apart from Reykjavik no other district had sent more than one woman to Copenhagen. Many midwives were also educated in this district by the district physician with their number growing from 11 to 20, most of them working in the area. Breastfeeding was quite common here characterized by low infant mortality, which was different to Rangárvallasýslur in the South district where artificial feeding continued longer than was the case in other areas. This difference has been explained by contributing factors of how individual physicians and midwives had different knowledge and ambition to promote incentive to abandon the prevailing practice of artificial feeding (Garðarsdóttir, 2002, 2005). Regional differences have also been found in literacy, which was higher in Þingeyjarsýslur, with the Southern part having much lower literacy rate. Still in 1870 more than half of the parishes were without an educated midwife, but gradually education of midwives improved and at the beginning of the 20th century very few districts did not have access to educated midwives (Garðarsdóttir, 2002). Today, breastfeeding rate in Iceland is among the highest in the world. At one week after birth 98% of children are breastfed, at the age of six months; breastfeeding rate is 67% and on the first year birthday it is 14% (Jónsdóttir and Gunnlaugsson 2001).

In the 1870s and 80s, women's movement on women's rights was emerging and education of women was seen as essential to overcome subjugation, to become free and responsible equals of men. This happened as the Icelandic society was in the process of transition from the old farming society to the new modern one (Kristmundsdóttir, 1997). The first Midwifery act was passed in 1875; hence midwives took part in this social movement, being the oldest women profession in Iceland (Einarsdóttir, 1993).

One of the active midwives in this respect was the town midwife in Reykjavik, Þorbjörg Sveinsdóttir, who came back from Copenhagen in 1856. She started to teach midwifery students and had students living in her home. She was also well known for taking part in politics around the issues of sovereignty, fighting for the independence of the nation. She became the first president of the first Icelandic women association in 1894 which had at first the main goal of endorsing the establishment of a university in Iceland (Víkingur, 1962). Þorbjörg was considered to be a powerful woman in the town of Reykjavik and in Icelandic politics, one of the first feminists (Blöndal, 2005).

In the year 1912, when the Icelandic Midwifery School was founded the educational programme had been extended to six months. The first name of the school was the same as of the first teaching book, *Yfirsetukvennaskólinn í Reykjavik*, or "the Sitting Over Women School" in Reykjavik. Þórunn Á Björnsdóttir became a town midwife in Reykjavik in 1902 and when the school started, she became formally a teacher there. On her 70th birthday she published a book (Björnsdóttir, 1929) containing her birth stories about her work in Reykjavik in 1897-1930 which gives invaluable information about childbirth and midwifery knowledge in Iceland. For example she recorded midwifery care and outcome of 71 twin births and nearly 100 years later her data was used to compare with twin births of the present, regarding the health of the mothers and the babies (Eiríksdóttir and Ólafsdóttir, 2003).

In 1962-64 three books about working life of Icelandic midwives came out edited by Víkingur (1962) who wrote in his foreword that this book was about "folk narratives about silent women ...that have contributed an invaluable and particular share to Icelandic culture and welfare" (p. 8). These midwifery narratives from the period of the 19th and 20th century demonstrate midwives' religious beliefs and trust in God and how they receive strength to practise midwifery from higher power.

The second part of the 19th century and the early 20th was characterized by rapid development of professional medicine as well as of midwifery and the number of trained midwives increased considerably. In 1800 they were 13 and in 1875 the number was 76. At the turn of the 20th century they had become nearly 200. The Icelandic Midwifery Association was established in 1919 (Þórarinsdóttir, 1984).

In 1924 by new law, the professional name of the midwife was registered as *ljósmóðir* or "Mother of Light". The name of the school became *Ljósmæðraskóli Íslands* or the School of Mothers of Light in Iceland. Initially the education of midwives was of short duration, only three weeks, but by then the length of study became nine months instead of six as it was in 1912. By 1930, when the Landspitali University Hospital was opened, the midwifery school was housed there and by law the head midwife was also the head teacher along with the professor of obstetrics (then called *yfirsetufræði,* "sitting over theory") (Þórarinsdóttir, 1984). Since 1964 the midwifery education in Iceland has been a two-year programme (Þórarinsdóttir, 1984, Einarsdóttir, 1993). Until 1982 it was a direct entry programme but then

the admission requirements changed and a nursing education became the level of entry with the total length of education for midwives in Iceland being 5-6 years.

In 1994 the old Midwifery School was closed and in January 1996 a new 2 years Programme of Midwifery Education started on an academic level within the University of Iceland, which ends with a candidate degree (Candidata Obstetriciorum) with qualifications to be registered and legally licensed to practise midwifery in Iceland. Until this new educational programme started, midwifery education in Iceland had been headed by doctors. Thus, for the first time in the 235 years history of midwifery education in Iceland midwives had full control over curriculum building (Ólafsdóttir, 1995). Moreover the Latin degree awarded refers to the old term of obstetrix for the midwife, put to use in this way, after having been taken from us by medicine.

However, midwifery education takes place within the Faculty of Nursing, following a nursing degree, and even though midwives are in charge of their education interactively with midwifery practice, and direct the development of midwifery research and knowledge, there is resistance to midwifery withholding its identity separate and autonomous from nursing both in the academic society as well as in the Health Services. This can be noted when the name of midwifery is lacking in management structures, thus activity is needed to uphold the independence of midwifery.

This year, 2006, the process of fundamental changes in midwifery education has been going on for ten years. In order to enhance and give power to midwifery, steps have been taken to develop scientific methods and research and to advance midwifery knowledge and practice. Future plans have been made to set up midwifery as a separate department within the Nursing Faculty at the University of Iceland. Furthermore, it is on the agenda to change the requirements for midwifery education back to a direct entry bachelor/candidate programme. One of the arguments for this change is in accordance with the statement made by the Icelandic Midwifery Association in 1976 that it is preposterous that the entry requirement to the midwifery education will be dependent on education and working licence of another health profession (Þórarinsdóttir, 1984), i.e. nursing.

Maternity Services in Iceland

The rapidity of social and economic change created migration from the countryside to the urban areas growing most in the capital town area of Reykjavik where now a majority of all births in Iceland take place. The town Akureyri in the North is the second largest urban locality, providing service for the farming and fishing communities, including childbirth services with people travelling from 1-3 hours to the birth-place.

Births in Iceland were 4,249 in 2004 with fertility rate of 1.9/1000 for the period 2001-2005 (Statistics Iceland, 2006). The number of births has varied per year and has gone down in the last decade (7.7 %) (Geirsson et al, 2005). A shift away from midwifery care being provided in the community and all over the country has occurred and at this time there are about 10 birthplaces compared to about 24 in the 1970s. Similar to other countries in the Western world the rate of homebirth changed very quickly from being about 70 % in the 1950s - 1960s to being well under 1% in the 1980s or about 8 births per year. Since 2000 the homebirth rate has been increasing to about 20-25 births per year (Geirsson, et al 2004) and in 2005 homebirths were 43 or just about 1% of all births (Oral communication, Guðrún Garðarsdóttir, at the Birth Documentation, 6 July 2006).

Now about 70% of all births take place in the Landspitali University Hospital situated in Reykjavík. A worrying factor is that in the last 25 years the caesarean rate has gone up from 7.4 % in 1980, to be highest at 18.2 % in 2003 (Directorate of Health, 2006). However, in the last two years the rate has been going down and was 16.6 % in 2004 (Geirsson et al, 2005) and preliminary figure is 16% for the year 2005 (oral communication, Guðrún Garðarsdóttir, at the Birth Documentation, 6 July 2006).

Maternity care is free of charge as all Icelanders have health insurance paid by tax in accordance with the Social Security Act (see Minister for Health and Social Security, http://www. stjr.is). The system of maternity care is fragmented as it is in the UK and other countries in the Western world, and is analogous in many ways, but one should note the difference in the magnitude and complexity of the maternity services. The practice of health care midwives in the community is confined to prenatal care and in some cases home based postnatal and/or health visiting the young family up to 6 weeks after birth. Hospital based

midwives in the Landspitali University Hospital in Reykjavik provide antepartum, intrapartum and postpartum care on different wards and departments with limited rotation of midwives between these fields of practice. There are about 250 practising midwives in Iceland (oral communication with the president of the Midwifery Association of Iceland, May 2006). Out in the country midwives work at health centres in the communities and/or hospitals where births still take place and usually are able to provide continuity of care/er in relationship with their women. Number of births per place of birth per year varies from total of 15-400.

Since 1993 there have been some innovations in the midwifery services at the University hospital which are ongoing. Teams of midwives (MFS =**M**eðganga/pregnancy, **F**æðing/birth, **S**ængurlega/postnatal care) have offered continuity of care within a midwifery unit at the hospital for about 350 women per year. There has been a long waiting list and now in the year 2006 changes are being made to close down the MFS service to establish an integrated midwifery led care unit for at least 700 births per year. This includes a short stay in hospital and home care in the first week after birth. A drawback is the lowering of the level of continuity of care between antenatal care and attendance at birth. However, the aim is to develop and establish a continuity of care program between the hospital and the community, thus enabling midwives to work in both places and provide continuous care in relationships with women over time. Home postnatal care by the midwife with early discharge from the hospital was established in 1993. The service has been increasing and was in 2004 the choice of 64 % of women giving birth in the Reykjavik area (Geirsson et al, 2005).

Birth Stories of Icelandic Women

This study is focused on midwives' birth stories. However, in this cultural study, birth stories of women that I came across in the media or "came to me" informally are written in field notes. A book with birth stories of 70 Icelandic women in the period 1947-2002 was published in December 2002 with the title *Women with 1 cm dilation do not get any sympathy, Birth stories of Icelandic women* (Ingadóttir et al, 2002). These stories are used in part as the background of the study to set the scene in relation to discussion of findings.

The stories of the book were collected by women highly interested in childbirth issues who also were active members of a Home Birth Movement (which is currently not active). They introduced the goals of the book on a TV news talk programme and by sending e-mail to

women using a snow-ball method, asking Icelandic women to share their birth stories. In their foreword the authors described how they felt that a book about Icelandic birth stories was needed, for women to be able to echo their experience with fellow sisters of gender. Women were asked to write their stories and describe things they would have liked to know and which they would not normally find in pregnancy books. The authors concluded that the book had women's birth stores a voice that had before been isolated among closed groups of women and been a part of the oral remembrance; but now put in writing, they are a report of emotions, the testimony of the women, the silent part of what stands in between the lines of the official hospital reports of birth.

The women in this book are narrating parts of their life story, their birth stories which are very personal and honest. Everyone chose herself how she told her story, what she wanted to point out, share, criticize and change in the maternity care. The women experienced connections with and support from midwives and other health professionals and wrote about empowering relationships with midwives. Yet the power of the institutional medical context in shaping the contemporary women's birth stories is clear and sadly women also suffered uncaring encounters and abusive relationships with caregivers (Ólafsdóttir, 2002).

What stands out is that their stories are about life events, joy and grieving around the time of birth, relationships with the fathers and their environment. Many talked about the birth as a circle of life, their connections with their own mothers referring to the energy when the mother and the birthing daughter are together. They also referred to a type of continuity of care when the woman meets the midwife who was there when she herself was being born (Ólafsdóttir, 2002). Birth experiences are special to mothers as one described:

> "My births were the best ones for me, they are part of my life that makes them special, and they are part of my emotional life and experience and make me what I am". (p. 369)

My own story as a midwife and a midwifery teacher

This narrative study describes changes that have been happening in midwifery in Iceland in the second half of the last century to the present time. An interrogational part is my life-story as a midwife of 30 years, first as a student and now as a midwifery teacher and head of

midwifery studies at the University of Iceland. The following is my own story of becoming a midwife, about how I think about midwifery in Iceland based on my own experience and interpretations. Kristmundsdóttir (2006) points out that the researcher must be aware of herself as a location in social and cultural terms and make that awareness active in her research. She argues that the field can be subjectively defined in biographical anthropology which involves travelling in time and mind. This associates with how I in this study work with biographies of the working life of midwives of my own culture (see further discussions about validity issues in chapter five).

Life at midwifery school

While studying at the Midwifery School in Iceland, in September 1976-September 1978, I became interested in birth stories. I learned from many such stories including those told to me by people when they heard that I was training to become a midwife and also from new mothers and fathers, of their interactions with midwives (for example about what kind of information they needed) and last but not least I learned and got support from my school "sisters". We met regularly in each other's homes and between shifts and exchanged birth stories, as I think midwifery students and young midwives do all over the world, reflecting their practice, debriefing difficult situations and being emotional about beautiful births, the start of a new life and family. This was a time, when about half of the students lived in a dormitory situated in the hospital and not long before this (5-10 years) it was compulsory to live there, even if students were married and had children. Then students could be called day and night up to the labour ward to observe in different practice situations and learn from them.

Since then many happy stories have repeatedly been told in our group; stories of nostalgia about the life at school, the party life and practice of midwifery that after all is very different from what it is today.

Midwifery education in Iceland was at this time based on practical training in the hospital. The medical patriarchal model of care was very dominant in the midwifery practice and midwives did not question or have a critical view of their own work place and conformed to protocols such as shaving all women as though they were being prepared for surgery. It seemed at this time as though midwives were autonomous practitioners but sometimes they were just doctor's assistants. The care was based on patriarchy and the women did not have anything to

say about their own care. Midwives were dressed in green gowns with masks during every birth and our main concerns as students were how to wash our hands and put on gloves instead of thinking about the birthing mother or the skills of attending the birth and "receiving" the baby (as is the phrase in Icelandic for delivering the baby).

Lessons that focused on midwifery and midwifery models of care in particular were very few and the language we have today about our ideology of care did not exist. We learned in practice about midwifery skills under the guidance of the midwives. The head of the midwifery school was the professor of obstetrics and gynaecology at the University of Iceland. The doctors supervised our lessons in the bio-medicine subjects, pharmacology, anatomy, physiology, obstetrics, gynaecology and paediatrics. I remember clearly how I questioned in my mind after the first lessons about normal birth, which were taught by the professor, what normal birth really was. The lessons, titled "normal birth", had been about the pelvis the time and the passage of the baby through it, the uterus and the contractions. It was not about the woman, the person carrying the baby in her body and her giving birth.

One midwife came from the labour ward and brought a placenta with her to show us. This moment had a great effect on me, and I saw this woman who was what I was going to be, a midwife, as a role model (and still do and, incidentally, she is one of the midwives in this study) of how midwives should be and what kind of aura they can have around them. Even though we didn't get many formal lessons from midwives they were our teachers in practice; they told stories, were our mentors and we learned to use our hands to develop our practice skills. All women were to have their own midwife or student at their side, and the head midwife at the time, Kristin I. Tómasdóttir, put strong emphasis on midwives' presence with the woman during labour and birth (termed *yfirseta* or "sitting over" in Icelandic).

My story of being reborn as a midwife

Soon after graduating as a midwife I became a mother for the first time and now I have three children. My first one, my elder daughter, was born in January 1980 and the second, my son, 13 months later. I had prenatal care by an obstetrician I chose and respected, being one of my former teachers. At that time I did not think about going to a midwife for prenatal care. The midwives did not have their own caseload at that time and the women did not have their own named midwife. I got pethidine for pain relief which was routine and did not find anything

wrong with that. I was confused when I had my son, it felt as if I had been drunk, not remembering the birth of my baby; I was so ashamed that I did not tell anybody until now as I write this. However, I did not know what I was missing and in a way I experienced good births and was a happy mother.

In the years 1987-1992 I lived in Amsterdam which had a great influence on my views on childbirth, living in a culture where it was considered normal to have babies at home. I had gone through further education, and received a bachelor and a master's degree in nursing, focusing on midwifery. I had learned to be critical of my surroundings; I had read about different theories and research findings and asked myself questions about maternity services in general. I was starting to get answers to questions about what normal birth really was. A turning point for me (as I think for many other midwives) was also the talk of the midwife Caroline Flint at the ICM conference in den Hague in 1987 about the negative sides of fragmented institutional care and conversely about the importance of knowing your midwife and continuity of care in midwifery (see Flint, 1989, 1991). Later in 1993, Caroline was invited to Iceland by the Midwifery Association to talk at the first formal conference we held with a guest speaker from abroad. Many of us remember this conference as being a defining moment of the awakening of the "new midwifery" in Iceland.

When my youngest child was born in 1994, I had changed as a midwife and had different views about midwifery and childbirth and I was lucky enough to have the opportunity to give birth without having medical pain relief releasing my own endorphins. This was a completely different experience from the earlier births. It was an empowering experience of the triumph and ecstasy of having reached the goal on my own with the support of my husband and my midwife, having the same feelings as many women have described, ready to conquer the world. When my daughter was 5 months old I was given the post of developing the new midwifery educational programme at the University of Iceland, within the Department of Nursing, which started 10 years ago, i.e. in January 1996.

Since then I have been the Head of Midwifery studies in Iceland. One of the presumptions of this research has to be the following ideological statements of this new programme, which I wrote in 1995 (Ólafsdóttir, 2005) and now underpin the midwifery education in Iceland. These statements draw from the International Midwives' Ethics accepted in 1993 at the International

Midwives' Conference in Vancouver, the changing Childbirth Report (Department of Health, 1993) in Great Britain and the writings of Page (1993, 1995). Furthermore, they were influenced by my own study of 12 new parents' experiences of their interactions with Icelandic midwives, their teaching-coaching practice around the time of birth (Olafsdottir, 1992).

In line with these statements, the Icelandic Association of Midwives accepted and published their ideology and policy for the future in the year 2000 (Ljósmæðrafélag Íslands, 2000).

Ideological Statements of Midwifery Education in Iceland

- Midwives look at childbearing as a physiological process but not a disease and at birth as a singular event in people's lives that they should experience in a positive, individual and personal manner.

- Midwives give continuous care to ensure the safety of mother and child and at the same time preventing unnecessary interventions into the childbearing process.

- Midwives form a stable relationship with a woman and her family, provide holistic care and take into consideration physical, social, emotional and spiritual factors.

- Midwives keep in mind the right of the woman and her family to information about choices in health services regarding childbirth and support prospective parents in making independent decisions in choosing services.

- Midwives work with the expectant mother and father everywhere inside or outside health care institutions, on their own responsibility in order to empower parents to take active part in all decisions about their care.

- Midwives have knowledge of factors in the environment influencing the health of the woman and her family from birth to death. They also do preventive work and give the woman and her family advice and information to maintain and improve health and well - being.

- Midwives work in cooperation with other professionals in health services and seek consultation and refer to doctors and other professionals if the midwife's services are not sufficient for the woman and her family.

(Curriculum of the Educational Programme in Midwifery at the University of Iceland, December, 1995)

Chapter Three – Place of Birth and Models of Childbirth Care

This chapter is an overview of the cultural changes in maternity services in Iceland in the last century. It examines debates about place of birth in relation to conflicts between models of childbirth. It is not intended as a review of the vast literature about anthropological and social issues underpinning childbirth but more to illustrate the social background of midwifery practice in Iceland using midwives' stories from this study. Moreover, it is set out to show the social structures and narratives that relate to different views about childbirth.

Cultural Changes and Medicalization of Birth

It is well known that in the 20th century there was a huge cultural change in maternity services and place of birth. Underlying this are ongoing debates over place of birth which influence the context and culture of childbirth with different balances of power and control (McCourt, 1998). Birth has changed from being a social and emotional experience within the family and community to become a medical event in hospital with the routine use of technologies (Tew, 1995).

Medical sociologists, anthropologists and historians have produced a great amount of work demonstrating the successful penetration of Western medicine into our everyday life. Their writings reveal shift in who is seen as expert. This medicalization in relation to childbirth has been defined as

> "the process whereby the medical establishment, as an institution with standardised professional guidelines, incorporates birth in the category of disease and requires the medical professional oversee the birth process and determine treatment" (Van Hollen, 2003, p.11).

Experiential knowledge is replaced by scientific and the doctor replaces the woman and the midwife. Yet it was not until well into the 20th century that cultural authority was bestowed to scientific medicine. In the United States almost no woman saw a doctor prior to birth in the early century, while almost all receive such care today (Barker, 1998). Modern medical systems have turned the "normal" complications of birth in quantifiable "risks" which has created the possibilities of legal actions against health carers in the form of malpractice suits,

as has been most visible in the United States (Cartwright and Thomas, 2001). This has migrated to other countries in the Western world, including Iceland and has cast "a dark shadow" on health professionals working in maternity services in Wales and England, forcing obstetricians to defensive practises (Kirkham and Stapleton, 2004, p. 120). Questions arise about how the social-cultural changes around place of birth and conflicting models of care influence midwifery practice and knowledge.

Key trends in this cultural shift have been concerned with safety and belief in large-scale institutions (McCourt, 1998). Now in many countries birthplaces are closed down with the arguments that it is because of security precautions and too much cost. Similarly in Iceland many birthplaces have been closed. More and more women have to travel away from their homes and families where they have to wait for their birth for one to two weeks or more, perhaps with a risk of higher rate of obstetrical interventions. These organizational changes provide a limited choice of a place of birth for the women as well as the midwives who have lived and worked out in the country, some for about a half a century.

"I find this tragic, I mean just this instant when the baby is born has to be in Reykjavik. When does the conception have to be there too?

(Midwife-Elsa, 50 years' experience, interview 3)

"It is terrible for the women to leave maybe with two children and a family to Reykjavík and they may have to wait for a month. I feel sorry for them to have to leave".

(Midwife-Anna, 47 years' experience, interview 1)

"It is crazy that women have to travel away from their hometown as if the midwife is not able to deliver [receive] a first child. I just did not believe it when I heard this first. I think this is very negative this is not an encouragement for the women. Many of them are not satisfied neither the midwives nor the women. The women are wise and they do not think that this is so terrible [to have a baby]...They expect everything to go well".

(Midwife-Hanna, 48 years' experience, interview 7)

These quotes from midwives, who have lived and worked in very different cultures of childbirth, show how they have belief in the abilities and wisdom of women and the normality of childbirth.

Today studies based on midwives' stories (Crabtree, 2004) support the notion that many people have lost contact with the natural aspects of childbirth as a rite of passage or life

process, and that many women have lost faith in their ability to give birth in a normal way. This is maybe not surprising as technical assisted births and the caesarean rate rise in the Western world and fewer women experience normal physiological birth. There is divergence between views and definitions of what normal birth "really" is. Medicalization of birth results in the danger that it will no longer be possible to know what births were like before medical manipulations as "most health care providers no longer know what "non-medicalized" birth is" (Wagner, 1994, p. 114).

Birth might then no longer be seen as something that women do but what is done to them and it can be presumed that both women and midwives lose, along the way, some of the gifts, insights and skills of traditional midwifery, which used to be an integrated part of their every day life and culture.

Childbirth in Different Times and Places

To point out different social structures around childbirth the following paradigm narrative has been chosen. By that I mean that the narrative is exemplary for a different cultural time of birth. The underpinnings of this narrative are the changes in place of birth and of the midwifery relationships with the women and their family in the community. It is a collective "stored wisdom" of a midwife who does not just construct a narrative, but constructs a social world (Silverman, 1993) of midwifery in Iceland in the 1950s, which we can also look at from the perspective of the present, having the evaluation *"It went splendidly well"*.

The place - A farm in Iceland in the 1950s

There was one birth on a farm. I want to tell about how it went. It went splendidly well. But when I look back which I did not find particular at that time, this woman was 43 years old. She was not much younger than my mother and her eldest child was the same age as I, and I had been a babysitter for her other children when I was 8-11 years old. So this woman was for me more like a mother than a woman giving birth. She was in her 9th pregnancy and was 43 years old. This would have been considered abnormal [today] or at least there would have been fuss around this birth. It was summer, light night and it was so quiet and there were many children. The eldest had left home. I went to her in the evening and she gave birth to a lovely, beautiful daughter. I remember that her husband was with her or he was to reach. The fathers were with their women at that time and when my mamma had her babies my dad was always with her. When the baby was born and I was ministering to her, the father went out to the kitchen. When I came out he was fast asleep on a chair with sheep clippers in his hand. This was so peaceful and looking back I think, the woman was 43 years old and having her 9th child and the birth was wonderful. I was well into my pregnancy at the time and my first child is the same age as this one.

(Midwife-Elsa, 50 years' experience, interview 3)

The same or similar story with the same atmosphere of peace and a sacred moment could have been told in other places all over the world but this narrative written down 50 years later has its own life and a perspective, its own emergent aspect but can be interpreted in different ways. This story shifts according to the time it is written or read (Riessman, 1993) and the midwife tells how her story would have been different if she had told it at the time it happened, because as she said, *"I did not find particular at that time*". There she refers to the current standardized professional guidelines about the woman's age and criteria of high risk pregnancy and where women are supposed to give birth. *"This would have been considered abnormal [today] or at least there would have been fuss around this birth".*

Births that now have the label of being high risk or abnormal were "normal" home births (out in the country) and peaceful family events with the birth as a rite of passage for the childbearing woman as well the midwife herself, and were simply a part of everyday life. The point of this story is that it is sheds light on the changes of culture of birth in Iceland. There are embedded stories not told about fathers being with their women before the time of hospital birth and there are stories about the environment of birth, e.g. the light summer nights. The name of the midwife in Icelandic, as was mentioned before, is "the mother of light". It refers to how the baby is born into the light, hence the title of this thesis. Many birth stories in Iceland include narratives about the light as the baby was born.

Nevertheless, there has always been danger around childbirth and this calm atmosphere was not always at the place of birth. There is no need to romanticize the good and suggest that the old times were always good. Here is a well known story that still lives in the North and East part of the country which I was told a few times by different people as it has stayed in the memory of the community. No one wants to go back to this time and people expect that centralization of care with technology will provide safety for the newborn and the family. Back then, in the 1960s, in this small country hospital working conditions could be very difficult and there was *"Nothing you could do"*.

This was in December in a screaming snowstorm, a woman came with twins [about 36 weeks pregnant] and she was bleeding. There were no beds for the babies, just wooden boxes and no incubator and hardly any instruments...Twins, they were born with the stream of blood, both alive and well when they were born. What could I do? I tried to make a bed for them in a wooden box to keep them warm, with blankets, I don't remember, I made a plastic tent over them and I had oxygen. I didn't have the knowledge and I fought alone... They both died, the latter one at about four or six in the morning...I cannot be sure but I always have believed that if they had had help from a doctor right away then ... This was a terrible night... This was the time I felt the greatest powerlessness in my life. There was nothing you could do...After this an incubator was bought. There was a screaming snowstorm and it was not possible to get a flight with an incubator. There was nothing you could do, really nothing.

(Midwife – Solla, 45 years' experience, interview 2)

Embedded in social narratives like this one are many untold stories about preceding happenings and what is happening now. They are rhetoric and can have relevance to the culture of childbirth and could give explanations to different views of childbirth care in a risk society. Technology can be a hope for a better world (Wagner, 1994, p. 35). In this town there are no births anymore.

Traveling Places of Birth and Concepts of Risk versus Safety

With reference to the risk society of birth, the midwives who have lived through huge cultural change talk about *"the danger which could be hidden around the corner"* that dominates. It is a paradox that increasing knowledge about obstetrics and technology and treatments can create fear, can *"scare to death"* as well as being looked at as a safety measure.

It is obviously a great difference to have the CTGs and this technical equipment. It helps a lot but at the same time in a way it makes you scared...I have known some midwives who have been obsessed with this terrible fear...When I was at school we learned about the danger which could be hidden around the corner but it was not the main thing, it did not predominate.
(Midwife-Elsa, 50 years' experience, interview 3)

When I had been here in the province for some time as a midwife I went to Reykjavik not for the first time to take a course [in the 70s]. They described all the abnormalities that can happen and I started to think about why I was there up North practising, when all this could happen. I started to feel unsafe and started to think about all the doctors that do not want homebirths...I felt very unsafe and I just did not understand why I was doing this [running her own birth centre at her home on a farm]. But then I came home and everything was the same, everything was okay. It was funny, there I got this feeling and now I understand the young doctors. They have been scared to death because of all these bleedings and everything that could happen.
(Midwife-Hanna, 48 years' experience, interview 7)

The above descriptions can be related to the medical model as a part of a wider conceptual framework of medicalization, the process of social change over time from a social to a more bio- medical model (Teijlingen, 2005). They show how obstetrics gained control when they developed as a speciality branch within medicine; roughly contemporaneous with industrialization, with the notion that doctor attended hospital birth is safer than homebirth by the midwife (Simonds, 2002). Hence, the medical model and the concept of risk govern the modern maternity services.

Assessment of risk is not value free. Risk has been defined as the "dangers that are believed to be most immediate or- as in case of obstetrics- dangers that practitioners believe they can or must control" (Cartwright and Thomas, 2001 p. 219). Danger implies a fatalistic outlook on birth and risk implies an activist stance requiring birth to be accompanied by medical technology, monitoring and often intervention (DeVries, 1996).

Many of the stories told by the midwives working out in the country were about the weather and the "journeys" to the woman and with the woman to place of birth with different aspects of risk and safety in the background. This narrative takes place in the year 2000 and because of economy and changes in hospital staff, the surgery had recently been closed.

I have been thinking about how my practice has changed from being an active midwife attending births [in a community hospital] ...Now I am travelling between my hometown and to the central hospital [about one hour's drive] with screaming women. This is not good for the women. Last summer I remember one [journey]. It was a woman who was having her second child and had had a difficult birth the first time with vacuum extraction and therefore she was to be transferred... We left in hurry and she - I mean it - she screamed all the way. The driver was young, the same age as my elder daughter and he was replacing someone and he was drained after this trip. We came to the hospital and she had started to push and she pushed for 20 minutes. The head was high but then the baby came, one, two and three. Everything was fine with the baby. This was not a nice journey. The boy, the driver was drained. I waited for the birth of the baby and the woman was very thankful. These journeys are not nice, they are not nice...and they are not without risk. There are four single lane bridges on the way. Bad bridges because two of them have a blind road towards them. There have been serious accidents there, which have led to death. If I go on doing this then it is possible statistically that something happens to me. I do not look forward to that.

(Midwife-Dora, 32 years' experience, interview 5)

In an Icelandic study, the metaphor of women journeying has been used to describe powerful experiences of giving birth, coloured by circumstances and expectations of the woman, with the birth as a unique life experience at the journey's end (Halldórsdóttir and Karlsdóttir, 1996). Page (1993) had also described the birth as a journey where "a skilled companion, the midwife accompanies the woman on a long, intense and tumultuous journey" (p. 22), a journey of finding new meaning in life, covering a great spectrum of human emotions which even though it gives real joy it does not always make you happy.

In this story it is interesting to read how the metaphor of journeying changes because of circumstances that are "coloured by" the travelling place of birth in a community of an ambulance, highlighting the risk of the journey itself, on the way from home. Furthermore is the embedded story of the young driver, his outlook or "new meaning" of childbirth, his social narrative of birth that in turn can have influence on the changing views of childbirth.

Halldórsdóttir and Karlsdóttir (1996) described the woman's sense of self as having a sense of being in a private world, being vulnerable as well as sensing a strong need for control, caring

and security, and suggested that if, during the journey, the needs of the woman were fulfilled it created positive feelings about the whole journey. This cannot be said about the feelings of this midwife.

The midwives in this study formed storylines with a number of striking cultural themes that show conflicts between models of care. Technological interventions are a fact of childbirth care; undercurrent is the changing views in society about childbirth, in relation to the concept of risk and the fear of litigation which now is a part of the dominant discourse or narrative about childbirth.

This fear has negative effects; in the past if something came up, this was nobody's fault. There was nothing to do, this was destiny, it should happen this way, and there was no request for payments [litigation].

(Midwife-Hanna, 48 year experience, interview 7)

These new social structures in reference to technology, risk, safety and to travelling to places of birth are embedded in contemporary stories, and *"the argumentation is misleading".*

Now she was in her third normal pregnancy and the baby was in a head position. She said: "I am going have a vaginal birth and I am not going to be transferred. I am not going to need a caesarean and everything is going to be fine". She was starting in labour and I told her that I would do a check and CTG and that we would not put her in any risk...the water broke and it was green. Then the doctor came and he said: "You are going to transfer her". I said: "I am going to check, she is not going if she is going to have the baby on the way". I checked her and she was dilated just about 4 cm, but with lung soft edges and I said to her: "It is your choice, do you want to have you birth here with me or do you want to have your baby on the way on one of the bridges"? She said: "I am not going anywhere; I am going to have my baby here. It is not nice to give birth in the ambulance". And we put on some music and tried to have it cosy and she had her baby within the hour, a 4 kg fine boy. But the support I got from the doctor was as he said: "You could have been in trouble if something had gone wrong" and I said: "What do you mean? Would I have been safer if I had received the baby in the ambulance? Think about the woman and what would I have done alone? I knew the boy would be born on the way. This argumentation is sometimes very misleading.

(Midwife-Dora, 32 years' experience, interview 5)

This narrative about changes in place of birth because of the centralization of maternity services and medicalization of birth shows how this brave midwife resists and works in cooperation with the woman. And in line with how Leap (2000) described the role of the midwife as being with the woman and exploring with her the physical, intellectual, social and

spiritual challenges as well as the ramifications of childbirth. She works with the woman and her community, collaborating with other health professionals if necessary to ensure a safe and supported transition to new motherhood, taking into consideration the woman's individual circumstances and wishes (p. 4).

Social Narratives and Conflicting Models of Childbirth Care

We live in multiple stories that represent different social narratives about childbirth and conflicting models of care. Childbirth has become a battleground of health professionals competing within organizational economic situations and, more importantly, of different ideologies and values.

Two key models or schools of thought have been documented in the midwifery literature about childbirth care: the midwifery model usually associated with the social model of childbirth, and the medical model. In short, the midwifery model has a focus on the physiology of birth, this being a social life event, which is believed to be normal until proven otherwise, and it is women centred within the family. On the other hand, the medical model has a biomedical focus where the birth is at risk, needing interventions and considered normal in retrospect. These models of care have been described and contrasted by many authors (e.g. Rothman, 1982, Davis-Floyd, 2003[1992], Oakley 1993, Briar, 1995, Kent, 2000, Walsh and Newburn, 2002a, 2002b, Teijlingen, 2005).

My experience is that the above short descriptions of these contrasting models are easy to understand and therefore useful on a practical and an ideological level, both in midwifery education and practice. Icelandic midwives use these definitions and they are a part of midwives' discourse when identifying their underlying model of care or how they want to practise. At the same time it can be presumed, as authors have pointed out, that practices both of doctors and midwives are usually not "either – or" their practice is somewhere in between two ends of a continuum and not static. Yet these distinctions between models of care have been an important help for midwives to identify themselves as independent professionals. The ideology of midwifery models of care explain how midwives look at childbirth, interact with women and provide midwifery care. The dialogue about different models of care shape and help to make progress in the working places of midwives and the way they work.

Following is a list of different concepts that relate to the two schools of thought drawn from the literature and listed by Teijlingen (2005). These contrasting concepts are embedded in the narratives of the midwives in this study as will be discussed in the finding chapters.

Medical model	Social/midwifery model
Doctor centred. Body as machine	Woman/patient centred. Whole person
Objective	Subjective
Male	Female
Body-mind dualism	Holistic
Pregnancy: only normal in retrospect	Birth: normal physiological process
Statistical/biological approach	Individual/psycho-social approach
Biomedical focus	Psycho-social focus
Medical knowledge is exclusionary	Knowledge is not exclusionary
Intervention	Observation
Public	Private
Outcome: aims at live healthy mother and baby	Outcome: aims at live, healthy mother, baby and satisfaction of individual needs of mother/couple

In a technocratic society, where childbirth is being transformed with new ways of culturally "shared understandings" (Lyotard, 1994), it is logical that many stories of mothers are structured around positive experience of births that are now carried out in a technical environment which may be considered "normal".

"When the doctor had given me the epidural, everything was fine. I felt comfortable and helped my husband with the word puzzle while we waited for the baby to come. I felt a little bit of pain, but it was not unbearable in any way...It is a boy; someone said and delivered over my head a slimy and bloody package. The midwife took him before I could see him...she brought him back and put him on my shoulder, there was a tent over my breasts and my hands and arms had tubes in them so I had not much opportunity to hold him. He seemed to be a handsome boy, wrinkly and completely bald. I was so happy and I saw everything in pink colours. It is impossible to describe how I was overwhelmed with wellbeing and joy".

(Freyja, baby born in 1999, quoted in Ingadottir, p. 357)

This modern story of childbirth illustrates the technocratic model of childbirth, which Davis-Floyd (2003 [1992]), based on Rothman's work (1982), identified as the core paradigm underlying modern obstetric practice, where the female body is looked upon as a defective machine that will work better when this defective working machine is hooked up to other machines, such as in this case, machines used in a caesarean birth. Davis-Floyd considers machines as symbols of how they are valued over bodies and technology over nature. She

analyses obstetrical procedures as rituals that convey cultural core values to birthing women (Davis-Floyd, 1987) which also encourages deconstruction of birth into identifiable and controllable segments which again are reconstructed as a mechanic process. Technocracy expresses not only the technological but also the hierarchical and bureaucratic dimensions of the culturally dominant model (Davis-Floyd, 2001).

> " The rise of obstetrics and its eventual dominance over midwifery was achieved in part by the argument that those who care for childbearing women can only do so properly by viewing the female body as a machine to be supervised, controlled, interfered with by technical means" Oakley, 1993, p.71 [originally presented in 1988]).

The centralization of maternity services, linked with medicalization of society, has created the third cultural model of "care" in midwifery practice, identified in terms of the institution or as an industrial model. It originates in the Enlightenment positivist thinking and in the drive to control nature, which influenced the groundwork for the Industrial Revolution. Scholars have pointed out that in that context, women's reproductive bodies came to be viewed as machines which should operate in a uniform and efficient way to facilitate "re- productivity" (Van Hollen, 2003). In line with the application of a technological model to the human body this can be traced back to Descartes's concept of mind-body dualism, the body being distinguished from the mind. A model of body-as-machine is based on the notion that problems of the body are technical and require technical solutions (Rothman, 1982).

Consequently a model of assembly-line factory production was implemented when birth moved to hospitals and obstetrics developed tools and rituals to improve the inherently defective process of the woman body to give birth (Davis-Floyd (2003). Furthermore, as a result of this change of place of birth, the support people also changed and the health professionals took over the roles of the family and friends at home. Gradually, professionals have turned to technological care, reducing supportive care to the extent that is now is an exception rather than rule (Hodnett et al 2006). This is prevailing in industrial models of care where the institution constitutes a more significant social unit than the individual or the family (Davis-Floyd, 2003).

The industrial structures of hospital care have also separated midwives from women and this has alienated midwives from practising "real" midwifery (Page, 2004) in relationship with the

woman. With ongoing organisational change and increasing demand of managers, the workload has been increasing and contemporary midwives are in a dilemma and experience crisis in their workplace negatively as is demonstrated in the following narrative. It gives a glimpse of a midwife's working life in the busy central hospital of Reykjavik and highlights how by necessity, she, like midwives in the UK, has to work "with institution" instead of "with woman" (Hunter, 2004). Midwives experience stress and burnout creating emotion work for midwives which is strongly influenced by the context of their practice (Hunter, 2005) and therefore they have strong support needs (Kirkham and Stapleton, 2000; Deery, 2005). Presumably UK midwives agree with this Icelandic midwife's comment that than in these circumstance their "*midwife heart is not ticking*".

I went home in the morning without having had anything to eat or gone to the toilet... There were 13 women on the ward during the night, 9 of them came in and 5 of those were high risk... We were 4 midwives and a 1st year student and 3 midwives were called in extra at different times. All midwives were occupied in the labour rooms and I had 3 women and I ran between them...all women had some complications and had to be looked after constantly. I felt all the time everything was going out of boundaries and that we were working in unsafe surroundings and I did not have overview of things. When I came home I sat down at the kitchen table and took the Newspaper. There my husband found me crying. I slept badly, and thought about getting another job...this was one small example and not the only one [the third busy shift during that weekend].
It is very seldom that I go home and think; today I worked as a midwife...the work I love gives me pain. When the situation is like this our midwife heart is not ticking.
(Field notes, a midwife's diary from a night shift in May 2004)

Concepts of safety seem to have a different set of meanings than that of technology, for the midwives of this study, depending on place of birth. This midwife experienced *"unsafe surroundings*", in the technical "safety" on a busy labour ward where the rules of the institutions dominated. These stories of busy-ness are technocratic and industrial. It is noteworthy, how the calm of the farm-life has disappeared (see narrative p. 30.).

Birth stories of mothers are carried by them through life and they also say much of the cultural context of birth and can also be most useful in identifying underlying models of care. In reading mothers' stories, awareness of the midwife's busy-ness underpins many anxieties of women and their families. This is apparent from women's experiences in studies in the UK (e.g. Edwards, 2005, Hunter, 2004) and from stories from hospital labour wards in the United States (Hanson, et al, 2001) and in Iceland from midwives in relation to this study and

mothers' birth stories (Ingadóttir 2000 et al, Bjarnadóttir, 2005). These experiences result from institution or industrial models of care.

Next is a woman's birth story from the field notes of this study, a specimen from the summer of 2005 where industrial model of care is apparent. The story is part of an assignment of one of my midwifery students starting her midwifery studies. The students were asked to bring a birth story from their surroundings, to discuss in class, considering underlying models of care, relationships with women and what they could learn from it on their learning journey of becoming a midwife. It was published in the Icelandic Midwifery Journal and the following is an abstract from the story told to her by friend, repeatedly told in *saumaklúbb*, or "a sewing group". *Saumaklúbbur* is an Icelandic cultural phenomenon, a meeting place for women, in which young women can share their birth experiences that in turn become a part of the discourse about of how people think about childbirth, midwives work, and modern maternity services.

"About seven o'clock, Anna is on the labour ward and the work there is crazy. They [the midwives] were running hard around. Anna was five cm dilated and they were there for about two hours and once in awhile someone checked on them, the midwife told them that she was also delivering twins. In two hours' time they were asked to go out and wait in the Fathers' room [or the corridor in front of the lift]. Anna was just coping and found it hard to walk because of the pains... about ten o'clock she got a labour room, the midwife was in and out of the room and told them without them asking that she had been working in the morning, that she was on an extra shift now and that she had a morning shift tomorrow. Most of the time Anna and her husband were alone. There was an exchange of shifts and another fresh, lovely midwife came, however, she often had to go out. In the end Anna's husband put his foot down and said now someone had to be there, unless he was to receive the baby, he did not trust himself to be there alone with her. The midwife stayed but instead traffic increased into the room, people opening the door asking for things... This disturbed her a lot... She liked her midwife and found her encouraging and liked the fact that she called her by her name. At one o'clock a healthy girl was born, but Anna" would have died" if this had been her first born as she said herself. "Of course the midwives were doing their best and not working the way they the wanted", she said." But is this allowed, are there not some security regulations?" she also asked. – This was her side of the story

(Bjarnadóttir, 2005, p. 13-15.)

Social narratives about birth have changed from being about birth being a natural life-event to be a technical event to be afraid of, and this has influenced midwives' work and independence. This development is in part accepted by midwives. Teijlingen (2005) discusses how the medical model is the dominant ideology, while midwifery has developed conflicting

ideologies. This means that midwives tend to adapt to their workplaces instead of standing by their own ideology of childbirth.

In medicalized settings working in an industrial model, midwives tend to "go with the flow" of the organisation (Kirkham and Stapleton, 2004). However, the dominance of medical models of care is also resisted by many midwives. Midwives' prevailing discourse about promoting and keeping birth normal, alongside with increasing technical interventions, gives women conflicting messages about different models of care. Freyja tells a story how she experiences herself as being *"a rope in a tug of war"*. In such circumstances, the care *"waited for"* is likely to accord with central social narratives and expected medical model of care.

"Everything should be so natural, just water and relaxation and everything would go well, I thought about if I could do it. Should I try birth without analgesia? Should I try to become one of the elite groups"? ... Then I got more confused, the women from the Homebirth Association and the midwife who was afraid of water [did not support water birth] had a debate in the newspapers about the welfare of women during birth and they accused each other of high handiness and of being ignorant. I felt as a rope in a tug of war. I gave up; I felt that I had not the knowledge to make a decision about what was best for me, not without help. All the messages I got [social narratives] were conflicting and inconsistent. I did not trust myself to think more about it, I waited for what would happen and hoped for the best"...

(Freyja, baby born 1999, quoted in Ingadottir, 2002, p. 353)

The move from home to hospital made midwives take on nursing structures and the hierarchical task oriented approach of the hospital. This had destructive effects on midwives, who had to leave behind the tradition of being part of life and communities (Hunt and Symonds, 1995, Page, 2004) providing fragmented care. Sometimes, as in the fragment above, the midwife is not present to help make decisions based on midwifery models of care and in relationship with the woman.

Place of birth has been defined as " the woman's own space in which she can trust her body and give birth with loving support in a way that she feels is right for her "
(Kitzinger, 2005 p. 14). This definition is appropriate because it is open and can be applied to different situations and women all around the world. The question is: do women have a space and support that feels right for them? And is there a midwife at her side? In the following chapter the relationship between midwives and women will be discussed as well as the concepts that constitute midwifery models of that relationship.

Chapter Four – Midwives' Relationships with Women

This chapter discusses midwives' relationships with women around the time of childbirth, its uniqueness and how midwives have through research identified their midwifery models of care. It is based on a review of the literature of interrelated studies about the experiences and outcomes of birth and of midwives' support and continuity of care. In addition to this, midwifery research in relation to midwifery models of care in different Western countries, particularly in relation to the Icelandic and Nordic context, will be presented. This chapter is, however, not supposed to give an extensive or critical view of the broad literature concerned with these issues, but to point out fundamental functions and central concepts of the relationship between the midwife and the woman.

Models of Care and Midwifery Relationships

Pioneers in midwifery writing and influential thinkers of midwifery practice in the UK have pointed out how special and even unique the relationship between midwives and women can be, and how it is the "heart" in midwives' practice (Flint, 1986, Kirkham, 2000, Page, 1988, 1993, 2003, 2004). Nevertheless, the industrialised world of medicalized and fragmented care in hospitals has "served to divert midwives from this fundamental relationship" (Kirkham, 2000, xiii) and has in some places led to

> "...a destruction of the individual relationship established over time between women and their care providers. Yet this relationship is the crux of effective, sensitive, autonomous care" (Page, 2003, p.119)

Some midwifery models of care have been designed based on research findings in different parts of the Western world. The key thread of these models is the centrality of the relationship between the midwife and the woman, looking at birth as a normal –live event (Pairman, Guilliland, 1995, cited by Pairman, 2000, Fleming, 1998; Freeman et al, 2004, Kennedy et al, 2003, Kennedy et al, 2004). Authors identify central concepts that refer to the forming of relationships, such as partnerships of equality, sharing of power and responsibility (Pairman, 2000, Lundgren, 2004) by being present (Fleming, 1998, Siddiqui, 1999) based on trust and respect (Kennedy, 1995, Anderson, 2000, Leap, 2000, Page, 2003,) and reciprocity over time (Fleming, 1998, Pairman, 2000, Stevens, 2003) that can be in or out of balance (Hunter, 2006)

with the potential for sharing of information, joint decision making and empowerment for both women and midwives.

The relationship between midwives with women has been described as a partnership. Pairman (2000) did a study with a pair of 6 midwives and 6 women who were their clients exploring and refining a Model of Midwifery Partnership which was based on philosophical beliefs which arose from her reflection and her colleague, Guilliland, (Guilliland and Pairman, 1995, cited by Pairman, 2000), drawn on their experiences and observations in their practice as midwives, as well as from discussions with many other midwives and women in New Zealand. These beliefs included: pregnancy and childbirth as normal life-events, midwifery is an independent profession; midwives provide continuity of carer in a woman centred way.

The partnership was defined as: "A relationship of "sharing" between the woman and the midwife. Involving trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland and Pairman, 1995, cited by Pairman, 2000 p. 221). This Model of Partnership has led to a new definition of midwifery professionalism in New Zealand that directs and underpins all aspects of midwifery, politically, in education and within the day to day practice. Later the central concepts of the model have been examined and discussed in more depth by Pairman (2006), but its implementation and use in practice has not yet been evaluated by research.

The content of this partnership model of care appears to strike a chord with midwives around the world as they share the same ideologies both based on experience and research. In 1995, on the other side of the world, parallel notions to the Model of Partnership were included in the ideological statements of the new midwifery curriculum in Iceland about childbirth being a physiological process where the forming of a stable relationship was addressed, keeping in mind the right of the woman to receive information; midwives being independent in their practice, empowering women to make independent choices and take active part in all decisions about their care (see before in chapter two p. 26).

In a much larger study than Pairman, Fleming (1998) developed a research based conceptual model of midwifery practice based on interviews with 250 midwives and 219 clients in New Zealand and Scotland with grounded theory methods. This model relates to the Partnership

Model based on reciprocity between the midwife and the woman and refers to the phrase or slogan, "women-with-midwives-with-women" and is about the coming together of the woman and the midwife, constructed in linear fashion illustrating the relationship with common elements having more impact at different points in the relationship. The major categories of being with the woman were: attending, presencing (sic), supplementing and complementing the woman with reflection and reflexivity in order to encourage participants to reflect upon the influences of their background and the extent to which this shapes their beliefs and actions around childbirth. The concept of reciprocity was identified as the essence of all successful midwife-client relationships. It was concluded that since each relationship is unique the coming together and the peak of intensity between the midwife and the woman may occur at any time along the continuum of pregnancy or the postnatal period based on reflexivity with each woman (Fleming 1998). In that sense the reciprocal women-with-midwives-with women model was considered to be episodic, interdependent and not always equally balanced.

The Pairman study (2000) defined the partnership as a "professional friendship". This relationship was described by the women as being a friendship with the characteristics of knowing each other, women -with-women equality and trust. For both groups, the midwives and women, the term professional friend captured the unique nature of the midwife-woman relation, describing the equality, trust, intimacy, reciprocity and personal knowing developing over a time (Pairman, 2000). Other studies in midwifery of the Western world are congruent, such as the study of Harding (2000) based on interviews with 15 midwives in British Columbia in Canada about their experiences of shared decision making with women, which reflects the equal, collaborative nature of the midwifery relationships with women as the essence of midwifery practice where expertise of the midwife is a recourse rather than a directing factor. The feeling of friendship being professional is in accordance with the findings of a qualitative study in the UK (Walsh, 1999) where 10 multiparous women who had experienced continuity of care expressed their experiences of friendship during their relationships with the midwife. Women in the Icelandic studies of Halldórsdóttir and Karlsdóttir, (1996) and Ólafsdóttir, (1992) also experienced elements of friendship with their midwives.

While the Partnership Model of care focuses on equality as a core concept of the partnership, findings of the study of Freeman et al (2004) indicate that a midwifery partnership can be

achieved with little emphasis put on the need for equality in decision making. This study was also done in New Zealand with 41 hospital and homebirth midwives and 37 primiparas with low obstetric risk; the goal was to examine whether equal power is essential to the perceptions of partnership. Rather than using terms of equality and sharing power, the midwives in her study described partnership as: woman having her own voice, sharing information, working together, feeling comfortable with each other to make decisions co-jointly. The authors suggested that partners could negotiate tasks and responsibilities, each might assume and develop a "shared decision making -"shared endeavour"- concept model", being aware of the differences of background between the midwife and the woman.

Recognizing the study of Thomson et al (1989) as seminal for early development of midwifery theory in the USA, Kennedy (1995, 2000) and her colleagues (Kennedy et al, 2003, Kennedy and Shannon, 2004, Kennedy et al, 2004) have conducted a number of ongoing studies in the United States on the process, outcomes and different aspects of midwifery care. These studies, which will be described below, are being used to structure a research base to develop comprehensive models for theory development in the context of USA. Their findings are in line with ongoing midwifery research in Europe and the partnership model in New Zealand,

In a phenomenological study with 6 women, the relationship with midwives was described as being built on respect, trust and alliance which empowered the women to determine and direct their care (Kennedy, 1995). In a Delphi study of 52 midwives and 61 women, Kennedy (2000) developed a model of exemplary midwifery practice in the USA, supporting the normalcy of pregnancy and birth, vigilance and attention to detail, respecting the uniqueness of the woman with the art of doing "nothing", intervening and using technology only when the individual situation required. This study was one of the included studies of an exploratory meta-synthesis of six qualitative studies using a variety of methods which was done on midwifery care in the USA with participants of women and midwives, altogether 174 (Kennedy et al, 2003). Findings clearly indicated that the practice of midwifery is a "dynamic partnership" that reflects on environmental perspectives with the midwife as an instrument of care and in alliance with the woman. The researchers concluded that, in a country with a standard of highly technical childbirth care, maybe the most outstanding developed concept of the model was that of the midwife as "instrument" of care. An interactive conceptual model

was made representing the continual flow between "taking control and letting go" between the midwife and the woman.

In a narrative study where the narratives of 14 midwives, and 4 women were analysed, three broad themes were identified: 1) the midwife in relationship with the woman, 2) orchestrations of an environment of care and 3) the outcomes of care, called "life journeys", of the midwife and the woman (Kennedy, et al, 2004). Although a variety of relationships between the midwife and the woman was identified it always appeared to be professional with a personal connection, partnership and often friendship.

The concept "presence" has been identified as being essential for women's experience of childbirth, leading to a formation of trusting relationships on women's own terms with a sense of control (Berg et al, 1996, MacKinnon et al, 2005). Siddiqui (1999), identified key elements of the relationship, based on her interviews with midwives in the UK, as: authenticity of being, conscience, commitment, presence, compassion and empathy. She believes that although many of these elements of caring may be applied to other professions they have a particular significance for midwifery values. Other authors' work is in agreement (Lundgren and Dahlberg, 2002, Halldórsdóttir and Karlsdóttir, 1996a, Lundgren, 2004) that in their research draw on phenomenology and aspects of caring encounters between the midwife and the woman.

In a caring relationship, the midwife is required to develop communication skills that span the whole spectrum of interaction which includes receptive and perceptive approaches, shifting from an intense interaction of communication at a very deep level to a masterly inactivity (Siddiqui, 1999). This can be related to how Kennedy (2000) identified one of exemplary practices to be the art of doing "nothing" well and to the concept of "the less we do, the more we give" (Leap, 2000) which involves, checking that all is well, then go into a corner to be quiet and non-directive and with people the woman chooses herself to provide support. The underlying philosophy was according to Leap to promote the empowerment of the woman by: 1. Minimising disturbance, direction, authority and intervention, 2. Maximising the potential for physiology, common sense and instinctive behaviour to prevail, 3. Placing trust in expertise of the childbearing woman, 4. Shifting power to the woman (see later the story of midwife Linda p. 198).

Support and outcome of birth

> "One of the most import and effective things a midwife can do in labour is to ensure that women have constant support" (Page, 2000 p. 113),

A great deal of research has been undertaken on support which has been identified as closely related to the concept of "being with" the woman during birth and its influences on the experience and outcome of birth for the mother and the baby. These studies using quantitative and qualitative methods have been conducted in different countries, places of birth and cultural contexts of maternity care, for example between Europe where midwives most commonly provide care during labour and North-America where nurses, along with doctors, are the main providers of childbirth care.

Bowers (2002) explored in a literature review of 17 qualitative studies conducted in the years 1993-2001. These studies included the experiences of 533 women's support in labour from midwives, nurses and doulas. The cultural background of studies is an important part of how findings are interpreted and it is unfortunately not always well defined or described. However, findings were discussed in relation to how support had physical, emotional and informational aspects had positive effects. The importance of continuous support for positive birth experiences was also identified by Hunter (2002).

Hodnett (2006a) did a systematic review based on 14 randomized trials involving more than 5000 women with the aim of assessing the effects of continuous support during childbirth provided by health care professionals or lay people on mothers and babies. In summary, results showed that continuous presence of a support person had a number of benefits. It reduced the likelihood of medication for pain relief, operative vaginal and caesarean births and a 5 minute Apgar score less than 7 after birth. Positive experience of birth was also in favour of continuous support. Conclusions could not be drawn about the comparative effectiveness of midwives, nurses or lay women at birth and Hodnett suggests that the characteristics of the support person may be less important than considerations of cultural appropriateness and cost. She recommends flexibility in staffing of labour wards with experienced support person (e.g. doulas), including female relatives, and actions towards midwives (and nurses in the USA) spending more time to provide support, in other words on being present at the side of the woman during childbirth.

Another systematic review by Hodnett, and her collueagues (2006) based on 15 trials involving 12,791 women showed that continuous support during birth was associated with greater benefits when it began early in the labour and in settings in which epidural analgesia was not routinely available.

A literature review on 15 quantitative studies on the effects of labour support on mothers, babies and birth outcomes with the selection criteria of randomized controlled trials comparing continuous support during labour with usual care (Sauls, 2002) showed significant positive influences on different outcome measures such as: length of birth, rate of caesarean, use of oxytocins, intact perineum, rate of analgesia, temperature after birth, use of pain relief, episiotomy rate and obstetric intervention. All the studies found evidence of beneficial physical effects of support in labour. Psychological outcomes were also positive. These included attitudes to motherhood and family relationships, higher self esteem and sense of control and being less distressed. The babies were more likely to be breastfed for a longer duration and there were higher levels of maternal-infant attachment behaviours. Individually the studies found varying effects of support on mothers, babies and birth outcomes and not all positive factors were statistically significant.

Furthermore, it was suggested that support in labour has long lasting benefits. Influences on the baby were found to be: higher Apgar score, they were admitted less frequently to intensive care and more likely to be discharged within 48 hours. Sauls (2002) also reviewed four meta-analyses of the effect of labour support which found that it reduced analgesia, lowered the rate of caesarean and operative vaginal births, improved outcomes of babies and provided emotional benefits for mothers.

In studies carried out in North-America it has been shown that intrapartum nurses only used from about 6-12 % of their time in supportive care (McNiven, 1992, Gagnon and Waghorn, 1996, Gagnon et al, 1997, Gale et al, 2001). This has led to the creation of trained support person, the *doula,* whose support has been shown to have strong positive effects on emotional and physical outcomes of labour (Sosa et al, 1980, Klaus et al 1986, Hofmeyer, et al, 1991, Sauls, 2002, Hodnett et al 2002). Randomized controlled trials demonstrate that in hospital characterized by high rates of routine practices, continuous labour support by nurses do not affect the caesarean or other medical or psychological outcomes of birth (Hodnett, et al 2002)

and if the carer is not a member of the hospital staff it seems to have greater benefits (Hodnett et al 2006), which implies that organizational standards, routine practices and a culture of high intervention rate has negative effects on the outcome of continuous support in labour.

Because of underlying cultural issues in maternity care, such as between North- America and the UK there has been debate about the identity and background of support persons at birth, whether or not it is the professional support, trained support or family that lead to positive outcome of birth. In modern maternity care it is, however, of concern to midwifery if trained support persons, such as the doulas, take over the "with woman" role of the midwife, meaning that the midwife is no longer at the side of the woman and she is merely left to supervise the instrumental care of the institution.

Continuity of care

Due to the institutionalisation of birth, the structure of care has become fragmented which lessens the possibility of providing continuous support. Health services in the UK have striven to make changes that have had an influence in other countries, such as Iceland (Ólafsdóttir, 2005). Recommendations to restore continuity of care/er have been made at a national and local level policy, for example in the government policy referred to as "Changing Childbirth" (DOH, 1993) which aimed at providing continuous supportive care in relationship with women.

Thus in the 1990s the phrase continuity of care for development in midwifery was the catch-all phrase for development in midwifery, a necessary solution to many of the problems of midwifery (Page, 2004). Systems were created where midwives followed through the whole system of care of pregnancy, labour and birth and postpartum care, being responsible for and having authority within the medical system to make decisions together with the woman about her care. Page (2004) pointed out the values of the midwife-woman relationship and how it can be empowering for the midwife.

> "I experienced the way this personal relationship motivated me to challenge dogmas and routines because I could see how important it was to the woman and her family. I experienced the authority it gave me in a large busy medical system to know the woman personally. Crucially I experienced the responsibility felt but also the enjoyment of being at the centre with woman during pregnancy and birth" (p. 15).

The importance of knowing the midwife in continuity of care schemes has been considered a fundamental part in establishing relationships with women (Flint, 1991, 1993, Page, 1995). An important component of the different continuity of care schemes is the reassertion of the control over the heart of the practice of midwifery in terms of midwives claiming discrete sphere of knowledge and expertise, legitimated by a desire for a more equal partnership with women in an area where medical care has been criticized, but this has also been seen as a process of professionalism within midwifery (Sandall, 1995).

Continuity has assumed greater significance due to the increasing fragmentation of care; yet it has had "bad press" (Mander, 2001, p. 71). Misunderstandings about what continuity of care and/or carer means have created problems when establishing and evaluating research around issues of continuity in varied organizational forms of midwifery care (Page, 2004).

The program of One-to-One midwifery was established in 1993 to put the principles of "Changing Childbirth" in practice. This included women centred care, with women being involved in making informed decisions about their care in a midwifery relationship of trust developed over time with a focus on continuity of carer (Page, 2003). This differs from an approach taken by a number of other services for midwives working together in groups, for example called team midwifery or midwife led care (Mander, 2001). The One-to-One service aimed at responding sensitively to the individual needs of the woman, her family and the local community, enabling a positive professional relationship between women and their midwives. This was accepted as a fundamental aspect of the pattern of practice, essential to more sensitive, individual, and personal care. Evaluation of this service showed higher levels of satisfaction and confidence, stronger perceptions of personal control and of the role and responsibility of midwives (McCourt et al, 1998). Satisfaction with care was related to a high level of constant support in labour which again can be associated with reduction of epidural analgesia and a shorter second stage of labour (Page et al, 1999). Evaluative cohort studies have also shown lower intervention rates, lower rate of epidural and analgesia, episiotomy, operative delivery and caesarean rate (Page, 2003).

Evaluations of different forms of continuity of care projects that have been created in the UK and elsewhere, have also shown that responses of women indicate greater satisfaction and more positive responses to the experience of pregnancy and birth and maternity of care.

Clinical outcomes in general indicate increased likelihood of normal birth and reductions in the intervention rate (e.g. Flint, 1989, 1991, McCourt and Page 1996, Page et al, 1999, Green et al. 1998, Reid, 2002, Benjamin Y, 2001). What these studies have achieved, is to distinguish and show that continuity has benefits compared with routine fragmented care of multidisciplinary carers (Mander, 2001).

However, it has not been made clear whether these are due to greater continuity of care or midwifery care in general (Hodnett, 2006b). This may not be a surprising finding as the term continuity is inadequate to describe the complexity of what happens in a reciprocal relationship between midwives and women. Therefore and because of lack of conceptual clarity, reviews of continuity of care programmes in midwifery have demonstrated continuing controversies (Page, 2004). This needs to be taken into account and clarified in future evaluation studies of practice development in midwifery.

Underlying the continuity of carer ideology is the relationship between the midwife and women. Yet, in a Swedish study the identity of the midwife or the continuity of carer was not considered the prime concern (Waldenström, 1998) but rather the environment and nature of care. This can be linked to other important elements of continuity of care that have been identified in the literature such as making explicit the implementation of common philosophy of care and consistency in support, advice and information giving (Mander, 2001) based on midwifery ideology and philosophy of care.

Green et al (1998) concluded in their review on midwifery services that attendance in labour by a known midwife should not be the main determinant of a service. While they admit that it was difficult to draw these conclusions because of the many features of a midwifery service, they claimed that even though women's experience of having a known intrapartum carer were positive, the majority of other women who did not have continuity of care, did not see it as important. Their arguments are in line with conclusions of reviews of Waldenström (1998) and Mander (2001) who claimed that it was clearly the care and the shared philosophy underpinning that care that mattered more to the childbearing woman than knowing the individual carer.

However, Page (2004) claims that these conclusions are biased as syntheses were not drawn from similar services and that in regard to one-to-one care they were flawed because the reviewed studies were not aimed at continuity of carer, but rather continuity of care and in some case midwifery led care without continuity. Neither do these interpretations take into account cultural differences nor how social structures and narratives have an influence on women's views. Furthermore, it must be pointed out that if women do not expect or have not had the experience of having a known midwife during birth then they are not as likely to sense the importance of knowing the midwife.

It is equally important for the midwife to know the woman as it may prove fruitful for service development. The findings of the study by Stevens (2003) made clear in a one-to-one practice, the midwives' "knowing" the mother would deepen over time, continuing into subsequent "maternity care episodes" (p. 308) which meant having clinical, social and psychological knowledge about the mother. The benefits of this kind of knowledge became transparent and held important implications for midwives and their practice in the sense that reciprocal relationships help sustainability of work in terms of high levels of job satisfaction and of less burnout (Sandall, 1997, Stevens and McCourt, 2002).

Underlying innovations to promote different types of continuity in midwifery care is the idea of allowing the midwife and the woman to know each other in order to facilitate support and mutuality in a continuous relationship; research findings reveal that the quality of the relationship improves outcomes of births and has emotionally positive effects, for both midwives and women.

Central concepts of midwifery relationships – a growing body of knowledge

There is abundant evidence to show that midwifery support and relationships with the woman during birth have positive effects on emotional and physical outcomes of birth. Even though there is a growing body of knowledge about the different aspects and central concepts of the "unique" midwife- with- woman relationship being at the heart of midwifery practice, midwives have just begun to address the matter through research.

There are hints as to why this relationship is "unique" and how it may differ from other health care relationships. Leap (2000) suggested that the midwife-woman relationship is intrinsically

different from other health care relationships in that it is one of the few fields where a health carer works with clients through a life event, a rite of passage. Page (2003) has expressed her view that much of the success of the One-to-One project of continuity of carer, lies in the strong focus on the relationship. Wilkins (2000) considers the relationship between women and their community midwives to be "special" and important in itself, in fact extending beyond being professional. Elsewhere (Siddqui, 1999), it has been identified as therapeutic relationship, that develops between the woman and the midwife, suggesting that it is the act of caring, essential part of midwifery, providing the basis of midwifery practice and knowledge.

A synthesis of results of 4 selected qualitative studies (Lundgren, 2004) about women's and midwives' experiences of the encounter during childbirth were conceptualized under the heading of "releasing and relieving encounters". These concepts added a deeper meaning to the interactions but they do require further exploration. These variations from terms that are commonly used about interactions between midwives and women emerged in Lundgren's synthesis and they mean that the woman has to look at the encounter within herself as well as with the midwife. The midwife must in turn pay attention to the woman and her development of trust in her own capacity, her feelings of control and her limits and ability, for example with regard to receiving medical pain relief during birth. This links to the notion of reciprocity being an essential part of the relationship (Fleming, 1998) which means that the woman will let know if her limits are reached and that the midwife will ease or help when that happens. These ideas of reciprocity and the model of interdependence by Fleming were applied to the findings of a study by Hallgrímson and Ólafsdóttir, (2004) on the effects of midwifery intervention and women's position on perineal outcome. There it was found that the self-selected position by the woman had significant positive impact, while encouragement to push had negative effects. The authors suggested that the reciprocal relationship and the midwives' reflexivity in sensing the woman's need to choose her own position to give birth were fundamental in their effective midwifery care and that this constituted an important part of the art of midwifery.

The midwife is then in a role of anchored companion offering a trusting relationship (Lundgren and Dahlberg, 2002, Lundgren, 2004). In line with the partnership models of birth, the balance of power is negotiated and mutually agreed and shared through information, through decision-making and through recognizing and enhancing each woman's sense of

control (Pairman, 2006). Lindgren (2004) maintained that this kind of process could constitute as one of the unique elements that need to be explored further within the contemporary paradigm of midwifery as it shifts according to social and cultural changes of childbirth.

> "A sharing of responsibility between midwives and women, and own participation for women is crucial for this process, and may be understood as a unique feature which differs form other caring encounters" (Lindgren, 2004 p. 373)

In the dominant medical system of maternity of care where "normal" has been defined only for those births which fall within certain parameters of the protocols of standard care (Davis-Floyd and Davis, 1997), midwives' belief in normality of birth can be looked at as being "unique", or maybe absurd. However, there is an urgent need to normalize the uniqueness which "must be understood in the context of techno medical pathologization of that uniqueness" (p. 336).

Halldórsdóttir and Karlsdóttir (1996) identified four major categories of the experience of birth as a journey in their Icelandic study about experiences of birth, 1) before the journey, focusing on the circumstances and expectations 2) sense of self during the journey, which encompasses being in a private world, in control, in need for caring and understanding and for a sense of security, 3) in the journey itself, travelling through labour and delivery and 4) at the journey end, including the first sensitive hours of motherhood and the perception of the uniqueness of birth as a life experience. The needs for caring consisted of: companionship and assistance in good relationship with the midwife including different aspects of kindness, reassurance and support as well as connection and involvement. These concepts of caring relationships can all be related to the spiritual side of midwifery which will be explored in chapter nine with reference to the midwives' stories. What is this spiritual side of midwifery and how strong and important is it?

Mavis Kirkham (2000) pointed out in her edited seminal book *The Midwife-Mother Relationship*, the first book published on this topic, that midwifery is conducted in and through the relationship between the midwife and the woman. Therefore it may seem odd that it is not until recent years that midwives have begun to identify in a formal way the nature of midwifery relationships and models of care. However, midwifery as a discipline is young, and central concepts of the relationship between midwives and the woman are examples of

practice knowledge that has been hidden for ages and taken for granted until know when there is a growing scholarship around these issues.

It is apparent from the midwifery literature that different terminology of central concepts is used across studies depending on the cultural background of the authors, their methodology and way of writing. Familiar terms and concepts identified in the literature are descriptive and still relatively under-developed, but associated with ideologies of midwifery. They show how midwives all around the world think alike and phrase and aim their interaction with women. Examples of common terms and phrases are: woman centred care, presence, trust, continuous support, equality, sharing power and responsibility, empowerment, partnership, reciprocity, mutuality, alliance, joint decision making, responding to and respecting woman's wishes.

A universal knowledge base is developing within midwifery research about the nature of the midwife - with - woman relationship and midwifery models of care. In general, midwifery models that have been identified, have many similarities, but also some differences, especially regarding the complex power imbalance; positive and negative experiences; interpretations and definitions of equality and shared responsibility between the midwife and the woman. This will be discussed further in relation to the study findings in chapter eight and ten.

Chapter Five: Methodology, Relating Theories to Methods

In this chapter the theoretical background of the study will be described. Thinking methodologically is theorizing about how we find things out and about the relationship between the process and product of research (Letherby, 2003). Ethnography is mind work; not only a set of techniques for looking, but as ways of seeing (Wolcott, 1999) and the ethnography of the narrative approach will be used to explain my thinking. It is my understanding of ethnographic methods that they are not far from the approach we use in everyday life to make sense of our world. However, as a researcher I use systematic methods to produce knowledge, employing interview techniques as the major aspect of fieldwork, experiencing, enquiring by means of midwives' birth stories. Bearing in mind that I must be aware of myself as "a location" (see chapter two my own story of being a midwife and the head of midwifery studies in Iceland), I will try to ensure the accountability or at least the transparency of my interpretations (Kristmundsdottir, 2006), of the narratives I chose to present when describing my own midwifery culture. This validity issue will be pointed out throughout the thesis, when relevant.

Ethnographic Qualitative Narrative Research

Ethnography is a type of research method used by social and cultural anthropologists, but there is no single paradigm in ethnography but a diversity of approaches. Data is collected in an unstructured way to learn about views, meanings and functions of the informants (Hammersley, 1989, Wolcott, 1999). This involves immersion in a culture over a period of years which leads to the production of ethnographies or conceptually derived descriptions of whole cultures, focusing on how people communicate (Silverman, 1993).

Narrative research is here defined as a subset of qualitative design in which stories are used to describe human actions (Polkinghorne, 1995). Qualitative researchers employ those stories and narratives with a variety of meanings and theories. This research is concerned with a midwifery narrative which is more than a single story (Emden, 1998). The methodological approaches of this study are clarified and defined in the following sections and in the method chapter. In the concluding chapter further developments of narrative methodologies and use of birth stories in midwifery are discussed.

Definitions of narratives and narrative analysis

In the context of this narrative research narrative is a type of discourse composition that draws together diverse events, happenings, and actions of human lives, configured into a temporal unity be means of a thematically organized plot (Polkinghorne, 1995, Kvale, 1996). The plot is defined as "a type of conceptional scheme by which a contextual meaning of individual events can be displayed" (Polkinghorne, 1995, p. 7). The notion of plot in relation to midwifery narratives will be discussed further in chapter ten in relations to discussions about the core narrative of this study.

Narrative research can be defined as a hermeneutic project in itself because by narration we structure our interpretations of the world, meaning that narration is the core of understanding (Wiklund et al, 2002). The analytic development of a narrative from the data or the different stories of the midwives involves recursive movement to an emerging thematic plot, an evolving plot that serves to configure the data into a coherent narrative. This follows the principles that contributes to the creation of the narrative and involves the to-and-fro movement from parts to whole, thereby testing beginning attempts with the data, identifying what items should be included or not in the final storied account (see further about development of narrative findings p. 94-95). The final story should fit the data but at the same time bring order and meaning that is not apparent right away. The move to narrative configuration should extract a higher order than from every day's experience (story) of each midwife in her working life that could be a paradigm narrative or a core narrative of midwifery practices. The roles of these kinds of narratives will be explored in the concluding discussions in chapter eleven and twelve.

Narration is a creative process in which the narrator and the reality is reborn (Frid et al, 2000) which makes every story a new one depending on when it is told and what is remembered to be important at that time. The plot shifts and the story could even have a new ending. Keeping in mind what Mishler (1995) noted that "all factors of memories, motive, and context influence what they include in their accounts or stories. Which are necessarily and irremediably selective and incomplete" (p. 96), it is challenging to use birth stories in order to identify midwifery knowledge and epistemologies even though one could question if this is a

good way of doing research as stories are always changing but knowledge and truth are not static either.

However, the truth of the story told is not the primary issue, as the meaning the midwives convey, their explanatory conclusions and evaluations is what matters. At the same time it is important to be aware that interpretations can be different depending on whom the reader or listener is (Riessman, 1993). The same story of the same events can also be told in different ways from different points of view by the midwife, the woman, the father, the doctor, the grandmother, the sister and so on. One can say that the difference between the story and the narrative is that; it is the way the story is told that constitutes the narrative at the particular moment it is told or written; an example is the narratives presented in this study.

The narrative analysis and my research interest as it has evolved through the research process have been a guide for literature research. The outcome of the narrative analysis is the story where the researcher searches for pieces of information that contribute to the construction of a narrative that provides an explanatory answer (Polkinghorne, 1995). The following are working questions that have been underlying the research process: What stories do I hear and find? What are they about? What is the point and what is the outcome? What do they represent? What is the impact of the stories? In what stories am I and midwives in Iceland? What stories attract and what stores distract and why?

Types of narrative analysis methods

Polkinghorne (1995) identified two types of narrative research methods. The first one is the analysis of narratives and traditional logical-scientific mode of knowing which relates to positivist knowledge called paradigmatic cognition. The second, narrative analysis and the storied knowing refer to narrative cognition, and relates to the experiential, emotional knowledge (Denzin, 1997, Silverman, 2001).

The analysis of narratives collects storied accounts for its data which results in themes that hold across stories and characters or settings, identified in groups or categories. This type can be related to thematic analysis of qualitative research in general (DeSantis and Ugarriza, 2000). On the other hand the narrative analysis collects descriptions of events, happenings and actions which are synthesized or configured by means of a plot into a story of stories

(Polkinghorne, 1995). This form, Denzin (1997) modifies and calls the analytic or storied approach to narratives. It embraces experimental, experiential, and critical readings that are always incomplete, personal, self-reflexive, and resistant to totalizing theories. This understanding requires a move away from narrative methodology based on positivist thinking defined as "complete and accurate and representative of the larger population of text from which it is drawn" (p. 241). The above types are concerned with stories and even though this study identifies with the second one, in my mind they overlap and they are used intermittently as analysis strategies, as will be described in the following chapter about methods and procedures (see pp. 89-94).

People lead storied lives and tell stories of those lives and in narrative inquiry, researchers describe such lives, collect and tell stories of them and write narratives of experiences (Clandinin, 1992). The challenge is not to de-contextualize and reduce experience into categories, but to construct a structure through which experience can be most meaningfully communicated (Johns, 2002). Thus, in this study the goal was to present the midwives' birth stories as much as possible as a whole and in relation to fragments of stories and the literature to provide a context for understanding experiences allowing stories of midwives to speak for themselves.

Mishler (1995) proposed a typology of three models about central tasks for narrative research that allows comparing aims and methods of the different approaches; these are:
1) Reference and temporal order: The "telling" and the "told", 2) Textual coherence and structure, Narrative strategies, 3) Narrative functions: Context and consequences.

The first one, *Reference and temporal order: The "telling" and the "told",* is about the principle of temporal ordering that gives the narratives its distinctive character as one form of discourse. In the analysis, the researcher reconstructs the "told from the telling" or makes "a telling from the told" and this becomes the narrative for further analysis.

The second one *The textual coherence and structure, Narrative strategies,* is about defining features and the focus is on how narratives are constructed and on different sources of language and how it is used or formed to create a meaning, relating to linguistic and narrative strategies.

The third one *Narrative functions: Context and consequences* is about the work stories do and their effects on the settings in which they are produced, what purposes they fulfil and what functions they have for the storytellers themselves, their audiences and their larger communities.

In this study the third model was used as I was most interested in storytelling and exploring the hidden knowledge in birth stories of midwives, their functions in developments of knowledge and skills in midwifery practice. My interest also centred on the conflicting social narratives referring to different models of care, birth stories around us, which influence our views about childbirth care. My type of narrative analysis works

> "upward and outward from the concrete to the larger set of meanings that operate in a particular context, these contexts interpretive practices are connected to systems of cultural discourse" (Denzin, 1997, p. 247),

in relation to place of birth, medicine and midwifery, but also gender, women and their families. Those are structured by narrative history woven through interpretation of the past and its representations, locating experts to verify authentic accounts, i.e. the midwives of this study, myself as the researcher included.

Midwifery Knowledge, Feminist Theories and Research

Conventional ethnography has been criticized by feminists for capturing surface appearance and being concerned with documenting current patterns of events and description rather than being directed towards bringing emancipation (Hemmersly, 1998) as is the goal of feminist research. This type of critical ethnography tries to understand what is wrong in order to promote changes (Wolcott, 1999).

All research occurs within a society, and social beliefs, ideologies, traditions and structures have impact on knowledge in multiple ways (Hesse-Biber et al, 2004) such as by gender and feminist issues. It has also been claimed that the status of midwives reflects the status of women in society (Thompson, 1997). Therefore, and as nearly all midwives are women (all in Iceland), it is relevant to look in the direction of feminist concepts and theories to help us understand social and cultural influences on midwifery knowledge and practice.

Feminism is difficult to define and has manifold qualities and a wide range of approaches to explore characteristics rather than a concise central core (Beasly, 1999). There is multiple feminism, not just one (Hesse-Biber et al, 2004). This discussion is not intended to be an overview of feminist methodologies but to select ideas to draw from that are relevant to the methodology of this study.

Feminist theories have been acknowledged since in the 1970s and early on, feminist scholars began to criticize the medical management of pregnancy and birth (Simonds, 2002). Such theories offer explanations about the socialization of women, using different approaches, with regard to how and why women have less power than men and how this imbalance can be challenged and transformed (Squire, 2003). Foucault (1975, cited by Kent, 2000) identified this relation of power and knowledge as bio-power, grounded in gender. A Foucauldian analysis enables us to see the development of male obstetrics as a way of extending control over and controlling female pregnant bodies (Kent, 2000).Thus, history of midwives is integrated with the story of women's power imbalance which can also be related to the status of midwifery knowledge and its inequality compared to dominant medical knowledge.

Feminist knowing must start from a woman's life and her understanding and experience to create knowledge (Smith 1987). By using auto/biographical methods, one starts from the aim of making a social and cultural sense in understanding and locating oneself in social structures. Furthermore, from this, to extrapolate to understand and respect the experiences and feelings of others (Letherby, 2003), acknowledging that women are different within and between cultural groups (Moore, 1993). This trend in feminist methodology which can be linked with the subject's first accounts of the pioneer women anthropologists can be radical, as it was and they were, before their time, in carving a space within a dominant positivist paradigm, a female subjective anecdotal rather than the male objective explanatory mode (Wisweswaran, 2003). This methodology could fit midwifery in developing a body of knowledge of new midwifery within the academia.

Standpoint theory within post modern feminism starts research with the lives of marginalized people and critically focuses on the relationship between politics and knowledge which is produced for marginalized groups that need emancipation (Hesse-Biber, et al 2004). Similarly,

this study starts with the marginalized knowledge of midwifery with a female orientation. Standpoint theory also examines the lives of the dominant groups and how they maintain a hierarchical power relation (Harding, 2004, Hesse-Biber et al, 2004) which in this case links to the dominant knowledge of medicine which has been male oriented. Their type of knowledge and research is a form of domination which enables dominant groups to exercise more effective control (Hammersly, 1998).

Critical research of this kind is important because otherwise the threat is that the voices of particular forms of knowledge such as midwifery may be drowned out, systematically silenced or misunderstood (Edwards and Ribbens, 1998), particularly when dominant academic disciplines have control of academic, public and political discourse within organizations and in the media. Examples of this are when midwives use their knowledge to fight with "traditional" dominant medical knowledge and research methods such as RCTs (randomized controlled trials) being the golden and the "right" method to provide evidence, upon which to base innovations in maternity services such as: continuity of carer practices and free standing birth centres and/or maintaining homebirth practices, small scale and rural places of birth.

Medicalization of childbirth in the 20th century is a result of the re-conceptualization of pregnancy as a biomedical instead of a social model. Central to feminist analysis of power and patriarchy is the loss of control by women over the birth process (Kaufert and O'Neil, 1993). This is in part a result of the acceptance by women themselves, based on individual experience. Kent (2000) pointed out that experience is discursive and that it can be difficult to use that experience to explain the world for example using methods based on essential phenomenology. It is the experience itself that needs explaining by social structures and influences.

Individual experiences do not take into account the dominant social structures and interactive factors which influence understandings of culture of childbirth. The dominance of such social processes has, however, been discussed and resisted by feminist activists, sociologists and anthropologists of childbirth (e.g. Rothman, 1982, Kitzinger, 1988, Jordan, 1993, Oakley, 1993, Davis-Floyd and Sargent, 1997, Teijlingen et al, 2004).

Social constructivists focus on the social and cultural processes that shape men and women as being socially produced rather than being naturally or biologically determined (Kent, 2000). Woman's experience of hearing a birth story about natural childbirth may afterwards construct her views and expectations about her future births differently. At the same time, other views concerning medical models of birth can conversely shape her expectations and experiences. Thus, the root of women's criticism differs based on their ideologies and traditions. It can be the belief in power of technology to preserve life and conversely lack of it to cause death, and/or the philosophy of birth as a natural process. Midwives' place in society is affected by social structures and cultural ideas about pregnancy and childbirth; therefore midwives, based on their relationships with women, do not care for all women alike.

In this sense, dualism and dichotomous thinking has divided men/woman along opposing lines, such as of the body/mind or matter/spirit and the relationships between the two pose fundamental questions (Williams, 1975 cited by Jordanova, 1997). It has been maintained in post-structural feminist lines of argument that duality can become more slaving than liberating, that it forces oversimplification and acceptance of one or the other view with people manifesting themselves at the different ends of the pole (Annandale and Clarke, 1996). Haraway, (2003) also considers feminists being trapped between these poles of dichotomy because all inside-outside boundaries in knowledge are theorized as power moves, but not towards truth or knowledge which is situated in-between.

These conflicts appear in the writings of Annandale and Clarke (1996) who criticized the line of demarcation they draw from the literature about the polarization between obstetrics and midwifery, referring to the notion that the alternative model female/midwifery to the dominant male/medical is better, with little understanding of the fact that many women may not be in a position to make the better choice even if they wanted to. They contended that there has been silence around the difference of women and that some women might feel liberated by technology of birth.

This is in accordance to how authors have questioned and criticised that medical models of care have been viewed as a masculine domain because women have themselves been agents in shaping the obstetrics and reproductive technologies, both having gained and lost in the process (Riessman, 1992), for example in relation to medical pain relief methods during birth.

By ignoring women's agency in the medicalization process, scholars only perpetuate the kinds of assumptions about women that feminists have tried to challenge, rendering them passive and subordinate (Riessman, 1992). Added to this, it has been suggested that medicalization cannot proceed unless cooperative population exists (Van Hollen, 2003) which is, however, exactly what disciplinary power requires and the main concern then is the methods that health professionals doctors and midwives use to gain that cooperation (Fahy, 2002).

In a particular context of dominant medical knowledge systems and social changes of place of birth, midwifery has been developing redefining its role towards "a new midwifery". Annandale and Clarke (1996) in their critics on this process say that midwifery defines itself by engaging "the dichotomies of biomedicine to develop its own narrative" (p. 29) and that within this opposing framework, midwifery is "revealed only as the largely un-researched antithesis of obstetrics" (p. 30). This kind of writing could be an example of the implicit power that is embedded in medical discourse of society, which in turn becomes a mechanism to facilitate medicalization of birth (Barker, 1989). Annandale and Clark (1996) paradoxically seem to, as Campell and Porter (1997) state in their response to their article, privilege experience of individual subjects over the social process by which subjectivity is shaped and their approach seems to "undermine feminist midwifery and bolster masculine obstetrics" (p. 356). Talking down to midwifery and insinuating that midwifery has "little or nothing to offer on its own terms" (Campell and Porter, 1997 p. 348) shows the marginal position in which midwifery sometimes finds itself, also within the academia of feminism. Nevertheless, feminist perspectives and conceptualization of power and knowledge can be useful to understand why midwives' ways of knowing has not had the power to be authoritative in childbirth care.

Belenky et al (1986, 1997) as other feminist writers (e.g. Harding, 1987a, 1987b, Ribbens and Edwards, 1998; Hesse-Biber et al, 2004) believe that conceptions of knowledge and "universal truths" that are accepted and articulated today have been shaped throughout history by the male-dominated majority culture. Similarly, in midwifery, "Midwives by virtue of professional status and expertise hold the potential of power over women" (Page, 2004, p. 29), however, if they are able to work in the best interest of or for the woman, both become empowered. It is working for the woman by knowing her and responding to her needs that authorizes the midwife this kind of relationship (Page, 2004). This relationship has been

described as partnership and was discussed in the chapter before. Midwifery is a feminist issue and potentials for empowerment of women in general, through their birth experiences can not be overlooked (Pairman, 2006). Nothing could be more feminist than the practice of midwifery with the most potent lesson of childbirth being the revelation of essential feminine force (Davis, 2004).

In this study I choose to hear the "in-between" different valid viewpoints that become apparent in narrative knowledge of midwifery. Narrative knowledge as described by Lyotard, (1984, p. 20) are the "popular" stories that could be called

> "positive and negative apprenticeships (Bildungen): in other words, the successes and failures greeting the hero's undertakings. These successes or failures either bestow legitimacy upon social institutions (the function of myths), or represent positive or negative models (the successful or unsuccessful hero) of integration into established institutions (legends and tales). Thus the narratives allow society in which they are told, on the one hand, to define it's criteria of competence and, on the other, to evaluate according to those criteria, what is performed or can be performed within it".

Thus developing new authentic knowledge in midwifery practice with diversity of opinions, where dualisms of universal truth in line with positivist scientific knowledge might give way to multiplicity of truths that can be both positivist as well as subjective based on the situational context of the childbearing woman and her family. By examining basic assumptions of older academic disciplines such as the dominant medicine new conclusions could be drawn.

The groundbreaking book *Women's ways of knowing* by Belenky et al (1997 [1986]) was based on 135 in depth interviews with women about their experience and problems as learners and knower. The five major epistemological categories that they identified were successive levels of silence, received knowledge, subjective knowledge, procedural knowledge and constructed knowledge. Their work about these perspectives from which women view reality and draw conclusions about truth, knowledge and authority has been given a key place in discussions of feminist epistemology and it has been valuable in informing the findings of this study about midwives' ways of knowing around the time of childbirth, as will be described in chapter eleven.

Wiswewaran (2003) claimed that first person narratives could be a strategy for self-discovery, which is in line with the research methods of this study, a "self-discovery" for midwifery, where midwives make sense of their working life through birth stories within the cultural and social structure of childbirth and midwifery care. I argue, that as the texture of everyday life from which feminism at all times flows (Kristmundsdóttir, 1997), so does midwifery, and that while using birth stories to describe midwifery knowledge I endeavour to do so without colouring their stories with the "shades of other political isms" meaning that midwifery knowledge "echoes the fundamental content of feminism i.e. that feminism and its advocates, women, be taken for what they are rather than reflection of something else" (Kristmundsdóttir, 1997 p. 236).

New academic disciplines such as midwifery have to develop their own body of knowledge, and one way is looking at birth stories, which provide a context for understanding what midwifery is. This way is a step in identifying epistemologies, which underpin midwifery practice and childbirth care, uncovering and developing authoritative knowledge that counts and has the ability to influence health care and social activity around childbirth.

Based on her anthropological research, Jordan (1997) wrote about the notion of authoritative knowledge and claimed that in any particular domain several knowledge systems exist but some carry more weight than others, either because they explain the state of things better for the purposes at hand, or because they are associated with a stronger power base, usually both. In line with a feminist approach, of changing who can be a knower and what can be known (Harding, 1987b, Hesse-Biber, et al, 2004), one could say that the knowledge system of midwifery, which is a women's profession and less powerful than the male orientated mainstream knowledge of medicine, needs emancipation.

Authoritative Knowledge and Narratives

Through history, birth stories and midwifery narratives present complex social and experiential knowledge. Such knowledge has not been presented or worked on in a scientific way. It is not authoritative in that it lacks power relative to simplified and currently dominant narratives of birth as something to be feared and rendered safe by experts with technology.

Yet, sharing an experience, told in a story can be strengthening (Kirkham, 1997) and entering the relations of storytelling is empowering for persons, relationships, and communities (Frank, 2000). One of the main social functioning of narratives is maintaining social ties (Kvale, 1996).

Frank (2000) wrote that stories are more than "data for analysis" in that storytellers call for other stories in which experience is shared, commonalities discovered and relationships built. In the Western world, midwives all around the world have "shared experiences", written diaries and books to document their work and to inform other midwives, students and prospective mothers (e.g. Björnsdottir, 1929; Gaskin, 1975, 2003, Armstrong and Fieldman, 1986, O'Connor, 1995, van Olphen-Fehr, 1998). Some were written as early as the seventeenth or eighteenth century, and republication makes their midwifery knowledge available today (Schrader, 1987, Ulrich, 1991, Höjberg, 1995).

In recent years in addition to Iceland (Ingadóttir, et al, 2002), in other countries such as in Australia (Vernon, 2005), UK (Wolf, 2001; Beech and Phipps, 2004) stories about birth experiences have been published which can give childbirth carers insight into what women want, relating how they think about birth but at the same time criticizing the medical health system.

When put into writing, stories from experience surpass oral history and provide sociological insight, strengthening and shaping professional identity (Hulst and Teijlingen (2001). Books that have been useful for developing collective identity of midwives have been published drawing on oral history of midwives in Iceland, including genealogy and descriptions of history and professional development and occupational rights of midwives (Einarsdóttir, 1984, Þórarinsdóttir, 1984, Sigurðardóttir, 1984) also the books about memories of their work and other people's stories of them, their place in the community with people around the time of childbirth (Víkingur, 1962-1964). These biographies and descriptions about organizational changes and ideologies through history provide important insights into the background of midwives and their ideologies and knowledge even though this kind of work lacks analysis, especially of their midwifery work. What stands out is the heroic image of the midwife and often the father or the doctor, travelling in all kinds of weather using all kinds of transport, to the woman or with the woman to seek further help. Many stories like this were told in this

study that referred strongly to this heroic culture of midwifery care and knowing, which at that time was authentic or dependable, but has changed in the last 50 years.

One night there is knocking on the door, and the father is there to "pick me up" to go to this woman. There is a huge snowstorm and he came on a tractor ...and I said "why did she not call me?" then they had forgotten to connect the phone line, this was not more secure than that [laughs]. Nothing happened [went wrong] I was there in good time, this was a long way into the Valley, when I went there I had to use all kinds of transport...I remember one birth in the 1950s, you had to go over a river, and carry things over and I went on a horse.
(Midwife-Hanna, 48 years' experience, interview 7)

The paradox is that when communications have improved (for example, new roads built that are kept open all year or emergency flights quickly organized), birthplaces close down. Difficulties in transport and communications in the context of Iceland, might after all, sometimes be the strongest risk factor of childbirth.

I think it is crazy that women have to travel from their hometowns [to have a baby] ...
It does not take such a long time to transfer if needed. It is in very few cases that you have to transfer and you have the time if something comes up. I think this is just – I am used to all kinds of situations, with women on the way in difficult conditions [because of snowstorms], if you compare it to how transportation is know... It is strange to think about it; today the transportation is much better than 20 years ago when the roads were cleared off snow once a week. Now it is done often every day. There has been great change. Now I wake up on Sunday mornings at seven o'clock as they run through, even though there is no snow, or whatever. And now everybody has a mobile in the pocket and you can phone for help.
(Midwife-Hanna, 48 years' experience, interview 7)

Similarly, books on studies of midwifery have been published in the UK about past practice of midwifery (Leap and Hunter, 1993, Marland, 1993, Reid, 2000) that portray cultural backgrounds of midwifery work and knowledge in the community with the woman and her family before and after the time of hospital birth and professional midwifery (Hunt and Symonds, 1995).

In other writings midwives and others in different countries have given an overview of and set the scene of what has or is happening and challenging in midwifery practice and maternity services (e.g. Kitzinger, 1988, Marland, et al, 1997, Devries, et al, 2001). That again has given information about global midwifery which brings us back to traditional midwives who until the introduction of Western medicine were the main source of knowledge, with a spiritual authorization to help and support women giving birth. Cultural studies have been conducted in

developing countries which give us insight into this traditional way of knowing in midwifery (e.g. Jordan, 1993, Vincent-Priya, 1991, Sargent and Bascope, 1997, Pigg, 1997, Comerasamy, 2001, Van Hollen, 2003, Maimbolwa, et. al, 2003). These constitute epistemological knowing in midwifery that have been influenced by Western medicine, but would be interesting to explore further in relation to modern midwifery knowledge and its social and cultural structure, but that is a story to be told in another time and place.

Different disciplines construct different narratives following different set of rules for what counts as legitimate statements or discourses, in other words authoritative knowledge. All forms of discourse employ narratives to present their ideas and according to Lyotard (1984) "knowledge is a kind of discourse" (p. 3). But there are different types of narratives and creating and retelling stories are two different actions (Greenhalgh and Hurwitz, 1998). All discourse underlies with values and rhetorical intent. Sometimes conflicting values are transmitted as when, on the one hand, we have repeated narratives by midwives about birth being a normal family event or that breast is best for the baby; on the other hand, we have medical narratives about the risks of birth and the dangers of homebirths or the need for a determined level of infant weight gain which may entail supplementary bottle feeds to breastfed babies.

Society accepts a medicalized view of birth and child development. It is therefore not surprising that such conflicting discourses are seen in the media. A few years back in Iceland (in May 2004), these kinds of narratives appeared on the morning TV, where there was a debate between a paediatrician and a homebirth midwife about the safety and risk of home birth. There, on TV, the debate went on for two days in a row, a story about the same events was told in different ways by different people, representing diverse competing views or models of care, the medical versus the midwifery. The medical narrative referred to many stories about the danger of homebirth and how all women should give birth in a high technology hospital because of the risk. The midwifery narrative, on the other hand, was about the childbirth being a normal life event where the woman has the right to an informed choice of place of birth, homebirth included.

This kind of debate can be linked to how Foucault wrote about disciplinary power which can be difficult to detect as it requires cooperation and first becomes visible when resistance is

met. Central concerns of his were about the role of practice professions and their corresponding institutions such as hospitals, which cooperate to gain power (Foucault, 1979 cited by Fahy, 2002). This can be applied to how midwives' stories can make visible and serve as rhetoric resistance and to how some women resist giving birth in hospital and want to have home birth where they are in control and are not under the disciplinary power of the medical or institution models of care. Yet it is apparent that women differ and have different views on childbirth influenced by the society we live in. Childbirth care is a political issue which evokes very strong feelings so childbearing women are often subjected to unasked for advice and judgements for example about choices of place of birth. Authoritative knowledge has also been defined as: "...the knowledge that participants agree counts in a particular situation that *they* see as consequential, on the basis of which *they* make decisions and provide justifications for causes of action" (Jordan (1997 p. 58). The question is; on what knowledge or a type of knowledge systems is the justification based?

Epistemological and Theoretical Considerations

This study started openly with a collection of birth stories of midwives without using a theoretical framework, as concepts and theory were to arise inductively from the narrative data. However, no study can be conducted without an underlying theory or an implicit personal model about how things work (Fetterman, 1998). This epistemological position stresses the importance of being aware of how my own views, my "location" shaped the entire research process and how I have striven to be honest about my theoretical presumptions and about my personal impact on the midwives' choice of stories to tell and thereby possibly on the findings of the study. This concerns the design and the validity of the study as will be discussed in the next chapter (see for example pp.77-79).

In practice, I have been using a set of qualitative research strategies, categorizing general concepts or sets of concepts (Hamersley, 1998) and have been trying to reach a level of understanding with movements up a conceptual ladder - mixing and matching patterns and building theory from the ground (Fetterman, 1998) or, in this case, narrative knowledge to use in midwifery research, education and practice. What was very challenging was to put my own previous ideas aside, wait for and look at what ideas emerged from the midwives' stories. The research process unexpectedly led to a focus on diverse aspects of the midwife-with- woman

relationship and inner ways of knowing, as was introduced in the first chapter. How this happened will be explained in the following chapter in relation to development of methods and descriptions of the interview strategies (see pp. 78-85).

Narrative form of theorizing about midwifery

In telling a particular story the midwives of this study, chose components to convey a meaning they intended to be taken from that story (Bailey and Tilley, 2002). They reconstructed and selected events and actions they wanted to express as important, that having had influence on their development of midwifery skills and ways of knowing. Most of this storytelling is done without conscious consideration of all that is tranmitted, but their storytelling reinforces different aspects of their own values (Kirkham, 1997). This constitutes the midwives' frame of reference or the epistemologies of their midwifery practice.

Furthermore, the narratives they used entail parts of midwives' working life which have an underlying implication by a plot which gives a point and evaluation (Polkinghorne, 1995, Emden, 1998, Wengraf, 2001). Thus, the midwives' evaluations that are drawn out in this research can, within a midwifery paradigm, be seen as a step in identifying theoretical foundations of midwifery. The weaving of theoretical hypotheses, interpretations and conclusions into the midwifery narrative as a part of the research findings, is here defined as being a narrative form of theorizing about midwifery. This enables us to look at midwifery work in different contexts and from different perspectives. These issues and how the narratives of this study uncover epistemologies of midwifery will be discussed in the final chapters. How it is imperative to develop further methodologies of narrative research in midwifery in order to find new ways of developing knowledge by identifying new forms of storytelling to advance midwifery practice.

PART II - THIS NARRATIVE STUDY

Chapter six – Methods, data collection and analysis

Narrative research has been in a rapid growth in the last decade and Mishler (1995) stated that the study of narrative is a problem centred area of inquiry with multiplicity and diversity of approaches. In this chapter the research design, the integration of methodology and methods will be described in a reflexive way. Direction of work will be made clear about how and why I have changed strategies as the research design has developed.

Collecting Birth Stories

In this study interviewing has been used as the main method to collect birth stories. Stories were mainly collected from midwives with different backgrounds who have practised midwifery in Iceland from the early 1950s to the present time. It has been established that interviewing is the most widely used technique for conducting systematic social inquiry and to generate empirical data about the social worlds. In this respect interviews are special forms of conversation, a pipeline for transmitting knowledge (Holstein and Gubrium, 1997). Focus groups interviews have been considered invaluable when exploring how knowledge, ideas, story-telling, self-presentation and linguistic exchanges operate in a cultural context (Kitzinger and Barbour, 1999, Wilkinson, 2004). Furthermore, the goal with focus group interviewing is to seek validity of research findings (Bender, 2003).

Interviewing has been a continuing process with analysis periods in between. There have been at least four phases of data gathering with different interview strategies which have developed to encourage different kinds of stories, relating to how the focus of the study shifted and narrowed down. Below is an overview of the interview periods, followed with more detailed explanations of how birth stories were collected and the background of the midwife group.

- The first phase was the piloting period of an open way of interviewing seven midwives who had work experience out in the countryside and the rural areas of Iceland, most of them having practised alone. These interviews were conducted from August 2001 to March 2002.

- The second phase or the next group of interviews, were held through March to December 2004 with 11 midwives with different backgrounds either having practised out in the country or at the Landspitali University Hospital in Reykjavík, some of them having experience from both places of birth. The research interest at that time had gradually moved to explore birth stories of midwives that included narratives about the different elements of midwives' relationships with women with focus on their intuitive knowing and spiritual awareness.

- The third phase was a going back to the field phase, both for validity reasons and to examine and get more birth stories. A focus group interview with six midwives with different backgrounds was held in December 2004 about particular aspects of interest from earlier stories in relation to midwives' relationships with women and their inner ways of knowing.

- The fourth phase was to "thicken" the data and collect stories from a wider representative of homebirth practice of midwives. Therefore, at the final stage of the study in February 2006, two interviews were conducted with homebirth midwives in the Reykjavik area.

- Lastly, birth stories from preliminary interviews with two hospital midwives, which had been recorded as field notes at the Landspitali University in the beginning of the second phase of interviewing, were added to the transcripts.

More birth stories from different sources were written down as field notes: the media, public and personal documents and observations by living and working in the culture, or in "field under study".

This narrative research was conducted in an ethnographic framework and in accordance with my understanding of ethnography methods, I took notice of and was continuously gathering data in my mind (which in a way I am always doing as a dedicated midwifery lecturer and researcher). I wrote notes on pieces of paper, cutting newspapers and magazines and keeping it all in a "safe place" because I thought it might be relevant later or because it could be useful

for the analyzing process and discussions of research findings. Birth stories that I found relevant to use were added to the data of the study, especially from the point of view of women, and some of them are presented in this report (see for example story on p. 40).

The field – backgrounds and access to the midwife group

The first phase of the study was designed in line with one of the aims of the study, i.e. to explore the culture of midwifery practice in Iceland in the context of place of birth. At first, the focus was on the working life of midwives who have practised out in the country, in rural areas of Iceland. The goal was to meet and learn from the experience of midwives with extensive work experience, especially from the older ones who were about to retire, not wanting to lose important knowledge grounded in their midwifery practice of different time and place.

The midwives were all very willing to tell their story. They all had more than 20 years' practice experience out in the country and five of them had worked more than 40 years in the same place of birth. At first, six of them practised homebirth. Later they worked in regional community hospitals where technical facilities needed for emergency interventions were available. They also worked at health centres in the community performing antenatal care. They all graduated from the Midwifery School in Iceland in the years from 1950 to 1979 and only one of them had a nursing education after graduating as a midwife.

In their practice the midwives had been able to offer continuity of care through pregnancy, birth and postnatal care, and utilize their skills with their women in their community. However, in some of the places where the midwives worked, there are no births any more and in these places all women have to travel away from home for about 1 to 3 hours to give birth. In other places the births have become fewer and fewer both because of downfall in population and also because of the tendency to transfer all women to centralized high technology hospitals (see table 1).

Table 1 - The first interviewing phase - backgrounds

Interview	Period	Midwife	Education / years of experience	Place of birth/work experience
1	August 2001	Anna	Midwifery School of Iceland 47 years' experience	Out in the country, home birth and in a health centre
2		Solla	Midwifery School of Iceland 45 years' experience	Out in the country, home birth and in a community hospital
3		Elsa	Midwifery School of Iceland 50 years' experience	Out in the country, home birth and in a community hospital
4		Rosa	Midwifery School of Iceland 25 years' experience	Out in the country, in a community hospital
5		Dora	Midwifery School of Iceland Diploma in Nursing 35 years' experience	Labour ward at the University Hospital. Out in the country, in a community hospital.
6		Rebecca	Midwifery School of Iceland 45 years' experience	Out in the country, in a central referral hospital
7	March 2002	Hanna	Midwifery School of Iceland 48 years' experience	Out in the country, homebirth, in a central referral hospital

In the second interviewing phase, conversations went on with 11 midwives with different backgrounds either having practiced out in the country, at home or at community hospitals or at the biggest central referral hospitals in Reykjavík and Akureyri. In Reykjavik about 3000 births take place per year and in Akureyri there are around 400 births. Thus, even though both places have obstetricians working and technical services at birth, they are different regarding size and in opportunities to provide continuity of care, knowing and being with the woman and her family around childbirth.

This group of midwives had work experience ranging from 2 to 40 years; nearly all of them also have a nursing practice background, trained before or after their midwifery education. Some of the midwives had worked for a time in the different places of birth around the country, but others had only worked at the Landspitali University Hospital on a high technology and busy labour ward (see table 2).

Table 2 - The second interviewing phase – backgrounds

Interview	Period	Midwife	Education / years of experience	Place of birth/work experience
8	March 2004	Bella	Midwifery Education University of Iceland , BSc degree in nursing 6 years' experience	Labour ward at the University Hospital. Out in the country, in a community hospital
9		Gudrun	Midwifery School of Iceland Diploma in nursing 26 years' experience	Labour ward at the University Hospital. Out in the country, in a community hospital. Clinical mentor of students
10		Monica	Midwifery School of Iceland Diploma in nursing 36 years' experience	Out in the country at a community hospital. Labour ward and birth centre at the University Hospital. Clinical mentor of students
11		Eva	Midwifery School of Iceland Diploma in Nursing 28 years' experience	Labour ward and different wards at the University Hospital, birth centre. Clinical mentor of students
12		Sigrid	Midwifery Education University of Iceland, BSc degree in Nursing 6 years' experience	Labour ward at the University Hospital. Out in the country, in a central referral hospital.
13		Kristine	Midwifery Education University of Iceland, BSc degree in Nursing 2 years' experience	Out in the country, in a central referral Hospital
14		Helga	Midwifery School of Iceland 36 years' experience	Labour ward at the University Hospital. Clinical mentor of students
15		Astrid	Midwifery Education University of Iceland, BSc degree in Nursing 3 years' experience	Labour ward at the University Hospital.
16	December 2004	Sara	Midwifery School of Iceland Diploma in Nursing 20 years' experience	Labour ward at the University Hospital. Clinical mentor of students

Four of the midwives are of the younger generation of midwives, educated in the new midwifery educational programme at the University of Iceland (thus, my former students), and the others were educated in the old direct entry Midwifery School of Iceland. Four of the midwives had moved out to the country in recent years, now having about 1-3 years'

experience in a new place of birth, working most of the time alone with their women during birth in calm peaceful surroundings

In the third interviewing phase, I wanted, in a focus group, to gather more information from midwives. The focus group interview was conducted in December 2004. Total of nine midwives were recruited who all wanted to attend, but three had to cancel; one because she was on call and had to attend a birth and the other two because of sickness in the family. Thus, in the end the group included 6 midwives with different backgrounds regarding work experience and education (see table 3).

Table 3 - Focus group interview – backgrounds

Midwives	Education / graduation	Work experience
Midwife 1	Midwifery School of Iceland Diploma in nursing 25 years' experience	Labour ward and birth centre at the University Hospital. Out in the country in a health centre
Midwife 2	Midwifery School of Iceland 29 years experience	Labour ward at the University Hospital.
Midwife 3	Midwifery School of Iceland 29 years' experience	Out in the country at a health centre, labour ward at the University Hospital
Midwife 4	Midwifery School of Iceland, BSc, MSc in nursing 14 years' experience	Out in the country at a central referral hospital and in a health centre. Lecturer in midwifery and nursing
Midwife 5	Diploma in nursing Midwifery School of Iceland 18 years' experience	Labour ward at the university Hospital, health worker in developing countries
Midwife 6	Midwifery School of Iceland 38 years' experience	Labour ward and birth centre at the University Hospital

In the fourth interviewing phase, I wanted to add to the data information from midwives working outside of mainstream maternity services which was gathered in interviews with two experienced midwives that, at different times, were pioneers in homebirth practice in Iceland (see table 4).

Table 4 - The fourth interviewing phase - backgrounds

Interview	Period	Midwife	Education / years of experience	Place of birth/work experience
17	February 2006	Saga	Midwifery School of Iceland 50 years' experience	Labour ward at the University Hospital, birth centre, homebirth.
18	February 2006	Linda	Midwifery School of Iceland Diploma in Nursing 38 years' experience	Labour ward and different wards at the University Hospital. Out in the country, in a central referral hospital, homebirth

Lastly the transcripts of the field note taped interviews with two midwives on an evening shift at the labour ward at the University hospital that were at first used to develop interview strategies, were added to group of one-to-one interviews. This was done because the midwives' stories confirmed and gave rich descriptions in relation to different types of inner knowing in the busy hospital environment (see table 5) in connections with women.

Table 5 - Interview data from field notes – backgrounds

Interview	Period	Midwife	Education / years of experience	Place of birth/work experience
19	June 2004	Ruth	Midwifery School of Iceland Diploma in Nursing 35 years' experience	Labour ward at the University Hospital. Out in the country, in a health centre
20	June 2004	Bjork	Midwifery School of Iceland Diploma in Nursing 30 years' experience	Labour ward and birth centre at the University Hospital. Clinical mentor of students

How midwives were chosen for interviewing

Midwives were chosen by convenience for different reasons. Out in the country there were not many to choose from as usually only one or two midwives work in each place. Travel distance and the ease of finding a way to meet up were also decisive factors. I considered it important for the midwives to have a broad diverse practice experience and background related to place of birth so that they were better able to compare and contrast that experience. Various other factors were also important to keep in mind, such as having different length of practice experience, coming from different schools, being considered experts in their practice and able to break down and reflect on that experience and certainly having stories to tell. Some of the

midwives also had a good reputation as clinical teachers or mentors in practice. Still, it was not so important who the midwives were, as all birth stories could be relevant for the study. Neither could I know in advance if the midwives turned out to be good storytellers or had the natural gift of storytelling. It was therefore a bonus when the midwives were able to let whole stories enfold, sometimes in a very inspiring and touching way that I found helpful on our journey to uncover midwifery knowledge.

How the midwives were approached

All the midwives I contacted, except one, were very happy to talk and describe their working life through storytelling. This one midwife in her humbleness worried about her confidentiality towards her women and said; *"it was their story to tell"*; later she took part in the focus group interview. I approached the midwives by phoning them a few days before the interview and at the same time we decided when to meet. On the phone (based on the interview design that will be described in more detail below), I asked them to think about stories from their practice experience either a joyful or a difficult one, which had made an impact on them and they had learned from or they thought had made a difference for the development of their practice skills. I also prepared the interview by explaining that the interview was to be very informal, like a conversation or a dialogue and that I saw them as co-researchers searching for and identifying midwifery knowledge and skills in practice.

Design and Evaluation of the Narrative Interviews

The narrative interview was designed with one open question aimed at inducing narratives or stories concerned with memorable experiences or critical incidents (Benner, 1984) in midwifery practice with minimal interruptions and in a conversation style. This type of interview or dialogue has been described by Ann Oakley (2005 [1981]) from a feminist point of view, encouraging informal interactions based on equality between the researcher and the informant.

In the beginning of the interview, I addressed my participation in our dialogue by putting forward an introductory letter (see appendix 1b and 1c) about the research and repeating that I looked at the midwives as co-researchers, pointing out that in our dialogue I wanted us to exchange midwifery knowledge. Based on their storytelling, their practice experience and

their views of social and cultural influences and on a professional level, we discussed developments in midwifery in an Icelandic context.

The interview had a biographic aspect, meaning that biography is influenced by the working life (Wengraf, 2001) of the midwife especially if she works in a small community. In the first phase of the study, I generally asked about how it came about that they became midwives and after that they told stories in a chronological way even though they sometimes went back and forth reflecting on their views, communications and experiences in relation to their stories. In the end of the interview I usually asked what midwifery was for them. One description from one of the country midwives had an influence on how my research interest developed:

Midwifery is to be there when you are needed and help the parents at this wonderful moment in their life. I think that is the core...I feel I am a friend, as if I am one of the family, when I am with them [the women]. Like a family friend even though you are not related or that you don't know them a lot. It is just that you are so close, yes in close connection and cooperation and it is touching and there are a lot of emotions and I experience them with them.

(Midwife-Rosa, 25 years' experience, interview 4)

The dialogue - my relationship with the midwives

All the storytellers of this study knew me as the head of midwifery studies in Iceland. This fact and that I knew all the midwives and some of them better than others, both as colleagues and friends, is a validity point and it had influence on the design of the study and interview strategies. In order to minimize my impact, the midwives were openly asked to tell stories of their own choice. Still, I acknowledge that the stories told might sometimes have been mediated by my relationship with them. This issue of how the midwives responded, some of them being my former students, is a practical and a validity concern as well as an epistemological and a theoretical one. One can not know how my interest had influence on the midwives' choice of stories but and example of my influence as a midwifery lecturer was when a former student of mine laughed and said in the beginning of the interview that she found it funny and was a little bit ashamed that the story that came first to her mind was a difficult one and not a normal one, that being the main focus of midwifery care; *"because I am a believer in the normal, yet a difficult story came up, the abnormal".*

Indeed, some of midwives were concerned about the utility of these conversations and gave comments like: *"I am not sure I have stories that are worth telling, they are so many"*, and asking afterwards if I thought this interview would be useful for the research, saying "*I hope you can use this*"; suggesting that what she had to tell was not so important. This I could understand in a way because during the whole research process I often had these doubts myself, that nothing was new, and all this was common knowledge about midwifery. In a way I sometimes fell into the trap of not respecting "the taken for granted" embedded knowledge of midwives. The reading and rereading of the transcripts, however, helped to keep me on track as the different aspects of midwives' ways of knowing came to light.

Midwifery is a young discipline at the University of Iceland and it is important to build a theoretical research base in midwifery in an Icelandic culture. In this we were in full agreement. In our dialogue it was important to ask the "right" questions and think about how or if we had a mutual spirit of understanding between us. Even though we might have different views coming from different settings, theory and practice, we all were midwives, bearing in mind that:

> "Human action is the outcome of the interaction of a person's previous learning and experiences, present-situated presses, and proposed goals and purposes".
> (Polkinghorne, 1995, p.11)

The interviewing – struggling to identify midwives' way of knowing

It has been noted that it can be a struggle to access the practice knowledge of midwifery. Therefore, in the first interviews it was not a surprise that in my conversations with the midwives, midwifery skills, practice interventions or care were not always discussed in detail. This relates directly to what the literature says about the difficulty in breaking down expert knowledge (Benner, 1984) and articulate and describe the taken for granted knowledge (Jarvis, 2000) or the inner subjective knowing (Belenky et al, 1997).

At first, I worried that I did not pay attention to and did not get enough stories about particular interventions and skills of midwives. I sometimes forgot to ask them to clarify or explain and as I am myself a midwife and a teacher they did not always feel that they needed to. They knew that I would know what they meant and what they would have been doing for the woman in question. Therefore, depending on the type of research it could sometimes be better

not to be a midwife while interviewing about midwifery skills. I tried to solve this as the interview design developed and used the strategies influenced by reflective techniques, guided reflection questions (Johns, 2002) when appropriate. In line with qualitative methods, I bracketed or put aside my beforehand thoughts about midwifery as much as possible and waited for what would come up, and the above issues became not as important.

Interview strategies, narrowing down the study

The opening question about birth stories was similar through the whole study as I started with the following question:

> Could you tell a story from your practice, either a happy one or a difficult one, which you learned from, which you remember to have made a difference and has had influence on the development of your midwifery skills, your way of knowing?

In our conversations topics that came up in former interviews were discussed. These were analysis driven segments of the midwives' stories that later developed into being the main subject of the research. In the first 2-3 interviews the midwives told me (without being asked) that even when they worked alone in their midwifery practice they thought they had someone with or behind them. They were *"not alone"*.

You are not alone, for example when you are breaking down because you are very tired and maybe anxious, then you go aside and talk to someone [and you receive some energy to go on]. There is someone who has been a guide. I do not believe in psychic things but I feel that I have had guidance from someone we can call god... it is like the sixth sense is behind which you cannot identify.

(Midwife-Elsa, 50 years' experience, interview 3)

I asked all the midwives in the following interviews if they had had the same experience and explored with them what the meaning of this could be. All of the midwives who had working experience out in the country had this kind of experience of "not being alone", but were not sure what it was. One of the midwives said that, as she had been lucky, she therefore assumed she was not alone. At the same time she was quite sure that she had help from another world and she was not the only one. The midwives also talked about God or someone who gave strength or helped them to go on, enabling them to be rational and make the right clinical decisions. They also related this experience to different aspects of their relationships with the

woman, being with her, knowing her, using their intuitive knowledge in their practice to "diagnose" that everything was going well, or to detect variations.

I am not sure, I do not know what it is, no I do not think I am alone...I felt this soon [after graduating] when you sensed that everything was normal, but it can also be the other way around [when you do not feel that everything is normal] because if you know the woman, and you have been with her through her pregnancy, then you can have this - behind your ear, then this [the pregnancy] is not how you want it to be, even though you cannot point out what it is."

(Midwife- Rosa, 25 years' experience, interview 4)

Themes emerged of different aspects of midwives' relationships with the woman that I found interesting to explore further, which in my hypothesis also could be seen as examples of the midwives' ways of knowing. These themes were: Being With – Midwife's Skills -Know the Woman - Know the Midwife – Trust - Connections With the Woman – Reciprocity - Empowering Factors – Confidence – Safety - "Someone Behind"- Sixth Sense, Intuition and – Spirituality.

I drew a diagram or a working model about midwives' ways of knowing and different aspects of the midwife-woman relationships in order to organize my thoughts in the process of making a narrative (see diagram 1). Furthermore, this diagram was used as a framework for questioning during the next interviews as the research progressed and also for literature search.

Relationships with Women – Midwives' Ways of Knowing

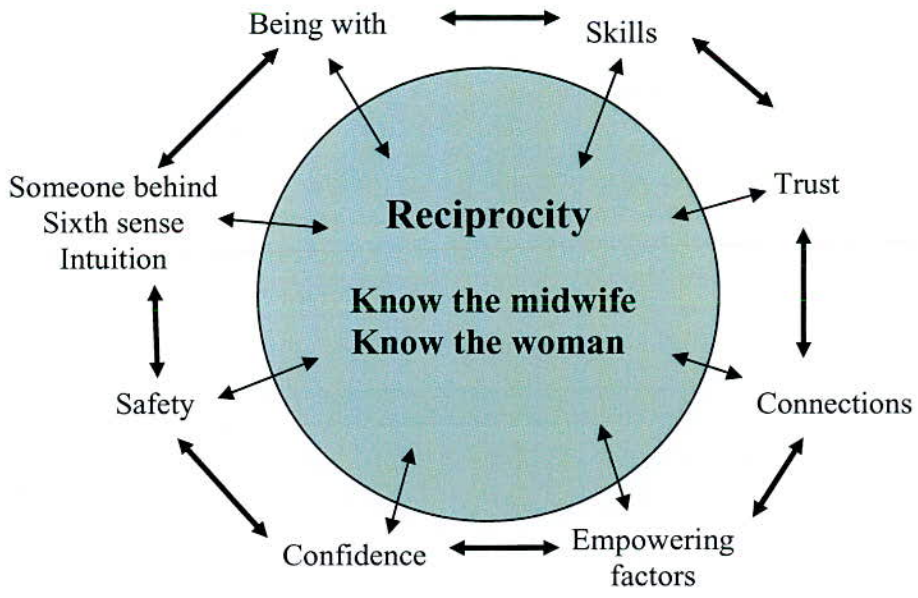


Diagram-1

In the following interviews the aim was to discuss the midwives' relationship with the woman at birth, based on their birth stories, focusing on their subjective knowing, intuition and spiritual abilities and exploring what this kind of knowledge in midwifery consists of and how it develops. I prepared them by forming and adding focus questions about the relationship with the woman and clarifying questions about midwifery skills.

During our conversations the act of being present with the woman during her birth (*yfirseta* "sitting over" in Icelandic) was discussed as a crucial part of midwifery practice and questions around this concept were formed. I also wanted to address and hear midwives' views about the use of stories in midwifery practice. The following are examples of the trigger questions I had in mind, but as the interviews were informal they were not always asked, but rather when the situation arose or when they fitted into the dialogue.

Focus questions about the relationship and "being with" the woman

•Can you tell stories where you experienced a relationship with a woman that has had influence on your midwifery skills/ professional growth?

•Can you describe your relationship with the woman, what influence did it have on your practice and skills?

•Can you talk a little about the presence and being with ("sitting over" in Icelandic) the woman during labour, what does it mean to you as a midwife and how has it the changed through the years?

Clarifying questions about midwifery skills and knowledge

•Can you tell stories and describe your skills, knowledge, assessment and interventions when you suspected something could go wrong and when you had to react in a confident way – or when you knew everything is going to go well?

•Can you describe how this experience has had an influence on your midwifery skills in practice?

•The midwives that have practised out in the country and I have been talking to, told me that they thought they never were alone at birth even though they were, and they also talked about how they sensed if everything was ok or not. Do you have similar experiences, stories to tell?

•Can you clarify and talk about your interventions and skills - explain why and how you did know what to do and maybe tell other stories, use other examples?

•How did it happen? Why did it come a about? What did you do? What did you feel or think?

Clarifying questions about storytelling in midwifery practice

•How does this experience that you describe in your story inform your practice, could you or how would you use this experience for others to learn from?

•What is your experience of using stories/narratives in midwifery practice? Do stories influence your practice? If so, how?

•What conclusions can you draw from your stories / narratives for education, research and the society?

The above questions were important and useful when exploring the midwife – with - woman relationship and midwives inner ways of knowing. Identifying how relationships are formed with the woman, and how midwives develop and use their inner knowing in practice; what their subjective, inner knowing consists of.

The Focus Group Interview

The focus group interview was conducted with a threefold purpose. Firstly, to explore further and add stories about the midwife-with-woman relationship and midwives' inner ways of knowing, also in relation to safety of birth. Secondly, to discuss and seek validity and compare and contrast work experiences and birth stories between midwives and explore in more depth emerging concepts and thematic plots. Thirdly, to discuss the role and use of storytelling in midwifery practice.

The selection of midwives was based on the same principles as before in earlier interviews. Yet, added to the group was one midwifery lecturer who also is a practising midwife. The focus group meeting was held at the midwifery school and a midwifery student was my assistant and moderator. She transcribed the interview and took part in the analysis process. Her dissertation with the translated title; *"Sitting over", the uniqueness of midwifery care at birth*, was in part based on the focus group findings (Blöndal, S, 2005).

The structure of discussion during the meeting was based on examples from earlier interviews. This was done to trigger new stories or to find out if they had similar stories to tell, such as about different types of inner knowing and what constitutes the relationship between the midwife and the woman. For clarification, the same sets of questions listed above were used.

Harmony existed between the stories of midwives in the focus group and the midwives from the earlier interviews. The narrative findings were recognizable and similar concepts emerged during our discussions. Their experiences provided rich information that added to the validity of the study as their narratives were parallel to the other midwives' telling. This supported the study findings, which will be discussed in depth in the final conclusions of this thesis.

Field Notes

Information for field notes was all around in birth stories told in the community based on different views and perspectives. Bits and pieces of information from these birth stories were collected from the media and written material. Stories were also received (not necessarily asked for) both orally and written down for example on e-mail, or from midwifery students. Midwives and different people told stories when they heard about my research work and interest in birth stories. In some cases if I did not write notes, I later asked for further information and asked: "will you tell me this story again"? Also, midwives sometimes came to me after the interview to tell more stories, stories that were not told and only remembered after the interview (an example is Eva's story on p. 143).

Living in this midwifery culture I observed and looked at the narrative form of discourse about childbirth care and wrote down comments about relevant issues which influenced my thoughts and research interest, notes that also could be used to clarify the cultural background of the study and to use as real examples in discussions at a later stage when writing the thesis. Examples of notes written down that were used as data are outlined in the following sections.

Book of birth stories from Icelandic women

An example of written material of birth is the book mentioned before (Ingadóttir et al, 2002), with over 100 birth stories of 70 Icelandic women that was published in December 2002. Most of the stories are contemporary or from the latter second half of the 20th century (1947-2002). At first, the plan was to collect birth-stories and interview women, to learn about and compare their stories with those of midwives. However, because of the time frame and what could be lost in terms of exploring in depth the study material that plan did not go through. Instead, field notes about women's stories were used for "setting the scene" as a picture of the background of the study place.

Diaries from the labour ward at the University hospital

In June 2004, the Head Midwife of the labour ward at the University Hospital gave permission to use anonymously written diaries from five midwives about their experience of heavy workload as data for field notes. These diaries were written as a strategy to support midwives, for them to debrief and give information about their experiences of their working patterns. The midwives had protested, experiencing emotional exhaustion with signs of becoming burnout,

leading them to think about leaving their profession (see stories p. 37 and 175). These diaries about their work were written after a busy period as a result of fewer midwives working on each shift for different reasons (for example because of summer vacation and an increase in number of births as birthplaces out in the country often close in the summertime). These midwifery narratives supported other stories collected in the interviews and added to rich data about the background of midwifery practice.

Notes from the media

While working on this research I wrote down notes from the media that I came across. One type of discussion about childbirth in the Western world was found on Global digital TV shows, (Canada, April 2003, Australia, July 2005, and the UK (October 2004, April 2006), which confirms how the medical model dominates maternity services. Many birth stories are depicted as dramatic and make a persuasive beautiful picture of normal births as being technical, dangerous and at risk, which at the same time shown to be women centred and focused on holistic experiences of the family, with women and their partners making informed choices about their care. In addition, notes from the media in Iceland were noted and some of them were used as examples of the social narratives of conflicting models of childbirth (see for example discussion p. 67).

Analysis Approach of this Narrative Study

In this section the theoretical concerns that underlie the analytic process of this research, the strategies and structures of the narrative data, will be explored. The goal of the analysis has been to develop a working life narrative of midwives as it is expressed through their birth stories. Furthermore, to learn about how midwives think about and view the developments of midwifery skills, different ways of knowing and cultural and social influences on midwifery care.

There are different ways to interpret narrative data, one being the interpretative phenomenological which differs from the ethnography which has been chosen for this study. Phenomenology differs from ethnography in the sense that is does not aim to explicate meanings of particular cultures, or certain social groups, historical periods and biography. Instead, phenomenology attempts to explicate the meanings as we live them in our everyday existence, to gain a deeper understanding or learn about the nature of meaning (Van Manen,

1990). It ascribes meanings to the events and asks questions about what a person, who structures her narrative around a plot in a particular way, really wants to tell about herself and her emotions (Wiklund et al, 2002). In phenomenological type of analysis, the narratives perform to bridge functions between teller and listener in order to understand why events happen in a situation which again is to create a deeper meaning to make new narratives for further analysis to understand the meaning of the text (Frid et el, 2000, Koch, 1998). In context with a caring paradigm it has a deeper understanding of the person's sense of self (Wiklund et al, 2002).

The ethnographic approach used here is conducted from another standpoint and is not about the deeper personal experience or lived meanings of being a midwife, in other words her sense of self and emotions, but rather about her professional life and cultural identity. This means that this research is involved with the examination of stories that tell more than their tale and speak of context and values (Kirkham, 1997) and are identified in the interview data (Bailly and Tilley, 2002).

Narrative knowledge is maintained in stories with plots (Polkinghorne, 1995) and storied episodes, which is the narrative style of this study. This approach was chosen to avoid the empiricist narrative methods that reproduce an image of positivist reader who does not hear the story as it is told but rather hears and reads "within a set of predetermined structural categories" (Denzin, 1997, p. 249). In a sense, this analysis method was also considered to be a validity issue, as the goal was not to turn the story into a story analyzed, sacrificing the meaning for analytic rigor, but to " hear the story as it was told" (Denzin, 1997, p. 249). To sustain credibility of the research findings, the ethnographic interpretation was aimed at the meaning the midwives convey through their stories and evaluations about their professional practice.

Analysis process, notes and practical concerns

The interviews were tape recorded and transcribed verbatim, some of them by me; others in order to save time were transcribed by a medical secretary (who, being a health professional, was sworn to confidentiality towards the midwives).

During the analysis process, midwives' stories as whole events, segments that make a story or narrative were identified. This was done by using text markers with different colours to mark the beginning and the end of a story and notes were made in the margin about emerging themes and plots. Furthermore, I listened to the tapes and went back to the transcripts repeatedly, comparing, contrasting, and sorting themes or thematic plots that gave the stories a point leading to evaluation and explanatory conclusions made by the midwives. These were grouped together and stored in story – maps.

This study is in itself like a drawing of a map of the culture of childbirth and midwifery in Iceland. A list of story - maps was made and was at first long (over 30 maps). As the study narrowed down, the list was shortened to five groups which were then divided into two areas with frames of narratives, leading towards the narrative finding (see in chapter seven, frame 1, 2, 3). The story-maps were a useful tool and a good way to have an overview of huge material of both fragments of stories as well as whole stories or narratives.

Analysis notes were written about:

•How the research process went, changes and reasons for new developments and ideas.

•The research interest and how the subject narrowed down.

•Evaluations after the interviews, points about what would be interesting or important to explore further and compare with other midwives' stories in following interviews.

•Notes were also written about new things coming up in our conversations.

•New strategies in issuing stories in following interviews (as was explained before).

•Ways to organize findings such as in story-maps and in different folders or sub maps (see chapter seven –overview of findings).

•Connections in the data as themes and plots emerged and different theoretical working models and diagrams that were drawn to organize thoughts on which to base the next steps.

•New questions to have in mind when going back to the tapes and transcripts.

•Graphics of narrative threads and relations between the midwives' conclusions were continuously drawn to use as frameworks as the study progressed,

•Notes on how to translate from Icelandic and phrase things in English.

Analysis strategies, structuring the narrative data

As described before, two approaches to narrative inquiry have been identified (see p. 56-58). Firstly, analysis of narratives contains thematic data that lacks the historical and the developmental dimension. Answers to questions of the researcher are categorized, put forward as information about the present and or belief of the informant. Secondly, narrative analysis is a collection of individual cases in which analysis moves from case to case instead of moving from case to generalization. This collection of storied experiences provides a basis for understanding new action episodes by means of analogy and is searched to find one that is similar in some respects to the new one (Polkinghorne, 1995).

In this study both approaches were used intermittently as analysis strategy. This was done in two stages as the approach shifted and strategies changed depending on the interview data, how the midwives built up their story or how their way of telling their story was. This is outlined in detail below.

The first stage referring to analysis of narratives has been to:

- Identify midwives' narratives as wholes i.e. stories containing both a point and an evaluation.
- Analyze and identify themes and interpret the narratives, conceptualizing themes and collecting them into the story maps.

The second stage referring to narrative analysis has been to:

- Identify articulations, events, fragments of narratives, thematic plots leading to evaluation and explanatory conclusions and collecting them into story-maps.
- Synthesize events, actions and thematic plots into a story of stories or storied approach to narratives.
- Identify the main plot of the midwives' narrative plots, leading towards a conclusion about a core narrative in midwifery in an Icelandic context.
- Search the literature to provide for discussions in relation to the content of the narrative and different theories.
- Translate into English, edit and write a midwifery narrative as a research product, focusing on midwives' reasoning to come to a conclusion.

Through the narrative structure or the plot of the story, people understand and describe the relationship among events. Based on Polkinghornes (1995) steps in developing a narrative, the thematic plots were used to compose or configure events into a story or a narrative by:

- Marking temporal range, the beginning and ending of the story.
- Choosing criteria and selecting events and situations to be included in a storied episode.
- Ordering events temporally into an unfolding movement culminating in a conclusion.
- Clarifying and making explicit the meaning the events have for the midwife and of her story as a "unified whole".

The challenge was among others, how to extract a narrative from a stretch of discourse where the midwife moved back and forth in time, and/or told her story about midwifery work in one sentence like this one; *"it went splendidly well"*, referring to how apparent it was that births should go well. There were many such stories based on the belief that " birth is normal until proven otherwise", which can be considered to be a core rhetoric narrative of Western midwifery that travels across time and places and between midwives and students with many underlying stories; a constant frame of reference for midwives.

Furthermore, the goal was to identify the fully formed narratives with the six common properties; abstract, orientation, complicating action, evaluation, resolution and coda, described by Labov and Valetsky (1967 cited by Wengraf, 2001). Abstract refers to the summaration of the narrative to follow; orientation is identified as the introduction of the participants and the scene; complicating action is the sequence of events or the story; evaluation is the significance and meaning of the action, how the narrator is affected and her attitude; resolution explains what finally has happened and coda refers to the returning to the perspective of the present (Riessman, 1993). An example of this kind of narrative was presented earlier in the chapter about the changes of place of birth (see story of in the 1950s, p. 29).

Another example of "stored wisdom" from a young midwife in the year 2002 is the following fully formed narrative where the plot concerns the place of birth, the midwife-woman relationship and aspects of the midwife's ways of knowing. It is about how the midwife is

developing her midwifery skills and learns to become a strong midwife by telling a story and talking things through with the parents. This narrative is also about the "social world" of the community around midwives' practice, the fear in midwifery practice of coming up against litigation or "*the aftermaths*" and it is about how midwives can deal with these issues in practice. This kind of story could be identified as an exemplary narrative or a new form of storytelling in midwifery that can be used to advance midwifery knowledge in practice. These issues will be discussed in more detail in the concluding discussions of chapter twelve.

This was when I went out to the country to stand in for the midwives there. There was a woman who was giving birth for the second time; she lived in a small fjord not far away with very few people living there. I had seen her couple of times so we had formed our relationship. The baby she had before had been very big, she was in the pushing stage for two and half hours and it had been born in this place.
She is now in her 41st week and induction of labour had been discussed but I wanted to delay it as long as possible. She comes with the boat, and when I see her - I think this woman has to be induced. She was very big around her, with this story, big baby and I ask her if she is ready to start all this. There you know I am my own boss and I decide on this induction ... I examine her and she is about 2-3 cm and I do an amniotomy, and the water is clear. Then this starts slowly and calmly and about 4 or 5 o'clock she is in good labour. She is doing fine and walks around, and I had forgotten all about this being a big baby. I have to tell in between that two weeks before the midwife I was relieving had had a very difficult shoulder dystocia, and the whole village was under pressure because of this, the baby had been sick and was now just back home. This story was out of my head, when I was in there with this woman, everything went well and we listened to the news on the radio. She is fully dilated, and in semi fowler position in the bed and this head comes down and it takes a long time. I started to think, yes this will take long to come and I have an IV ready, and thought it best to call for assistance right away and I call the nurse. The head is born and the chin slobbers and there it stops ...and there is another contraction, I go up with my hand and I can not find either shoulder, ...I tell the woman to go on all fours, and she turns herself; one, two, three and I find the posterior shoulder, and she pushes on all fours. The nurse said oh no, not again, and I ask her to put up the IV and the woman turns and is again on the back, and the shoulder comes ...This was of course about 4-5 contractions and I had to pull a bit. There this big boy was born, and he cries right away. Then the doctor comes, and he says "it is good to hear this cry, I will not worry", he had attended the other baby.
I take the baby to the table and examine him, and he is ok, but he does not move the other arm. The doctor took over, and I took care of the woman. She just needed a few stitches and she was very happy that this was over and was not aware of what had happened, but the father was very scared. I put everything away and the baby goes on the breast and everything is fine, but we are observing the arm. There were no aftermaths.
I sat down with them and explained to them that the baby had been in great danger, I had experienced this as a victory and that I had saved the baby, a midwife with one year experience was able to save -, but the father did not [have the same experience]. Slowly he understood what I meant [after talking things through]. The baby had physiotherapy and a year later I got a card where they told me the boy had the same strength in both arms, with special regards from the father.

This is a story which was empowering for me as a midwife and I now understood, because I have always had great respect for midwives, why they can be brusque, firm and with wrinkles after all their experience. I had not always understood why they could not just be gentle and nice and I got stronger after this experience and I got to respect myself as a midwife. This is the story that came first up, in my mind.

(Midwife-Astrid, 3 years' experience, interview 15)

Astrid goes on to another resolution and coda, a returning to the perspective of the present, can be identified in her story

Maybe I learned from the previous story [about the other shoulder dystocia], the midwife in that case did not keep on caring for the people, as they went quickly away to Reykjavik. She had not worked things through and had not had a debriefing with the people, and she did not feel well. I always need to talk about what I come up against. There I did not have anyone but them [the parents].

(Midwife-Astrid, 3 years' experience, interview 15)

In a way the same story was told by an older midwife, but the narrative was very different, only a few sentences. It was different both because of different time, education and experience background of the two midwives, one having the advanced training and tools to reflect on practice in detail and the other not. Also because of the intrinsic embodied holistic skills, in this case the hands of the midwife, skills that often are expressed as "not knowing how" or "just knowing".

"I remember some births, maybe two or three, when there were, what do you call it? - yes shoulder dystocia, you really did not know how you did this, - luck followed your hands"

(Midwife-Solla, 45 years' experience, interview 3)

Going back to the tapes and transcripts

The process of going back to the tapes was done both for validity reasons to increase the credibility as well as looking for the "facts" to be a base for my analysis and combinations of the data and for the creation of new meanings from the data (Sandelowski, 1998). This process was done repeatedly in relation to identifying models of care, the different issues and ideas that came to mind throughout the analysis process.

As mentioned above, the midwives did not always give detailed descriptions of their midwifery practice. Their attention and action was in the background of the story and these

aspects were not always immediately visible. Going back to the transcripts, to look again, helped to dig deeper and draw out the midwives' viewpoints. Furthermore, this was done to generate new questions in relation to the development of the midwifery narrative in progress. I went back to the transcripts based on my working model of the narrative analysis of the study (see diagram 1, p. 82) in order to look at:

- How the woman was presented in their stories and to look for words and descriptions about what the midwives do for and with the woman, how they talked about their communications and relationships with the woman, identifying sub themes of central concepts of midwives' interactions with the woman, such as aspects of *trust, connections and reciprocity.*
- How the midwives reflected and learned from their practice and how they transmitted that knowledge forward into the interview, telling the stories of particular situations in relation to *intuition and spirituality.*
- How the midwives structured their stories, chronologically or historically going back and forth in time, commenting on the culture they live in, providing information about the background of the study to use in the first part of the study report (see chapter three).
- How the midwives reasoned and provided answers to questions such as about why they found it important *to be with or stay* with the woman during birth and what influence it could have on the outcome of birth if they did not succeed in doing that, and about what terms the midwives used and how they described their inner knowing in midwifery practice.

New themes or storylines kept emerging relating to the experiences of the midwives' relationships and midwives' ways of knowing which generated questions to narrow down the study and deepen my understandings of what "being with" and making connections with the woman meant, also in terms of place of birth which was my starting point. Articulations of the midwives could indeed be interpreted in relation to familiar concepts found in the midwifery literature, such as about belief in normality of birth, connecting and forming of relationships based on reciprocity which included the support of women in making their own choice or decision of care.

Drawing on the work of Denzin (1997), the narrative logic was unravelled and connected to specific narrative representations with a multilevel and a multi-method approach. I, as a researcher, sought to fit narrative methods to their historical and cultural moment and the structures that define that moment. At the same time I interrogated and criticized this moment and its narrative or storytelling, contextualizing the narrative and connecting it to specific cultural practice and social formations (see later discussions about battlegrounds of birth and cultural concepts and themes in relation to changes in place of birth pp. 186-197).

The development of narrative findings

The development of narrative findings and the writing of the research report has also been a strategy for analysis of the narrative material of the study. Instead of writing up the narrative of each midwife, the intention was to rewrite a narrative that included parts of the stories of all the midwives. I was fairly confident that it would be easy to mould the many different happenings into coherent and contrasting stories of all the midwives as their views and their work biography and stories seemed to have similar characteristics. They were of the same voice, with the midwifery model of care coming strongly through, but with different narrations, style of telling, depending on their background and workplace. However, because of the huge research material and the broad perspective of the study, this took some time. In the end, rather than writing up a new narrative based on the midwives' stories, I decided to present a storied episode of the working life of midwives, allowing their own telling to be the structure of this Icelandic midwifery saga. This decision contributed to the sets of criteria and strategies, what was considered to be an important validity issue for the study.

Guidelines for writing up the narrative analysis

When writing up the narrative findings, I looked at guidelines for developing a narrative based on seven criteria proposed by Dollard (1935) adapted by Polkinghorne (1995), as well as developing my own. They were as follows:

- Identify the plot of the narrative which concerns place of birth, midwife-with-woman relationships and midwives' ways of knowing and select or include those thoughts, actions and events in the narrative finding chapters.
- Test the plot with the data (to-and-fro movement).
- Use fragments, vignettes from midwives, leading to a storied episode of the working life of midwives in the narrative finding chapters.

- Think about if the "right" data was included and to allow dissonance in the final narrative.
- Ask myself and make clear my contribution to the plot and storylines, my context values, role and effect on shaping the narrative episode.
- Ask myself and make clear why I select particular stories.
- Let the solid narratives of the midwife stand for itself with my background explanations in relation to the literature.
- Let the interpretation of events and meanings be largely left to the midwives themselves in terms of using their own words.
- Present the narrative analysis of different issues as frames with list of "facts", structures or configurations of the midwives' stories, which included the midwives' articulations, their reasoning, hypothesis or theoretical propositions, in other words their epistemological position.

Validity Issues

Every study has biases and threats to validity. However, there are different ways of recognizing credibility of research findings and the researcher's involvement in the research process. "Drawing on Contemporary Synthesis of Validity Criteria in Qualitative Research" (Whittemore, et al, 2001), various techniques were used to produce valid knowledge and maintain credibility. They are synthesized as a part of the research design as has been outlined before throughout the descriptions of the methods of the study.

Sets of criteria and techniques used:

Embedded in the development of this narrative study and the analysis approach are different sets of criteria and techniques in relation to validity. Authenticity and integrity towards the midwives' stories about their working life was represented through recursive and repetitive checks with the data while analysing and writing up midwifery narratives bearing in mind alternative understandings or dissonance, for example regarding imbalanced encounters with the woman. Hopefully, this helped to present a congruent thorough report that gives insight into my critical judgements and theoretical reflections that also helps to present the findings of the study with clarity.

A focus group meeting was held for validity reasons to compare stories of midwives between different groups and to explore further and receive more information to "thicken" the data (see p. 71). Towards the end of the study two interviews were conducted in order to portray the Icelandic culture of midwifery practice in a more adequate way, contributing to the quality of the data of the study. In addition, interview data from field notes were added to the narrative material to support the narrative analysis of the study.

Furthermore, I have been conscious that my "location" as a researcher has influence on the research process and report, organizing the data elements into coherent narratives by choosing and presenting particular stories. Summing up, my personal narrative is connected to "the subject under study". Inherent in this study is that I have a network of relationships that could have had influence on the midwives choice of birth stories and thereby on the findings and the soundness of this research (see also critical reflections on this issue in the final chapter).

Working between two languages

As this research is conducted in Icelandic and presented in English, it is important to point out that use of language is a relevant cultural and validity issue. All transcripts were typed and analyzed in Icelandic but narratives that were drawn out and used when presenting findings were translated into English. I decided to translate the narratives, which I used, myself and I found it be a useful strategy in the analysis process.

Icelandic is a North-Germanic language and originates, just like English from the Indo-European group of languages. Even though many related words do not have the same meaning in contemporary language they may have the same roots which sometimes helped to get a deeper understanding of concepts and to make decisions about how to analyse and describe findings. The switching between languages with a play of words helped. An example was when the word "sense" in English was used to refer to aspects of inner knowing, with the added meaning of wisdom in English and "emotion" in Icelandic. These conceptualizations created a deeper meaning within a midwifery paradigm about aspects of midwifery relationships and knowledge (see an example about *sense instead of non-sense* in the narrative p. 142).

Sometimes decisions were made to translate literally. Many of the words used in midwifery language in Iceland are not parallel to the medical terms that are everyday language in English, but are terms that have foundations in midwifery rather than medicine. Examples are "green water" instead of "meconium stained water" and "lung soft edges" when describing "embodied" knowing of the dilation of the cervix (see story p. 33). The concerns I had related to language also helped to choose ways to express and make explicit findings of the study, such as how the concept of "being with" woman is linked with Icelandic concept of "sitting over" at birth. The meaning of this concept as one of the main conclusions of the study will be explored in depth in chapter eight and ten.

The text and writing of the narratives of midwives and this report might therefore sometimes look childish or maybe charming for the English speaking person, or give indications of the bad writing in English. Yet, this way of using the language gave me a new meaning to the "phenomena under study" and this emphasizes the fact that this study is not conducted within an English mother tongue cultural group.

This language "factor" of the study helped to develop and write a midwifery narrative which includes a theoretical framework of midwifery on practical, ideological and analytical levels (Teijlingen, 2005). This again relates to how an ethnographer decides to write and represent research findings which is a validity issue because ethnographic writing as a disciplinary authority can be a rhetoric strategy to persuade readers (Conquergood, 2003) to produce, add new knowledge and to verify in a narrative that they "really" have been there (Hammersley, 1998), open to interpretation of the reader.

Writing up and representing findings

Validity issues in relation to research methods have to do with "truth" and if findings are trustworthy and presented in a rigorous way. Blumenfeld-Jones (1995) presented the concept of "fidelity" in contrast with truth, characterized as a "betweenness" that is constructed as an obligation between the teller and receiver and as a resonance between the story told and the social and cultural context of the story. She used another criterion, "believability", to credit if narrative findings convey convincingly that events occurred and were felt in ways the researcher is asserting. Fidelity rather than truth becomes "an obligation towards preserving the bonds between the teller and the receiver by honouring the self report of the teller and

obligation of the original teller to be as honest as possible in the telling" (Blumenfeld-Jones, 1995 p. 28). Thus, the "truth" of the story told was not the primary issue, but rather the meaning that the midwives conveyed through their storytelling, their explanatory conclusions and evaluations which are the foundation of this study's findings.

It has also been cautioned that involvement of an inquirer can have influence on the ability to speak authentically for the experience of others (Lincoln and Denzin, 1994); hence, in light of relations with the midwives, ethnographic, rather than phenomenological interpretations were chosen as analysis method. To reduce bias, the technique of ethnographic narrative analysis approach included honouring the midwives' telling and letting the stories of their own choice speak as much as possible for them. Linked to this, the open perspective of the research and interview design was considered to be a validity strategy.

While this research has been in progress I have regularly presented preliminary findings and methodology in research seminars and at midwifery conferences, both in Iceland and internationally. In my mind this has been a good way to get feedback and support in developing this study further. The presentations have been based on the midwives' narratives with a different focus related to the methodology, place of birth, relationships with women and emerging concepts in relation to inner knowing of midwives. The preliminary findings presented have been recognizable to the audiences of midwives, creating positive response. An example of "believability" is the response I got at the International Conference of Midwives held in Brisbane, Australia in the summer 2005, where I had inspiring and supporting dialogues with midwives from different parts of the world about their practice and knowledge. This also indicated that findings of this study could be applied to other settings of midwifery care.

Ethical Considerations

In this study ethical strategies in relation to confidentiality were addressed on three levels, when gathering, keeping the data and when making the findings public. Ethical issues of research are first and foremost concerned with the notion if there are any potential negative effects for participants. However, to take active part in the interviews of this research, identifying midwifery knowledge, ideology of midwifery and social and cultural influences,

was rather considered to be empowering and beneficial for the midwives, both professionally and personally, as the midwives shared and talked about stressful as well as positive experiences of their working life.

Application for approval

The research proposal with an introduction letter and a form for consent to participate (see 1a and 1b) was sent for approvals to the The National Bioethics Committiee (NBC) in Iceland. The main role of the NBC is to evaluate applications for research proposals in Iceland that concern the participation of human subjects regarding health issues in one way or another (see www.http://visindasidanefnd.is/English). According to the regulation of The NBC, it was unclear if approvals were needed as this study was not done among clients of the health service but with health professionals. However, as I was collecting birth stories of midwives which included sensitive events of their clients' personal lives, I considered that the resesearch proposal needed a review from a scientific ethical body, even though the midwives were privileged as health professionals and they would take that into acount when telling their stories.

The application was evaluated by the NBC allowing the research to proceed with usual recommendations about using accurate scientific research methods. But as information gathered in this research did not include health or disease information of the participants the BNC evaluated that it was not compulsory to have ethical approvals (see appendix, 2a).

Approvals were also sought and received for the research to take place at and in cooperation with the Women's Department of the Landspitali University Hospital. All the midwives of the study had at one time or another worked there as student midwives and most of them for a shorter or a longer period after graduation. The hospital is also the central referral for maternity services for the whole country, hence all midwives have to consult or refer to the Women's Department of the hospital, often called the *Móðurskip* or the Mother Ship of the maternity services in Iceland (see appendix, 2b). Furthermore, based on a treaty between the University of Iceland and the University Hospital that forms a legal basis for development of structures and integration of academia and practice, I hold a position, within the Women's Department as an academic leader to collaborate in the development of midwifery research

and teaching in the practice setting of the maternity care. This study is considered to be part of that collaboration.

A notification was sent to the Data Protection Authority according to The Act on the Protection of Privacy as regards the Processing of Personal Data, No. 77/2000 (see appendix 2c). The term personal data is defined by the act as: any data relating to the data subject, i.e. information that can be traced directly or indirectly to individuals (see http://www.personuvernd.is/English).

Informed consent to participate

In line with the informal design of the interviews being a dialogue of "co-researchers" who knew each other well beforehand, consent to take part was negotiated with midwives on a relatively broad basis, based on trust without written approvals being signed. In general, a letter outlining the work was introduced before the one-to-one interviews, and a similar letter was sent to all of the midwives who took part in the focus group to request co-operation and introduce discussion points and to provide contact details of when and where to meet (see appendix 1b 1bc). Introductions of the goals of the study were made orally by a phone call, as has been described before, explaining the main introductory questions about birth stories, also stated in the introductory letter. A more formal process of consent might, from a scientific point of view, have been more appropriate. However, as Icelandic midwives are not known to be very formal with each other and as their stories just started to flow, while I again introduced the outline and purpose of my work, I soon decided that this informal way befitted the research design and helped to gather rich information from the midwives. The midwives usually began with a sentence like; *"After you talked to me on the phone, this story came to mind"* and then went on telling a story of their own choice.

However, before all the interviews, confidentiality and anonymity of the information given was discussed (all midwives with a pseudonym) as well as the possibility of withdrawal from the study. All the midwives were very willing to participate and from my point of view they were not pressured to be co-operative even though some might have thought that it was their duty as professionals to give information and take part in this midwifery study. Some said they were honoured to take part and I always experienced a relaxed atmosphere with an easy run of storytelling.

Confidentiality

Issues of confidentiality in Icelandic research are always compounded because of the small society and this of course applies also in the field of midwifery. Individuals, although not named by their right names, could be immediately recognised by those familiar with the situation. Therefore, total anonymity could not be assured and was not always considered necessary. Even though I strive to seek anonymity by using pseudonyms, knowledge of who the storytellers are and what the place of birth is could in this kind of study in some cases be helpful in order to understand better and receive more information about situational context, also, in order to influence change and to give strong messages to emancipate midwifery knowledge and practice. At a later stage this strategy could be used when presenting and discussing implications of findings in practice or officially by publication and in conferences with control and approvals from those concerned. Maintaining confidentiality of the women and their families, as well as other people in the midwives' stories' was, however, considered critical as the potential for damage was very real.

Data control - gathering and keeping information

Interviews took place in private surroundings, often in the homes of the midwives. Tape-recordings were stored off-site not in the same place as printed transcripts and both were anonymous with codes. As the content of tapes and coded transcripts could clearly identify some speakers, access to these was restricted to me, kept in a safe place in my office and on my lap-top, which has personal password, unknown to others. A separate list with the real names of the participants and their codes was only placed on my lap-top. As mentioned before, most of the interviews were transcribed by me or my assistants who were privileged to keep confidentiality. Tape-recordings will be deleted after the research is completed.

Publication of findings

This third level in relation to confidentiality concerns how to make findings public, confuse or hide identities and situations. Permission was sought and given by the midwives to use their telling when presenting findings. As the midwives were telling stories about their clients they did not use names of people and places in their accounts and this was also attended to during transcribing and writing of the study report. This ethical point relates to the validity issues discussed above about the complexity of presenting "true" findings. Informed consent requires that the participant be made aware of any potential negative effects. In this case risks of damage

were not considered to exist for the midwives personally. However, of course we were not to know if the findings themselves would be negative for the midwifery community and thereby have negative feelings and be bad for the morale of midwives and their workplace. In light of the small community of midwives and their compassion for midwifery practice, I sensed my responsibility from an ethical point of view, of keeping confidentiality and not harming midwives when choosing and presenting narrative findings to become public knowledge. At the same time, I kept in mind to be honest about the situation and self-critical of not compromising negative views in order not to present midwifery in Iceland too positively. Further critical reflections on the study findings will be discussed in the final chapter twelve.

Summary

The research process, methods and analysis strategies that have been described in this chapter give information about how childbirth narratives of this study will be used to theorize about midwifery in an Icelandic context. In the following chapters of findings, efforts will be made to discuss and:

- Explore the nature and forming of a midwife-with-woman relationship, based on connections and reciprocity that has impact on midwifery knowledge and safety of birth.

- Search for core narratives and point out underlying conflicting models of care that influence midwifery practice and knowledge.

- Explore and support a philosophical base of midwifery practice in an Icelandic context that are in accordance with the ideological statements of the midwifery education in Iceland established in 1995 and incorporated in the policy of the Icelandic Midwifery Association in the year 2000.

- Draw out midwives' stories which bring to light and provide a deeper understanding of inner knowing of midwives, intuition and spiritual awareness in relation to their connections with women at birth in diverse situations of midwifery practice.

- Argue the nature of that knowledge and its adequacy and legitimacy and how midwives use inner knowing in balance with other knowledge systems.

- Identify types of narratives which could to be used to encourage and promote new forms of storytelling in order to advance midwifery knowledge in practice.

- Demonstrate how the narrative method of this study has been useful to provide a deeper understanding of the multidimensional knowledge around childbirth

PART III - FINDINGS AND DISCUSSIONS

Chapter Seven– Findings – Overview

This chapter describes and gives an overview of the findings and how they emerged in relation to the narrative analysis and to how decisions were made in narrowing down the study. The findings on the one hand refer to narratives that are woven together about different aspects of the midwife-with-woman relationships and midwives' ways of knowing. On the other hand, they are about changes in place of birth and social narratives about childbirth, represented in conflicting models of childbirth care, discussed in relation to relevant literature.

Frames of Narrative Analysis and Story-Maps

The beginning phase of the study, which focused on the work of seven midwives in the rural areas of Iceland, came to yield insight into the nature of and diversity of midwifery and childbirth care, and also into how the midwives make sense of their working life as midwives. In telling their stories they drew on their own repertoire of their midwifery culture and practice, culture being defined here as an abstraction of describing behaviours, with an ethnographic record about how people go about their daily activities (Wolcott, 1999, p. 89), thus midwifery practice from their own point of view.

The following list of story- maps (see frame 1) was used as a working-tool to keep my data analysis together. It includes a number of sub maps, which of course contained uncountable fragments of midwifery narratives. This overview shows what kind of stories stood out and what socio- and cultural elements came across, relating to the different aspects of midwifery care, with many underlying thematic plots of stories that make a narrative or a story of stories. The midwives' main points which were reflected in a biographic way with back and forth movements in time can be seen in the names of the story-maps divided into four sections.

Frame 1 - A working tool of story maps

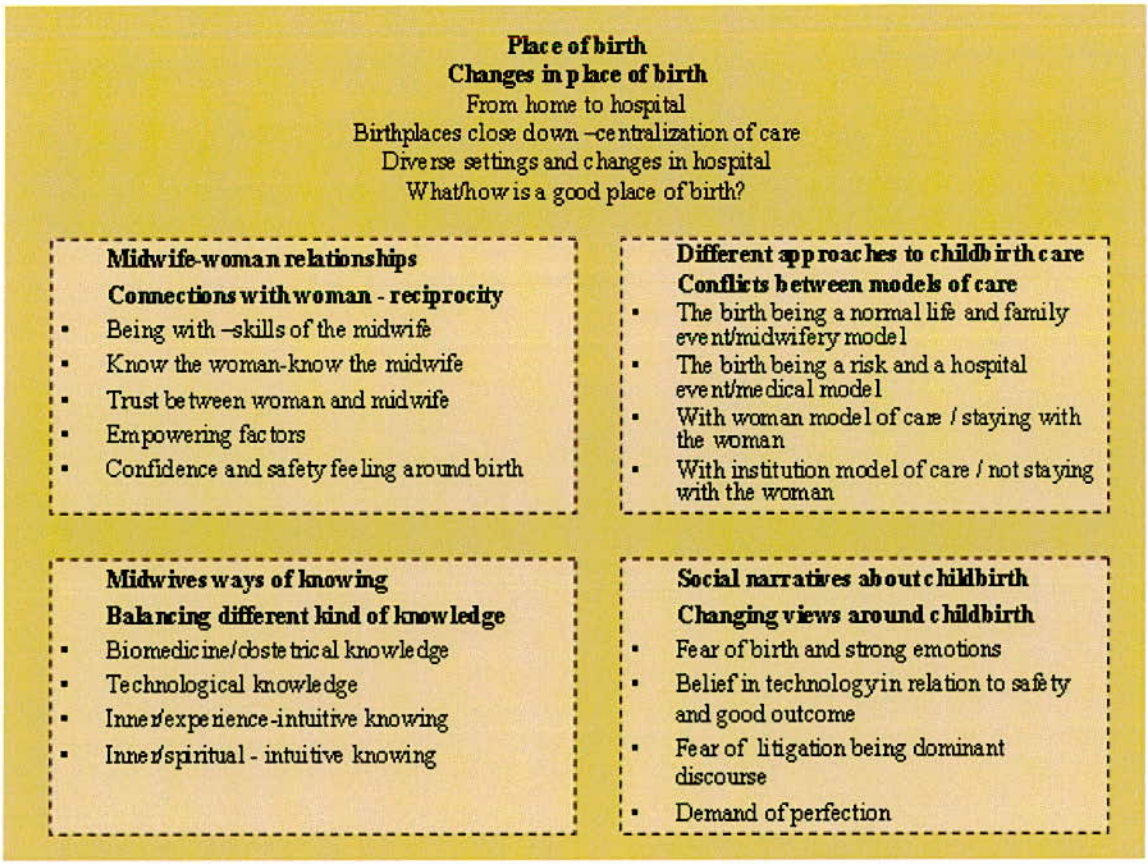
Midwifery working life out in the country
Being and deciding to become a midwife
Life at the midwifery school
Sisterhood with other midwives (storytelling)
Change in working situations and workload
Changes in midwifery education
Time of birth - Christmas, light summer nights etc.
Emotions – celebration, bereavement, humour
Weather conditions and influence on birth
Travels and transportations to the woman and with the woman
The birth being a normal family event, life event
Skills and interventions being with women in diverse situations
Dealing with risk births and emergencies – taking charge
Helplessness, need for knowledge and technical equipment
Relationships with the father and the family
Changes in relationships with doctors – based on respect or disrespect
The community and the midwife's role
Place of birth
Changes in place of birth, from home to hospital
Centralization of maternity care (birth-places close down)
Midwife in control / not in control of her practice and place of birth
Cooperation with central and referral hospitals – different attitudes of colleagues
The social narratives about childbirth
Conflicts between different models of care and knowledge
Fear of birth and strong emotions in society and among health professionals
Birth being a risk and a medical event
Pressure because of litigation (dominant discourse)
Belief in technology in relation to safety and good outcome
Women's views and choices around childbirth
Changing views in midwifery practice - from patriarchy to partnership
Changes in midwifery practice – use of technology
Relationship with the woman and midwives' ways of knowing
Being with the woman, using her skills, doing check ups
Continuity of care – to know the woman
Trust between woman and midwife – empowering factors
Connections with the woman – reciprocity
Spirituality - "not alone" around birth
Intuition - sixth sense about pregnancy and birth
Confidence and feelings of safety around birth

The research progressed and the interest shifted to stories in the last section, focusing on the relationship with the woman and midwives' ways of knowing. During the analysis phase, drawn from the storyline of midwives' narratives, I had developed a working hypothesis about how the concept of "being with" woman seemed to be the thematic plot of the midwifery narrative. This finding will be discussed in depth in chapter ten.

Fragments of narratives were identified focusing on analysis questions, such as about, why the midwives found it important to "be with" and stay near the woman during birth and what influence it could have on midwifery skills and outcome of birth if they did not succeed in doing that. Furthermore, the narrative analysis focused on how midwives think they develop different kinds of inner knowing and how they talk about and use this kind of knowing in balance with other kinds of knowledge in practice.

In keeping with the process of data analysis and while narrowing down the study, I found it useful to reorganize this working-tool of story-maps. The list of maps was shortened to five maps again with many folders referring to this main focus of the study and also to capture the cultural background and social narratives of childbirth (see frame 2).

Frame 2 - Place of birth and sociocultural changes



This figure above summarizes and illustrates aspects of midwives practice in different places of birth and cultural settings where approaches to childbirth are in conflict with midwives in relationship with women balancing different kinds of knowledge or their ways of knowing.

When decisions were made about how to present the findings (see chapter one about the structure of thesis), I found it a helpful strategy to divide the story-maps into two different sections with the place of birth in the background. The first was considered to deal with the individual stories of the midwives' practice (on a micro level) and the second refers to the broader picture of the changes in place of birth or the social culture of childbirth (on a macro level) that influences childbirth care and how the status of midwifery knowledge is perceived and developed (see frame 3).

Frame 3 - Strategies to present the narrative findings

Place of birth

Micro
Midwife-woman relationships –Connections with woman – reciprocity Being with the woman to provide safety **Midwives way of knowing** - Balancing different kind of knowledge Inner knowing - based on experience and/or spiritual awareness
Macro
Different approaches to childbirth care — Conflicts between models of care **Social narratives about childbirth** — Changing views around birth

In line with the analysis, strategies and the structuring of the narrative data, I chose to present narrative analysis as frames with lists of "facts" or narrative structures, which include the midwives' articulations, their reasoning or hypothesis (theoretical propositions) along with the midwives' whole stories or storied episodes. The following is an example of a frame with the configurations of how the midwives of this study identify the role of storytelling in midwifery practice (see frame 4).

Frame 4 - Narrative analysis. The role of storytelling in midwifery practice

Midwives say they use stories:

- To learn from older midwives
- To give information to mothers and fathers (have favourite stories to use)
- To teach and give explanations to midwifery students (have favourite stories to use when appropriate)
- To reflect while telling a story of a practice situation – and to learn from it
- To get support or give support
  - -in a group of school sisters
  - -with the woman and her family
- For debriefing in grief because of difficult births or when there is crisis at work
- For consultations on the ward with other midwives and doctors

These kinds of frames are presented here as part of the narrative findings. In addition, the midwives' own stories and narratives are allowed to speak for themselves as much as possible with discussions in relation to the literature. These frames can be seen as the structures or the underpinnings of the midwives' own stories and the thematic plots of this midwifery saga of Iceland. They are the central narratives of the midwives in this study, referring to different aspects of midwives' relationships with women and their ways of knowing, influenced by the social and cultural context of place of birth.

Chapter Eight – Midwife-with-Woman Relationships

In this chapter the narrative configurations of the midwives' stories about midwife-with-woman relationships will be presented. Central concepts and factors that relate to and influence the forming of relationships, such as being with the woman, making connections based on trust and reciprocity, place of birth and models of care are drawn out and discussed.

Connections with Woman - Reciprocity

The midwives of this study described in their stories the nature of their relationship with the woman, how they connect to the woman and form a relationship based on reciprocity, using and developing different kinds of knowledge. This includes an inner knowing of sensing if mother and baby are safe.

An overview of how this relationship is formed with the woman linked to midwives' different ways of knowing is outlined by identifying the thematic plots or the narrative configurations (see frame 5) that demonstrate an exemplary forming of a midwife-with-woman relationship. This is also illustrated in the following paradigm story told by Bella who works out in the country in a community hospital. The story is about a woman who had made a decision to give birth in her hometown "with the midwife". Even though the pregnancy was by "the rules" post date, the woman decides not to take a "journey" (see chapter three, narrative p. 33) to a referral hospital at least an hour ride. This story of an exemplary midwifery relationship demonstrates how the midwife uses different kinds of knowledge which include a connective knowing based on trust and reciprocity which in the story had empowering effects on both the midwife and the woman.

I do not know, I feel, it [the forming of a relationship] has to come from the woman herself. There was this woman she was 42 weeks pregnant and I got to know her during her pregnancy. This was her 3rd pregnancy... and it was important for her to be here as she did not want to leave her hometown and give birth in unknown surroundings. She wanted to give birth with me; I had made a connection with her. There was this trust between us, a connection. I got a consultation from the obstetrician and everything was normal and I was quite sure about that as well. She gave birth the day after, and the birth was wonderful, she got acupuncture and everything went well. She was very satisfied, with herself, she felt she had won; she had herself made the decision.

(Midwife-Bella, 6 years' experience, interview 8)

Frame 5 - Narrative analysis. Thematic plots of forming a relationship

Midwives form relationships based on reciprocity by:

- being with ("sitting over") the woman using their skills and knowledge initiating trust
- knowing the woman and/or "reading" the woman
- the woman knowing them
- making connections
- sensing and supporting women in making their own decisions about their care
- sharing power and becoming empowered
- using and developing different kinds of knowledge
- developing inner knowing, sensing if mother and baby are safe

"Sitting over"

Icelandic midwives, as has been noted on before (e.g. p. 23), have the term *yfirseta* for the act of being present with the woman during birth. This term literally means "sitting over" and an old name for midwife in Icelandic is *yfirsetukona*, "the sitting over woman". Midwives talk about having had a "sitting over" during the shift and we count how many "sitting overs" midwifery students have had as well as how many births or babies they have "received".

Being with woman during birth has been defined as the "the provision of emotional, physical, spiritual and psychological presence/support by the caregiver as desired by the labouring woman" (Hunter, 2002, p. 650). This definition links to how the "sitting over" – or "being with" is the central concept of the model of care for women during birth in and an Icelandic context.

The midwives practising on the labour ward in Reykjavik who usually base their work on fragmented care and do not get to know their women before the birth talked about how they found it important to "*read*" what the woman wants, to have time to "*sit over*", to connect with the woman. In this context the concept reciprocity describes how midwives cooperate with the woman to find out what the woman wants and also to give and receive information in order to know what she is capable of e.g. in terms of having a normal birth, and to meet the woman's wishes and support her decision about her own care.

How much I have to give of myself for the birth to come to harbour, how much I can expect from the woman. You quickly find out how and if the woman is ready to give birth normally.
(Bella, 6 years' experience, interview 8)

It was not only getting to know the woman, the midwives also wanted to tune in to the labour itself *"to know what they had in their hands"* which can be related to the task of being a clinical monitor to check if everything is fine, or the "instrument" of care (Kennedy et al, 2003) to pick up cues to provide safety.

Related concepts to the uniqueness of "being with" to midwifery (Hunter, 2002) are presence and support that overlap and are often used together when describing midwifery care at birth. In line with this, the midwives were clear in how being with did not have to mean *"being present literally"*, that they could be there in thought and spirit because of the connections that had been made with the woman (Siddiqui, 1999, Olafsdottir, 1992). Similarly, a midwife (in Iceland and elsewhere) can be physically present but deficient in presence, emotionally or spiritually detached, which can be linked to uncaring traits that are unsupportive, lacking competence, following routines and rules and being cold and harsh (Halldórsdóttir and Karlsdóttir, 1996b). In this report of findings, the concept of "being with" is generally used when referring to the holistic process of being with woman, acknowledging that this concept involves the many elements of midwifery skills, including the presence of continuous support during childbirth and the culturally embedded concept of *yfirseta* "sitting over" in midwifery practice in Iceland.

Reasons for "sitting over" with woman

There are many reasons for "sitting over" with woman at birth. When discussing their relationships with women the midwives talked about why it was important to be alongside the woman during birth, to make connections and to provide safety for the woman and her baby for the outcome of birth, they also talked about how they felt that the parents should be made to feel safe by those who looked after them. In order to be able to do that they needed to spend time with the woman to assess the birth, check if everything was going normally and to plan how to monitor the birth, how much "sitting over" or presence was needed during childbirth (see frame 6).

Frame 6 - Narrative analysis. Thematic plots of reasons for continuous presence at birth

The reasons for midwives' continuous presence, or "sitting over" during birth are:
• To provide safety for the woman and her baby for the outcome of birth
• To enable the woman and the father to feel safe by those who look after them
• To assess the birth, check if everything is going normally
• To plan how to" sit over", or how much presence ("sitting over") is needed during birth (in order to provide safety)
• To form a relationship based on continuity of care/er
• To form a relationship based on reciprocity by interacting
• To make connections with the woman and find *"what you have in your hands"*
• To find out, "read", what the woman wants and if she is capable of going on without pain relief
• To have time to give the woman information; cooperate and support her decision and meet her wishes
• To empower and work with woman to prevent unnecessary interventions
• To ensure better outcome "*Women want to have the midwife at their side and it ensures better outcome".*

The reasons the midwives gave in their narratives of why it is important to be alongside women at birth are in accordance with how Leap (2000) portrayed one way of being with, which she called "doing things" for the woman and involved talking, finding common ground, making jokes, massage, eye contact, loving attention, sitting beside her throughout labour, encouraging her with the sponge and iced water constantly poised. This type relates to the following narrative of the time before the epidurals. Midwife-Ruth thinks midwives "*can decrease the intervention rate".*

I miss the time when we did not have the epidural, because then you were able to reach the women and form a strong relationship, breathe with them and use massage and just fight with them through the birth...I am quite sure that if we can be with them we can decrease the intervention rate.

(Midwife-Ruth, 35 years' experience, nr. 19)

To be or not to be with the woman

The storylines of midwives who had experience of not being able to "sit over" or spend time with the woman during birth demonstrated what the consequences could be. Sara, who had always practised in the labour ward at the University hospital, described impacts on midwives' relationships with women and how difficult it could be when they are always being disturbed

on the ward and how it cut on her connections with the woman and had influence on the process of birth (see frame 7).

Frame 7 - Narrative analysis. Storylines of midwives' absence at birth

If the midwives are not continuously present "sitting over" at birth, they:

- Lose their connections with women, they are cut or are not made at all
- Do not know what the woman wants
- Become shy with women
- Tend to leave the woman, do not stay, even if they have the time
- Cannot support woman in having normal birth
- Are not as encouraging *"to make a deal"* with the woman to keep birth normal and use natural pain relief methods
- Tend to ask more often for epidurals for the woman
- Do not experience reciprocity and do not get feedback from the woman and the father
- Are not satisfied with their work – show burnout signs – *"think about leaving"*
- Lose midwifery skills. *"You need the "sitting over" for a time"*

"I am so tired of this intrusion on the ward, the phone is always ringing outside [the labour room], this interruption, we never get peace … you are doing many things at the same time and you don't get the time you need with the woman. There is always this interfering which can be very disturbing because you are always cutting on this connection [with the woman] always just dropping out, always leaving, this is disturbing, this interferes with the birth unbelievably much"… It is a deluxe if you are with one woman…this inattentiveness changes your methods of working, because you have to get used to this. You do less of "the sitting over" by the women and it has the effect that you move back, and you seek to leave [the woman] more often. I think that when there is less of "the sitting over" it disturbs the process of birth and it of course increases the intervention rate - I think so. You do not know about the woman and she does not know about you".

(Midwife-Sara, 20 years' experience, interview 16)

Sara's story can be seen as a paradigm story, a model for what is happening in modern technocratic hospital practice of midwifery even though the situation is not always bad. The hospital place of birth contains different worlds, as midwife Eva described:

"*There is great difference in all this. When I have good time to focus and do not have too much on my plate and I can be with this particular woman, then this world becomes very different from what it is when I have to jump between complex projects.*

(Midwife-Eva, 28 years' experience, interview 11)

Levels of connections and reciprocity

The relationships with women seemed to differ in relation to levels of connections and reciprocity, depending on where and at what time the birth took place. The midwives who had worked alone with their women out in the country for decades, pointed out that they knew the women from their own community and that their relationship with the woman was also empowering for them as the following descriptions show:

You knew these women and I think I always had a good relationship with them. They trusted me and when you feel that you have to do well.

(Midwife-Anna, 45 years' experience, interview 1)

When you feel that the woman wants to have you and she finds help in you and you feel the trust you become empowered.

(Midwife-Elsa, 50 years' experience, interview 3)

This interplay of reciprocity was also found by the younger midwives, reflected in how they connect and have influence on each other.

There you have a certain trust, which is very important. If they feel that I am insecure they also become insecure, that is a fact...If I am calm, really cool and believe and have trust [in normal birth] then...

(Midwife-Bella 6 years' experience, interview 8)

The above descriptions can be linked to how home birth midwives in North America find courage (Davis-Floyd and Davis, 1997) in their connectedness to the women and babies they attend, as midwife Maggie said: "Mothers and midwives mirror one another. I know that I can get all of my courage from the mother. And I bounce it back to her, and she gets her courage from me...It is a dance- the woman has to trust her midwife, and the midwife has to trust her woman for that bouncing back" (p. 337).

The midwives working on the busy labour ward at the University hospital were also able to narrate similar experiences, contrast and compare as they did "*not always have the time to be inside with them*" to use the embodied knowledge of their hands to help women to feel safe and experience normal birth.

We have not always the time to be inside with them [the women] and I just wanted to be with this woman if it would help her not to have pain relief. She was very tense, but she did not ask for anything else, just for me to hold her hand, very tightly and I said "I will hold your hand and you try to relax". I just kept on, telling her that I would not leave and that I would hold her hand. The dilation was completed and she just pushed and I get tears in my eyes thinking about this. She paid me so much compliment. She said: "when you held my hand I just felt safe, something happened inside me and I just felt calm". And I said "Yes, the body got to work on its own" She said: "yes, I just did it". She was very happy, and proud of herself. She also said. "I congratulate you for having this - in your hands". This was lovely and I recognized what you can do without using medicine. You feel empowered when you are allowed to be like this, inside [in the labour room] with the woman.

Midwife-Bjork, 30 years' experience,interview. 20

Rosa also described in a humble way her connective knowing with the woman where their reciprocity affected both her and the woman.

One of the best praises I have got was from this woman who had her seventh child. Her husband was there also and he had not always been at the births. We really connected ... After the birth she said that this was the first time she really knew how to give birth and she said: "I have never been taught or talked to like that". This was just because we connected, she did all this herself and we connected, but I was somehow proud.

(Midwife-Rosa, 25 years' experience, interview 4)

This type of reciprocity is also in line with how the women living out in the country have different views about childbirth from the women living in the city and how women can teach midwives about birth.

Many of the women were farmers, they had sheep, and were active in the lambing season and helped the cows as well and they felt this was a normal thing and they told me that the birth was going to be fine but it would take time. They really taught me a lot.

(Midwife-Dora, 32 years' experience, interview 5)

There are many narratives in midwifery that have embedded stories about how midwives learn and use complex approaches and communications with women.

... it is so complex to be with a woman at birth, sometimes you are just there and the woman does everything herself, you are just to assist, and you have to have insight for this woman. They are so different, I don't think I approach women ever in the same way. I find that I always have something new in my hands. This is this woman and then I am like this, and then there is another and then I sometimes think you are in some kind of actor's role ...and you just have to be assertive and then the woman doesn't always understand why, and you have to explain afterwards why you had to be so assertive. You are never the same, that's my experience even with the same woman.

(Midwife-Sara, 20 years' experience, interview 16)

The midwife can feel uncomfortable when she does not make connections with the woman and there is *"always this wall"* between.

Once during birth I experienced this very strongly. There was nothing wrong and everything went well, but there was always this wall. I had difficulties reaching her, there was always this wall between us and it was very uncomfortable. But when she had given birth then a page was turned and she changed. This feeling [of wall] was not there anymore. I did not ask about this and I did not find it appropriate to tell her that this was my experience during the birth. She became another human being and this experience persisted to have influence on me.

(Midwife 1, in focus group)

The midwives described different situations when making connections with women and how they had to learn new ways of "being with", such as when the father first came into the equation in the 1970s and midwifery began to shift from patriarchy towards reciprocity.

I had good relationships with the women, right away it was an exception if not. Therefore, first when the fathers attended, they disturbed me. I did not reach the woman the same way [did not have the same control of the situation]. It took me some time to learn this. In relation to this I have to tell you a story about a farmer who came with his wife. This was during the night sometime around three or five o'clock and here she was going to give birth and I asked him to wait in the corridor. He said: "I am not leaving; I am going to see my baby being born". It was a wonderful experience to see this father. He was so happy and the tears nearly flowed. But this man he nearly came straight from the cows, dirty and all that. I could not control him. I was just thinking about the mother and the baby, but this was a wonderful experience.

(Midwife-Rebecca, 45 years' experience, interview 6)

Knowing and listening to the women

In general, the midwives in this study seemed to be of one voice that they were working on the basis of a model of women centred care acknowledging the woman's concerns and choices. Still usually, their stories did not take into account power relations between them in relations to how midwives as professionals use their knowledge to influence women's concerns and decisions. Exceptions of this are the following narratives about either the midwife or the

woman having the power. First, there is a story where a young midwife uses her knowledge and intuition to know better than her woman.

I had this woman I knew very well; I was still a student midwife. She was expecting her seventh baby and she had two times given birth to a still-born baby, and one of these at full term. I felt that this would be a very good birth and everything would be fine, I just felt that, and followed that feeling. But the woman, at a particular time, she was very frightened and she was sure that something was wrong. She was on four leg position and then you can not always listen to the heart beat in a good way, but there was nothing that told me that something was wrong, rather I was really sure that everything was fine and no danger at hand. The birth went fast in the end, wonderful birth, healthy baby and all that...She said that the pains were exactly the same as when she had the still born baby, and was sure that something was wrong. She said that she was a little bit surprised how sure I was, and she therefore started to believe that – but she was of course always afraid...I always try to listen to the woman, but in this case I knew I did not have to do that, I knew her that well.

(Midwife-Kristine 2 years' experience, interview 13)

The above story makes clear how continuity of carer, being with the woman and knowing her has positive effect on outcome of birth, which links to the findings of studies about experience of women having continuity of carer or one-to-one midwifery where it was highly valued by the women to have high level of constant support, knowing each other over time (McCourt and Page, 1996, McCourt et al, 1998, Page, 2003).

But what kind of knowing is needed and how do midwives learn to be sensitive to the women's choices, to reciprocate with the woman on her terms? Here is a story that had great influence on a young midwife, a story that taught the midwife about important aspects of the "*sitting over*" as she said.

"This story had great influence and it happened just before graduation. They were my friends and this [experience] taught me so much about this process of "sitting over" what you allow yourself with the woman and all that...She got intra dermal water, entonox, and massage and she did everything I asked her to do, took a shower and all that, and then she got IV [oxytocin stimulation]. There she was this fine lady sweating, her hair was, her hair was all wet, and when she was fully dilated, she was just losing control. Yet, I think, yes she is doing great... and I am very glad. I am not going to give her anything and I am going to have it like this, but he [the father] was in shock and both of them. I did not realize how shocked they were, I was just so glad that I had got her through this without pain relief. The best thing in the world, and that mattered most to me. Then she started to push and she did not have any energy left and had to have vacuum extraction...Gradually I realised that they were not satisfied with this birth and would have wanted her to have something [like the epidural]. This experience stayed with me for long and ...I had difficulties to work this out. This taught me to listen more to the woman and not go forward like a general [laughs]. I was so passionate during school and had learned about different complementary ways to help. This time I had not seen the whole picture, it is so strange that I often think about this birth.

(Midwife-Astrid, 3 years' experience, interview 15)

Imbalanced encounters

The midwives acknowledged in their accounts that they did not always connect with women and sometimes even they felt let down by the woman. The women can have the upper hand. They can be controlling, refusing to follow advice while the midwife finds ways to accommodate.

I once travelled south with a woman around Christmas. She needed a caesarian but she refused to go before Christmas. Therefore I had to go with her [she was in labour] and the weather was crazy. She said: " I am afraid" and I said: "hold my hand and if you feel that I am relaxed you do not have to be afraid [voice changes, a caring tone]. The ambulance came out to the airport and she said: " I knew it, the weather is not okay, you did not tell me the truth". I said "I could not tell you that there was bad weather"... You have to take care that the woman does not know even though you may worry

(Midwife-Anna, 47 years' experience, interview 1)

Also when the woman is in need to "act out" because of sensitive personal problems at birth:

Some women are extra vulnerable and there is a lot to work with, something that lies under and it is not ours to solve conflicts that are ongoing and sometime they need to act out, and you let them. I once got caught in one and she cursed me big time. There was a medical student there and he was appalled because the woman was so foul-mouthed, how I could stand it, she cursed again and again I just acted as if I did not hear it. Later I got an explanation [from herself], she had had a divorce, and an affair with another man and got pregnant and was together with her husband again and he did not know this.

(Midwife-Sara, 20 years' experience, interview 16)

The woman can also overstep boundaries not always following accepted social norms of behaviour, upsetting the midwife.

Normally it goes well, but there is always one and one, I remember once, I never forgive myself for not going out, but she later asked for forgiveness ... I was very upset. She was very vulgar this woman and aggressive, but still, people have to have boundaries. She knew that she overstepped the boundaries.

(Midwife-Sara, 20 years' experience, interview 16)

Technology, connections with woman and safety

Not surprisingly, safety is one of the key issues that are in the background of the midwives' stories; however, concepts of safety that came up seem to be different from conceptualizations used in official medical discourse about childbirth which usually links safety to technology. Midwives, especially those who had worked in smaller places of birth one-to-one with their women, put it in context with trust and connections with the woman as well as with an underlying common goal towards a healthy mother and baby.

Safety is there in your unconscious mind I feel that often. I do not know what it is. Sometimes I am a little nervous before I go, you are on shift for 24 hours and you do not know if you are all geared up for a birth. But when you are there with the woman and you do your check ups and you start to feel, yes feel with your hands, then this safety feeling comes.

(Midwife-Rosa, 25 years' experience, interview 4)

I had always worked in "the safety" [the high technology hospital] and had had a lot of people around me. I was nervous of course when I was to work there alone [out in small community hospital], but soon I felt safe. I remember that I was with this woman and all of a sudden I felt safe. She trusted me and us [the doctors] and she had a lovely birth. The first stage was long but when the cervix was dilated everything went well. This gave me [confidence]" ...There is no question about it, I soon felt this...

(Midwife-Dora, 32 years' experience, interview 5)

It is interesting to look at how underlying concepts of safety in midwifery, *"everything was fine"* come up in this and other stories of midwives in relation to concepts of knowing the woman. This connective safety net is important and there were also stories of the older midwives that addressed the idea how the trust between the woman and the midwife really had to work both ways. The following is an example of this. This narrative about decisions having to be made about transferring and leaving the hometown, makes us aware of how the reciprocal relationships between the midwife and the woman are fundamental in providing safe care and how both have to take responsibility.

She did not tell us about it [that she had had a post partum bleeding in her first birth]. I was never satisfied with that, I wanted them to tell me the truth – but sometimes they did not want to leave [be transferred].

(Midwife Anna, 47 years' experience, interview 1)

In the past, the women did not always want to leave as midwife Anna described above. This suggests that then there was a broader view of safety regarding choices of place of birth that in a sense translates to the remote Indigenous communities in Canada (Kaufert and O'Neil, 1993) and Australia (Kildea, Wardaguga and Dawumal, 2004 cited by Leap and Edwards, 2006). In these communities women feel that it could be more dangerous to be removed from their kith and kin, than to give birth locally at home. In the modern Icelandic context, it can be presumed that there are other issues of cultural safety appearing that need to be explored both from the point of view of women and their families and health professionals in the maternity services.

This following story illustrates confounding ways to provide safe outcomes of birth, to fight with technology which is not always used in a sensible way. This story is often used by the midwife to teach midwifery students about not relying on technology and developing their own hand on skills. In there is also a narrative about working relationships with doctors, how they can differ in respecting the knowledge and skills of the midwife. A lot of stories were told about different kinds of relationships with doctors, both holding very positive and negative feelings.

This story occurred in Sweden as the technology was arising in the years 1980-1981. I had this woman in labour. The water broke more than 24 hours earlier and it had been blood coloured. She had the CTG on and the strip was fine. I went to the woman, and I just became furious, because this woman had abruption, that was my assessment and nothing else. She had a tense and responsive uterus and constant contractions and she had had blood in the fluids for a long time. I call for the specialist, and tell her that we have an abruption and the labour has just started but we have to speed this birth. She comes in, looks at the CTG and says: "This strip is fine". Then I wished all CTGs out to the sea. There I would have liked to get rid of all this trash.
I was terrified and I could not do anything. I could not change this. This goes on, she is not really in hard labour and well about 1-2 hours later then suddenly there comes a deep dip, just down, and I call again and another specialist comes. He was releasing the other one, and he had not got any report about this woman, so this doctor did not worry or was not expecting any problems in there. I gave him my report, how this was, that this was an abruption and we looked at the strip and the heartbeat was down and was not coming up. This man just looked at me and took notice of what I said, and just one, two, three, we went into surgery. This really was grand abruption and the baby got 1-2 in Apgar, it was just dying. But it lived. However, I don't know how this ended. There I learned what I have since been trying to teach that babies that are bleeding out do not give signs on the strip until just before death. This baby had been bleeding from the day before. People were just so secure in that, if CTG was fine, then everything was, and did not look at the broad picture. There was this over focus on the new technical equipment that was coming.

(Midwife-Eva, 28 years' experience, interview 11)

Midwife Gudrun said she felt more secure when she was away from the busy labour wards and technology, where she had worked for decades. Now out in the country in a small hospital in calm surroundings, she had the time to be with the woman during her birth, able to trust her own skills as a midwife. The key for her was the "sitting over", being able to stay with the woman. Gudrun described also what to her, the basis of midwifery professional skills was and how safety of the birth also depended on her connections with the woman. This quote from Gudrun exemplifies her *"professional connections"* as she called it, her connective knowing with the birthing woman, her values and involvement with the woman.

Midwifery skills is just this...sitting over with the woman... to connect with the woman and that I know what I have in my hands, many things go around in my head and I am very involved in what is happening. I often think about this as an art form, thinking as an artist painting who thinks,-no this is not right like this, it should be otherwise or something - you know. This is this feeling when you have become professionally skilled on some level.

(Midwife-Gudrun 26 years' experience, interview 9)

Discussions

It is clear that the nature of midwifery relationships with the childbearing woman has many facets. In the following sections selected themes of concepts will be discussed. Some will be elaborated on in greater depth while others will be mentioned, focusing mainly on balance of power relations with woman in terms of making connections with the woman based on reciprocity.

Balance of power in relations with woman

In some groups, different kinds of knowledge come into conflict, in others they become a resource for constructing a joint way of seeing the world (Jordan, 1997), such as is indicated by the midwives of this study. Models of midwifery relations that were introduced in chapter four were found to have many similarities but also some differences, especially with regard to power imbalance in midwives' relationships with women.

There has been debate about how concepts linked to equality are interpreted. The Australian midwife, Leap (2000) suggested that "to describe the midwifery relationship as one of equals denies an inherent power imbalance" (p. 5). Other authors have questioned if women have any "real" power and enough information to become empowered to make choices and "to take active part in all decisions about their care" as it says in the ideological statements of the Icelandic education curriculum. Also in nursing, authors have claimed it unlikely that equality and informed choice can be achievable between a health professional and a client (Halldórsdóttir, 2003a, 2003b). These are almost inevitable as the partners always have different levels of expertise and perspectives. Research findings have also indicated that health professionals steer or drive decision making, enduring "informed compliance" (Stapleton, et al, 2002) to promote the "right" choices (Kirkham and Stapleton, 2004) maintaining the hierarchy imposed by medical and organizational models acceded to clinical protocols (Levy, 2004).

Evidence from Icelandic studies on woman's experiences of antenatal care suggests that women in general are satisfied with care in terms of presence, time and information received (Karlsdóttir, 1999). Yet, emphasis is not put on making informed choices, but rather on physical health and sense of security for themselves and their babies, to know that everything

is fine (Gottfreðsdóttir, 2002, Kristjánsdóttir, 2004). In this, they put their trust on the midwife and a sense of security was linked to professional competence of and knowing the midwife. With regard to informed choice and prenatal screening, the women followed the norm controlled by the agenda and what was on offer by the medical institution (Kristjánsdóttir, 2004), or in other words what choice existed (Levy, 2004). The studies of Gottfreðsdóttir (2002) and Kristjánsdóttir (2004) indicated however, that in terms of women centred care there was congruence between the voices of women and midwives.

It has been emphasized in the midwifery literature that women want to be in control of their care and make their own decisions. Nevertheless, the midwives in the focus group of this study pointed out that often women just put their trust on the health professionals to know what is best. This is in accordance to Leap's (2000) view that the women want to have the midwife to draw on her expertise, experience and knowledge," they are asking us to provide them with a safety net, a point of reference that they can choose to use as a resource in a world where there are more questions than answers" (p. 5). Freeman et al (2004) are in agreement and based on their study they proposed a model of care with the partners negotiating and making decisions co jointly, thus sharing power but recognizing the differences of background.

As one of the theoretical concepts in the New Zealand Midwifery Partnership model for practice is equality (Pairman, 2000, 2006) it is important to explore what is meant by that idea. Pairman (2006) states that it is essential that the midwife recognizes and respects the woman as having an equal status with an equally valuable contribution to the partnership even though there may be many differences between them. Equality means for the midwife to take responsibility for, acknowledging and respecting those differences.

Yet, it must be highlighted that midwives hold "disciplinary power" which refers to when women are coerced to do what the doctor or the midwife wants. This can be a medical power which operates "most effectively in co-operation of the midwife and the submission of the childbearing woman" (Fahy, 2002 p. 5). By using discourse of equality in a partnership it can obscure the power relationship, as if it does not exist (Freeman et al, 2004). Power in itself can be "impartial" it is the way one uses power which decides if both partners "feel" equal

(Halldórsdóttir, 2003a, 2003b) Thus it depends on the health carer, how she uses her authoritative knowledge in a relationship with the woman.

Perspectives of the environment shape the beliefs and actions of people; therefore, reflexivity (Fleming, 1998) as part of the midwifery model is useful to encourage midwives and women to reflect upon the influences of their background and the extent to which they influence joint decision making, and for the midwife to reflect if medical model of care is by her accepted or resisted. It matters if she keeps normal birth in the forefront in her place of birth and finds ways to negotiate actively and support normal birth with each woman (see frame 7, p. 114).

Choices in increased technology are complex, and the advocacy role of the midwife becomes more important in protecting the woman from the medical system that complicates the birth process. This entails integration of the scientific and the artistic components of midwifery practice, for example for the midwife to provide meaningful explanations of the interpretation of statistics that are based on populations, for people to make personal choices (Thomas, 2000), but at the same time influencing and changing cultural perceptions and activities based on midwives' different ways of knowing.

In modern maternity care with standards of technical interventions, it can be assumed that women choose technology over physiological birth. In the narrative study of Kennedy et al (2004) in the United States, the structure of the relationship with woman was described as founded on mutuality, suggesting that the midwives regarded themselves to be on equal level with the woman who also brings her own knowledge base to the clinical situation. This is in accordance with central concepts of the Midwifery partnership model of care in New Zealand (Pairman, 2000, 2006). However, when the midwife and the woman do not share the same values or opinion coming from different sets of knowledge base and environment, this kind of relationship can be hard work of negotiation, not always with positive experiences. This was for example apparent in Astrid's story presented above (see p. 120) which links with the following narrative from a midwife in the USA.

> "I had a hard time letting go of the fact that people don't necessarily feel like giving birth as something that should be a challenge. They say "I want an epidural, why would anyone want to go through pain?"... So I've had to give up some of that thinking – you know. Being able to support people in their choices, though they might not have been my choices" (Midwife, quoted in Kennedy et al, 2004, p. 17).

There is tendency to transfer all women to centralized high technology hospitals because of safety reasons, which presumably in turn has impact on women choosing to go away from their hometown to give birth. Belief in technology and the contemporary model of childbirth care in Iceland, influence them to leave. In other words, the dominant medical narrative has impact on people's choices and views. This seems to be some kind of a vicious cycle that is difficult to break. In the past, there was no choice with regard to place of birth; all births took place at home, also out in the country in community hospitals. Today both the midwife and the woman are in a dilemma, faced with uncertainty of birth, concerned if it is okay to stay at home rather than travel to the referral hospital.

Like one woman said to me this last autumn "you say that we should decide ourselves, for example if we give birth here [in the home town] or there [in the referral hospital]. And you say that this is such and such [give information] and then we are to make a decision. But if we feel that you [are not certain] - in the end you have to tell what is okay". Thus you are very well aware that the responsibility is ours. If we say to the woman you have to decide where you give birth, and she asks if it is okay to stay and we do not say yes or no the woman feels insecure, and she is dependent on us. If we say, yes it is okay that you stay here and everything is normal, and then something comes up, we are of course responsible, we have to think can we really say that everything is okay when we can't intervene [with technologies if something comes up] this is our battle, here out in the country.

(Bella, 6 years' experience, interview 8)

When put into the context of choosing a place of birth, for midwife Bella there will always be a power imbalance on many levels based on social structures and conflicting models of care. She has professional responsibilities that she feels she can not shift to the woman, or in other words, she will not delegate the authority of her knowledge (Vanderplaat, 1999) to the woman. Pairman (2006) claims that the Midwifery Partnership Model is a framework to provide guidance for midwives and women that challenges professional power structures and medical dominance. That it is a starting place to develop partnerships with women based on

concepts such as equality and reciprocity. Pairman goes on to say that the midwife carries power associated with her professional role that has limited effect if the woman does not contribute the knowledge of herself or if she is not willing to work with the midwife.

For example the study by Stevens (2003) put emphasis on how meaningful relationships are formed in one-to-one practice when the midwife knows the woman and the "knowing" deepens over time. Such knowing enhances assessment and gives depth of clinical care that increases safety, not only physical but also social and cultural. This very nature of the relationship affects both midwives and women being emotionally meaningful and reciprocal (Stevens, 2003) and therefore mutually effective.

The Icelandic midwives develop interpersonal relationship in fragmented care that is influenced by the context in the sense that relationships are formed on different levels of reciprocity and connections. As in Bella's story above, even though women in partnership with midwives might "feel equal" and share levels of responsibility of decisions jointly made, ultimately responsibility lies with the midwife. On the other hand, if the woman feels "culturally safe" with the midwife, the woman can in turn delegate the authority of her knowledge to the midwife. In this way the conceptual pairs of equality and reciprocity interplay together in a midwife-with-woman relationship. This requires self-knowledge, strong and effective communications skills and it takes time, trust and the ability to be reflective of our views and emotions (Pairman, 2006). In modern times midwives, like Bella with her women, are likely to go on being faced with uncertainty and complex joint decision making about place of birth.

Empowerment and equality in midwifery

In midwifery writings, as in other health promotion, education and social welfare literature (Vanderplaat, 1999), concepts related to empowerment as an element of the midwife - woman relationships come strongly through. This concept of empowerment has been used rhetorically on an ideological level in midwifery curricula and models of care (e.g. in the ideological statements of the Icelandic education) and as such the relationship has been considered to have possibilities of emancipation (Leap, 2000, Page, 2004, Pairman, 2006). This relational

empowerment should therefore have possibilities to make a difference and promote change in midwifery.

The discourse and definitions of empowerment differ across disciplines and the context in which this concept is used, "ranging from simple acquisition of specific skills to politically motivated consciousness" (Vanderplaat, 1999, p. 774). The concept of empowerment means a process whereby power is given, granted, or delegated by one with the power to one without that power (Vanderplaat, 1999); in other words the professional midwife has the power of having knowledge about childbirth care to give or share with women for them to make their own choices. Leap (2004) however, points out that the notion of "midwives empowering women" is contradictory to feminist thinking and that power cannot be given and has to be taken. However, she goes on stating that midwives can create situations that shift the locus of power to women.

There are indications that the concept trust is an outcome or consequence of a relationship instead of being a base for a relationship (Freeman et al, 2004). It can be argued that the concepts that constitute the midwife-with-woman relationship and have been identified are interrelated and therefore difficult to define what comes before the other, and that human relationships are not linear but circular or have spiral foundations. In the context of this study, midwives connections with women had empowering effects on the midwives which is in accordance with how partnership models of care are reciprocal and described as being a two-way sharing and mutual exchange that creates shared meaning, beneficial to both (Pairman, 2006).

However, the midwives' relationships with women, is not always beneficial and can be emotionally rewarding as well as difficult. The midwives of this study pointed out that it was not possible to make connections with all women, that there could be a wall, something hindering. These experiences made them feel frustrated. Furthermore, even when midwives begin their relationship from a position of mutual respect and equity, they in the end can be vulnerable; they might feel let down and hurt for example because of the threat of litigation and of the close connections they had.

"There has to be equal responsibility, but it is nearly impossible because of litigation and that some people think they can get some money. Things have changed, and it hurts when you feel betrayed by the woman, and this is the shadow side of midwifery practice and especially if you give of yourself and work in close connection with the woman, but you have to live with this. I want to be involved and would not want to work with the woman in any other way".

(Midwife 6, in focus group)

This midwife who has experience of working in close relationships with women based on continuity of care through pregnancy and childbirth also talked about how midwives have to develop communication and professional skills when distinguishing between when "everything is fine" and when "it is not" and they have to intervene and take control. Then the midwife has to learn, as she might have to do, to go against the woman's wishes, which can be very difficult when her work is based on this philosophy of women centred care based on reciprocity. This midwife's reflections can in part be applied to a model of midwife-woman relationship proposed by Hunter (2006) about relationships between community-based midwives and mothers in the UK, which takes into account that relationships can be non-reciprocal as well as reciprocal, indicating that exchanges with women can be in or out of balance. For this midwife she wants to *" live with it"* and would not have it *"any other way".*

These power relations are complex and imbalance in reciprocity creates power differences and can have negative consequences for both women and midwives (Stevens, 2003), which could explain midwives' uncaring behaviour experienced by women (Hunter, 2006) that has been identified in the research literature. Women have expert knowledge of themselves and their lives and hold their own power to give to the midwife. However, there is always this question of who in the process of empowerment has the capacity to empower. It can be postulated that by taking into account the different backgrounds of midwives and women, it is possible to achieve some sort of "equality" based on trust, if that is the ultimate aim with reference to how the concept of equality is defined or what phrase is used. Midwives might have the same intention but the question is how to do it. However, this would depend on the levels of connections between the individual midwife and woman, their mutual ideology and how they form their knowledge of childbirth and the context of place of birth.

The women's and the midwives' negative and positive experiences

In this study the focus is on the midwives narratives not the women's. This does not mean to dismiss or lessen the importance of listening to and learning from their birth stories. The

studies of Halldórsdóttir and Karlsdóttir (1996a, 1996b) about experiences of childbirth and caring and uncaring encounters during birth from the point of view of women were done in an Icelandic context, in the same geographical areas as this one. There is a certain "fit" and their findings are in agreement and support the narratives of the midwives of this study when they describe their reasoning for being in relationships with women and how they talk about connections with women on their terms. "This connection was very natural, and that was very important for me, to be able to be completely myself..." (Halldórsdóttir and Karlsdóttir, 1996b, p. 369). Furthermore:

> "... it was very important to me that this was a human being that I could relate to and that I could show my feelings, whether I was happy, scared or feeling bad, that I could show her everything without having to be shy "(Patricia 36, mother of two, quoted by Halldórsdóttir and Karlsdóttir, 1996a, p. 53).

The feelings of these mothers link to the concepts of trust and connections with the midwife which are fundamental parts of the midwife-with- woman relationship. The following quote about how quickly a midwife can connect to a woman to provide a sense of security, never "deserting" her, refers to how the presence of a midwife, the "sitting over", is also important form the perspective of the woman.

> "My perception was that she never deserted me... I never lost this great sense of security I experienced as soon as she arrived. Just from the moment she introduced herself to me". (Susan, 40, mother of two, quoted by Halldórsdóttir and Karlsdóttir, 1996a p. 54).

A contradiction is that the findings of Halldórdóttir and Karlsdóttir, (1996b) also showed negative experiences of women. Midwives were perceived as uncaring had "unfortunate characteristics", a sense of indifference, lack of respect and cooperation. Such encounters were also apparent in my study, which meant that the women and their husbands did not form a relationship with the midwife (Ólafsdóttir, 1992). In general, this type of midwives was seen as un-supportive, hurried and in a rush, and insensitive. "She gave nothing of herself. She came there and went, and she did nothing, so my husband was my support there this evening in that room" (Halldórsdóttir and Karlsdóttir, 1996b, p. 372).

The US homebirth midwife Davis (2004), thinks that birth could profoundly transform woman, strengthen her faith and deepen her identity. Hence midwife as guardian and facilitator of that process is intrinsically feminist by her work. A woman who labours on her own terms and triumphs in spontaneous birthing will mother in a fiercely independent fashion, with strength and inner certainty spilling out in every other aspect of life.

Yet, there is vast evidence that midwives in some cases abuse the relationship (Anderson, 2000, Fahy, 2002). The midwives might not form a relationship with the woman because of uncaring encounters (Halldórsdóttir and Karlsdóttir, 1996b, Ólafsdóttir, 1992). Individual experiences do not take into account the dominant social structures and interactive factors which influence understandings of culture of childbirth. The dominance of such social processes has, however, been discussed and resisted by feminist activists, sociologists and anthropologists of childbirth (e.g. Rothman, 1982, Kitzinger, 1988, Jordan, 1993, Oakley, 1993, Davis-Floyd and Sargent, 1997, Teijlingen et al, 2004). Sadly midwives have to admit, as Anderson (2000) pointed out, that "an insensitive and intrusive midwife can just as easily block a woman's being able to do this, undermine her confidence in her own body and turn her experience of giving birth into a nightmare" (p. 117).

The birth stories of the important book of Icelandic birth stories (Ingadóttir, et al 2002) also give insight into the experiences of childbirth in Iceland, and there are many stories to learn from, both about depressing negative experiences of interactions with midwives as well as the rewarding ones. From my point of view, the underlying message of the stories is that women want to feel in control and take part in decisions of their care in cooperation with caregivers they trust. This following description of a woman about what "being with" of the midwife meant to her during birth is encouraging and uplifting for midwives and exemplifies their roles at birth (Ólafsdóttir, 2002, p. 371).

> "It sounds strange but in my mind I assumed that analgesia and medicine were an integrated part of birth. In all the pregnancy books everything was explained about the possible and impossible analgesia and pain relief on offer during birth, just like this was a menu in a restaurant. Now, I know that the nearness of a person you trust, a person who tunes into the birth with you, and does not leave you in a cold hospital room, is better than any analgesia"

In this study the midwives did not use terms related to equality, but rather relational terms of being in different roles of a caring friend, partner, mother, grandmother which changed as the midwife got older. They talked about meeting the woman's wishes, finding out what she wanted. These can be considered to be elements of reciprocity that make connections with the woman that also refers to midwives' inner ways of knowing which will be identified and discussed in the following chapter.

Chapter Nine – Midwives' Inner Ways of Knowing

This chapter is about the narrative analysis that relates to midwives' inner ways of knowing and aspects of their relationship with the woman, identifying different types of inner knowing that midwives use in balance with other kinds of knowledge systems. Relationships have been explored in the chapter above in the context of trust and connections based on reciprocity. Through midwives' birth stories, these issues will be explored and discussed as components of inner knowing, intuition based on work experience and/or spiritual awareness in midwifery practice.

Experiences of Inner and Spiritual Knowing

Limited literature is to be found on the topic of inner knowing and spirituality in midwifery. However, in different countries in the Western world, rules and descriptions of midwifery practice (e.g. Iceland and the UK) as well as definitions of the International Confederation of Midwives of the role of the midwife (Hall, 2001), include the spiritual as an integral part of the holistic care of midwives. Likewise, midwifery writers bring up this aspect of midwifery, but in a passing and a taken for granted way without further explanations or definitions. One element identified in the literature as an aspect spiritual care is "openness/using intuition" (Hall, Taylor, 2004). The question is, how midwives experience this phenomenon and what constitutes spiritual care and inner knowing, how this kind of knowledge is gained and used. The midwives' experiences of this study begin to give some answers.

"This sense that comes"

The inner knowing or intuitive knowledge of the midwives in this study was discussed and articulated in various ways by the midwives (see frame 8). A common thread was how this feeling was a combination of skills and helped them to be confident in their work and to have strength to ensure safety of the mother and the baby. One of the midwives described this as "this sense that comes".

"I think all midwives learn from themselves. We learn and find out what there is inside us. It is a combination of skills and intuition and being able to unite it. It is this sense that comes when you know if everything is normal or not".

(Midwife Bella, 6 years' experience, interview 8)

Frame 8 - Narrative analysis. Midwives' senses of inner knowing

Midwives talk about their inner knowing and describe this sense of:
• Safety for the woman (and her family) that comes when you know if everything is normal or not
• Someone being behind you (he or she can be either on the right or left side).
• Being guided by
• Something inside you, difficult to explain (in your unconscious mind)
• Inner strength (also because of the relationship with the woman)
• Restlessness
• Something does not fit, not satisfied with what you find but you cannot put a finger on it
• Having to be on your toes,
• Getting messages (cannot always read or do not always want to (if it is about personal problems of the woman)
• Strong feelings which take over and do not let you in peace
• Not being alone (I must be a little crazy, have always felt that someone was with me)
• Whispering voices telling you what to do
• Having an antenna on the head
• "Angel shift" and experience
• Not knowing why or how you intervened
• Being at the right place (where interventions were needed) or being chosen to be in a difficult situation when problems arise
• Something bad is going to happen, this threatening and strange atmosphere
• Doing things and not having control over them
• Premonition of problems that the midwife is going to meet before meeting the woman or coming to work or the shift starts

"Not alone"

As discussed before (when explaining the narrowing down the study, see p.80-82), the older midwives who had worked alone out in the country for decades told stories of not being alone when they attended the birth, not meaning that the doctor was there.

I have asked for help from the other side, I think I never was alone. I found strength in this I do not have a strong belief but I feel that it is good to have someone behind you. I remember once during a long birth I asked for help and I got it. It does not do harm.
However, I did not call the doctor in the first years, later that changed. If a doctor was there people said," what is wrong"? - A doctor meant something was wrong.

(Midwife-Hanna, 48 years' experience, interview 7)

In one of the indigenous places of birth in the far reaches of the topical rainforest in Malaysia, midwife De Ode also found strength in having someone behind:

> "...We call the spirit Raib and it is like the wind, it cannot be seen, but we know that it is good and will help us when we need it. The delivery of a child is easy when the spirit is around" (De Ode, quoted by Vincent-Priya (1991, p. 151).

Midwives that worked in the central hospitals could identify with the experience of midwives having "someone behind", but some were not sure. A number of midwives were very clear on this even though they did not have long practice experience or only had a working experience from a busy hospital labour ward. This is in contrast with how Hall and Taylor (2004) claimed that in the UK it was a fact that nowadays midwifery students are qualifying without seeing many physiological births and that they were therefore losing intuitive skills very early on, or even missing the chance to develop them.

I am definitely a little bit crazy, I feel that someone is with me, I have always had this feeling that someone good is with me. I only have to learn to trust this ... [gives an example about when she had premonition of shoulder dystocia, and should have called earlier for assistance, for someone to be with her.]

(Midwife-Sigrid, 6 years' experience, interview 12)

One woman said, when you came in it was like an angel was coming, she told me afterwards, I don't know what she saw, this was very strange, somebody was there with me.

(Midwife-Sara, 20 years' experience, interview 16)

I also sense when I do not have somebody behind me and then I am not always calm, I even go aside, to the toilet and say;" now come here".

(Midwife 6, in the focus group)

Belief in normal birth

Astrid, a young midwife, talked about belief in normal birth in a spiritual way. She described how she sometimes struggles to hold to this thought and how the environment around her, the place of birth, has effect on her to *"fall into a trap"* of stopping to work by a midwifery model of care. This placed her in conflict with her inner knowing and with her trust in normal birth, not able to facilitate empowerment by believing in women to inspire confidence, to know when to intervene and when to withdraw (Leap, 2000, Guiver, 2004). In this story the midwife had fear (or bad spirits!) with her rather than support from "someone behind". Still, she got the support from another more experienced midwife on the ward. This is in accordance with how

the midwives in the focus group addressed the need for a sisterhood of midwives to stand together and get support from each other in the the battle of keeping birth normal.

"I can not really say that I feel that someone is with me, I don't know, but I am very focused on the normal, I must admit that, unless there stands eclampsia or something and I know I have to work based on that, and then I work like a machine and follow standard procedures. I am firm in this thought that everything is going to go well until proven otherwise. I have of course come against a lot of things on the hospital but there you have a lot of people around you and I am in a safe environment... "I do not think that I have come against anything serious and maybe therefore I can hold on this thought about normal birth ... I can not say that I feel that someone is with me, but must admit that sometime you allow yourself to fall into a trap, thinking about the risk of something happening, like this uterus rupture. I once started to think about it when I had this woman who had an earlier c-section, and I allowed myself to fall into it. I met this midwife out in the corridor and I said to her; "you know I am falling, and I am always thinking about it "I just became so afraid. " I don't understand this, I feel a contraction and I just think; wow there is going to be a uterus rupture. Then she says: "This is okay; tell me about this, everyone is becoming afraid here. So I tell her what I am thinking and such, and she said: " go in and put down the drop, then you will feel more calm" and I did that and felt much better and had got rid of this [fear or bad spirits!]I had with me.

(Midwife-Astrid, 3 years' experience, interview 15)

Development of Intuitive Knowledge

Hardly any research has been done on intuition in midwifery, the exception being the study of Davis-Floyd and Davis (1997) about intuition as an authoritative knowledge which was based on interviews with 22 homebirth midwives in USA. Those midwives were found to use a type of care based on intuition that seemed to involve body and the spirit but not necessarily the rational mind. Intuition developed and emerged "out of their own inner connectedness to the deepest bodily and spiritual aspects of their being as well as out of their physical and psychic connections to the mother and the child" (Davis-Floyd and Davis, 1997, p. 339). This fits well with the narratives of inner ways of knowing of Icelandic midwives.

In general, the midwives did not agree on or know from where this kind of knowledge came, but they all talked about how they had to learn to listen to it and take notice of it, which could sometimes be difficult being under pressure from conflicting models of care.

After all this happened [intrapartum bleeding and transfer to a referral hospital] I knew why I had been uneasy; because in my unconscious mind I knew something was going to happen...I have to learn to take notice of myself. I knew this feeling, I had sensed this before, and then I knew that something was wrong...I have to believe myself, but sometimes I am concerned or afraid that this is a false feeling, that I am losing my courage, that I am afraid, I do not want to make problems, because I have trust in birth. This feeling is a – [sign].

(Midwife-Bella, 6 years' experience, interview 8)

This echoes how Davis-Floyd and Davis (1997) found that learning to trust intuition was an ongoing process. The midwives gave different explanations about how they develop different types of inner knowing (see frame 9). Most of them related this kind of knowing to different aspects of being "in relationship with woman". One of them said:

...to be able to use intuitive knowledge, you need the "sitting over" for some time ...If I feel this trust, then I feel well, then maybe I open up for this sense [of inner knowing].

(Midwife-Monica, 36 years' experience, interview 10)

Furthermore, Kristine addressed how different places of birth could influence development of intuition.

Where you have all things around you [other midwives and doctors to call upon as well as technical equipment], you can allow yourself to be insecure for a longer time. Here [out in the country] you learn to have trust in yourself and to listen to intuition

(Midwife- Kristine 2 years' experience, interview nr. 13)

Eva pointed out that because of the dynamic nature of childbirth and midwifery practice the midwife has to develop her skills of inner knowing.

"You need a certain training, knowledge and skills, to take hold of the technology skills in your backpack and that might take some time and energy at first. Then I think no matter how else it goes that the other [the inner knowing] takes over, gradually. This is a question about the dynamics, the training is so dynamic, you never are at a standstill with everything under control, and you can't get away from this [inner knowing] even though you try to.

(Midwife-Eva 28 years' experience, interview 11)

Frame 9 - Narrative analysis. Explanations of developments of inner knowing

Midwives develop their inner knowing by:
• Being with the woman ("sitting over")
• Making connections with the woman based on trust *"maybe there is some fusion there" "merge with the woman"*
• Finding what is inside her, *"we all do that"*
• Combining skills and intuition being able to unite it
• Learning to listen to it, take notice of it, and believe in it
• Being *"old enough to listen to it"* - *"it takes over gradually"*
• Gathering information for the unconscious mind which pops up when she needs it
• Balancing the two (the obstetrical and the special intuitive inner knowledge of midwives)
• Having belief in normal birth, the energy and the physiology of birth
• Having shared power (empowering and being empowered by the woman)
• Being aware of the "normal" uncertainty around the birth, therefore having to use inner knowing
• Being human "the same thing, what parents have to develop as human beings"
• Being in challenging situations.
• Being physically close, *"allowed to touch"*

Types and Use of Inner Knowing

Within nursing, intuition as has been identified as a type of "tacit" knowledge, an understanding without rationale (Benner, 1984, Benner and Tanner 1987, Benner et al, 1996) as an integration of forms of knowing in a sudden realization which again precipitates an analytical process which facilitates action in patient/client care (King, Appleton, 1997). The concept of intuition has complex interrelationships between its elements. Intuitive thinking is holistic in nature and an essential part of the process of looking at the individual as whole person (McCormack, 1992).

Three types of inner knowing were identified from the midwives' stories. The first one is in accordance with the nursing literature, a pattern or recognition that occurs in response to experience and expert knowledge in practice (Benner, 1984, Dreyfus and Dreyfus, 1996) and is a trigger for nursing action and/or reflection and has a direct bearing on her interventions in

practice (King and Appleton, 1997). This kind of knowledge has been internalised and the practitioner cannot always explain intuition judgements and decisions. The second type is more mystical or supernatural and is even more difficult to acknowledge or understand and does get very little place in discussions or research of midwifery knowledge. "This kind of evidence sits firmly outside the realms of normal science and so called rational thinking" (Wickham, 2004, p.165). The third type coincides with the descriptions of intuition as inner connectedness between the midwife and the woman (Davis-Floyd and Davis 1997) and develops on different levels where the other two types overlap and is used in reciprocal relationships with the woman, as connective knowing in a situational context of place of birth in balance with other types of knowledge systems (see overview in frame 10).

Frame 10 - Narrative analysis. Overview of different types of inner knowing

Midwife - with - Woman Relationship **With Woman and Connective Ways of Knowing**	
Inner knowing –Practice experience	**Inner knowing- Spiritual experience**
The midwife	**The midwife**
Learns from experience	**Has this sense from the beginning**
Becomes confident in her skill	Knows, when it becomes stronger with experience
Compares experience with	**Is not always open to this sense**
Biomedicine knowledge	Can't use it when she is *"working as a machine"*
What has been experienced before	following protocols
What has been observed before	or when she is *"on the run"*
Has backpack of experience	**Knows the feeling when she is open to it**
Pops up when needed	It is *"connection"*
Midwives in busy hospitals	**Midwives out in the country**
Have great responsibility	Have great responsibility
Pressed to use the protocols	Need to" have someone behind"
There has to be calm	There has to be calm
Balance of knowledge systems	Balance of knowledge systems

Inner knowing and spirituality mean different things to different people. Everyone has psychic or spiritual abilities, but people experience them differently: with regard to interest in developing them, importance in their lives and potential to allow them to grow. In the context of the inner voice of spirituality Eva reflected:

Inner voice, what about that? I do not know I think it is something of being human everywhere. I think it is the same thing, what parents have to develop as human beings, which you develop in challenging situations...The midwife also has this great human closeness. She is in a very close connection with her client, both physically and spiritually. Maybe it becomes spiritual because you are allowed to touch the person physically, maybe there is some fusion there, because there are not any brick walls, that prohibit you to touch and when this happens one is moved before the other.

(Midwife-Eva 28 years' experience, interview 11)

Another midwife in the United States (Johnson, 2001, cited by Linhares, 2005, p. 10) described spirituality in the Midwifery Today journal in a similar way as the "core of humanness, an integrative energy that pervades, unites and directs the universe and human dimensions". Some of the midwives seemed to be certain where from their intuitive knowledge originated, if it "*must be the experience*" or if *"it was something else"*, based on spiritual awareness (see frame 11 and 12). The following are narratives that have been drawn out to represent the different types of inner knowing in Icelandic midwifery.

Intuition based on practice experience

This must be the experience ... It could be the subconscious mind that gathers information, that comes up when you need it, and out in the country you are always checking if everything is fine, and then you get this feeling... I do not know why, just this feeling inside you, there was this woman giving birth with her second baby, and everything goes well, the heartbeat and such, and the woman is fine. Her belly is different, but she did not have the contractions ring, you know, as should be if you suspect danger of a uterus rupture, but this not as it should be. She had CTG and the strip was fine, and she did not complain very much, but there was something. It is maybe foolish to say this but it was strange to examine her, okay I am there for the next hours [continues to describe how she is constantly checking, comparing different symptoms to the situation]. Another midwife came on shift and I tell her, that I do not know, but that I am not satisfied with this, there is something there, when you palpate her belly, something does not fit, that I have been on my toes for two hours. I said: "go on being on your toes". She had a caesarean an hour later, the heartbeat changed suddenly and the contractions ring appeared and she was just in surgery when the uterus started to rupture. I called a doctor, because I just had to tell him that I was not satisfied, and he understood what I meant but did not see anything either. This is possibly the strangest thing I have experienced. I could not put my finger on it, but I listened to this feeling because it was so strong.

(Midwife – Monica, 36 years' experience, interview 10)

Frame 11 - Narrative analysis. Thematic plots of intuition based on practice experience

Thematic storylines about inner knowing based on practice experience, by:
• Learning from experience, she becomes confident in her skills
• Having long experience, she is able to handle this, to become confident
• Comparing experience with what you have been taught in school, biomedicine knowledge, she uses her skills
• Comparing what is experienced now with what has been experienced before, observed before (compares incidents and reflects), she uses her skills
• Having the backpack of experience, she uses her skills

Depending on the situation Monica could identify when she would "rely on their extensive intellectual knowledge and accumulated expertise" (Davis-Floyd and Davis, 1997, p. 326) and on biomedicine or obstetrical positivist knowledge and not other kinds of knowledge such as intuition.

When you come on the shift and you get report about the woman and the whole ward, and you are the superior, then you do not know the women and you have to base on the report, this could be women in normal labour, but you know nothing... I would never have faith in intuition on the labour ward [in these situations]. I listen to the report and assess from that what to do [based on theoretical, obstetrical knowledge]. I would of course go in, and check...
(Monica, 36 years' experience, interview 10)

Midwives use intuitive knowledge in various ways and situations. The Concise Oxford Dictionary (1989) defines intuition as immediate apprehension by the mind without reasoning. By intuition one receives knowledge by direct perception. This definition relates to how the midwives in the focus group agreed that if they had the time to spend with the woman at birth they quickly could make connections with the women, even though they had not met her before. This action could be based on intuitive knowledge defined as "subjective, contextualised and transcended through new experiences" (Johns, 2000 p. 43). This type also links to the spiritual kind.

Intuition based on spiritual awareness

This is something else [than practice experience] because I felt this right after graduation, then I had this sense, and it could not be experience, and I thought it might be me not being confident, but this goes on...and this is not less or more, if you can talk about this in magnitudes. It just pops up once in a while: "this should not be like this", or "this is not going to go well". It is something, I do not know what it is, and you have this not such a good feeling. First you were insecure and you often thought, is this just nonsense? - But now I have more experience and I have the confidence. The walk to the phone [to call for advice] used to be shorter (laughs). I know that intuition is telling me the right thing. I think it grows and with experience you begin to believe in it, when you get more confident you learn to believe that this is a sense instead of "non-sense". It is not the same thing; it is like the intuition grows with the experience but not that it necessarily is dependent on it.

(Midwife- Kristine. 2 years' experience, interview 13)

Frame 12 - Narrative analysis. Thematic plots of intuition based on spiritual awareness

Midwives' narrative structures around inner knowing, based on spiritual awareness
• She is not always open to this sense or feeling, not when she is always being disturbed on a busy ward
• She talks to inner self, discusses and argues with inner voice about what she is doing, balancing knowledge
• It is there from the beginning not depending on experience
• She knows, when it becomes stronger with experience, that this feeling was not non - sense
• She can't use it when she is "working as a machine" following protocols
• She does not use inner knowing when the workload is high and she has to delegate and take care of many women at the same time.
• She (a busy ward midwife) understands what the midwives out in the country mean when they say that they are not alone, they need it
• She knows the feeling when she is not on the run, I call it "connection"

Crazy spiritual interactions

Some of the midwives used the term "crazy" which indicated that this kind of knowing is not valued or authoritative knowledge. Here is a story about *"a crazy experience"* that was different because it was not based on intuition from practice experience, but on spiritual guidance.

I got a woman who just came in, and she was hardly in labour, had been there once or twice before, and had pains not being in labour. This time they decided not to send her home, she was to have a rest and such. She had just had her door – test CTG and I talk to her and go with her to the labour room. I think at the same time why am I taking her into a labour room, she is not in labour. This is crazy, but I go on, and when we come in I put her on CTG, and again I think, - I just took her out of CTG, she should not need one until later to night or if something changes. I go on discussing this with myself in my mind and the CTG is fine, this fine heartbeat, I leave her with the bell, and go outside to do the paperwork, I often do this like this. Suddenly while I am in the middle of writing her in, I just stand up and I have to go in to her, when I open the door I see this fine CTG, reactive, long enough and everything is fine. Then the connection is out, cut out, not like a change in heartbeat or deceleration, and the normal thing would be to stop, and release the woman from all this. No, I took the sonicaid and start to search for the heart beat, and I just can not find it. And last I hear bum, bum very slow, one on one beats, I ask for the specialist, and put up an electrode and when he comes the strip is fine, a gap in it, and the doctor thinks all is fine, I tell him not, then just minutes later this happens again and the doctor comes again, asks for electrode and I say, it's there and working. He just looks at me and we run with the labour bed into surgery. I had to assist until the surgical nurse came. The baby had the umbilical cord woven around the neck many times and was admitted into neonatal intensive care, and when I visited there a few days later it still had a groove in the neck. The baby had been in a hanging rope and when the mother moved or she had a contraction, the blood flow in the cord stopped. The baby was fine and went home with the mother a few days later. I will always find it strange how I did this, talked to myself and did other things than I ordinarily would do, I can never understand this. Sometimes there are things that push you on, some signs or symptoms and you discuss with yourself what to do. This was different, this time there was nothing to base this on – I got guidance that day.

(Midwife-Eva, 28 years' experience, interview. 11)

Transcendence

The midwives drew attention to the fact that they were not psychic, but maybe sensitive or perceptive to people and their surroundings and believing in higher power like God. Those who had spiritual experiences to tell seemed to have contact to the spiritual world in a matter of fact way and some of the midwives reported that women or other transcendent people had told them or described to them who was behind them from the other side, possibly a named doctor or a midwife.

There is a midwife behind you; she is always there on your right side. Her name is Gudrun, and I said: "Is her name Gudrun, I don't know any Gudrun? I would have liked it to be Sigrid [the midwife who attended her mother's births at home].

(Midwife-Helga, 46 years' experience interview 14)

Embedded in the midwives' stories were narrative configurations about when and how they used different types of inner knowing (see frame 13).

Frame 13 - Narrative analysis. Thematic plots of using inner knowing in practice

The midwife uses her inner knowing when:
• She is in a relationship, in connection with the woman
• She knows that a woman needs her and when she does not
• She wants to play down stressful situations (twin births) tell doctors that everything is ok, and there is no need to hurry.
• She needs to be tough, to make decisions and take control of the situation
• She needs to know where the boundaries are between things being normal or risky
• She has early recognitions, to be at the right time performing emergency interventions
• She wants to form at relationship or make connection with the woman in very short time
• She is not *"working as a machine*" or following guidelines of treatment"
• She wants and feels safe to break the rules (protocols of the hospital, go against clinical guidelines, *"sometimes it is ok, sometimes not"*
• She receives energy, to make judgements, clinical decisions (especially if she is tired after a long duty, waiting and "sitting over")

Intuition based on connective knowing – with the woman

Below are stories that illustrate use of connective knowing in different contexts.

First there is a story about midwife Eva's sensitive care when she uses her intuitive knowing and connects with the woman and decides to be always at her side. In good cooperation with the doctor she "breaks the rules" by using her connective knowing that emphasizes not autonomy and independence of judgment but joining of minds (Belenky et al, 1997). Even though they had never met before, this story is about how the mother feels the midwife must be as hungry as she is after the birth, both being in primal need of getting back the energy they spent together, as one person.

Joining of minds

This woman was in death's anguish and was not able to communicate with words. She had lost a lot; there had been sickness and death around her. She had also had a premature baby before and this one was just under 36 weeks. I am not quite sure but I think she did not have any baby alive. And she just was not there, and I just allowed her – and decided always to be by her side. The heartbeat went down and the baby was delivered by vacuum extraction. I got this strong feeling that she just had to have her baby in her arms. There was a shift change but I did not go home. The sugar level went down and I did what was necessary there with the woman, provided intensive care for the baby in her arms and helped her with breastfeeding. When this story took place, this baby would have gone to the neonatal intensive care, now this has changed and this kind of care, keeping the woman and baby together, is a part of the routine care at the labour ward. - Because of the rules I was so afraid that she would not be allowed to have her baby with her to the postnatal and I had to leave the room to have a cry about that - After some time she suddenly took a deep breath and looked at me and said: "Are you, not getting hungry"? At this moment we were one, she knew it and I knew it. I knew I was doing the right thing. She went to the postnatal ward with her chubby baby, breastfeeding, and she milked a lot even though she was under stress. In all this I worked very well with the resident paediatrician, he understood very well what I was doing, and I think warmly of him.

(Midwife-Eva, 28 years' experience, interview 11)

Being at the right place at the right time

The midwives usually seemed to pick up intuitive information by making connections with the woman, yet on the high risk labour ward the midwives seemed to have an intuitive flash, and learned to pay attention to what was happening around them "in connection" to the ward, not needing any other tools than themselves being there. The midwives said that they often felt that they had been at the right place at the right time.

We don't need any more tools, I had two women and one was really normal having her second baby and should not have had a monitor and she just walked around and in room two. I had this other woman and then I just got this premonition and I just had to go in there. She did not ring the bell or anything. She had just gone to the toilet and and said to me: "there is a little bit of bleeding". To me this was a little bit more than that and I just asked her to lie down to check. There was more and more bleeding and I do not remember if I called the doctor before I took her to surgery. She had abruption and a total one, and the baby was just saved.

Midwife-Ruth, 35 years' experience, interview 19

This notion of having "someone behind", to my knowledge, has not been described in the health care literature in the West. However, the traditional midwife Buleh who lived in the village of Talang in Malysia and had been a midwife or *bidan* for 15 years, but had helped her mother before that, was in contact with her supernatural, close to her spirit. Buleh was a highly respected midwife for her spiritual powers, the spirit giving her confidence so it also gave

confidence to her women (Vincent-Priya, 1991). Even though the two places of birth are very different, there are similarities between Buleh and Helga's narrative below. Helga is a midwife with vast experience on a busy labour ward, but she had never worked "alone" out in the country. She is also known and respected for her "powers" of clinical skills from the old school, teacher and mentor of midwifery students. Her "gut feeling" and early recogntion of the problem (Peden-McAlpine, 2000) relates to how nurses in critical care think-in-action, the conscious awareness of an immediate grasp of the whole, brought to consciousness through action.

Yes, yes there is someone here [points behind her head], you know I have always found that someone is here, because often I have been in a situation where I just react in the right way at the right moment when something is happening. Then it is like someone is guiding you. What it is? It is something inside you. You often get this feeling, like it is coming from behind, something that points you [to go where you are needed on the ward] ... and through the years there is something that guides you to be there [with the woman] at the right moment. There comes this woman and she is having her second or third baby ... and they bring her into room one, and the kid is not down and in unstable position and there comes another woman and I am checking her and I think, there is something going on in there and just then the bell rings and I run, the water breaks and the cord falls.

(Midwife-Helga, 46 years' experience, interview 14)

After the interview some of the midwives made contact and said they took more notice of inner ways of knowing. The following story happened just a few days after the focus group interview.

It had been a busy night ...then the third woman rings and she is just starting in labour and I am getting a little bit lazy, but I tell her to come for a check, and the CTG is fine, nothing to point on, two cm dilation, too early for a water bath and she took a shower as she did not want any massage. This was about 07.00 and about 07.45 I listened to the heartbeat and everything was fine, but I did not examine her, as another midwife was coming to take over. I told her that she should go fairly soon to her and not wait to listen the report about the other women, I knew it would take some time as this was going to be a busy day. While I am walking out the corridor I decided to turn around and I went to the parents and told them I would like to listen to the heartbeat before I left, which then was going down. The other midwife took over, and I got a text message from her about the caesarean which was performed at 08.30. The woman had started in hard labour with the head pushing down, very fast and the baby got 2 in Apgar score. God is this not remarkable?

(Midwife 6, in focus group)

"Breaking some rules"

Rules are broken by using different types of inner knowing. When the midwives thought about what stories they would like to tell, some of them wanted to choose stories referring to *"When I disobeyed for the first time"*. However, they did not always get to tell them because other stories emerged during the interview. An example of this is a story not told about a water birth where the midwife "allowed" the woman to give birth in the water which was against policy. Embedded are many narratives that link to the situation at hand in relation to "the rules" where midwives were in dilemma because of rituals of obstetric practice (Davis-Floyd, 1987) and positivist knowledge of evidence based practice. They must help one woman (n=1) based on studies from population of many, knowledge that is by nature generalized (Page, 2004) as midwife Eva described.

Our system is like this, we have a lot of devils protocols that flex around our feet and hinder us, but we have to follow the rules and the women do not fit in with the rules
(Midwife-Eva, 28 years' experience, interview 11)

Kennedy, et al (2004) identified that the relationship between the midwife and the woman provided a foundation for the midwife to orchestrate an environment of care where the woman's desires were met, she was kept safe along the way and where normalcy was preserved. She used the term advocacy as a complex concept which included supporting what the woman wanted to have happen, aligned with what the midwife believes is safe to happen. Of interest is how the Icelandic midwives of this study described similar things as the midwives in USA in trying to keep interventions at bay and convincing medical staff that all is safe, using intuition to create calm and tell them there is no need to hurry and that guidelines are just guidelines. In this sense here the midwifery knowledge is authoritative in guiding actions; even though it is not made visible by midwives themselves or their colleague doctors.

Yes, you feel this, you can't control this, you sometimes feel that there is something wrong without...On the other hand you often - like at twin births there is a lot of stress around them, and then sometime you just have to take control, and tell them [the doctors] there is no need to hurry, relax and things get easy, and you sense that everything is fine.
(Sara, 20 years' experience, interview 16)

In a letter with pictures and news of twin babies (November 1989) with early Christmas greetings, the mother thanks Sara for her assistance at the birth, writing

> "I have wonderful memories of the birth where you energetically took control and provided for us a sense of safety, which is so important during birth, this remarkable event of all parents. Best wishes to you and your women colleagues – and even though it is still far to Christmas I wish you all a Merry Christmas and a Prosperous New Year. Regards..."

Connected to this, midwives reflected about how intuitive knowledge based on their practice experience was used to "break some rules" but with responsible certainty of professional knowledge.

You have to know how to read technology, it does not tell us all, and it can easily disturb you. You have to use your sense in this and of course I break some rules, e.g. allow the women to walk around, lowering the IV just using the doptone to listen. But with some women I would never allow it...sometimes it can be tough to do this...but I trust myself to take responsibility because I know what I have in my hands, sometimes people break rules without knowing what they are doing.

(Sara, 20 years' experience, interview 16)

Spiritual Relations and Sensitive Care

Although there has been increase in books and publications in relation to spiritual and intuitive issues in midwifery (Hall, 2001, Hall and Taylor 2004), spiritual aspects of faith and belief in higher power are just mentioned and not defined in depth or explored further. The focus has been more on the characteristics that relate to holistic midwifery care in general and is more often concerned with spiritual care referring to the assessment of the spiritual needs of the client. The recognition of personal beliefs, is essential in meeting those needs (Hall, 2001), also in relation to religious spirituality (Linhares, 2005).

The Midwives Alliance of North America (MANA) addresses spiritual issues of midwifery knowledge explicitly and states a philosophy that includes the intuitive and spiritual side of midwifery, expertise which incorporates academic knowledge, clinical skills, intuitive judgement and spiritual awareness. In their statements of Values and Ethics (Davis, 2004) it also says that they value mother's intuitive knowledge of herself and her baby before, during and after birth, the essential mystery of birth.

There are different aspects of "being with" woman that relates to sensitive spiritual care depending on the situation, as community midwives out in the country described in spiritual stories

This woman came to me after she had her first child, in Reykjavík and it was a premature birth and therefore she lost this baby. She was in trouble because of her breasts...this woman needed help every day and I went to her every day. She needed the psychological support, yes I was helping her with her breasts but it was a side issue. This mattered more. This is a part of this practice, so many mood swings in the woman's life, from happiness to more difficult times and then you have to give support.

(Midwife-Rosa, 25 years' experience, interview 4)

"If the woman has some spiritual problems and is tired I talk to her and say: Ask your husband to come with you and we can talk. It is like a psychological role during pregnancy and then later after birth during the infant care we can go on discussing things we did not finish, it can be about their family and work and so on."

(Midwife-Dora, 32 years' experience, interview 5)

Midwives described different actions and experiences of spiritual knowing (see frame 14).

Frame 14 - Narrative analysis. Thematic plots of spiritual awareness and actions

Midwives´ examples of spiritual awareness and actions. They:
• Pray for their woman,
• Get help or strength from God or someone else when needed (go aside and pray)
• Keep things with them for luck, lucky charms (e.g. ring from a grandmother who was a midwife)
• Feel someone (they even know who it is) being on the other side, working with them (often a relative midwife, or a doctor who has passed away)
• Sense someone coming with them to work (gets in the car and sits on the shoulder!)
• Have crazy experiences they can't explain with knowledge from practice experience
• Wake up in the night thinking about a woman (telepathy) when something is happening (feelings of strangulation at the exact time of the baby being born).
• Feel how the atmosphere changes in the house after the spirit or the soul of a baby is born

Some midwives talked about their need to pray for their women. In the focus group, midwives for example talked about how they prayed, when they really came up against challenges and had to *"taka á honum stóra sínum"* [seize their big one], for example to attend home births,

which is against mainstream maternity services, creating conflicts with colleagues and the dominant view in the environment that this is a dangerous thing to do.

Then I felt I needed [to pray], to receive something ...I can't explain (Midwife 4, in focus group).

Yes I always prayed for my women when I was out in the country, it didn't matter if I expected everything to be fine or not (Midwife 3, in focus group).

Siddiqui (2005) stated that in Western countries such as Britain there is no recognized spiritual power by the midwife. This is unlike the spiritual mandate that is recognized in developing countries by the traditional midwife and was identified in Indonesia (Vincent-Priya, 1991). Midwife Bie Dara had a strong religious orientation in her work and she believed that that it is not the medicine that cures but the person's prayers, the medicine being a vehicle, "it is God that really helps to get better" (p.114). To me, the Icelandic highly respected and successful homebirth midwife Saga, who kept on attending births at home when no one else did, had an authentic spiritual power.

I always prayed at birth, I sometimes thought that something could go wrong, but I warded it off and everything went well. I always felt safe

(Midwife –Saga, 50 years experience, interview 19)

Hall (2001) identified multifactor elements of spirituality from related literature of health care, such as transcendence, search for meaning and purpose, belonging/ connecting, relational aspects, self-awareness, hope and faith, without exploring these concepts in depth. All these aspects of spirituality relate to midwifery care in general which often are illustrated in birth stories told in a language of spiritual experience of life, the spirit or soul being born, no matter whether it happened in the family home in the community or in the hospital on Christmas day.

This was her 8th child and of them there were many boys and they were very powerful and pranksters but when their mother was in labour and had had her baby they changed into angels. They just stood, I delivered her 9-11th child and it was always the same. When the baby was born their dad had washed them and they all stood calm at the door and watched me bathe the baby, this I found to be a sacred moment".

(Midwife-Elsa 50 years' experience, interview 3)

Yes, you feel this, you can't control this I do not always know, cannot always read the message, but there is some restlessness. I remember on Christmas day and when we arrive we had an easy shift, I say to the girls there is something in the air and there is something happening, very strange, very repressive. Then two women come both with lifeless babies...yes and when you feel their belly, then everything is empty there is nothing there, no life. There are so many things you sense, and you can't control it. Sometimes you are very easy when you have a bradycardia and you know that you can take it easy, but sometimes you just react quickly.

(Midwife-Sara, 20 years' experience interview 16)

Discussions

It is paramount to go on exploring and developing concepts that refer to the different types of inner knowing and spiritual awareness in midwifery practice. Hall (2001) suggests that human relationship is needed by the spirit and that spirituality is demonstrated through actions to others, which applies to the midwife-with-woman relationship and developments of the different types of inner knowing.

While there is a growing body of knowledge about intuition in nursing, very little research has been done about these issues in midwifery. Still, there is ample anecdotal "evidence" of intuition and spirituality described in midwives' and women's stories (e.g. in Midwifery Today Journals and Conferences) about spiritual births and beliefs of birth as a holy moving event which is to be celebrated with the woman, the family and the community (Gaskin, 1990 [1977], Gaskin, 2002). Davis (2004), author of a textbook of midwifery, a well known independent midwife and a promoter of natural childbirth in USA and an influential midwife of MANA describes the holistic role of the midwife as being spiritual and considers the inner knowing and spiritual sides of midwifery as being "special".

> "Beyond her repertoire of medical techniques, her skills encompass less concrete abilities to intuit, evoke and channel energy. Her hands are her most precious tools, as she senses, heals and blesses with her touch. Ever attentive but infinitely patient with the process of birth, she waits, and waits, and waits some more. Quietly aware, she serves as a mirror, striving to reserve judgement but speak the truth as the need arises. Above all else, she keeps the following dictum in mind: "It's not my birth". Upholding this tenet of woman-centred care means surrendering her expectations to whatever the mother and her supporters need or desire". (p. 7)

Because of the multifactor elements involved in spiritual relationships, the literature reveals that there is inconsistency in the definitions of the concepts of inner knowing and spirituality. Interrelational aspects of the wholeness of mind, body and spirit are acknowledged and the spiritual dimension is related to health and well being, expressed in an individual way, affected by cultural background, how persons are brought up and the social structure of their environment (Hall, 2001).

Underlying the narrative approach is the belief that people make sense of their world most effectively by telling stories (Baily and Tilley, 2002). The Icelandic midwives do not talk about spirituality as being mystic but rather in a very down to earth way. The Icelandic hospital priest, Haukur Jónasson, described spirituality in a roundtable discussion about holistic health care in a similar way; "when I talk to people about the soul and spiritual life then I am not talking about something that is spooky, mystic, unclear and sacred, rather something very down to earth" (p. 53). In the same roundtable, as a matter of fact, a doctor whose speciality is geriatrics, Jón Eyjólfur Jónsson, commented on how Icelanders like to tell stories and tend to give answers by telling a story. He pointed out that often if you have difficulties and are in need of words to explain what you mean, then that can be solved by storytelling (Tímarit hjúkrunarfræðinga, 2005).

Definitions of spirituality link to human relationships and have aspects of being able to give and receive love and give practical care (Hall, 2001, Hall and Taylor, 2004). These are relevant issues to women and midwifery in the creation of family, loving partners and children. There is also a growing acknowledgement that the relationship with women with the supportive care of the midwife (Mander, 2001, Hodnett, 2006a, 2006b, Hodnett et al, 2006) is important in ensuring successful and positive experiences of birth that have inspirational effects on people for a long time, included in the birth stories around us. The term spirituality as applied to midwifery could be the experience of the connections between body and soul. At the same time body and soul are not opposites, but the whole person, the woman giving birth.

This is in line with midwives' writings about spiritual challenges and experiences of birth (Leap, 2000) in reference to sensitive care in relationships with women (Page, 2000) and how midwives of this study experience spiritual relations with women as rewarding and even empowering.

Chapter Ten – A Story of Stories – a Midwifery Saga

This narrative study belongs to the field of midwifery. In context of a midwifery empirical paradigm, I have been paying attention to birth stories of Icelandic midwives, identifying and searching for the plot that directs the narrative and makes the narrative of midwives. This chapter summarizes and discusses the core narrative of the study, the integrated narrative threads of different backgrounds of place of birth and models of childbirth. This Icelandic Midwifery saga is more than a single story. It is a narrative structured around being "with woman" and connective ways of knowing in midwifery.

The Plot of "Being With" Woman

The roles of stories differ within and across disciplines (Mishler, 1995); thereby the plot of the narratives is also different. In medicine it has been identified as being the "why question" of the clinical problem leading to a diagnosis which can overshadow the experiences of the patient (Greenhalgh, 1998, p. 4). If this is the case in medicine, then it is challenging to identify the plot in midwifery narratives and to explore what makes them unique and different from core narratives of other health care professions.

Therefore, while examining the birth stories identifying their contents of knowledge from a wide perspective I have asked myself the question: what do the midwives' stories have in common? The answer became clear when the plot of the midwifery narrative emerged, as "being with" woman, the point being that all midwives talked about being "with woman", in one way or another, in other words the woman was always present in their stories. Yet, the stories differ according to the background, social and cultural context of place of birth.

The plot of a narrative was defined by Polkinghorne (1995), as mentioned before, as "a type of conception scheme" which links well with the plot of "being with" and how the concept of being "with woman" has been central in the philosophy of midwifery which has historical roots in the word mid-wife meaning with-woman. Hence the phrase or slogan "with woman" has been rhetoric in the midwifery literature, and even though, by hindsight, this was not a surprise finding, to me it was a confirmation of how "real", meaningful and intrinsic this philosophical underpinning is in Icelandic midwives' working life. Terms for midwives in other languages have the similar connotation, such as "obstetrix" in Latin meaning a woman

who stands before (Donnison, 1988) which compares with other old terms of the midwife in Icelandic, besides the *yfirsetukona* "the sitting over woman"; a well known word is *nærkona* or "the woman being near".

Narratives are configurations that generate a story (emplotment) and the plot's integrating operation is the story and when the happenings of the story are configured they take on a narrative meaning as it is understood from the perspective of the storyteller or its contribution which explains the influence it has on a specific outcome (Polkinghorne, 1995). In this study the outcome relates to the clinical practice of the midwife which is influenced by different aspects of midwifery practice.

When the many threads of the midwives' stories were drawn together, the unifying thematic plots of "being with" woman and "safety" were identified as linking and directing the making of the core narrative in midwifery in an Icelandic context. The main theme of midwives' stories is the plot of "being with" the woman to provide safety." *Women want to have the midwife at their side and it ensures a better outcome"* (Midwife 3, in focus group).

This guides the story and the forming of a relationship between the midwife and the woman which is also essential in the development of midwifery knowledge. It refers to how: The act of "being with" or "sitting over" with the woman during birth is fundamental in learning and developing midwifery skills, and how, especially by making connections with the woman and the labour itself, midwives learn to trust and listen to their inner voice and develop different types of inner knowing in balance with other types of knowledge systems in midwifery practice. *"You are not able to learn it elsewhere. You are just able to learn it there, with the woman"* (Midwife 5, in focus group).

Around the plot of "being with", is the fact that technology has become an integral part of the childbirth care in the Western world and attitude towards childbirth changes and people's expectations of a good outcome have grown. It is worth mentioning that the concept of or the term risk (in Icelandic *áhætta)* was not a part of the midwives' discourse. Yet, the midwives talked about when something might go wrong or in fact went wrong and how they challenged those and other emergency situations. Related concepts to risk came up when midwives talked about how the society around childbirth has transformed, especially in relation to the fear of

litigation, as has been discussed before. The demand is that everything should go well, the baby should be healthy and nothing should happen to the mother. Yes, everything is to be perfect and if something goes wrong then it is because midwives and doctors have failed in their professional performance (see frames 2 and 3 in chapter seven).

This core narrative synthesizes the findings of this study and is illustrated in the analysis model below, which also gives an overview of the study findings (see diagram, 2).

"With Woman" and Connective Ways of Knowing

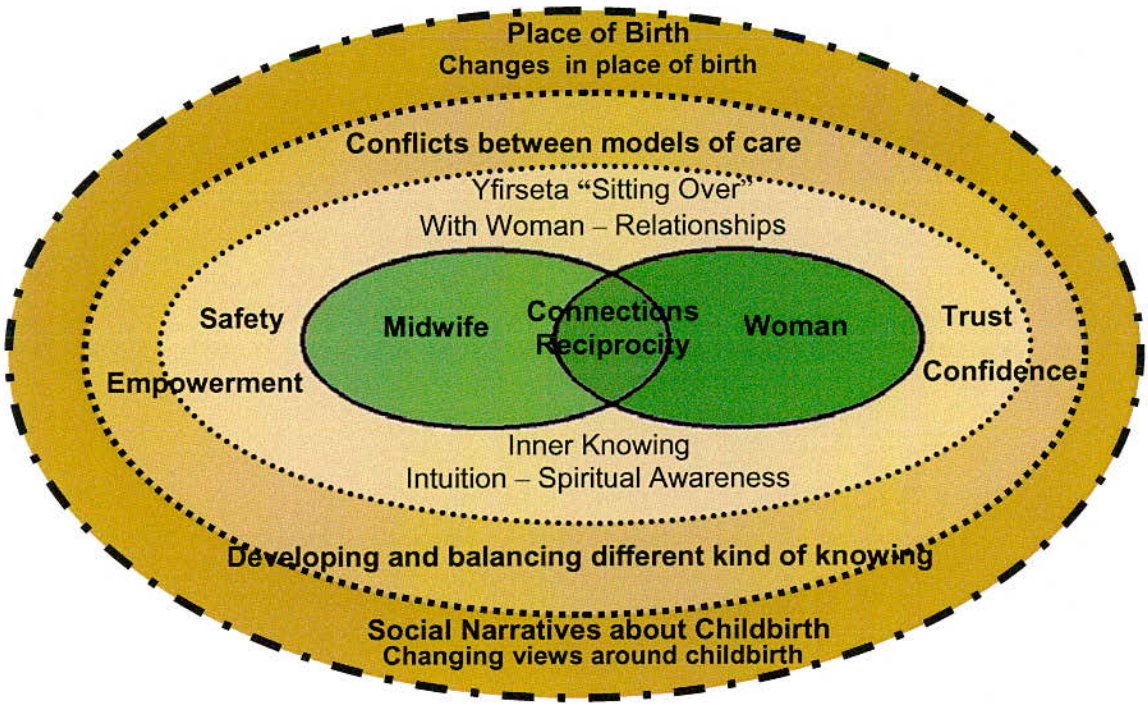


Diagram-2

This narrative of, "With woman" and connective ways of knowing, can be written in many layers with threads in between. Therefore, there are open lines in the circles that represent the layers in the earth colours of green and brown with the midwife-woman dyad in the centre (women centred care) and the context of environment around them. Floating are the central concepts of the relationship. The midwives place great value on the term connection when they talk about their midwifery work with women. Here it does not have to be a two way connection. One layer would regard connections between the woman and the midwife, the

child, the father, other health carers, social structures and cultural building blocks of the place of birth. Another layer concerns the learning and developments of inner knowing of the midwives and the women, in balance with other kinds of knowing that link to many philosophical foundations and conflicting models of childbirth care. These influence learning and put pressures on decision making and choices around pregnancy and childbirth.

Therefore, the storytelling of the midwives varied in context with time and place of birth and was in a way consistent with how and if they used the midwifery model of care or if their work was based on medical and/or industrial models of care. Even though the midwives had negative stories to tell of the hospital environment such as about the heavy workload of fragmented care, they did not forget the woman and placed her views in the forefront of their telling. In the following sections different layers of this story of stories are discussed in and supported by relevant literature in relation to midwifery.

Balancing Different Ways of Midwifery Knowing

While the midwife learns and listens to an inner voice, her connective knowing, she balances different ways of knowing and knowledge systems. Furthermore, she deals with underlying conflicting models of care in her place of birth, wanting to base her work on midwifery ideologies, preserving and promoting normal birth. Midwife Bella is not going to *"create problems before they happen"*.

I do not know maybe, maybe, there is something behind [you] there is always a voice that says: "This is okay, be calm and do not be uneasy". Like my first birth here [out in the country], maybe I should have been a little bit uneasy, but there was something [that told me everything was okay]. I do not want to be uneasy...I am not going to create problems before they happen. It is very important...while everything is okay and while you do not find any signs that tell you something is abnormal, no concrete signs you should go on [not intervening].

(Midwife-Bella, 6 years' experience, interview 8)

By being present "with woman" during birth, midwives use their skills to identify clear clinical signs as well as identifying *"the sense that comes if everything is normal or not"*. With the woman *"you do your check ups, you start to feel, yes feel with your hands then this safety feeling comes"*. Midwives also have premonitions that something could go wrong which keeps them *"on their toes"* to make decisions either to wait or to intervene for the

safety of the baby and mother, also by calling the doctor or transferring to a central hospital "if the midwife's services are not sufficient for the woman and her family" (The ideological statements of midwifery education in Iceland, 2005 [1995], see p. 26).

While the outcome of a healthy baby and mother might drive birth stories and not the plot of and the different aspects of "the being with", the act of "being with" to spend time near the woman during birth, is crucial in midwifery practice, to make connections with the woman, use "this sense" of knowing to provide "sensitive" safe care in another way than depending on technology and medical interventions, thus keeping birth normal. It is not always the end of the story that is the main point, but rather how the story evolves. With changing views and the organizational structures around childbirth, it is clear that there are different ways of "being with" in midwifery practice, based on different models of care, the medical, midwifery or institutional.

Another core narrative of all midwives in all settings contained descriptions about how he midwives proceeded as "clinical monitors" doing tests and screening with their own hands-on-skills to safeguard. Then they often used a mix of the scientific medical and the midwifery language even though they might be talking about intuitive midwifery skills. The following is a description from a midwife who worked for a long time out in the country (over 20 years) without the technical facilities of a surgery, in a place where closure had been imminent and has now indeed been closed down, despite excellent outcomes, indicating that they as "clinical monitors" provided "sensitive" care and always knew when to "send" the woman away from her hometown.

It is very important to do these tests, you have to screen the women, then I think you become more sensitive ... maybe you miss something else, but I just bear in mind this sense, yes screen them out...there you of course have to learn to work like this and depend on yourself, you try to safeguard yourself with this, yes by being continuously present...to be quick and intervene if you consider there is need for it, you can of course never safeguard yourself for everything. It is of course easy just to send her and her [send all women to be on the safe side] but this [being clinical monitors] is in context with something else -

(Midwife 3, in focus group)

The medical model of positivist knowledge has been the dominant ideology of childbirth and has assumed monopoly on knowledge, while midwifery has developed conflicting ideologies

which embrace systems of values and attitudes (Teijlingen, 2005). Now Icelandic midwives describe their work as *"being in two worlds"*. One links with a factory line, standing by a conveyer belt where "restoring" of the personal relationship is crucial (Page, 2000). What runs through this midwifery narrative is that even though presence, being with women, is very little valued within a "culture that values action and measurable skill" (Kirkham, 2000, p. 243), the importance of "sitting over" is inevitable. The other world is calmer with a place for effective care in relationship with woman where the midwife can use her intuitive connective knowing.

Instead of *"sending all women"*, midwives make decisions to wait and see, maybe to *"fall into a closed world"* with the woman, to watch without disturbing the *"covering around the women"*. These are phrases the midwives used about their *"sitting over"* at a normal birth admiring and believing in the woman, which can be associated with how a skilled and sensitive midwife "can create an unobtrusive atmosphere of safety and calm, which allows a woman to feel secure enough to 'just disconnect' mind from body" (Anderson, 2000, p.117).

"There is nothing more astounding...I get tears in my eyes, when I see a woman who really is under influence from her endorphins and she is like she is alone in the world, with curtains before her eyes, moving around and swaying and I just - wow"

(Midwife 1, in focus group)

Conversely, the following narrative illustrates how a senior midwife in the same place of birth but in a different situational context plans the "sitting over" process on the shift's product line, working "with institution" being *"professionally near without being there"*

You can be professionally near without being there, if you read the situation, one, two, three, you know if you have to stay or if you can leave and when to come again and stay, also for other midwives that have the woman, like the less experienced or the students.

(Midwife-Eva, 28 years' experience, interview 11)

It is of course difficult to define concepts of childbirth grounded in empirical philosophy because nature is not static and individuals experience a whole range of feelings and emotions about this important life event. Thus knowledge about childbirth is uncertain and subjective. Midwives work and face uncertainty and can never totally safeguard themselves and their women, against the fact that childbirth does not always proceed normally or against the threat of litigation in modern maternity services. Even though there is an underlying tension in the midwives' narratives that relates to the technocratic versus the holistic paradigms (Davis-

Floyd, 2001), they embrace uncertainty in a down-to-earth way, as one of the senior midwives said *"you are always learning, expect the unexpected"*, having to use all kinds of knowledge, e.g. of obstetrical and technological interventions, sometimes to save lives.

"Being With" and Changing Traditions in Midwifery

It is clear that traditions in midwifery have been changing as has the context within which midwifery knowledge develops. New ways and technology in midwifery and dominance of the medical model of care is a part of today's practice with the closing down of small places of birth and centralization of maternity care, as is the case in Iceland and elsewhere.

In everyday life, events and all kinds of birth stories go by. I am going to tell one of mine that has not left me and it came back to me because it fits with the plot of "being with" woman at birth. This story has stuck in my mind since I was a midwifery student 30 years ago. It is a story I often tell when discussing birth stories with students and what midwifery is. During the narrative analysis, when this plot of "being with" emerged, I was brought back to the year 1976:

> When I started my midwifery training I was 20 years old and "green behind the ears", coming straight from college or out from the street, so to say. I had never worked in a hospital, but had some work experience from working in a bank and in a hotel during summer holidays. After being in class for 2 weeks we were sent out to the clinical placements. On the labour ward, my first shift was a night shift and my first assignment was when the senior midwife said; "go in to this woman, sit by her side, put your hand on her belly and feel the contractions. Be nice and show her warmth". This was before the time of monitors. She taught me to count how long it was between contractions and how long they lasted and to listen to the heartbeat of the baby. This was the "sitting over". There I sat through the night and worried about what to say to the woman and thought about how I was learning to become a midwife. Then I started to feel a sense of calmness and connection with the labour and this woman, not necessarily with words - was this midwifery?

Since then many things have changed, not all for the worse. However, the paradigm of midwifery has shifted and due to changes in the maternity services midwives do not spend as much time with the woman at birth as they used to. At this time there had been a move towards routine care on many levels and "the factory line" had been established.

About this technology, it was there in the 1970s, when the new professor came [Icelander trained in the UK] then a directive was made for women not to carry longer than 41 week and their legs were put up in stirups, two and three at the same time, bombed and driven on with the IV lines. This was of course terrible there were dozens of women that were not allowed to give birth, to start their birth with their own contractions

(Midwife-Helga, 46 years' experience, interview 14)

Technocratic models of care have rationalized childbirth to make it understandable in order to control it (Davis-Floyd, 2001). It has also been suggested that, as the childbirth is indefinable in the experiential sense, it has been deemed unscientific and must therefore be confined within measurable limits (Siddiqui, 2005). These have been set by those with a positivist philosophy of knowledge about childbirth, thereby rendering it to be certain and objective. Consequently, clinical guidelines and protocols rapidly fossilize into rules that guide practice. The midwives of the focus group of this study pointed out how positivist knowledge became dominant in the 1970s-1980s when everything should be done by new dictates of the workplace, imported and made by the obstetric Icelandic professor coming from the UK, intuitive knowledge being ignored causing the midwife to *"sort out her prejudices"* against this kind of knowing.

When I was training then this [intuition] was just blown out and everything was performed by dictates, and if it had been possible they would have done dictates on spiritual things as well [general laugh] ...There was very strong emphasis on these dictates, this was new and it took me a long time to sort out my own prejudices, to stop to depend on these dictates.

(Midwife 1, in focus group)

Historically, women have been considered superstitious while men have been the progressive light of reason (Jordanova, 1999). It can be argued that in midwifery practice in the last decades the messages from above have come from doctors via protocols hence the metaphors of doctors being "Gods placed on a pedestal", the inner voice connected to intuition and spiritual guidance being silenced. Relationships have also changed due to technology. Midwives who remember time before and after technology are worried that midwives may be losing their skills and identities. In a modern techno- society many things disturb the calm. This applies to the woman's skills and knowledge to give birth. It can be difficult to use "connective knowing" with the woman, for example because of the mobile ringing:

I sometimes want to stretch the boundaries [interfere with the woman's wishes] and ask people to shut down the mobile, it both disturbs me in connecting with the woman but also that in a way; it hinders the woman in making connection with herself.

(Midwife 4, in focus group)

In contrast to how the medical culture of positivist knowledge has dismissed or diminished other ways of knowing (Jordan, 1997), midwife Eva, as a connective constructive knower, with embodied knowledge, sees beyond limited compartments and advances her understanding to how knowledge is constructed (Belenky et al, 1997).

Before the technology, you trusted your clinical skills, had this in yourself, but not in some machines... I am very happy to have had my training before technology. I can not thank enough for that. But you have to learn to use the technology, to take part in this professional community; otherwise you have problems after graduation. There is debate about these two schools and discussion about how good technology really is, but we need the best of both. You cannot argue against one and agree with the other, you have to choose the best from both.

(Midwife-Eva, 28 years' experience, interview nr. 11)

This contemporary midwife's analysis of different knowledge systems in her midwifery practice is maybe in line with Foucault's writings in 1963 in one of his seminal books "The Birth of the Clinic", (2003), that the sciences of the past are not simply false constructs but coherent systems of concepts that define and determine knowledge in a given historical period, thus in this period in which we are living now we *"have to choose the best from both"*.

Eva's words, as well as those of other midwives about the "sense" as a way of midwifery knowing, can be applied to Lesley Page's statements in reference to integration of knowledge systems from individual relationships with women, in the "new midwifery".

> "The basis of the new midwifery is an ability to be sensitive to the individual needs of each woman and her family, and to form and work from an individual relationship with each woman. It also requires an ability to use scientific knowledge to ensure that care is likely to be of benefit to individual women. In short, midwives need to bring together personal sensitivity scientific understanding, and ability to continue learning and effective clinical skills. They need to bring together both science and sensitivity to practice" (Page, 2000, preface, 2004 p.19).

From patriarchy towards partnership

Midwives were adamant in how interactions with women had changed from being based on patriarchy towards being based on women's wishes and choices which has also been the policy of midwifery practice in other countries in line with the "new midwifery "of women centred care (Page, 2000, 2004). They talked about a *"revolution"* when things started to change for midwives and women in the mid 1980s and 1990s from patriarchy towards partnership. Before this, similar to the UK, midwifery training was dominated by a nursing model and subordinated to medicine with a familiar

> "hierarchy of the hospital system - where different professions constitute a quasi-kinship system of doctor as paternal, nurse as maternal and patient in childlike role – was embodied in the training of medics, nurses and midwives " (McCourt, 1998, p. 34).

...the trend was that the woman was a patient and people just agreed to everything and did not expect to get explanations...Now there are other times, they know much more, read more, follow what is happening, get more information and expect to get it, ask questions. In those years you could just say what to do, and they did not ask any questions.

(Midwife - Monika, 36 years' experience, interview 10)

This change from patriarchy to partnership is illustrated in the following web of birth stories across 20 years in Iceland which echoes a web of values and awareness of conflicting models of care within each story. It is appropriate to present this narrative because it is very powerful and I recognize the earlier story from my own experience when I was a midwifery student and I could have been in this inhuman "*room full of people*". This is a story to learn from about different aspects of midwifery relationships which in a way speaks for itself.

While this story shows how maternity services can be abusive and disempowering, it hopefully also demonstrates that progress has been made in midwifery care in Iceland. It reflects changes in services with ideology returning towards midwifery models of care. These changes can be related to the ideologies stated in the midwifery educational programme at the University of Iceland introduced before and in publications such as the Changing Childbirth report (DOH, 1993) which called for woman – centred services to meet individual needs, moving from patriarchy to women centred care, informed choice, control and continuity of care. From my point of view, these concepts have had rhetorical influence in the

development of models of midwifery care in Iceland, and they interrelate as common conceptualizations of midwifery models of care in other Western countries, both on a practical and an ideological level.

A web of a birth story across 20 years

... I fell into the old patriarchy, like it had been in the year 1978, when I came [to the prenatal clinic at the hospital] there I see a doctor who knows everything much better than I, he was always telling what was best for me, I felt that he talked over my head... he was trustworthy and he wanted to do everything for me, I followed him like a dog on a leash. He didn't say a word but looked to check if I did not follow him [on the way to be examined] then he said he was going to keep my journal. I had later to steal my journal and go back to the community centre.
My situation was related to sickness and old ghosts from before appeared, - felt I was losing control. But it was great support to be in the contact with the same persons [a midwife and a midwifery student]. To be in a stable relationship with the same persons who knew my expectations. To have personal relationship through the pregnancy with people I know and have them with me during the birth is invaluable. There is a connection that is difficult to describe with words some kind of empathy, caring and a complete trust.
It is not possible to compare this; then I felt that I had been invaded, in the most private part of myself. It is maybe rude to say it, but this was next to, being raped. I was there wide open, and there were people running in and out, I felt dirty. I felt I was alone, very much alone, yet the room was full of people. It would have been good to be able talk about this experience afterwards ... this negative experience followed me for many years. At that time the baby was just a health problem, as he was taken with a vacuum extraction, and he was taken away. Now, on the other hand I was involved all the time, not under the influence of drugs. I felt when he moved his fingers during the birth, and that sense made mother's love flow out of my ears. I got him in my arms, new, wet, and he smelled so good and I felt this connection, breastfeeding and so on...
It is difficult to describe how it is to go through labour without getting any analgesia. I felt as if I merged with a Universal mother. My grandmother and my great grandmother were both capable of do this and so could I. I saw myself as a strong woman. I would be able to give birth just as women were able to do through centuries. I suddenly got this feeling of being a woman. I felt like a Universal woman. After my first childbirth in 1978, my only thought was to crawl back into my bed; underneath the sheet hoping that I would never have to see these people again. I had no self respect left and I felt as if I was just a crotch. I did not have a name I felt just like a crotch having a baby. This time I felt like a Universal woman.

(Margaret, baby born 1998, told in Ingadóttir, 2002, pp. 55-56)

This web of a story above shows the way it can be used to identify models of care, interpret previous experiences and link with the experiences of others in different times and places of birth, between countries and the universe. Such a network of links, made by a narrative like this one, can also be used as an analytical tool to compare social and cultural contexts when researching and developing midwifery knowledge and models of childbirth care.

The latter story is highly educational for midwifery practice as it weaves together knowledge used in practice with the human approach embedded in the relationship with the woman at the centre stage (Page, 2004) as well as indicating the strength of the ideology of midwifery model in making progress and new traditions in maternity care for some women, illuminating the personal connection of the relationship between the midwife and woman as the mother Margaret described above: *"There is a connection that is difficult to describe with words, some kind of empathy, caring and a complete trust".*

"With Woman" and Connective Ways of Knowing

The narrative of "with woman" and connective ways of knowing, is structured around how the midwives form relationships with their woman by being there, learning to know her, developing trust, making connections, using ways of knowing from different knowledge systems, including the intuitive and spiritual, acknowledging the woman's concerns and choices.

Elements that have been identified from health research literature relating to relationships and spirituality are ; recognizing value and acceptance of each person, giving support/having presence, "being there", self-awareness, understanding, openness/using intuition, willingness to help others find their own spiritual meaning, counselling skills, love and compassion (Hall, 2001, Hall and Taylor, 2004). These elements have also been identified in reviews of qualitative research findings about experiences of birth and of the role of midwives (Bowers, 2002). As a part of midwifery practice the spiritual around childbirth may therefore be incorporated as a dimension of midwifery practice but in a silent way, a "tacit" knowledge that is in part uncovered and identified in the midwifery narratives of this study.

Davis-Floyd and Davis (1997) found that there were differences in how the process of developing intuition was experienced between CNM (certified nurse-midwife) midwives who are educated and trained within medical settings and CM (certified midwife) who are direct-entry midwives empirically trained by midwives, usually in the homes of the woman. The CNM midwives seemed to regard intuition with mistrust, then move into trust through lived practice experience, whereas the other midwives seemed to begin by trusting intuition and move into confirmation from practice. They wonder if midwives trained in didactic models of medical care are less likely to trust and rely on intuition. However, as their findings were only from home birth midwives they needed more information from midwives working in medical settings.

Interestingly, even though the midwives of this study all are trained in a medical setting, though not in USA, these different processes of intuitive knowing were also identified by the Icelandic midwives. In general they recognized intuition as an important part of midwifery knowledge and experienced both types of processes, irrelevant of their practice background; some had always worked in a busy technical hospital setting of fragmented care and some had as short as 2-6 years of experience.

Spiritual abilities can grow in emotional situations, such as when celebrating beautiful births or grieving the death of a newborn. It is self evident that stories were told about when things went wrong, about events that perhaps help to develop spiritual knowledge. Stories, the midwife *"would like to be without".*

"Of course it sits in your mind... a story you would like to be without. I got a very difficult shoulder dystocia and I just could not get the baby out, it was so difficult – It was difficult and it still is. It was the doctor who got the baby. He, this wonderful boy was harmed and lived only for a few months and it was because of the birth, but the heartbeat was fine. This is something you don't want to happen. I would have liked to be without this story".
(Midwife-Rosa, 25 years experience interview 4)

It can also grow when the midwife has to challenge complex surroundings around childbirth, for example deal with emergencies to save life. When Rebecca told a story about how she assessed a woman and an impending uterine rupture and had to fight for an acute caesarean, she said:

I think I have someone, without doubt, someone who is fond of me and goes behind me, even though I have not been looking for this [because she is not psychic]. It just is there, when you need it.

(Midwife-Rebecca 45 years' experience interview 6)

The question is if Icelandic midwives sense of having "someone behind" is because of the great responsibilities that is inherent in midwifery work or if, in a medically dominated practice, they do not have confidence in their own authentic professional knowledge. It could also be the other way around, i.e. that they are confident and empowered because they have the higher power, something like God or spiritual guidance with them as part of hidden legitimate knowing in their midwifery practice. Thus midwives who have this kind of authoritative knowledge on which actions are based (Jordan, 1997) are often highly respected by their colleague midwives and doctors in practice.

Practitioners draw from previous experience or intuition to receive information about how to proceed, reflecting a deeply embodied sense of personal knowing in practice. As was outlined before, first the midwives talked about how they learn at the side of the woman from experience and become confident in their work and learn to use intuition. They talked about how they reflect and compare what is happening now with what has been experienced or observed before, also with their knowledge of bio-medicine, obstetrics and textbook midwifery. Secondly, they talked about how this inner knowing is there from the beginning, not depending on a long practice experience, but more on her spiritual abilities, faith and unknown resources. And thirdly, they describe inner knowing which grows in unity with practice experience, in connection with the woman and the birth itself.

These different types of inner knowing interconnect on different levels interplaying with different knowledge systems in the maternity services from positivist scientific knowledge to higher power of spiritual guidance to the naturalistic power of women's own knowledge about their birth.

Through storytelling the wholeness of the experience appears, not so much in words but also in atmosphere, similar to the descriptions of homebirth midwife Linda of how she senses if the baby is born when she arrives, the home changes. In light of the spiritual side of midwifery, the uniqueness of a relationship between the midwife and the woman could be linked to the

fact that during childbirth a new spirit or soul is being born. By working as a "skilled companion" (Page, 1993 p. 24), the midwife, in her connective ways of knowing, combines clinical skills and scientific knowledge with an inner sensitivity to this significant event as a new circle of life begins.

Partnerships and reciprocity

The findings of this study are in line with ideas behind the Model of Midwifery Partnership in New Zealand (Pairman, 2000, 2006) and they support the model of interdependence (Fleming, 1998). They also relate to the conceptual representations of midwifery models in studies of Kennedy et al (2003, 2004) and Freeman et al (2004).

The concept reciprocity has been identified as one of the key concepts of the midwife-with-woman relationship (Fleming, 1998, Pairman, 2000, 2006, Stevens, 2003, Hunter, 2006). In summary, authors describe it as being: episodic and reflexive, interactive and not always equally balanced and constituting positive and negative experiences. These descriptions fit the findings of this study and the diversity of the midwifery relationships. In general the notion of reciprocity is a core element of midwives' writings about midwifery relationships with women. The different terms of the interdependence and the interacting of giving and taking; keeping control or letting go; releasing and relieving express the reciprocal nature of midwifery relationships with women

Underlying the Icelandic narrative of midwifery relationships are the ideas of One-to-One midwifery of continuing relationship that allows the midwife and the woman to get to know each other and develop trust over time (Page, 2003, 2004). They preserve a "with woman" relationship even in fragmented care, using time effectively when they "sit over" or are present with the woman at birth. The midwives narratives also coordinate with the ideological statements of Icelandic midwifery education, particularly the following (see also p. 26)

- Midwives form a stable relationship with a woman and her family, provide holistic care and take into consideration physical, social, emotional and spiritual factors.
- Midwives keep in mind the right of the woman and her family to information about choices in health services regarding childbirth and support prospective parents in making independent decisions in choosing services.
- Midwives work with the expectant mother and father everywhere inside or outside health care institutions, at their own responsibility in order to empower parents to take active part in all decisions about their care.

The findings of the study therefore support the notion that Icelandic midwives have a common philosophy of care that is associated with a midwife-with-woman relationship, women centred care.

In Stevens' study (2003) on caseload one-to-one midwifery in the UK reciprocity was identified as a major theme that referred to "the involvement of 'self', reflecting the different nature of the relationships midwives could form with mothers in this type of service", encompassing something of their "individuality that they gave and something that they received in return" (p. 221). Even though most of Icelandic midwives work in a system of fragmented care, then they often seem to experience a similar type of reciprocity as Stevens described. The smallness of Icelandic midwifery could there partly explain this as reciprocal relationships could more likely be formed in small scale birth settings, such as out in the country away from centralized care. One of the younger midwives compared her experience between these places and described how instead of debriefing or talking about the birth with other midwives on the labour ward she talked with parents *"I had no one to talk to but them"*.

In today's midwifery care, where there is this strong focus on cooperation and reciprocity, the old fashioned term of *Yfirseta* "sitting over" may be seen as patriarchal, rather than a partnership, hinting towards surveillance, the "gaze" over or from above, borrowing Foucault's concept of disciplinary power (Foucault, 2003, Fahy, 2004). In contrast, it also can be linked to how the "sitting over" means being continuously present with the woman, which is fundamental in the forming of relationships which in turn can be empowering for both women and midwives to provide safety of birth. Accordingly, having this term in Icelandic and using it on day to day basis as part of the professional language seems to help midwives to identify their roles in practice and how they develop their holistic midwifery skills, including the connective ways of knowing with the woman.

Hunter (2006) uses the notion of reciprocity as a tool to explain negative and positive experiences of midwives' interactions with women and hopes for a debate about "the nature of midwife-woman relationships and the factors that make them a satisfying experience for all concerned" (p. 2). This study, however, proposes that the concept of reciprocity can be used to explain the developments of connections with the woman. This is based on the identifications of concepts and themes in the narratives of this study, and in reference to the midwifery

literature. In other words the quality of the relationships depends on the midwife's "being with" where she bases her communication on reciprocity. Reciprocity means in the context of this study; shared information between the midwife and the woman to make joint decisions, and bring together aims and aspirations involving trust and sometimes compromise. The midwife and the woman constantly respond on different levels of interconnectedness with potential of empowerment for the woman and the childbearing family, furthermore with potential for the midwife and midwifery knowledge. – "With woman" and connective ways of knowing.

Furthermore, reciprocity entailed not only being able to connect with the woman, to learn to know and meet her needs, but also to tune in with the birth itself, with embodied knowledge of feelings, attached to their examinations of the body (Pitt, 1997, Davis-Floyd and Davis, 1997). This was demonstrated in their language of how they "felt with their hand" or had to be "on their toes" for possible problems, or how they looked at the electronic monitoring as being detached and unreliable as is apparent in the exemplary narrative of midwife Gudrun below, (see p. 171).

These issues need to be studied further and it is important to go on exploring the concept of reciprocity to clarify what the term means and how it can be used in different studies, contexts and cultures, both from the point of view of the woman, her family and the midwife, to describe what is occurring in midwifery relationships with women.

The uniqueness of midwife-with- woman connective - relationship

The findings of this study have begun to yield some answers to an underlying question about why midwives talk and think about the midwife-woman relationship in midwifery as being unique, the heart of midwifery. The question is put forward as an important step in identifying midwifery body of knowledge as separate from other health care disciplines.

Based on the midwives' stories, I suggest that "the uniqueness" lies in the "connective knowing" of reciprocity between women and midwives, where the midwife uses her holistic midwifery skills, including the intuitive and spiritual knowing, and puts her trust on the woman and has belief in her abilities to give birth rather than in technologies. This shift into subjective knowing can represent a move towards greater autonomy and independence and

towards a kind of maturity that has been called "connected knowing" (Belenky et al, 1997) that can be related to the uniqueness of the midwife-woman relationship as a key component of midwifery knowledge (Siddiqui, 2005).

Furthermore, the answer could relate to the concept of reciprocity and the making of connections as being components of the midwife-with-woman relationship that has effect on the development of midwifery skills and knowledge and thereby on normalcy and safety of birth.

Surprisingly, little discussion was found directly on the concept of connection as being an essential part of the relationship. In the midwifery literature the term is more used in passing. Maybe this is because midwives do not separate their midwifery knowledge from the knowledge gained from their interaction with the woman (Guiver, 2004) and because it can be difficult to identify or "see" how connective knowing develops as a part of holistic skills of the midwife. The relationship is indeed a complex interplay between body, mind and spirit in a social context (Leap and Edwards, 2006). In this study, step by step, the narrative knowledge of midwives begins to uncover this interplay, ways of connective knowing with the woman.

Exemplary narratives of connective ways of knowing

Midwives in Iceland are aware of and have had their education based on the parameters of the modern obstetrical scientific knowledge. They constantly weigh their trust in normalcy of birth using different ways of knowing, including inner knowing, against the consequences of straying too far outside of medical protocols that are regarded as authoritative in courts of law. This view was represented in many stories with underlying discourse about litigation. They told about how they keep strips from the monitor "for the lawyers", which is in line with the homebirth midwife in USA (Davis-Floyd and Davis, 1997) who said:

> "Assisting women at birth... is intuition...I listen to the baby's heartbeat, but I don't really care about it, because I have this inner knowing that everything is fine...The heartbeat almost never tells me anything, except it looks nice on a piece of paper to document it" (p. 327).

In one sense midwifery practice has not changed in Iceland. Midwives are still at the side of the birthing mothers even though they experience crisis at the workplace and have to fight for

their place and work in a very different environment from half a century ago. They, as midwives in the Western world, are aware of what is required of them by the rules of protocols and clinical guidelines of the positivist knowledge and of technocratic medical models of care. Awareness of these "rules" is underlying most of the birth stories in this study.
Yet, other aspects are present which was illustrated before in relation to how the midwives deal with these rules (see pp. 147-148). The following story is in harmony with the account of the homebirth midwife above and with how the midwives in Siddiqui's study (1999) linked intuition with a way of knowing when assessing normal birth. This story is also exemplary for a narrative form of theorizing about midwifery, about developments of and use of inner knowing in balance with other kinds of knowing or models of care.

In the context of a birth place out in the country in calm surroundings of a community hospital, midwife Gudrun has developed a midwifery way of knowing, following her "inner voice", not putting her trust only on the rules of technocratic models of care, but rather on the birthing woman herself in a reciprocal connective way (see also Gudrun's narrative before on p. 122). Her midwifery care is based on ways of connective knowing as a whole, between her and the women who in this story *"just knock it off...with this kind of view"*.

...this has to do with the experience you have got in this profession, what happens there, this inner voice which in some way helps you. The angel shift as I call it...It is a long time since I started to take notice of it. I maybe did not do it at first, you were concerned with how things should be following the book, the technology, how long to use the monitor and such. But now when you have this experience, working out in the country then I just follow this inner voice. I use the monitor if I feel it is needed, and if not, then I just don't do it. I don't care if I don't have a strip, maybe this is not professional, but I just look, what is happening, what is effective and I even use the old pinard, I find that incredibly cool...and if I don't think that is enough I just use the monitor to go on with, I just don't find the monitor to be a secure tool, you have seen so many things [when it gives wrong information] and it is so controlling...you can not blindly put your trust on it. And it is just like the women out in the country they are more cool, just near the grassroots, also the first time mothers, they just knock it off, they just go into the birth with this kind of view.

(Midwife-Gudrun, 26 years' experience, interview 9)

Place of Birth and Conflicting Models of Care

One of the oldest references found about "being with" women or "sitting over" the main plot of the midwifery narrative in Iceland, is to be found in this narrative by Sigríður Jónsdóttir Vídalín around 1800 (Steffensen, 1990).

> "When she [the woman] doesn't want to move around she goes to the bedstead usually to be on the side, because [we] the untrained midwives think it is harmful to lie on the back (about other midwives who follow "the sitting over women" theories that the late Jón Sveinsson, the state physician translated, I do not talk about). When the woman has lain down, the midwife sits at the back of the woman and puts her hand on her where she wants her to and where the birthing pains are the worst. Very few midwives examine the woman as the most experienced ones think it is harmful and unethical, rather waiting patiently for the nature to complete its role successfully" (Steffensen, 1990, p. 158).

Sigríður was one of the midwives of her generation who did not receive formal education but was one of "the wise women who was entrusted to carry out the important task of helping women in childbirth" (Garðarsdóttir, 2002, p. 18) and devoted themselves to the vocation of midwifery which was not easy in a sparsely populated country, having to travel long distances, on horseback across turbulent rivers. Travelling to place of birth has been a part of the midwifery culture for a long time as can be seen from the working life stories of this study presented in chapter three and five. The above old narrative mirrors the philosophy of midwifery of belief in normality of birth. It is women centred, but it interestingly, also has the elements of conflicting models of care that are apparent in contemporary narratives of Icelandic midwives.

The medical model is the dominant ideology of childbirth care in modern times which is in part resisted by midwives with consequent tension between doctors and midwives as they usually have different views about childbirth care, influenced by their educational background, working environment and professional speciality. This contrasting continuum between their respective models of care (Teijlingen, 2005) is also flowing in the public domain, represented in social narratives about childbirth. One of the things I had in mind when I began doing this study was to explore how these models of care are presented in the birth stories of Icelandic midwives, asking the questions: What is the central narrative of the midwife's work and is it medically or midwifery oriented?

Even though the background of the midwifery narratives is medically orientated and institutionalized, the midwifery values and beliefs came strongly through with the woman and

her views being present in their stories (see discussions in the method chapter about going back to the transcripts p. 93). The midwives in the study seemed to be of one voice, with the same themes of "with-woman" model of care coming up in the stories of all the midwives. This was not only found in stories from those graduated from the new educational programme incorporating ideological statements of midwifery models of care, which indicated that this ideology had long stayed with Icelandic midwives. This also supports the ideological base of the midwifery educational programme. Overall, the central narrative about childbirth identified in the midwives' storytelling contains midwifery language and orientation.

Yet, it was clear that midwives in this study often feel they have little control over the ways they practise midwifery. This they experience in a negative way as can be seen in the paradigm story when the midwife's heart is "not ticking" (see before p. 37). Midwives at the University Hospital experienced tension and frustrations because of dysfunctional organization of maternity services and because of conflicting models of care, and therefore are unclear about what theories guide midwifery practice.

All this technology is degeneration and I find it terrible how everyone is afraid, how people [midwives and doctors] do not dare to make a decision about anything on their own. They are afraid that they are going to do something wrong, simply put, because of legal actions. We know about midwives that have stopped working because they have been unfairly drawn to into the mud. The time has changed in a terrible way, before you were respected and you experienced trust.

(Midwife-Helga, 46 years' experience, interview 14)

The midwives' stories indicate solidarity of a less powerful group that speaks against authority (Roberts, 2000), feeling that they are pushed to work by these modern authoritative social narratives. This change overtime has been ongoing in the industrialized Western world, since the 1960s with the introduction of the universal hospitalization of birth that has in some places alienated midwifery (Page, 2004). This organizational context of midwifery care has served to distract midwives from the fundamental relationship with women (Kirkham, 2000), leading to the situation where the profession of midwives, in a society preoccupied with risk, continues to become subsumed into technological science and away from the "with woman" focus (Tracy, 2006).

However, even though this is reality, and the situation can be emotionally difficult for midwives, their telling represents a balance of complaints on behalf of the women where midwives, ironically, find ways to keep a "women-centred" factory line.

If you want to have the midwife "sitting over" with the woman, having it as a part of the process, you have to have the staff. I always thought it very good to have the students, then they sat over, especially if they were further along, then you could be on the run and looking after 2-3 women and also being supportive both to the students and the women.
(Midwife-Helga, 46 years' experience, interview 14)

These working life stories of the midwives include negative experiences and this kind of working environment make the midwives feel disempowered. As one of the midwives with 18 years' practice experience, working on the busy labour ward at the University hospital for 11 years, described in a story she told in one moment of truth. She was concerned because her woman could not be reassured of having a midwife at her side during birth. Her work *"gives her pain"* which is a source for emotional work (Hunter, 2001, 2004) and represents how this kind of working patterns together with fewer midwives on shift, just as in the UK, results in exhaustion and burnout as well as the need for professional support (Deery, 2003, Kirkham and Deery, 2006).

"I fight the battle between these feelings of liking my profession, which today gives me pain, rather than fulfilment, and the feelings of not being able to stay on the job. When I go home, there are very few shifts when I think: today I have been a midwife, working with my woman, helping her to take on this strange journey of pain that the birth is, helping her to be a strong woman. There are constant examples of when I am performing tasks that are far too many for one person. I even have two women at the same time, where one is not as far along as the other woman who a year ago required a continuous "sitting over" but today she can not be assured that she is going to have it".
(Field notes, a midwife's diary in May 2004)

This occurs in the fragmented centralized maternity services where the workload has been increasing and access to midwifery care has changed because of the powerful political and social factors. Reference is often made to what is allowed in the maternity services and the theme "you don't like to ask" recurs in so many women's accounts of their maternity care and show that they, and also midwife Helga, are aware of the busy-ness of the midwife in the UK (Stapleton et al, 2002, Kirkham and Stapleton, 2004).

There are many midwives leaving and new midwives do not come instead. How can you serve when being on the run? This is of course not good. A big part of our practice is enabling the women to feel safe....You should not come in [to the birthing room] like a fly. The women are aware of this and don't dare to ask because then they trouble us - it is of course terrible and I think there is a lot of this now.

(Midwife-Helga, 46 years' experience, interview 14)

Conflicts of different knowledge systems and models of care are transparent in the stories above and they also give insight in the complexity of holding a balance while trying to work with the woman rather than with the rules of the institution. To conclude this chapter on a lighter note (or a good story for midwifery), the following narrative was chosen as a paradigm exemplar of a midwife-with- woman relationship based on midwifery ideologies in a modern hospital labour ward practice. It illustrates and defines the concepts of connection and reciprocity, how it underlies the relationship and identifies an aspect of empowerment. In this battleground of conflicting models of care, it is clear which model of care won. In this situational context of place of birth, the midwife stood by her midwifery model of care, not afraid to give information based on her knowing - with the woman - their connective ways of knowing.

This is a story I find a good one, I was in Reykjavik, with a woman with twins, her second birth. She had an induction ... and I met her before she was in hard labour and we talked a lot. She was into natural childbirth and the birth went on very well. Then the doctors came and wanted her to have an epidural, because she had twins and was in risk of having a c-section, she really should have had an epidural. She did not feel that she needed that and neither did I. She said if I need one acutely, I could have anaesthesia. She did not want epidural and I supported her in that. They just came back, and now there were two of them, and they said she should have it. She was not satisfied with this, and asked for explanations, and they talked about what could happen with twin – B. She decided to keep it open, if she felt she could not cope she would accept this, but it never came to that. I was able to be with her all the time and she gave birth just fabulously to both her babies. I found this wonderful and a victory for her, the doctors wanted her to have this epidural, just because that was the routine. I was very happy that I got to meet her before she was in hard labour, we could talk, and we got this connection based on trust. She followed me in what I had told her, rather than the doctors, I liked that...I found her decision to be the right one.

(Midwife-Sigrid, 6 years' experience, interview 12)

A good place of birth, *"there has to be certain calm",*

Keeping in mind that birth stories carry on midwifery knowledge and traditions; what do they carry for future midwives, mothers and their families? Are we going to be stuck in the birth

story which tends to be medically dominant and institutionalized with conflicting identities of midwifery practice, or are there ways to recreate traditions, preserve and restore the midwife – with- woman relationship and hold on to midwifery and women's unique skills and ways of knowing about childbirth?

Davis-Floyd and Davis (1997) stated that post modern midwives are becoming experts in balancing the protocols and demands of technologically obtained information with the intuitive knowledge they experience in connections with the woman. They proposed that these midwives have the potential of restoring intimacy around childbirth and that the deep connective woman-to-woman webs can make a difference in turning around what is happening to childbirth.

Many of the midwives talked about the disturbance or being on the run on the busy labour ward and then they were not always open to inner knowing, intuition and the spiritual side of midwifery. The home birth midwives in America (Davis-Floyd and Davis, 1997) also indicated this by claiming that there were degrees or levels of connections that they could maintain with the mother and the child depending on the degree they had with their own flow of thoughts and feelings.

Midwife Monica, who had for most of her time worked on a busy labour ward, but also in continuity of care midwifery group service within the University hospital, was not sure if she had "someone behind" her as the midwives who had been practising out in the country. But she understood what they meant spiritually and said that there *"you need this, it is a great responsibility to work there".*

Even though Monika's background of place of birth was not out in the country, her following narrative of *"there has to be certain calm",* is parallel to stories that take place there and it shows that there are opportunities to create a calm atmosphere or setting in the hospital where there is a; "connectedness that facilitates as essential to receive intuitive messages" (Davis-Floyd and Davis, 1997, p. 326).

Otherwise, if the midwife is "running" not with the woman, these feelings can be shut down and she can't hear her inner voice and experience and must therefore increasing rely on

theoretical knowledge and accumulated experience from a routine practice which can be intuitive or become internalized but based on another type of inner knowing, i.e. work experience (see before, frame 10, 11 and 12).

This is not the end of the story. In most Western countries midwives are still supposed to be at the side of the woman as they have been through the ages. But we are at a turning point and it is vital to reform the place of birth. As one of the midwives in the focus group said: it is *"not only to have the "sitting over" but also to have calm surroundings"*. Many authors agree with this midwife (e.g. Berg et al 1996, , Halldórsdóttir and Karlsdóttir, 1996a, Fleming,1998, Kirkham, 2000, Page, 2000). Leap and Edwards (2006) also claim that the relationship between women and a known midwife is helpful to create this calm and decrease the influences of the technocratic birth culture.

> "The continued calm presence of the midwife, particularly during labour, demonstrates to the woman that her experience is normal. The midwife conveys by her unruffled presence that what she witnesses is to be expected and can be coped with and that all is well" (Kirkham, 2000, p. 243).

In small scale communities and cultures of childbirth and maternity care such as Iceland, there are potentials. Monica's paradigm narrative should be a guide for practice development in all places of birth for the woman and her partner. It describes a good place of birth for all women and their families where the midwife has the facilities to *"get this feeling"* to make connections and balance different ways of midwifery knowing.

I get this feeling, but there has to be certain calm, I need to be in a peaceful mind, I am not running - when I get this feeling or when instinct works with me. Then I would be doing something for the woman in calm surroundings. It is not only when I have to be on the toes, or when I sense problems coming up. I can just as well get this feeling when everything is normal. This natural event is happening and you are doing your best, guiding the parents. I call this connection, or something, it is not exactly that, it is in the unconscious mind.

(Midwife-Monika, 36 years' experience, interview 10)

Chapter Eleven – Epistemology, Cultural Themes and Legitimate Knowing

This chapter begins to summarize and synthesize this study's findings, in a narrative form of theorizing about midwifery knowledge, its epistemology and legitimacy, focusing on the cultural context of and changes in place of birth in relation to the core narrative about "with woman" and midwives' connective ways of knowing

Uncovering Midwifery Practice Epistemologies

This study started in a very open way, by collecting birth stories and narratives, without using a prior theoretical framework as theory was to arise inductively from the midwives' own storytelling, in this sense their telling and my choice of presenting their narratives provided the framework of the study. It has been challenging to access and uncover midwifery knowledge by looking at storytelling of their working life as a mine to dig in, and it has proven to be an appropriate way to uncover parts of epistemological foundations in midwifery.

Epistemology has been described as a "branch of philosophy which deals with theory, nature and scope and bases of knowledge (Greek *episteme*) or which investigates the possibility of the knowledge itself (Macy, 2000) that from a feminist point of view represents fundamental belief system about "who can be a knower", in other words; can women? What tests must beliefs pass in order to become legitimated knowledge? – "can subjective truths count as knowledge?" (Harding, 1987a, p. 3).

Epistemology is concerned with theories of knowledge production, meaning that the methodological reflection is itself an epistemological act (Letherby, 2003), which in my mind is what I have been doing, reflecting narrative methodologies about midwifery, focusing on the everyday working life where fundamentals of midwifery are put in the centre. Knowledge has been reflected from a midwifery point of view rather than from the point of view of other disciplines but in a cultural and social context. The study findings from midwives birth stories will contribute to a growing body of knowledge about midwives ways of knowing in relationship with woman at birth.

Integration of Midwifery Knowledge Systems and Authority

There are different kinds of knowledge systems within modern maternity services that tend to collide as can be seen from the midwifery narrative presented in this study. By doing research we are ultimately looking for "truth" or "correctness". However, when identifying knowledge as authoritative, anthropological analysts do not discuss correct knowledge but they rather draw attention to that knowledge being authoritative if it counts as legitimate and has a "status within a particular social group and to the work it does in maintaining the group's definition of morality and rationality " (Jordan, 1997, p. 58).

Research findings about intuition within nursing in many health care situations can be applied to maternity care especially within the hospital setting. However, in general there is a lack of recognition of this kind of knowing because it has not been considered legitimate knowledge. This is regardless of how it is an important component of decision making in clinical practice, used by a large number of nurses in different settings (King and Appleton, 1997, Peden-McAlpine, 2000). Similarly, although there has been a growing interest in how knowledge can be gained through intuition in midwifery (Wickham, 2004) and it has been identified as having authority among home birth midwives in USA (Davis-Floyd and Davis, 1997), this area of inner knowing has not been studied and explored by the academia as a legitimate way of knowing in midwifery.

Positivist knowledge, midwifery and uncertainty

In the period of Enlightenment there were shifts of meanings and changes in the way human society and its relations with the natural world were conceived with a true positivist knowledge being dominant instead of multiplicity of truths. In the term enlightenment there is "an appeal to light as a symbol of certain form of knowledge which has the potential for improving human existence" (Jordanova, 1999, p. 38), such as around childbirth.

Positivist knowledge of scientific medicine has been the legitimate and authoritative knowledge in midwifery practice. This type of knowledge is based on the principle of rationalism, "the establishment of scientifically determined standards generated through the accumulation of data" (Barker, 1998, p. 1072). Based on this model, a definition of a universal

"normal" is created, a composite of the body from which deviations are recognized as abnormal.

Experiential knowledge and intuitive midwifery skills have not been seen as appropriate when practising evidence based midwifery. Similarly, even though pioneers of evidence based medicine recognized that the best practice is a combination of good research data with practitioners' skills and experience (Sackett et al, 1997), less focus has been placed upon individual values and preferences, that is to look at the context of care or finding out what is important for the woman and her family, talking it through and reflecting on outcomes, feelings and consequences (Page, 2000). Instead the influence has been on narrow definitions of best practice, the "certain" ones of modern science with little attention given to the relationship between the care-giver and the woman, her skills and knowledge (McCourt and Downe, 2004), the complexity of relevant evidence for each woman.

McCourt and Downe (2004) stated that instead of taking this linear or positivist approach to evidence and knowledge, we could look at science as a paradigm of an ongoing dialogue, to put forward questions and look for answers where decision must be made in relative uncertainty. This dialogue can be looked at as one form of storytelling in midwifery practice. Having a dialogue may, however, be difficult since midwives and women have long been subject to external authority in most areas of life and particularly of childbirth.

The challenge is that midwives have learned and been a part of schools and institutions where the positivist knowledge has been dominant and still is handed down in forms of protocols and clinical guidelines. Consequently, there is always the tendency to think in dualistic terms with difficulties of balancing and tolerating uncertainty and complexity of one's own practice, especially if midwives are overworked and *"on the run"*, then it is easier to work by rules or *" work as a machine"* and adapt to circumstances.

The midwives of this study experienced different legitimate authoritative knowledge systems, one being the practice of patriarchy that was the norm until the1990s. Before that time women had less information themselves with no access to the Internet and few books were available. The same applies to midwives regarding levels of education, yet they were seen as having expert knowledge forming hierarchal relationships with women.

They [the women] just came in to give birth and were controlled by the midwives and the doctors

(Midwife 1, in focus group).

This skilled midwife, who took part in the focus group interview, a mentor for midwifery students, who graduated in the 1960s, gave her own humble reasons why, midwives and women, in silence, received knowledge (Belenky et al, 1997).

I would like to let you know, to keep it somewhere, that when I was a student I do not think you were allowed to think independently, everything was prepared for you, I did not, it was my experience and maybe we also interacted with the women like that as well, I am not sure.

(Midwife 2, in focus group)

Even though the midwives were very open about experiences of inner knowing in a matter of fact way, they tended to lower down their voice and smile shyly as they were not used to talking about this side of midwifery. Some of them had never talked about their prayers or the lucky charms they take with them to work, like the midwife who always wears her grandmother's ring, who also was a midwife, when she goes to work (see frame 14*), "I am just superstitious",* she said.

Midwives who graduated in the years 1970s-1990s explained how this kind of knowing was derided and described how they did not allow themselves to use intuitive knowledge.

"You pushed this away, you didn't trust those feelings, yes pushed them away, now I experience this as a part of my inner self...this is without doubt something you can allow yourself to develop... you learn gradually to trust this".

(Midwife 4, in focus group).

In this environment it can also be difficult to use intuitive knowledge in practice, when you have nothing concrete in your hands, as this midwife who had just herself, her inner knowing:

... Once [when she worked out in the country] I mentioned this to a doctor, and said that I wanted to transfer this woman because I sensed that the birth would not go well. There was nothing to find, and he quite told me off and said: "you should never allow yourself to sense things, you have to see". This woman was having her third baby and everything went well in the other two, but she had a very difficult birth and she had to be transferred.

(Midwife, 3 in focus group)

The dispute for midwifery as a health care profession is that intuitive knowledge does not fit into the parameters of dominant medical science (Wickham, 2004) and there is debate about the use of intuitive knowledge in decision making in evidence based practice as was apparent in the narrative above. This narrative and those of this study however, support arguments that this kind of knowing is a useful form of evidence that can be added to other kinds of knowledge to advance practice, which refers to constructed knowledge (Belenky et al, 1997, p.138);

> "truth is a matter of context in which it is embedded to greatly expand the possibilities to think about anything, even those we think is most elementary and obvious".

Subjective knowing, midwifery and certainty

Although subjective knowing is considered to be the opposite of positive knowledge, it is also rigorous in the sense that there is still the conviction that there are right answers; the foundation of truth simply has shifted locale (Belenky et al, 1997), meaning that the midwife can depend on knowing derived from inner experience, which has been defined by a psychotherapist as "a combination of readiness, willingness, openness, trust, imagination, creativity and determinism" (White, 2004 p. 75). The midwife can therefore be sure on some elementary level that things are right or not right. This knowing based on spirituality, feeling, intuiting and sensing appears to contribute immensely to a final revelation of assuredness how to practise midwifery skills with woman in different situations.

Subjective knowledge has been associated with myth which has been identified by Jung (1995 [1961]), as

> "the natural an indispensable intermediate stage between unconscious and conscious cognition. True, the unconscious knows more than the consciousness does; but it is knowledge of a special sort, knowledge in eternity, usually without reference to the here and now, not couched in language of the intellect". (p. 343)

The metaphor of voice and silence is well known in feminist writings in relation to imbalance of power (Belenky et al, 1997, Edwards and Ribbens, 1998). Belenky et al (1997) described this as the long journey women must make to claim power of their own minds and voices. This can be associated with how midwives of this study said they had to learn to listen to and take notice of their inner voice, connecting to the woman. This, for them, could be empowering and helpful if they have to fight for or with their woman in a medical system full of protocols.

Inner knowing in combination with knowledge produced by known scientific methods is a theoretical challenge, especially if it raises questions about the higher levels of knowledge as Jung indicated:

> "The maximum awareness which has been attained anywhere forms, so it seems to me, the upper limit of knowledge to which the dead can attain. That is probably why earthly life is of such great significance, and why it is that what a human being "brings over" at the time of death is so important", (Jung, 1995, p. 343).

Childbirth is a rite of transition (Van Gennep, 1960 [1908]), with psychological openness and receptivity (Davis-Floyd, 2003). Roots of midwifery knowledge lie in the universal history of traditional knowledge of childbirth where a long line of ancestor midwives, long before modern knowledge of midwifery and medicine, worked in "another kind of reality" or "intuition" where women "viewed themselves as a part of the larger cosmos" (Vincent-Priya p.18).

In a sense, inner knowing might be in Jung's words "brought over" through transition to modern midwives as a part of a higher level of knowledge by an "internet" of birth stories. They could be used to send out knowledge which is in-between the two poles of subjective and positive knowledge, to interpret experiences and link with the experiences of others, in different time and place of birth.

The following narrative from a UK midwifery researcher is an example of transmitting and receiving knowledge by the Internet. It represents global knowledge about midwifery in the form of a dialogue between midwives about midwives' ways of knowing of work in progress, i.e. "An exploration of the epistemological landscapes of holistic midwives in relation to post-term pregnancy" (Oral communication, 15th of March 2006 with Sara Wickham).

> ."I guess I've learned, I've grown to trust them more and more, these sort of feelings and sensations, and it might be also from talking to midwives who rely on that as well, what people have called intuition or common sense or that inner voice ... it's very difficult to talk about this without sounding holy or New Agey because I'm not New Agey. I've got my feet on the ground ... but I do have to say that occasionally when I've been at a birth and I've had to face something I've never had to face before, and I've never done before... I have inevitably felt accompanied by what I can describe as a multitude of midwives from, well the other times. It's a feeling, I still have that feeling on my back it's as if all of a sudden I grew these huge wings from the back of my body that were hundreds and thousands of faces of these old women, ancient women that were midwives and it's not something that I can describe very easily..."
>
> (Homebirth midwife, quoted by Sara Wickham, work in progress, March 2006)

It is noteworthy that, just like the Icelandic midwives, this midwife highlights that she is not talking about being "holy or New Agey", here again it represents an embedded knowledge which in a way is "rational".

Although we do not know a way to present appropriate proof of life after death or "perseverance of the soul after", there are experiences that make us thoughtful and can be taken as "hints" (Jung, 1995, p. 343). It is a fact that many of the midwives of this study think they are "not alone" at birth and that they have "someone behind" them. These kinds of spiritual abilities blended with the subjective assumptions of truth which have been intuited in practice in a private personal way as remains of absolute thinking (Belenky et al, 1997), are powerful and knowing this as legitimately known can be a revolutionary step to add to a growing body of diverse knowledge in midwifery.

Hall (2001) introduced her book "Midwifery, Mind and Spirit" by stating that writing it was for her a beginning to address spiritual issues seriously with the aim of encouraging research in order to gain credibility in academic disciplines. Even though the dominant knowledge system has been based on the positivist and concrete scientific measures and uncertain subjective knowledge is difficult to tackle, the mystic side of this kind of knowing should not be a drawback for midwives. It should rather reinforce and stimulate new ways of seeing and

doing research, to develop knowledge of midwives' inner knowing and to gain the respect and legitimacy of the academia which it certainly deserves.

As "a matter of fact" rational knowledge has been based on empirical information derived from the senses that were deemed to be the best foundation for secure knowledge (Jordanova, 1999), thus in the end this kind of knowing can hopefully be universally accepted as a "fact" based on the philosophy that something can be known without experiencing it (Siddiqui, 2005); it is there even though you can not see it. Even though the midwives' experiences of inner knowing defy rationalist explanations, they can be explained by subjective knowledge transmitted by language through narrative accounts with different types of qualitative research such as phenomenology or by using narrative methodology as has been done in this study.

Midwifery narratives can be looked at as examples of ways of knowing where hidden knowledge of midwives "comes to light", as a symbol of "new enlightenments" of knowledge in between dichotomies of opposed terms that mutually define each other (Jordanova, 1999) where positive and subjective knowing meet, with multiple truths of midwifery practice that in this study have been represented in the context and values of midwives' birth stories.

Midwives could go back to their roots and towards the future, recognizing both inner and outer perceptions, connecting to the wisdom of their ancestors by a pathway of inner knowing of intuition and spiritual awareness, grounded in their practice of childbirth and connective ways of knowing with the woman, in balance with other knowledge systems, such as positivist scientific bio-medicine.

Battlegrounds of Childbirth

Overall, place of birth has moved from home to hospital and from small birth centres to centralized high technology hospitals where the medical model dominates the services. This environment is transparent in midwives' storytelling, and it gives insight into the complexity for midwives to hold a balance, using different kinds of knowing, including the subjective while fighting to work with the woman to meet her wishes rather than those of social institutions.

The roots of midwifery lie in the support given by women to one another around the time of birth. Then the midwife works alongside with the woman, understanding her life and circumstances (Page, 2003). The midwives in this study usually work in this "old fashioned" way, as they have through the ages, and they are still alongside the woman during birth even though they mainly work in high tech surroundings and medicalized settings. However, as has been pointed out many times, there is a contrasting continuum between the midwifery and medical models of care which has, along with the influences of the institution, created a battlefield over birth, upsetting the workplace which again places many midwives in conflict with their own holistic paradigm of having trust in birth and the female body (Davis-Floyd and Davis, 1997) which in turn affects developments of midwifery knowledge.

Cultural themes and changes in place of birth

In preceding chapters it was identified that the midwives of this study were of one voice expressing midwifery ideologies and all of them experiencing and using different types of inner knowing, the intuitive and spiritual, irrelevant to place of birth and work experience. In part these findings were unexpected. In the first place, descriptions of the different types, such as the supernatural or transcendence, are not to be found in the Western midwifery literature. Hidden cultural elements of midwifery have "come into view" (Kristmundsdóttir, 2006) and as they do not fit the norm, they need explaining. Secondly, this was unexpected as one would have thought that peaceful places of birth, such as out in the country or at home, would more likely create the space needed for the development of the inner spiritual knowing, but not the busy industrial hospital labour wards of modern times. My attention was drawn to what Icelandic midwives could have "remembered" culturally, so I looked for theoretical cultural concepts to inform my findings in order to understand better what has had influence on midwives' way of knowing in different places of birth.

One way is to use symbols and metaphors in cultural studies which examine the natural and social phenomena in terms of oppositional characteristics that are familiar in feminist writings, as was discussed was earlier. They are the cultural and contrasting conceptual domains of midwifery and obstetrics (Rothman, 1982, Oakley, 1993, Davis-Floyd, 2001) that explain power relationships of gender in midwifery. This includes the hierarchy of knowledge in which the scientific positivist knowledge is inherently male and therefore claiming superiority over female intuitive knowing (Cahill (2001). The rhetoric is that women have a kind of

intuitive knowing as a feminine trait and feminist writers have pointed out that women have been labelled as such to imply a lack of their reasoning abilities (Annandale and Clark, 1996).

Transformations between sets of dichotomies performed all the time, with each polarity having its own history in relation to the other (Jordanova, 1999) could fit midwifery and place of birth in Iceland. The analysis of Hastrup (1985), a Danish anthropologist, who did a study in Iceland in the period around 1982, is relevant here. Hastrup identified major conceptual oppositions between "inside" and "outside" representing socially controlled areas as culture and the un-controlled areas of experience as nature (Ortner, 1974, Ardener, 1975a, Ardener, 1975b) in the social and cultural system of Iceland. Similarly, childbirth stands at the junction of the two worlds of nature and culture "Like death and disease, it is a biological event, but the defining feature of biological events in human life is their social character" (Oakley, 2005, p. 151), which in many ways is influenced by context of place of birth.

Until the late 19th century, there were no towns or villages in Iceland and farms were scattered around the country with livelihood from farming, which by nature is domesticated, and fishing which takes place in an untamed nature. The pairs of town and country therefore have roots in the Icelandic history of settlement. Local communities of *sveit* are embedded, meaning the "countryside" as opposed to "town" and of "tradition" as opposed to "modernism". The farm itself symbolized the social of inside as opposed to the "wild" outside and each of the farmsteads represented a complete social universe, (Hastrup, 1985) where births also took place with the midwife.

In the Icelandic farm life the social organization contained both male and female aspects and according to the analysis of Hastrup, females in Iceland were not always identified with nature as opposed to the male culture as has been argued within classic feminist anthropology (Rosaldo et al, 1974, Ardener, 1975a, Ardener, 1975b). Thus, culture was associated with the farmstead and nature with anything beyond the fence around the farm. Inside the society of the farm Icelandic women were not muted and had their voice. Generally the tending and milking of cows was considered to be female tasks in contrast to sheep-rearing, which was a male task (Hastrup, 1985). The men were inside the farm but also roaming about in the wild, engaged in "hunting", with additional space for "culture", that "asserts itself to be not only distinct from

but superior to nature, and that sense of distinctiveness and superiority rests precisely on the ability to transform- to "socialize" and "culturalize" – nature" (Ortner, 1974 p.73).

Interestingly, the older midwives of this study had male task roles inside the society of the farm and were often called to assist in the lambing season.

Through the years I have been called to help the sheep. The first time I went I did not know anything about how to do it, but I learned by experience and by how people believed that I would succeed in anything.

(Midwife-Hanna, 48 year' experience, interview 7)

In the spring in the lambing season, it was self evident for people that I should help the sheep, and I was not very competent. Once I found out that a sheep which could not give birth and the farmer who had examined had not found anything, that everything was closed. I examined the sheep and found that the uterus was retroverted and by turning the sheep around to be on the back I could turn - and the lamb was born, of course it was dead.

(Midwife Elsa, 50 years' experience, interview 3)

These narratives show how midwives were recognized as having culturally valued authority (Rosaldo, 1974) being considered to belong to a dominant social model rather than a muted one, having a place both inside and outside culture, and this having empowering effect, even giving them certain male characteristics. Midwives have to be tough as well as caring.

Migration from the countryside to the urban areas started in the second half of the 19th century and the pattern of high urban and low rural infant mortality frequently observed elsewhere in Europe was not found in Iceland. This has been explained by the fact that in towns or villages cow milk was not available and therefore breastfeeding was more common than in agrarian districts where milk was produced at the household level (Garðarsdóttir, 2002). This can be looked at as an example of how nature had been socialized inside the farm with artificial feeding of the newborn, whether male or female!

Northern mythology and the magic nature, superstition and beliefs in fate and predestination is embedded in Icelandic culture with *Huldufólk, or "hidden* people" still to be found, not only in living memory as a strong image of the nation (Harding and Bindloss, 2004), handed down from generation to generation and in folktales (Árnason, 1961, Jónasson, 1961), but also

regularly in the media, when these hidden people or elves disturb builders of houses, because they unfortunately have been moving and bombing their homes of rocks. Their spell is in evidence, machinery broken down and workers ill. Recently it was in the newspapers that the town council in *Vogar* got Erla Stefánsdóttir, a well known spiritualist, to talk to the "grumpy" elves and ask them to leave their hill, while the workers finished building a home for the elderly. They came to agreement and the elves said they would move back and take care to support those of the elderly people who needed it. Thus it is not so bad to have the hidden people for neighbours! (Grettisson, 2006).

Possibly this kind of national and cultural traits could, in part, account for midwives' connections and inner knowing. Many folktales deal with midwives who helped and attended births of the hidden people, and if midwives were thought to be incredibly lucky in their work, it was considered to be a sign of something supernatural or that they got help from the hidden people or the fairies. They were paid with the pledge that the midwives and their families would have a happy life and often they also gave presents, beautiful clothes made of silk or pieces of silver. Þorbjörg Þorláksdóttir was a lucky midwife who practiced for nearly 50 years in Rangárvallasýsa and died in 1824. She once helped a hidden woman early on and therefore she had good fortune and luck with her for the rest of her midwifery practice (Folktales by Guðni Jónsson, cited by Sigurðardóttir, 1984).

Women in general, while having a voice inside the social farm of Iceland, were however, excluded from the men's wild and remained inside for protection, as they were not considered to be able to perform in the environment of nature and therefore considered to be in danger when outside the fence under threat from uncontrolled forces (Hastrup, 1985). From a midwifery point of view, regarding its place within culture and nature, it is of interest how one of the most frequent dangers was meeting the hidden people who would for example capture women or "mid - wives" in order to help their women to give birth.

Movements and gendered midwifery knowledge and practice

Historically, midwives as females and the medical profession as males have been seen as struggling over professional territory linked to developments of modern health care systems (Kent, 2000). Analogy has been drawn between the patriarchal nuclear family and the relationships between the obstetricians, midwives and women. Here the obstetrician is seen as the "father" and the midwife as the "wife", necessary and useful, but inferior and the woman as passive and "good" and willing to make use of all the technology and give birth in the hospital (Squire, 2003). In this sense the changes of place of birth and the position of midwifery has been structured by gender relations.

> "The male role in obstetrics paralleled the male cultural role, socialized to be masters of their own fates, families and environments, the same kind of impulse possessed the men who first took over childbirth from the traditional carers of women, midwives". (Oakley, 1993, p. 71)

Iceland is known for having strong emancipation women's movements. A case in point is the commemorative event organized because of the United Nations proclaimed Women's Year of 1975. On October 24 that year around 25,000 Icelandic women took a day off to remind society of the role women play in its running, their low pay and value of their work inside and outside the home. Women marched down town in Reykjavik to speak up for women's rights and discuss women matters, a real grassroots of a quiet revolution of all kinds of women, and this was a wake up call for many.

Annadís Rúdólfsdóttir (2005), a feminist and now a lecturer in psychology at the University of the West of England, was 11 years old at the time; she tells this story in an article in the Guardian in October, 2005. She claims that this day was a spur for action and that the solidarity of women contributed to the five years' later election of Vigdís Finnbogadóttir, the world's first democratically elected female president. Vigdís shares that view. "After October 24, women thought it was time a woman became president"..."the finger was pointed at me and I accepted the challenge". Sadly 30 years on, Icelandic women still have to fight their way. A statistic shows that Icelandic women earn on average 28% less than men (Mósesdóttir et al, 2006). A second rally was organized for the 30th anniversary and women were

encouraged to leave work at 2.08 pm, the time by which they had earned their pay if they had been men.

Hastrup (1985) discusses how, given the firm position of women within the social farm and virtual non existence of female muteness, it seems paradoxical that women's movement in Iceland has needed to be so strong. She argued that women became muted by urbanization and new economic structures as in other Western societies and that when the entire society had gone "wild", women lost the positions and were relegated to the subordinate position they always had in the men's wild, rendering the importance of the women's movement in Iceland.

Kristmundsdóttir (1997) on the other hand, came to the conclusion in her analysis of Icelandic women's movements that their origins were far from peripheral, that they were situated in the centre of the ongoing social process, originating in social and conceptual factors particular to Icelandic society. With urbanization, women in Iceland were not inside culture anymore and had moved out to the dangerous wild where the hunting male at the seaside retained his position and dominated. Women were not supposed to be there and had no position. Place of birth was changing as well and by the end of the First World War the situation changed rapidly in Europe and midwives were "alarmed at the erosion of the practice of home birth" (Thomson, 1997, p. 21). Births became institutional and in modern times they take place in the "wild" busy hospitals.

In Iceland, conflicts between midwifery and medical models of care emerged in the Icelandic Midwifery Journal, which was founded in 1922. The first president of the Midwifery Association, Þuríður Bárðardóttir, who also was a town midwife in Reykjavik and a teacher of midwifery students, wrote in 1932, *Ljósmæðrapankar* or "Reflections on Midwifery" in the Icelandic Midwifery Journal (Bárðardóttir, 1932a) about the good results of high breastfeeding rate and low infant mortality rates, thanks to postnatal care of midwives and good cooperation with doctors. However, she also points out that:

> "It has become fashionable in this country, particularly in Reykjavik, to have a doctor present at all births even though there are no problems, and a midwife present who has the best education available. It is my view that this is unnecessary and a bad habit. People consider that it is the main responsibility of midwives to call the doctor if at all possible, when there are deviations, and that this they will not at all forget, thus people can rest assured" (p.2)

She also wrote,

> "a lot of help is often dangerous, and doctors more than midwives are at risk to act instead of allowing time and nature to lead. The fault also lies with the mothers and their families. The doctor is cheered on and it is in goodwill of all to speed the finale with great rewards" (p.4)

The Medical Director of Health at that time, Vilmundur Jónsson, reacted to these writings with a personal letter that illustrates power relations between doctors and midwives and his strategies to silence this leader of Icelandic midwives, as "this should not be discussed with others". Þuríður reacted by publishing his letter (Bárðardóttir, 1932b, p.13), in the following journal. The following is a quote from his letter:

> ..."Your article is presented in a way which is not befitting the president of the Midwifery Association of Iceland, and is likely to encourage conflicts between doctors and midwives. I know that doctors don't like your writings and some suspect that this is caused because of grudge and competition with the labour ward at the National Hospital, which is of course a difficult opponent for practising town midwives...I have to say that as the public depends on the cooperation of the two professions and on the supporting of each other in their important work, it is bad if conflicts arise between doctors and midwives. This it presented to you for guidance and will not be discussed with others".

Þuríður wrote her own response ending with the following words; ..."I will as before have an opinion, both on childbirth care and other matters, and make them official if the occasion arises" (p. 16).

Thus midwives have had to fight for the position and the roles they used to have at the place of birth and similar to women's movement in Iceland this springs "from a mesh of a social

processes, socio-structural relationships" (Kristmundsdóttir, 1997, p. 234). This could have enkindled contemporary midwives' "movements" to promote normal birth and midwifery ideology, working in partnership with women, which is mirrored in the battleground over birth with conflicting models and narratives of childbirth which in turn has influence on childbearing women, their views and standpoint.

Yet, the country midwives of this study talked with great respect about their working relations with doctors which perhaps originates in the cooperative status of women and men in the society of the farm, but also because of different cultural time and place. This changed with emerging medicalization of society and as the midwives said: *it all started to change when the old doctor left.* While doctors and midwives worked in different ways rooted in their professions' history, there was an overlap of networks which allows for human agency. Both doctors and midwives incorporated ideas and practices from different sources, operating in their historical moment in the countryside. In that sense modern conceptualization of medical versus midwifery models should not be imposed onto the past.

This kind of cooperation between midwives and doctors was also found in Pitt's analysis (1997) on gendered knowledge in midwifery and medicine based on five interviews with midwives and doctors who practised in the Swansea area between the end of the Second World War and the mid-1970s. Her findings suggest that it cannot be assumed that there is a correlation between the biological sex and the doctor/midwife divide and that male takeover should be framed in the terms of gender of practice rather than of the biological sex. Furthermore, there were male and female roles which could be performed by either sex. Normal delivery was, however, for the female while the male role was to intervene when the female process failed.

These roles have been historically manifested by the decline in midwifery in the 18th to the 20th centuries (Towler and Bramall, 1986, Donnison, 1988) and by the male monopoly over medical professionalization (Witz, 1992). Moreover, the developments of obstetrics in maternity services have in turn had influence on the medicalization of normal birth? Pitt's analysis revealed the following oppositional concepts.

Medical discourse	Midwifery discourse
Male	Female
Clinical beings	Social beings
Avoidance of risk	Acceptance of risk
Clock time	Nature's time
Control, interventions	Letting be, allowing
Seeing, examining	Listening feeling
Detached	Attached
Discursive knowledge	Embodied knowledge

These categories are not seen by Pitt as two solid separate categories, but rather as networks which overlap with each other in a wider social and cultural context. Individual experiences do not take into account the dominant social structures and interactive factors which influence understandings of culture of childbirth.

In the 1980s-1990s as the ideology of and standards of modern medicine became more technocratic and interventionist, the doctors in Iceland wanted women to leave the countryside, as midwife Anna said:

He wanted to be free of them. I did not think like that I just wanted to live up to it [accept the challenge and the uncertainty].

But at the same time she understood the new generation of doctors.

They do not learn, they need training, they do not have the confidence...It is of course different today because of litigation threats...that you were not aware of, this kind of thinking. You stood by your woman and you would not think that they would sue you or think that it was your fault.

(Midwife- Anna, 47 years' experience, interview 1)

Midwife Dora, who works in a country hospital where births still take place, but with the threat of closure, talked about different levels of working relationships with doctors not accepting the monopoly of positivist knowledge that concurrently undermines existing ways of knowing of folk wisdom (Barker, 1998).

Doctors are of course afraid, it is understandable, but I think we have to respect each others' views and work together, cooperation is important. But they do not always use wisdom. It is completely different to be clever and know about things and not use wisdom, but I think they are learning to accept this.

(Midwife-Dora, 32 years' experience, interview 5)

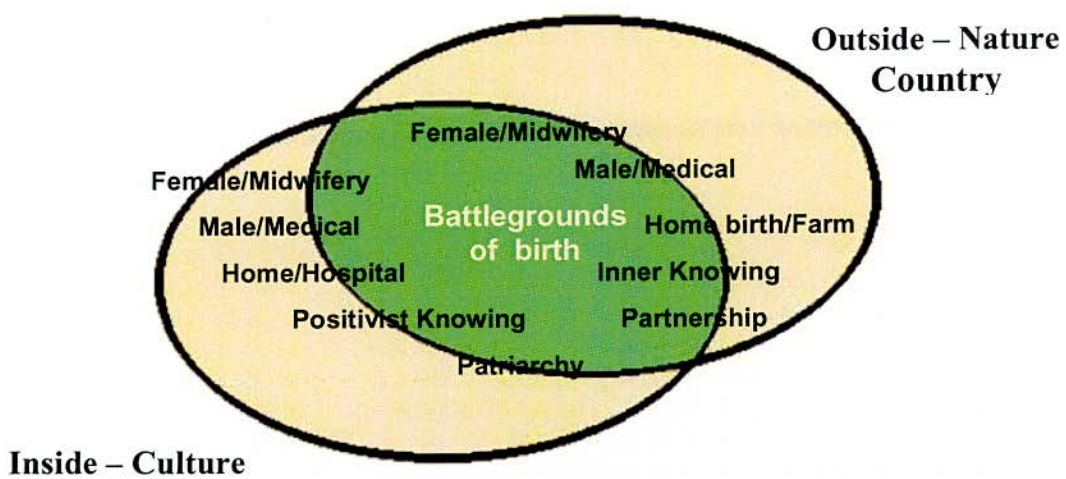
Implicit medical power is embedded in discourse about childbirth which facilitates medicalization of maternity services. This has influence on practising midwives, on what they stand for and it has made many of them silent about their work and knowledge. By the same token, social dominant powers in the United States propagated not to mention midwives in official reports and booklets about maternity care. This way of writing folk wisdom and midwives' knowledge out of the public health discourse on pregnancy and childbirth has powerful rhetorical influence and has helped to reconceptualise maternity care (Barker, 1998) not only in the United States but universally. Gradually this taken for granted definition of technocratic models of childbirth has been accepted in society (Barker, 1998). This has led to polarized thinking of "right" or "wrong" practice which means that everything between the opposing poles can be ignored. Such an environment of dualism can encourage midwives to go on being passive learners as they have long been "dependent on authorities to hand down the truth" (Perry (1970) cited by Belenky et al, p. 9), the "truth" of risk mediated and technocratic institutional models of care.

A well-known dualism that has "ensnared" midwives is the one of low-risk and high risk, where midwives have been considered to be the experts of the normal, or the low-risk. The analysis of Devries (1993) leads to, in his words, the "unfortunate conclusion" that if midwives keep on stating for example that they are "the guardians" of normal birth, it threatens their credibility as a professional group because prestige and power is given to those who manage high-risk situations. This puts midwives in the position that in order to enhance their status they might have to renounce their tradition and ideology which they in part already have done. Midwives have taken part in the implementation of technical routines, such as episiotomy, regular vaginal examinations and convenience inductions of labour, that all have been associated with increasing male intervention, the point being that such interventions are not female even though they are carried out by midwives (Pitt, 1997). Gendered discourse should therefore be fluid with constant process of negotiation between all parties concerned.

Following the migration to town, the Icelandic midwives at first retained their position in the place of birth at home as parallel to the farm, but in the hospital, the midwives were again in the wild dominated by the male but at the same time they kept on working in both places of birth, home and hospital - in nature and culture (both inside and outside). With midwives in this position, culture can not rely on the fact that under most circumstances it transcends natural conditions (Ortner, 1974).

In light of the extremely rapid and relatively recent changes from country to the town and drawing on the analysis of Hastrup, perhaps Icelandic midwives have taken elements of their knowledge from the farm life with them to the hospital where they still use inner types of knowing, not having lost their spiritual role as midwives. Icelandic midwives, have potentials for their voice to be heard to in different places of birth and are challenged to fight for their position. Given that culture implicitly recognizes and asserts a distinction between the operation of culture and that of nature and that its superiority rests on the ability to transform and to socialize the nature (Ortner, 1974) it is not surprising that midwives experience conflicts of associated models of care, as is illustrated below in diagram, presented as an overview of cultural themes and changes in place of birth (see diagram, 3).

Cultural themes and changes of place of birth



Dialogue between different sets of power relations and ways of knowing

Diagram-3

It is a "universal fact" that cultural conceptions and symbolizations of women, in this case midwives, are extraordinarily diverse and can be mutually contradictory, and that their relative power varies from culture to culture of different time and traditions (Ortner, 1974). The diagram above demonstrates cultural concepts and themes and even though they are oppositional they are not straw concepts of polarities but of continuities that mirror power relations on a battleground of birth where a dialogue is needed within different sets of power relations (Sandall, 1995) such as the managerial, inter-occupational between midwives and doctors and among midwives and women, to strengthen midwifery knowledge and integrate different ways of knowing in order to benefit childbearing women and the families in the maternity services.

Modern place of birth is the hospital which historically was the farm or the home of the woman and her family. With this is mind, both could be considered as parallel to the hospital rather than being the opposite, which in itself is a contradiction and illustrates the complexity of these cultural concepts as well as the reasons for midwives' position in society, their models of care and ways of knowing.

To be a midwife is a cultural and historical experience (Hunt and Symonds, 1995) that differs over time and between places of birth. The midwives of this study have gone through rapid changes and many continue to redefine their practice based on reciprocal relationships with the woman with negotiations and mutual decisions to be a "real" midwife, as homebirth midwife Linda describes as follows:

Through my long period of midwifery practice I have experienced a lot of changes. At first there were very few caesareans; maybe about 3% ... I took active part in learning everything about the technology, the monitors and epidurals. I didn't like it very much but I used it intensively as you do when you work in big institutions. Then I went to Denmark and there they used the monitor not as much [as in Iceland] and I learned about water and water births and I - just was set free. I just saw how wonderful this was for the women to use the water and how they were in control of their birth, and I started to think that maybe they should be allowed to have control - I have changed a lot. In homebirth I have distanced myself, more and more and I let the couple deal with it themselves. I just take care to listen to the heartbeat and check if there is bleeding and so on, and then they deal with this. It is great and I think that everything goes better like this. Now I feel as a real midwife, and I use my intuition more, I examine seldom, just when I am there, and then I just watch, I know in a way what is happening interacting with each woman.

(Midwife-Linda, 38 years' experience, interview 20)

Chapter Twelve - Concluding Discussions

This final chapter discusses conclusions and critical points of the study with implications for midwifery research, practice and education. This is done bearing in mind how, in searching for an authentic voice of midwifery knowledge, basic insights of constructive knowing ultimately comes to an understanding that "answers to all questions vary depending on the context in which they are asked and on the frame of reference of the person doing the asking" (Belenky et al, 1997 p. 138).

Critical Reflections

In this research I decided to take narratives seriously as a means of representing complex knowledge; therefore, it is pressing to think about authenticity and of the true value in narratives as a scientific method (Emihovich, 1995) and of the strength as well as limitations of this study.

Researcher writing own culture

As a researcher, living in and writing the culture under study, accounting for my role in the research process as well as being aware of my personal impact on the study, I am responsible for what narratives have been drawn out to make a point. This in itself has influence on validity and evaluation of the study, as has been addressed before (e.g. pp. 78 and 96). However, my position does not have to distort the findings but rather be a resource, when I, the researcher and the midwives of this study collaborated professionally in sharing midwifery knowing in a non-hierarchical partnership, similar to the one midwives engage in with women. During the writing phase which has also been a part of the methodology and of the narrative analysis, I have had freedom to be immersed in the research process. By thoughtfully considering what narratives to choose, explaining and reasoning the purpose of using particular narratives I have highlighted midwives' ways of knowing and underlying models of care in their practice. In a way these writings, while they have been a process of plotting a narrative of the culture and knowledge of midwifery practice in Iceland, they have also been my own personal saga of midwifery of 30 years. Is this saga of midwifery in Iceland believable?

The broad perspectives of the study

Limitations of the study could be that even though the research process was narrowed down to explore the relationship between the midwife and the woman and inner knowing of midwives, I kept the broad perspective of exploring midwives' birth stories and kept on asking for stories and responses to questions about their scope of practice in a biographic way. This may have been at the cost of getting more direct and detailed information about the research interest, resulting in a scratch of the surface, not digging deep enough. Unexpected information was uncovered in relation to different types of inner knowing of midwives that need to be explored further as will be discussed later in this chapter.

This is always the risk when the area under study is as diverse as in this case, i.e. midwives' knowledge in birth stories. This critique could also apply to the method of choosing the literature in relation to how the data emerged, attempting to grip the main issues and challenges that face midwifery both in Iceland and internationally, rather than using a more structured way at the beginning phase of the research, for example about intuitive knowledge. However, if I had gone for a deeper exploration on the midwife - with - woman relationship and the different aspects of connective knowing, it would have called for a shift towards phenomenological interpretation of the narrative method (which could have had influence on validity see discussion p. 87 and 98) or even grounded theories, also with interviews with women and prospective fathers. That would have been another study, a very important course to take for further research around this subject.

Lack of women's voice

In the end, this study focused mainly on birth stories with storylines about midwives' relationships with women. It is a limitation that the voice of the women depended only on the midwives' telling. Therefore, different sources were used to allow their experiences to emerge, mainly from the literature to support or confound the midwives' stories (see discussion pp. 37-38 and 129-131). Even though the moves to the "new midwifery", from patriarchy towards partnership with women and the families, are apparent from the midwives' stories, there is also a power imbalance between midwives and women in Icelandic midwifery causing negative experiences of maternity care. This is evident from the book of birth stories of Icelandic women (Ingadóttir et al, 2002, Ólafsdóttir, 2002). While many women in the book, who had experienced more than one birth, articulated that over time there had been a change

in communications with midwives and most of the stories contain positive experiences, there were also stories that described negative feelings, traumatized effects of bad experiences of interactions with midwives and doctors and other health carers.

This is very depressing and shows that the midwife was not always there "with woman" to give support and information or to meet the woman's wishes to make decisions together. The Icelandic studies mentioned before have also demonstrated that women have experienced uncaring and disempowering encounters (Halldórsdóttir and Karlsdóttir, 1996b), not forming effective and positive relationships with women (Ólafsdóttir, 1992). Experiences of childbirth and interactions with midwives from the point of view of the women and their families need to be explored further with a focus on midwifery relationships and developments of different types of inner knowing as will be discussed later in this chapter.

Support of "with woman" partnership model of care in Icelandic midwifery

This work is embedded in larger work of building a body of midwifery knowledge. Many studies related to experiences of childbirth and the midwife-with-woman relationship touch and inform the findings of this study, but here the standpoint of midwifery in Iceland has been reflected. Frank (2000) understands standpoint as a political and ethical act of self-reflection. To take a standpoint means here to privilege certain aspects of midwives' working life biography that they share with each other.

Irrelevant of place of birth, it was striking how the woman was always present in the stories of all the Icelandic midwives and in this sense no deviant stories were found. Hence, the core narrative indicates that Icelandic midwives have a common philosophy of care that is associated with a midwife-with-woman partnership model of care. This has been outlined before (see p. 167) as being incorporated in the ideological statements of the Icelandic midwifery education.

A critical point is to explore if this finding and interpretation is "true", or based on rhetorical influences, also in the sense that midwives could have been retelling their own stories with an underlying thread of self-justification (Kirkham, 1997), presenting themselves in a "proper" way. It was encouraging to see how the plot of "being with" formed the core of Icelandic midwives' birth stories. This, of course puts Icelandic midwifery in a good light, which again

raises questions about my impact on the midwives' choice of stories to tell, if their purpose was to tell particular stories to promote Icelandic midwifery. Rhetorical analysis has been defined as "the study of how people persuade" (McCloskey, 1985, p. 29). Such analysis, particularly when it is applied to stories told in conflict situations, pinpoints what the community of midwives sees as their "truth" and what constitutes their "authoritative knowledge about important subjects and what evidence the community uses to sustain or alter its knowledge" (Lay, 2000, p.12). Here too, as well as the medical model, the dominant midwifery model among midwives could have had an influence on their storytelling of midwives.

On the other hand, language and how we use it reflects the philosophy of people and while plotting and making a narrative, the advantage of a study of this kind is that it conveys tacit and unconscious assumptions and norms of the individual or of a cultural group (Wengraf, 2001). Also, drawing on the definitions of Polkinghorne (1995), the plot displays a contextual meaning of individual events; therefore, it should be difficult to hide "true" ways of thinking and reasoning. In nursing, Björnsdóttir (2001) argued that language is central in theoretical knowledge and research findings which is also political and shapes practice. The same can be said about language of midwifery knowledge which has been changing and as language both expresses and shapes the way we think (Kitzinger, 2005), it can influence and improve our communications with women.

The stories of the midwives contained midwifery language and midwives seemed to be of one voice in wanting to provide women centred care, respecting the woman's concerns and choices. Still, deviant data appeared in their stories regarding the forming of their relationships with women where they pointed out how they experienced imbalanced encounters and different levels of connections with women (see discussions p. 117-120) and balance in power relations with women (see pp. 123-129). This is in line with Hunter's study (2006) where she identified that reciprocity was not always balanced with a "give and take" exchanges between community midwives and women in the UK.

The findings of the focus group interview provided validity in the sense that the midwives were all in agreement. Their views strongly supported my notion from an earlier stage in the research process that the main plot of the midwifery narrative was about "being with" or the

"sitting over" (Blöndal, 2005) and that midwives think it is crucial to be with or stay with the woman to form midwifery relationships in order to provide safe care and to develop midwifery skills and knowledge.

Different ways of "being with" and cultural representations

It must be emphasized that there are different ways of "being with" depending on culture and the context of place of birth. Current evidence in the UK for example suggests that there is a gap between the rhetoric and reality in maternity care. This is apparent in women's and midwives' negative experiences (Kirkham and Stapleton, 2004, Deery and Kirkham, 2006),

Similarly, Icelandic midwives portrayed negative experiences of not being satisfied with their practice in different times (see stories on pp. 27, 32, 33, 37, 114, 173-175). They are subject to diverse surroundings at place of birth and different settings, in a busy central hospital, a small community hospital out in the country or at home. Even if the plot of "being with" highlighted the importance of midwife-with-woman relationships, and how *Yfirsetan,* the "sitting over" with the woman at birth, is fundamental in Icelandic midwifery practice, then underlying was how midwives are pressured to base their work on conflicting models of care, medical, midwifery and institutional (see also the story told from the point of a view from a woman on p. 39).

It inevitable that, individual midwives in different place of birth are likely to have different standpoints using different knowledge systems and interventions, depending on whether she compromises with the organisation and technocratic practices or uses her holistic ways of midwifery knowing. However, based on "the cultural coherence" of the shared storytelling (Lyotard, 1984, p. 112) of Icelandic midwives, they seem to have a collective identity of themselves as a professional group, which is in contrast to cultural norms of "us" and "them" found in Hunter's study (2005) in the UK about emotion work in hospital based midwifery. There conflicting ideologies between junior and senior midwives were noted. However, there might be another story to tell about occupational divisions between Icelandic midwives which could be suppressed and therefore not found in the study data (maybe because who I am or because of my location in the study).

From my own experience there have been internal conflicts between midwives in Iceland that have different backgrounds, for example of nursing, especially in the 1980s when an increasing number of midwives became nurses and decisions were made to change entry requirements to the Midwifery School to a nursing diploma. Such conflicts could be explained as oppressed group behaviour (Freire, 1971), because of frustrations and powerlessness in terms of loss of identity as midwives, feeling that their knowledge is less than that of nursing, unable to unite against a more powerful knowledge of medicine (Roberts, 2000).

When the education of midwives moved to a university level, there was a wide difference in education background of midwives and in this study it ranged form being a one year direct entry programme of the Midwifery School of Iceland to a six year total, i.e. advanced programme in nursing and midwifery at the University of Iceland. In such a diverse occupational group there are always members that might want to control other members and leadership who seeks to change practice and go against innovative care systems and resisting change. Still, from my point of view, Icelandic midwives are moving on and even though midwives are different within and critical of each other, most of them have an understanding of each other's background and views embedded in Icelandic culture and history of midwives. Junior midwives greatly respect the knowledge and wisdom or their seniors, while senior midwives are proud of how their followers with advanced education have new scientific tools to work with to empower midwifery and hopefully also women. Thus generations of Icelandic midwives have a reference point, a collegial relationship of reciprocity and in all a positive professional identity.

One must not forget that the community of midwives in Iceland is very small, only including about 250 practising midwives, so the discourse and rhetoric of the "new midwifery" travels fast and it is easier to withhold, change or restore culture in small scale communities than in the larger complex and multicultural societies, such as the UK. Student midwives might also have had influence on the discourse of the social group of midwives in Iceland and many of the midwives have also been clinical mentors in the last 10 years since the new midwifery programme started at the University of Iceland.

Storytelling of births or social narratives plays a big role in the cultural representation of childbirth and maternity services; this has roots in how storytelling is intrinsic in Icelandic

culture which should make transmission of Icelandic traditional knowledge of childbirth easier. Contribution factor could also be that the country has a high standard of education and until very recently Iceland was a uniform cultural group, therefore midwives know and are part of the culture of women.

The extreme smallness of the Icelandic society and that of midwives could also allow for "a more accurate estimate of the extent of particular phenomena, similarities and differences" (Kristmundsdóttir, 1997, p. 17) and can therefore support the study findings. However, further research is important in cooperation with other disciplines, such as anthropology, to look at the culture of birth and midwifery from outside, not biased by being part of the culture as I am myself, also to compare to other post modern cultures of childbirth.

Despite the centralization of care and huge changes in organization of midwifery practice, different cultural context, such as between the *country* hospitals and the capital *town*, changes in education and work experience of different times, midwives collectively seem to succeed in maintaining a balance. In this sense the narrative of this study is an exemplary one for midwifery that should be a commendable tool for practice development in Icelandic midwifery.

Challenges in Icelandic Midwifery

While many things have improved in midwifery practice in Iceland, others have not, as can be heard in midwives' stories of when they express negative feelings and work "with institution" rather than "with woman". Even though midwives in Iceland seem to have a collective identity of basing their work on midwifery partnership models of care, they are strongly influenced by a hardening environment of guidelines based on positivist knowledge and tend to "fall into traps" forgetting their holistic skills and connective knowing with the individual woman. At the same time some are very well aware of the issue and want to be involved in developments to improve practice.

Midwives tend to follow clinical guidelines in an uncritical way, as if they were rules, compromizing conscientiously to the authority of the institution and medical model of care. Midwives are part of the system and now they take part in the making of these rules, both by working in cooperation with doctors writing them up and by following them and *"have*

nothing against them, not at all, and views have changed" (Midwife 5, in focus group), meaning that there this is progress.

This is also a part of the "new midwifery" based on scientific knowledge and constitutes midwives' part in integrating different knowledge systems, constructing a joint way of authoritative knowledge between professions and colleagues in the workplace. Of course in modern services, multidisciplinary group work should be involved in the developments of standards, referral systems, protocols, risk criteria and audit. However, then it is of fundamental importance to clarify the standpoint of midwives, for them to have influence on the outcome.

There is an ongoing battle of ideologies and different ways of knowing and it is questionable if there is a middle ground, a compromise stance, between the poles, without midwives sacrificing too much. It is after all human to avoid conflicts by complying, looking for rules and adapt to circumstances not upsetting the workplace. This process that was identified by the metaphor of "going with the flow" (Kirkham, Stapleton, 2004) and relates to the "falling into traps" mentioned above needs to be examined further by midwives who have to develop strategies for new practices and find ways to endorse midwifery models of care instead of being a compromise to the authoritative medical model and that of the assembly line (Davis-Floyd, 2003). Within the discipline of midwifery, empowerment could align itself to work by the definition of "an intentional ongoing process centred in the local community, involving mutual respect, critical reflection, caring, and group participation" (Barr and Cochran, 1992, cited by Vanderplaat, 1999, p. 774).

Feminist historical writers have, in order to describe power relationships, used the dichotomy of the oppressor as being the powerful man of the culture and the powerless woman as nature, being the oppressed (Harding, 1987b) which again can be linked to midwifery as a women profession behaving as an oppressed group as has been described by Kirkham and Stapleton (2004) in reference to the National Health Service in the UK. In Iceland, from my point of view, midwives do not feel oppressed, and they have potential and characteristics rooted in our cultural history to make changes. However, they are in conflict with different models of childbirth as has been described in this report, which is hindering because:

> "Midwives need key skills in order to sustain relationships that help women to feel safe and able. One central example is midwives' belief in women, which enhances women's belief in themselves and is the key issue in trust, with all its positive effects. Yet this belief can only be sustained where midwives believe in themselves and the effectiveness of their skills" (Kirkham, 2000, p. 243).

Different work settings create different types of midwifery. The question is, how do structural arrangements and cultural values affect the meaning and practice of midwifery and conversely, how does midwifery influence social structures and culture?
"Technologies alter the relationships between nature and culture, and this is especially true of motherhood" (Oakley, 2005 p. 113). Time must be taken to reconceptualise and revise power dynamics between procreative women and medical authority (Simonds, 2002). If the social and cultural movements of medical models continue into the territories of birth, they will restrict or even destroy the ability of women as well as of midwives and other health carers, such as doctors, to deal with birth as a life event, for them to have confidence and belief in the woman's own natural process of birth.

Benoit et al, (2005) suggest based on their analysis of the social organization of maternity care systems in four countries, the United Kingdom, Finland, the Netherlands and Canada, that the logic of medical dominance can be successfully challenged under certain circumstances, for example when "maternity care is viewed as a social entitlement by the welfare state and where activist see midwifery as a vehicle to achieve accessible care" (p. 735).

There the role of midwives in facilitating the empowerment of women through their experience of childbirth is very important. Just as theorists of critical education describe their role in the empowerment process in terms of enabling or creating empowering opportunities (Vanderplast, 1999), midwives have the same role and have to develop direct ways to involve women and themselves in empowering their knowledge. The contradiction is that to be empowered depends on the willingness to recognize and challenge one's own disempowerment. In a sense midwives have to strive to be both empowering for women as well as being empowered. Both are agents and subjects of the empowerment process (Vanderplaat, 1999).

But not only that, it is the empowerment of their knowledge that matters most. Midwives have to ask hard questions about how our own practice makes midwives passive; maybe we should take a leave from fighting against the medical models of care and look within; commitment to mutuality requires that we on the one hand recognize power and privileged positions and on the other, we recognize that we might in turn be disempowered by our adherence to privileged disciplines and discourses. Midwives have to remove barriers, sometimes of their own making, that have prevented them from speaking up for midwifery knowledge, as well as going above the personal conflicts and compromise.

But midwives need support as has been identified in the UK (Kirkham and Stapleton, 2000, Deery, 2005, 2006) and to work together to find ways to speak up and make change. One way is to use new forms of storytelling in midwifery research, practice and education, in a constructive way and to stand by midwifery, influence change and identify ways as midwife Bella did in the following narrative about choices of place of birth out in the country.

We must keep the women at our side, we have to take care of this. It is the only way, we have to fight for it, and reach out to the women having their first child, especially now when the birth places are being centralized, and all birth should be at the big hospitals. We have to work together and believe in ourselves.

(Midwife-Bella, 6 years' experience, interview 8)

At the beginning of all interviews, midwives were asked to tell stories of important events that were illuminating in their memories, influential in their practice, singular moments that stood out highlighting the positive as well as the negative experiences. When asked to talk about their work in this way, it is maybe not unexpected that stories told often were positive. Midwifery is usually rewarding with elements of humanity with emotional and spiritual aspects, a wellspring of life. Research in midwifery should benefit women and childbirth and thereby midwifery. In the end this study is about exemplary practice regarding ideology, but it has critical points to make about contemporary midwifery practice.

Information from this research could be useful for midwifery practice and management. The diaries that were used as a part of the data included narratives about underlying conflicting models of care and unsafe surroundings of the centralized hospital birth, which puts women at the risk of losing control, autonomy and integrity (Leap and Edwards, 2006). This kind of experience was reflected by the midwives at the University hospital. They experienced

emotional exhaustion with signs of burnout, needing support in their midwifery practice. As a result of midwives' activities they were asked to write these diaries which already have served to have rhetoric and possibly real influences. Midwifery managers at the University hospital strive to make changes aiming for every woman to have a midwife at her side throughout the labour, if she wishes and especially when the woman is in hard labour (has progressed to 6 cm dilation). This indicates that this way of diary writing is a fruitful research method. It can also be helpful as a managerial strategy if there are resources and willingness to use the information to guide practice. The midwives let their voice be heard, and this method of writing diaries could be used in further research about these issues and be a helpful tool to change practice. This kind of midwifery narratives and that of others have potentials of empowerment to guide future developments of midwifery in an Icelandic context.

The Icelandic midwives of this study develop interpersonal relationship in fragmented care, influenced by context in the sense that relationships are formed on different levels of connections and reciprocity. Given that midwifery relationships have influence on good outcomes of birth, relational issues are fundamental to preserve midwifery skills, promote change and for midwifery practice development. Thus, the midwife's presence or the "sitting over" at birth is crucial and can be seen as a weapon to use in the battle between ideologies of childbirth.

Implications for midwifery and further research

The findings of this study have various implications for midwifery in Iceland, especially as this research is the first one of its kind in the country. The midwifery narrative presented here as a research product and the individual stories told by midwives provide fundamental information and constitute a theoretical base for future research in midwifery in an Icelandic context.

In some ways this midwifery narrative can be applied to other countries in the Western world, but others not as there are always differences in the culture of maternity services and in the social context of place of birth. Therefore, it is important to conduct further research in different countries to explore and compare the cultural and social structures of the maternity services. Research findings from different cultural settings of childbirth can give helpful

information on how the social and cultural context shapes the maternity services and what influence it has on childbearing women and midwives' ways of knowing.

The midwife-with- woman relationship and further research

The key component of midwifery care and practice as well as developments of midwifery knowledge lies within the dynamic relationship between the midwife and the woman. Central concepts of the midwife-with-woman relationship that have been identified in this research are in accordance with the midwifery literature. They interrelate and have similar meanings and indicate a common universal approach of midwifery models of care through the relationship with the women.

However, conceptualization of midwifery relationships tends to become blurred and again often become a matter of rhetoric. As central concepts have been identified through descriptive research, they need further exploration to define and evaluate what constitutes the different concepts. A theoretical base needs to be developed for further study, to advance practice and to provide effective care that leads to positive experiences and health outcomes for women, their babies and families, spanning pregnancy, childbirth and postpartum of new parenting.

Limited research is to be found on how the relationship between midwives and women affects development of midwifery skills and knowledge. In this study the narrative knowledge of midwives in part uncovers ways of connective knowing with the woman which need to be explored in further studies, for example in relations to embodied knowledge. Research is needed to identify the midwife's skills of forming relationships and how this relationship between midwives and women influences knowledge development in midwifery, including the different types of inner ways of knowing.

The midwife-with-woman relationship is the core element of effective midwifery care. In depth individual studies as well as secondary analysis and collective constructs of synthesizing research findings is needed between midwifery researchers. The aim would be to define, compare and contrast different terms to build theoretical frameworks. Central concepts of midwifery relationships with women, such as the concept of reciprocity, need to be clarified and developed further to build theories of midwifery in different contexts, between countries

and cultural placements of birth. The following is an overview of ideas of further research questions about:

- How the midwife-with-woman relationship influences knowledge development in midwifery.
- How the midwife-with- woman relationship links to the many facets of inner knowing, intuition based on work experience and/or spiritual awareness.
- How different components of the midwife-with-woman relationship, such as spiritual abilities of the midwife and the woman, has impact on the outcome of birth.
- How and what conditions in the workplace are needed to form the connective relationship with women, to support midwives in using the different ways of knowing
- How midwives synthesize clinical observations, theoretical knowledge, intuitive assessment, and spiritual awareness as components of a competent decision-making process to promote safety in midwifery practice.

Research on different types of inner knowing

Inner knowing of midwives is hidden practice and in this study unexpected findings came to light. Midwives usually do not talk about this side of midwifery as this kind of knowing is usually not valued or considered legitimate. Questions about these issues have also rarely been asked in midwifery research.

In modern maternity services there is a danger of midwives losing these kinds of midwifery skills. Therefore, there is an urgent need for further research to preserve or recover inner knowing of midwives either based on experience in practice or on spiritual awareness. Other types of qualitative research than in this study could be used, such as of phenomenology, to analyse and explore in more depth various experiences and meaning of different types of inner knowing in practice, both from the point of view of midwives and women and their partners. Many research ideas come to mind, inspired by the findings of this study, such as on:

- Inner knowing, what it consists of, how it develops and how midwives use subjective intuitive skills.
- Inner knowing in connections to and with woman in relationship.
- The characteristics and different types of inner knowing of midwives.

- The discourse and rhetorical practices of intuition and spirituality in midwifery practice.
- How midwives experience their inner knowing at birth.
- How midwives experience spiritual energies at birth.
- How midwives experience the supernatural, guidance from the "other side".
- How midwives incorporate and experience spirituality and prayers in their care.
- How Christian faith or other religious beliefs have impact on midwifery care.
- How midwives experience inner knowing in relation to the birth of a spirit or a soul.
- How inner knowing of midwives is "special" and/or similar to other professional inner knowing in health care.
- How this kind of knowing in a cultural context of place of birth has influence on midwifery skills to provide safety of birth
- How this type of knowing relates to expert knowledge in midwifery practice, such as in relation to embodied knowing.
- Ways to create potentials for this kind of knowing to develop separately and in combination with other kinds of knowledge systems about childbirth and midwifery.
- Ways for midwives to develop practices and create space to explore energies and other dimensions of confidence and safety than technologic ones.
- Ways to explore and link inner ways of knowing in midwifery with other forces of knowledge and disciplines such as of therapeutic psychology.

Women's and their partners' experiences of the midwives' "sitting over" at birth

The "meta" or the core narrative of this study surrounds the plot of being present with the woman at birth, or the culturally embedded "sitting over" in Icelandic terms. This refers to a metaphor and a common ground in midwifery practice, being essential for the forming of a midwife-with-woman relationship and crucial to the development of different kinds of midwives' knowing. Furthermore, research on these issues is crucial. The aim would be to explore in more depth the presence or the act of "being with" (the doing and not doing), to identify and ask whether the presence and support actions of the midwife are perceived as effective by the woman and if so how it is beneficial in an Icelandic context.

This study was based on midwives' birth stories; therefore, next it would be appropriate to examine women's birth stories, as well as the stories of their partners, with the aim to learn about the women's own model of care and how they experience the conflicting social narratives about childbirth care. Furthermore, the aim could be to learn about the partner's experiences and his model of care and to explore his impact on the process of birth and the childbearing woman's experiences.

Small scale pilot studies have already been conducted by midwifery students under my supervision, focusing on women's (Helgadóttir, 2006) and their partners' experiences (Pétursdóttir, 2006) of the presence of the midwife at birth, the "sitting over". Interviews were conducted with six women and five partners. A framework of a semi-structured interview was developed with open questions based on the main concepts of this study, such as presence of the midwife, trust, connections, reciprocity, empowerment and intuitive skills of the midwife. Both the women and the partners agreed on the importance of having the midwife present during birth process and they experienced reciprocal, empowering climate of trust where the mothers felt they were in control. All the women, except one, had positive experiences or connection with the midwife that entailed a sense of security based on the midwife's competence and intuitive skills, for example with regard to advising and choosing birthing positions that were effective for the woman to have a physiological birth. The prospective fathers defined themselves first and foremost as being in a supporting role. Some of them did not experience the same levels of reciprocity as the mothers and said they would have liked to be more involved in attending the birth, receiving more direct information and communications from the midwife. These issues are important to bear in mind and explore in further studies.

Thus, preliminary findings of the experiences of these parents support in part the findings of this study with regard to the forming of reciprocal relationships with the midwife. Based on these projects, the aim is to develop research frameworks for a future narrative study to explore the midwife's and woman's connective way of knowing, for example with pairs of women/partners and the midwife who attends the birth.

This kind of research could be conducted with different groups of women in different places of birth, who have been labelled either "low risk" or "high risk" by the medical model of care.

To go beyond the surface and to ask questions about how women experience the midwife's attitude and different aspects of risk and safety and how this has influence on them during birth and the outcome of birth.

Midwifery education

The study findings also have implication for midwifery education and supports the use of stories in midwifery teaching. It is important to endorse inner knowing of midwives in midwifery education and make it visible and part of the curricula, with the aim of activating students to listen to and learn to use their inner voice in combination with other kinds of knowledge, to stimulate them to be open to this kind of knowledge, not deriding it, but rather use it to become strong independent midwives in modern midwifery practices. The working life of the midwife is extremely demanding with overload of conflicting information and it is difficult for young midwives to weave their way through. They have to learn to connect and create calm surroundings of childbirth for the safety and good experiences of the woman and her family.

Reassessment of the curricula and the philosophical statements of the midwifery education in Iceland is required in order to clarify underpinnings of inner knowing and spiritual side of midwifery. The midwives in the focus group found it very important for midwives to keep on listening to their inner voice and to follow their instinct or intuition not least when teaching midwifery students.

I think that the students should be involved and listen to this kind of telling, yes - it is not only dilation and numbers and how far the head is engaged.

(Midwife 6, in focus group)

...I think this should be introduced to the midwifery students as soon as possible, even though it is not possible in many cases to explain what it is, just to recognize that it is there.

(Midwife 4, in focus group)

Discourse analysis of social narratives of childbirth

As has been described before, field notes were written from the media, not in a systematic way though. The following note was for example made from the programmes *Baby hospital* and *Birth Stories* on Living TV, broadcast in April 2006 which really illustrates conflicting models of care and how difficult it is for women to make real decisions to have normal birth

and how the professionals and the dominant social narratives are convincing when choosing pain treatments such as epidurals and choosing to give birth in high tech hospitals.

On the 23rd of April 2006 different birth stories were showed about women wanting different births from earlier pregnancies; one about a woman and her husband, an obstetrician. They were having their third baby with two earlier elective caesareans. This time she wanted to try for a normal birth. Behind that story were the risk elements of the environment, and her obstetrician husband being afraid for the safety of his child and the "50/50 chance" as the woman said, to have to have a caesarean again. After only 10 hours she had not dilated "with the labour slowing down", the baby showing signs of it being too risky to go on. The woman had her caesarean and a beautiful healthy baby and she was satisfied because she had "at least tried". The question is, in these circumstances, did she ever have a chance of having a normal birth?

A good thing about these kinds of shows is that they demonstrate different kinds of stories, places of birth and views, "normal" home births as well as "normal" hospital births where there is a belief in "the doctor thing" that can be informative but at the same time influential in maintaining the conventional way of giving birth in technological environments. Stories were also told of "special" pregnancy and delivery clinics for women experiencing problems, with real grave danger of dying, maybe both for the woman and the child with the joy and "real" terror.

It could be motivating for further research to conduct discourse analysis on these kinds of shows of "the dangerous business of childbirth" and of others to explore the experiences and influences they have on views about childbirth, both in Iceland and elsewhere, with the goal of looking at TV shows or other media programmes as a strategy, and develop to promote normal birth based on midwifery knowledge.

Development of narrative methodologies and use of birth stories in midwifery

It is just in the last decades that midwifery has started to build up and base its knowledge on academic learning and research. Exploring birth stories is one way of identifying and developing midwifery knowledge. Mishler (1995) pointed out that stories reflect different primary units of theoretical analysis, cultures, social processes, institutions and persons.

Given the broad perspective of this study, it lacked opportunities to focus directly on clinical issues and particular subjects which again could be done in further studies using narrative methodologies. Therefore, it is important to go on developing methodologies of narrative

research in midwifery, for example by exploring sub narrative and plots to examine in more depth different aspect of midwives' ways of knowing, also from the point of view of women and the family, based on individual care stories from practice or in larger studies.

Types of narratives have been identified throughout this report which have implications for midwifery and could be used to encourage and promote new forms of storytelling with the foundation of being exemplary or paradigm narratives to learn from. These stories or narratives have an evaluated function and provide answers that explain things and they include events and views that can be seen as a standard model or patterns of care to guide academic and practice learning in midwifery. When you read or hear them you can draw from them, learn and change your practice, your way of thinking and they can be relevant and linked to other stories happening in different places of birth and countries. Stories become stand-ins for lived experience or, as I suggest based on work of Benner (1984), identifications of midwifery knowledge, exemplars to learn from or to inform developments of midwifery practice, education and research. Midwives gain skills through effective storytelling (Kirkham, 1997)

This can for example be constructive narratives where midwives draw on their own experience to bring concepts together and relate to real practice which can be used for teaching, published in textbooks for midwifery students (e.g. Page, 2000, 2006) about the complexity of practice which is a part of discussions among colleagues for life long learning about midwifery and childbirth. Exemplary narratives in midwifery enhance and advance midwifery knowledge and have a point to make within a midwifery care paradigm which at the present time is imbalanced either shifting between patriarchy and partnership or from technocratic models of institution to midwifery models of care. Supported by the methodology and experience of conducting this study, the following overview gives indications of what new forms of storytelling based on exemplary or paradigm narratives entail.

<u>New forms of storytelling in midwifery</u>

- Include events and views that can be seen as paradigm to guide practice developments, models or patterns of care.
- Encourage ideology and midwifery skills to uphold normal birth.

- Give explanatory answers and have an evaluated function about diverse issues of childbirth and midwifery care to guide practice.
- Encourage ways to inform, promote and discuss normal birth with women.
- Associate with global birth stories in different places of birth.
- Can be rhetorical and proactive to change practice and ways of thinking about childbirth and midwifery care in order to win the battle over birth.
- Can be used in teaching and research to advance midwifery knowledge.
- Can be looked at as a narrative form of theorizing about midwifery and childbirth, to explore central concepts and build theoretical frameworks in midwifery.
- Can be used as a building block of narrative research internationally to advance midwifery - and interdisciplinary knowledge about childbirth.

Conclusions

This work of exploring storytelling as a hidden treasure to seek for and uncover midwifery knowledge yielded new understandings about the roots of midwifery with the midwife at the side of the woman. The core narrative of this study surrounds the plot of being "with woman" during birth in different time and culture of birth. It gives explanations of the many facets of midwifery relationships with women, based on reciprocity and connective ways of knowing.

In telling their birth stories the midwives of this study have been giving messages about their models of care and work in midwifery which have been their frame of reference and the theoretical framework of the study. The findings of the study propose that Icelandic midwives have a common philosophy of care that is associated with a midwife-with-woman relationship, a partnership model, incorporated in the ideological statements of the Icelandic midwifery education. Even though the statements have not been formalized as a framework to direct Icelandic midwifery practice, they seem to have strong roots, underpinning midwifery practice in Iceland.

Yet, increased workload in modern maternity care in centralized hospitals pushes midwives toward industrial and medical models of care. This can have detrimental effects on midwives' ways of knowing, particularly in relation to birth, on the *yfirseta,* termed "sitting over", and thereby on the potentials of forming relationships with woman based on reciprocity and connections with women. Furthermore, it destroys potentials of learning different ways of midwifery knowing including the intuitive and spiritual knowing. My argument is that therein lies the danger for Icelandic midwives to lose their "unique" midwifery skills and what it means to be a midwife.

In light of the conclusions of this study referring to the common plot of "being with" woman that drives the midwifery narrative, illustrated in how the woman is always present in the midwives' stories, it can be presumed that midwives in Iceland have yet not lost their skills (or the battle over birth). However, there are threatening signs and there is a vital need to preserve the "sitting over" of Icelandic midwives. If we are not successful, the plot of the midwifery narratives will change. In other words, there will be a chain reaction and the midwifery

paradigm might disappear and shift towards the technocratic models of care, which is the dominant one and usually accepted by modern society.

In this study the conflicting social narratives around childbirth in Iceland appearing in midwives' birth stories have been discussed. Furthermore, it has been explored how the different models of childbirth are both resisted and accepted by midwives and how cultural themes and context of place of birth, influence midwives' work with women.

The Icelandic Sagas, which are embedded in Icelandic culture, portray Icelandic women as strong independent individuals. The same traits of stoicism are apparent in many narratives of this study. Inherent in this midwifery saga is a well known Icelandic proverb: *Ekki skal gráta Björn bónda heldur safna liði* [Do not grieve the farmer Björn, just keep on battling]. Even though the midwives recognize the crisis of contemporary midwifery practice and sometime have negative experience of their workplace, it was not in the forefront of their storytelling, which is also in line with the professional aspect of the interview.

The study has made clear how midwives rely upon knowledge from different resources and integrate different kinds of knowledge systems aiming to form reciprocal relationships with women. The Icelandic midwives' stories demonstrate the complexity of holding the balance, while working with the woman rather than with the organizational settings of practice. In all, the study provides a storied episode of midwifery where midwives are "drawing on old concepts but fitting them into a modern health care system (Page, 2004, p. 23) on their way to succeed in creating what has been called the "new midwifery", battling on with a strong sense of a midwifery partnership model of care.

Further research is needed to identify and develop the central concepts of the relationship between midwives and women. This research added unexpected information and yields a deeper understanding of inner knowing of midwives, intuition based on work experience and/or spiritual awareness, in midwifery practice. More in-depth research is needed on these issues and on how the midwife-with-woman relationship affects development of different types of midwifery skills and knowledge. The narrative knowledge of the midwives in this study uncovers ways of connective knowing with the woman, which is paramount to explore in further studies.

This research is a step in identifying ideologies and the epistemology of midwifery theories that underpin midwifery practice, research and education. Narrative methodology was proven to be effective in identifying different ways of knowing as has been demonstrated throughout this research report. The use of birth stories in midwifery research should be developed in a constructive way to add to midwifery knowledge, of adequacy and legitimacy.

It is imperative to develop further methodologies of narrative research in midwifery - to identify, develop and enlist new forms of story-telling in order to advance midwifery practice and knowledge. Webs of paradigm birth stories from different places of birth can be used to learn from, change views and advance midwifery knowledge internationally. Such a network of links, made by narratives like the ones of this study, could be used as analytical tools in a social and cultural context when researching, comparing and developing midwifery knowledge and models of childbirth care.

Final words

Socrates's mother was a "mother of light", i.e. a midwife and he compared himself with being in that role when he was teaching, not focusing on his own knowledge but assisting the students to develop their own ideas, to create opportunities for them to think and react wisely. As a friend of wisdom he thought that all human beings should have the possiblities to understand and receive knowledge that being the essence of the midwifery role (Árnason, 1997). Thus, as the midwife receives the baby she awaits the birthing of ideas and different ways of knowing.

In a similar way, this Icelandic midwifery saga has been at different stages of conversations and conclusions, "coming to light". The outcome is a storied episode of the working life of midwives in Iceland from the mid twentieth century to the present. It is impossible to draw together all the threads of a midwifery narrative, many have to be left out, to be taken up and told in another story.

The fact is that the midwifery relationships with women are not static; they change and depend on the situational context and people's perceptions. This narrative of midwifery care and culture of childbirth culture in an Icelandic context are multifaceted and as diverse as life itself but with the main plot of "being with" which enables midwives to develop "with woman" connective ways of knowing.

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APPENDICES

APPENDIX 1 a-Application for approvals to the The National Bioethics Committiee (NBC)

APPENDIX 1 b-Introductory Letter to midwives taking part in the one-to-one interviews and a form for consent to participate

APPENDIX 1 c-Introductory Letter to midwives taking part in the focus group interview. .

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Nr. umsóknar:	Móttekin:	Afgreidd:

Umsókn til Vísindasiðanefndar

1. HEITI RANNSÓKNAR. Beðið er um fullt heiti rannsóknar, íslenskt eða erlent eftir atvikum.

Fæðingasögur og þekkingarþróun í ljósmóðurfræði
(Storytelling and narratives about childbirth: Knowledge Developments in Midwifery)

2. TILGANGUR RANNSÓKNAR OG LÝSING Í HNOTSKURN. Útdráttur úr rannsókninni, þar sem fram koma m.a. upplýsingar um markmið, þátttakendur, framkvæmd, vísindalegt gildi og vísindalegan ávinning. Útdrátturinn skal vera 300 orð hið mesta og er m.a. ætlaður til birtingar á vefsíðu VSN eftir að umsóknin hefur hlotið endanlegt samþykki.

Tilgangur rannsóknarinnar er safna fæðingarsögum og skilgreina þekkingu ljósmæðra og hugmyndafræði um barneignir sem birtist í þeim. Einnig til þess að skoða barneignarþjónustu og val á fæðingarstað á Íslandi út frá menningarlegu sjónarhorni. Rannsóknaraðferðin er eigindleg og frásagnargreining (narrative analysis) er notuð við greiningu gagna.
Í fyrsta hluta rannsóknarinnar sem var forrannsókn til að þróa rannsóknaraðferð var fæðingarsögum 8 ljósmæðra sem hafa unnið á landsbyggðinni frá árinu 1954 -2004 safnað í viðtölum og þær beðnar að segja frá atvikum eða aðstæðum sem hafa verið minnisverð. Einnig var rætt um breytingar sem hafa orðið í starfi þeirra í hálfa öld ekki síst með tilliti til fæðingarstaðar.
Í öðrum hluta eru fæðingasögur 70 íslenskra kvenna sem komu út í bókinni *Konur með einn í útvíkkun fá enga samúð* í desember 2002 skoðaðar og fjallað um þær frá feminisku sjónarhorni með áherslu á orðræðu kvenna, menningu og upplifun af barneignarþjónustunni.
Í þriðja hluta verður sögum safnað frá ljósmæðrum með ólíkan bakgrunn sem hafa bæði starfað á landsbyggðinni og/eða í Reykjavík á fæðingardeild Landspítala-háskólasjúkrahúss. Niðurstöður úr fyrsta og öðrum hluta rannsóknarinnar eru notaðar til að þrengja rannsóknarefnið og til þróa næstu viðtöl þar sem aukin áhersla verður lögð á sögur sem endurspegla samband ljósmæðra við konur, faglegt öryggi og færni í starfi, ekki síst þegar frávik frá eðlilegu ferli fæðingar eru greind og bregðast þarf við á öruggan hátt.
Mikilvægt er að byggja upp rannsókna- og þekkingargrunn í ljósmóðurfræði og skoða hvernig ljósmóðurstarfið hefur þróast í íslensku samfélagi og menningu. Ein leið til þess er að nýta þann fjársjóð sem falinn er í fæðingasögum. Engin sambærileg rannsókn hefur verið gerð á Íslandi og lítið um að fæðingarsögur séu skoðaðar með þessu hætti erlendis. Niðurstöður ættu því ekki eingöngu að nýtast við við uppbyggingu rannsókna í ljósmóðurfræði á Íslandi heldur einnig vera innlegg í þekkingarþróun á alþjóðavísu. Rannsóknin er unnin til doktorsgráðu við Thames Valley University í London

3. ÁBYRGÐARMAÐUR RANNSÓKNAR. Rannsakendur skulu tilnefna einn ábyrgðarmann úr sínum hópi sem annast samskipti við Vísindasiðanefnd og sem ber jafnframt faglega ábyrgð á framkvæmd rannsóknarinnar.

Nafn: Sigríður Dúna Kristmundsdóttir	**Kennitala:** 13.08.52-2389	**Staða:** Prófessor
Vinnustaður: Háskóli Íslands,	**V-Sími:** 5254508	**Fax:**
Deild: Félagsvísindadeild	**H-Sími** 5523604	
Heimilisfang vinnustaðar: Oddi	**GSM:**	**Netfang:** sduna@hi.is

4. AÐRIR UMSÆKJENDUR. Tilgreina þarf nöfn og vinnustaði allra rannsakenda, þ.e. annarra en ábyrgðarmanns.

Nafn: Ólöf Ásta Ólafsdóttir — **Vinnustaður/Skóli:** Háskóli Íslands, hjúkrunarfræðideild, Eiríksgata 34, 101 Reykjavík, Kvennasvið Landspítala-háskólasjúkrahús, Thames Valley University, London

Staða: lektor og námsstjóri í ljósmóðurfræði, forstöðumaður fræðasviðsins Ljósmóðurfræði og heilbrigði kvenna, Kvennasviði, Landspítala-háskólasjúkrahúss, doktorsnemi við Thames Valley University **GSM: 863-4623** **Netfang: olofol@hi.is**

5. AÐRIR SAMSTARFSAÐILAR (þ.m.t. fjármögnunar- og styrktaraðilar). Hér skal t.d. greina frá þeim stofnunum og fyrirtækjum, innlendum eða erlendum, sem að rannsókninni koma hafi slíkar upplýsingar ekki þegar komið fram í liðum 2 og 3.

Stofnun/fyrirtæki:	**Heimilisfang:**
Stofnun/fyrirtæki:	**Heimilisfang:**
Stofnun/fyrirtæki:	**Heimilisfang:**

6. VERKASKIPTING SAMSTARFSAÐILA. **Hér skal greina frá því hvaða aðilar hafa umsjón með einstökum verkþáttum rannsóknarinnar. Ef rannsakendur njóta styrkja eða annarrar fjármögnunar vegna rannsóknarinnar þurfa einnig að koma fram upplýsingar um tengsl fjármögnunaraðila við rannsakendur.**

Rannsóknin er einyrkjarannsókn unnin í Háskóla Íslands af Ólöfu Ástu Ólafsdóttur, lektors og forstöðumanns náms í ljósmóðurfræði og fræðasviðsins ljósmóðurfræði og heilbrigði kvenna við Landspítala-háskólasjúkrahús. Doktorsritgerð er í smíðum sem byggja mun á niðurstöðum rannsóknarinnar, og doktorsvörn mun fara fram við Thames Valley University í London, þar sem rannsakandi er skráður doktorsnemi. Aðalleiðbeinendur eru Lesley Page yfirljósmóður og Chris McCourt prófessor í félagsmannfræði og forstöðumaður framhaldsnáms við heilbrigðisvísindadeildina þar. Íslenskur leiðbeinandi í doktorsnefnd er Sigríður Dúna Kristmundsdóttir, prófessor í mannfræði við Háskóla Íslands og er hún skráð ábyrgðarmaður hennar í þessari umsókn. Umsjón með öllum verkþáttum rannsóknarinnar og fagleg ábyrgð er í höndum rannsakanda. Rannsóknin hefur hlotið styrk frá rannsóknasjóði Ljósmæðrafélagi Íslands, 250 þús. kr.

7. ÞÁTTTAKENDUR. **Tilgreinið fjölda þátttakenda svo og hvernig og á hvaða forsendum úrtakið verður valið.**

Um eigindlega rannsókn er að ræða og ekki ljóst við hversu marga þátttakendur verður rætt en gera má ráð fyrir u.þ.b. 15-20 viðtölum í viðbót við viðtöl úr forrannsókn. Val á úrtaki miðast við þægindaúrtak og óskað verður eftir sjálfboðaliðum innan kvennadeildar en einnig leitað eftir viðtölum við ákveðna aðlila sem rannsakandi telur að hafi sögur á takteinum og geti íhugað á gagnrýnin hátt í starfi, hafi fjölþætta reynslu bæði af landsbyggðinni og á LSH . Miðað er við að í úrtaki séu aðilar með mismunandi bakgrunn hvað varðar aldur, menntun og starfsreynslu. Síðar er haft í huga að hafa hópviðtöl/rýnihóp með ljósmæðrum og/eða konum sem hafa reynslu af barneignum til að bera undir, ræða og styrkja niðurstöður.

8. ÁVINNINGUR/ÁHÆTTA. **Tilgreinið í hverju ávinningur jafnt sem áhætta þátttakenda í rannsókninni verður helst fólgin.**

Litið er á ljósmæður sem meðrannsakendur þar sem í gegnum samræður er verið að skoða og skilgreina faglega færni í starfi, hugmyndaramma ljósmóðurfræðinnar og félagsleg og menningarleg áhrif. Ávinningur getur falist í samtalinu þar sem tækifæri gefst til að taka þátt í að skilgreina þekkingu og reynslu í ljósmóðurstarfi, íhuga og koma sjónarmiðjum og reynslu á framfæri sem getur verið styrkjandi bæði faglega og persónulega. Áhætta fyrir þátttakendur ætti ekki að vera til staðar.

9. ÖFLUN UPPLÝSTS SAMÞYKKIS. **Tilgreinið hvernig upplýsts samþykkis þátttakenda verður aflað, þ.m.t. hvaða aðili muni leita til þeirra eftir slíku samþykki. Athugið að ef afla á upplýsinga eða sýna frá börnum þarf samþykki frá foreldri eða forráðamanni. Afrit af upplýsingum og samþykkisblöðum skulu fylgja umsókninni.**

Rannsakandi leitar sjálfur eftir samþykki þátttakenda, auglýsir eftir sjálfboðaliðum á Kvennadeild LSH og skipuleggur hvar viðtal fer fram í samráði við viðkomandi og leggur fyrir upplýsingabréf og eyðublað um upplýst samþykki.

10. RANNSÓKNARGÖGN. **Hvers konar gögnum (persónuupplýsingum, lífsýnum o.s.frv.) er fyrirhugað að safna vegna rannsóknarinnar? Hvaða aðilar munu hafa aðgang að þeim gögnum? Hvaða öryggisráðstafanir verða gerðar? Hver hefur umráðarétt yfir gögnunum að rannsókn lokinni? Hvernig verður trúnaður við þátttakendur varðveittur?**

Viðtöl verða tekin upp á segulband og vélrituð frá orði til orðs. Hin rituðu gögn eru geymd á vísum stað á skrifstofu rannsakanda og eru merkt með bókstaf og nafni sem er ekki hið rétta og getu bæði gengið á íslensku og ensku (dæmi: R- Rosa), segulbönd eru merkt og geymd á sama hátt. Listi yfir þátttakendur og merki þeirra eru geymd sér í læstri hyrslu. Upptökum verður eytt að rannsókn lokinni.
Rannsakandi hefur umráðarétt yfir gögnunum og aðgang. Starfsmaður sem er læknaritari tekur þátt í að rita viðtölin og er bundin þagnarskyldu.

11. SIÐFERÐILEG ÁLITAMÁL. **Hér skal greina frá helstu álitamálum af siðferðilegum toga sem rannsóknina varða.**

Samkvæmt viðmiðum Vísindasiðanefndar um rannsóknir á mönnum er varða heilsu þeirra er óljóst hvort þessi rannsókn flokkast undir að vera leyfisskyld en þátttakendur eru ekki skjólstæðingar heilbrigðisþjónustunnar. Hins vegar er verið er að afla gagna frá heilbrigðisstarfsmönnum (ljósmæðrum) þar sem persónulegum atburðir skjólstæðinga þeirra koma við sögu. Þó svo ljósmæður séu bundnar þagnarskyldu og þær fjalli um starfsreynslu í samræmi við það, telur rannsakandi rétt að Vísindasiðanefnd fjalli um rannsóknina. Til að að trúnaðar sé gætt við skjólstæðinga eru þátttakendur undir nafnleynd og áhersla lögð á að í frásögum sé ekki fjallað um fólk undir nafni og staðir ekki nafngreindir. Sérstaklega er þetta haft í huga við birtingu niðurstaðna/frásagna í ræðu og riti. Verði undantekning gerð þar á verður það með samþykki viðkomandi aðila, bæði skjólstæðings og ljósmóður.

12. VÍSINDALEGT GILDI. **Gerið stuttlega grein fyrir þeim vísindalega ávinningi talið er að verði af rannsókninni.**

Þó ljósmóðurfræðin standi á gömlum merg og ljósmóðurstörf hafi verið unnin frá alda öðli er hún ung fræðigrein. Þekking í ljósmóðurfræði hefur fram að þessu verið byggð á reynslu í starfi en nám í ljósmóðurfræði fluttist ekki á háskólastig fyrr en árið 1996 og hófst þá við Háskóla Íslands. Samhliða þróun í kennslu er mikilvægt er að byggja upp rannsókna- og þekkingargrunn og skoða um leið hvernig ljósmóðurstarfið hefur þróast í íslensku samfélagi og menningu. Ein leið til þess er að nýta þann fjársjóð sem er falinn í fæðingasögum. Engin sambærileg rannsókn hefur verið gerð á Íslandi og lítið um að fæðingarsögur séu skoðaðar með þessu hætti í rannsóknum í ljósmóðurfræði. Niðurstöður þessarar rannsóknar ættu því ekki eingöngu að nýtast við við uppbyggingu rannsókna í ljósmóðurfræði við Háskóla Íslands í samvinnu við Kvennasvið Landspítala-háskólasjúkrahúss heldur einnig vera innlegg í þekkingarþróun í ljósmóðurfræði á alþjóðavísu.

13. FRÆÐIGRUNNUR RANNSÓKNAR. **Lýsa skal fræðilegri þekkingu á rannsóknarsviðinu og öðrum bakgrunni rannsóknarinnar, þ.m.t. helstu niðurstöðum eldri rannsókna. Taka skal sérstaklega fram hvaða reynsla er af viðkomandi aðferðum og/eða meðferð í fyrri rannsóknum. Þessum lið má skila á sérblaði eða vísa í ýtarlegri rannsóknaráætlun sem þá skal fylgja umsókn.**

Í stað þess að senda með rannsóknaráætlun frá árinu 2000, sem hefur breyst í samræmi við þróun rannsóknarinnar og í samræmi við eigindlegar rannsóknaraðferðir, fylgir með erindi um þróun rannsóknarinnar og fræðilegan bakgrunn þessa að skoða fæðingarsögur til að skilgreina þekkingu og hugmyndafræði ljósmóðurfræðinnar.

14. RANNSÓKNARAÐFERÐIR. **Gera skal grein fyrir aðferðafræði rannsóknarinnar. Taka skal fram hvort ætlunin sé að afla upplýsinga annarsstaðar frá en frá þátttakendum sjálfum. Ef ætlunin er að notast við upplýsingar úr sjúkraskrám, gagnabönkum (s.s. Krabbameinsskrá) eða sýnum úr lífsýnabanka þurfa afrit af tilskyldum leyfum að fylgja umsókninni (sbr. lið 23 hér á eftir). Koma þarf fram til hvers er ætlast af þátttakendum, s.s. hvers konar rannsóknir verði gerðar á þeim, hversu oft þeir munu koma í eftirlit eða mat og hvers konar sýna og/eða upplýsinga verður aflað. Þessum lið má skila á sérblaði ef þörf krefur.**

Rannsóknaraðferðin er eigindleg með mannfræðilegt sjónarhorn (ethnography) og frásagnargreining (narrative analysis) er notuð við greiningu gagna sem er aðallega safnað í viðtölum við ljósmæður en einnig í fjölmiðlum og úr rituðu máli um reynslu kvenna og barneigni.
Frásagnargreining felur í sér að safna saman frásögnum af atburðum og aðstæðum sem þræddar eru saman í eina heild. Ný saga verður til sem innheldur margar frásagnir sem geta í þessu tilfelli verið eins konar hugmyndarammi um ljósmóðurstarfið.
Í fyrsta hluta rannsóknarinnar sem var forrannsókn til að þróa rannsóknaraðferð, var fæðingarsögum 8 ljósmæðra sem hafa unnið á landsbyggðinni frá árinu 1954 -2004 safnað í opnum viðtölum/samtölum og þær beðnar að rifja upp og segja frá atvikum eða aðstæðum sem hafa verið minnisverð, bæði ánægjulegar og/eða erfiðar aðstæður. Einnig var rætt um breytingar sem hafa orðið í starfi þeirra í hálfa öld ekki síst með tilliti til fæðingarstaðar.
Í öðrum hluta eru fæðingasögur 70 íslenskra kvenna sem komu út í bókinni *Konur með einn í útvíkkun fá enga samúð* í desember 2002 skoðaðar og fjallað um þær frá feminisku sjónarhorni með áherslu á orðræðugreiningu (discourse analysis) þar sem orðræða kvenna, menning og upplifun af barneignarþjónustunni er skoðuð.
Í þriðja hluta rannsóknarinnar eru niðurstöður úr fyrsta og öðrum hluta rannsóknarinnar notaðar til að þrengja rannsóknarefnið og þróa næstu viðtöl þar sem aukin áhersla verður lögð á sögur sem endurspegla samband ljósmæðra við konur, faglegt öryggi, þekkingu og færni í starfi, ekki síst þegar frávik frá eðlilegu ferli fæðingar eru greind og bregðast þarf við á öruggan hátt.
Viðtalið/samtalið við ljósmæður tekur 1-2 klukkustundir. Litið er á ljósmæðurnar sem segja sögur sem meðrannsakandur þar sem í gegnum samræður er verið að skoða og skilgreina faglega færni í starfi, hugmyndaramma ljósmóðurfræðinnar og félagsleg og menningarleg áhrif.

15. ÚRVINNSLA GAGNA. **Tilgreinið hvers konar úrvinnsla (t.d. tölfræðileg) verður gerð og hvort stuðst hefur verið við "power analysis" eða aðrar hliðstæðar aðferðir við undibúning rannsóknar.**

Greining gagna er eigindleg og áhersla lögð á frásagnargreiningu (narrative analysis). Viðtöl eru tekin upp á segulband og þau rituð frá orði til orðs. Rituð viðtalsgögn og sögubrot eru greind og túlkuð af rannsakanda. Niðurstöður verða skrifaðar í söguformi og fjallað um barneignir og ljósmóðurstarfið á Íslandi út frá menningarlegu gagnrýnu sjónarhorni, út frá mismunandi hugmyndafræði og kenningum í samhengi við rannsóknarniðurstöður.

16. RANNSÓKNARTÍMABIL. **Tilgreinið hvenær áætlað er að rannsókn hefjist og muni ljúka.**

Óskað er eftir leyfi til að hefja gagnaöflun við þriðja hluta rannsóknarinnar í maí 2004. Gert er ráð fyrir að gagnasöfnun og greiningu gagna ljúki seinni hluta árs, rannsóknarskýrsla sé unnin í framhaldi af því og að rannsókn ljúki vorið 2005.

17. NIÐURSTÖÐUR RANNSÓKNAR. **Gerið grein fyrir fyrirhugaðri nýtingu og/eða birtingu / kynningu á niðurstöðum rannsóknarinnar.**

Rannsóknarskýrslu verður skipt í nokkra kafla sem verða uppstaða greina sem birtar verða í ritrýndum tímaritum. Efni kaflanna mun m.a. verða um þekkingarþróun í ljósmóðurfræði og fæðingasögur, fæðingastaði, menningarlegar breytingar í ljósmóðurstarfinu á landsbyggðinni og á fæðingardeild Kvennasviðs Landspítala-háskólasjúkrahúss, fæðingarsögur íslenskra kvenna frá feminisku sjónarhorni og samband ljósmæðra og kvenna - áhrif á öryggi og faglega færni.

18. FLUTNINGUR GAGNA. **Ef fyrirhugað er að flytja gögn rannsóknarinnar (t.d. lífsýni eða persónuupplýsingar) úr landi verður að tilgreina í hvaða tilgangi og formi það verði gert, svo og til hvaða stofnunar og lands gögnin verði flutt. Jafnframt ber að tilgreina hver á viðkomandi stofnun fái umráðarétt yfir gögnunum og/eða beri ábyrgð á þeim.**

Þó svo rannsóknin sé unnin að hluta til við erlendan háskóla verða gögn ekki flutt út úr landi. Útdrættir úr viðtölum verða þýdd yfir á ensku til að nota í rannsóknarskýrslu. Þessi liður á því ekki við.

19. VARÐVEISLA OG EYÐING GAGNA. **Hvar verða rannsóknargögnin varðveitt? Hvenær og hvernig verður þeim eytt?**

Rituð viðtalsgögn verða geymd á skrifstofu rannsakanda. Upptökur á segulbandsspólum verða þurrkaðar út eftir að rannsókn lýkur árið 2005.

20. SAMNÝTING GAGNA. **Tilgreinið hvort fyrirhugað sé að samkeyra upplýsingar rannsóknarinnar við aðrar skrár eða samnýta upplýsingar og/eða sýni við aðrar rannsóknir. Ef svo er, greinið þá frá heiti viðkomandi rannsóknar og ábyrgðarmanni.**

Á ekki við _____

21. EFTIRLIT OG TRYGGINGAR. **Hver mun annast eftirlit með heilsu og líðan þátttakenda og hvernig verður eftirliti háttað? Með hvaða hætti og hjá hvaða aðila eru þátttakendur tryggðir gagnvart hugsanlegum skaða?**

Á ekki við _____

22. GREIÐSLUR VEGNA ÞÁTTTÖKU. **Tilgreinið hvort greitt verði fyrir þátttöku í rannsókninni og þá jafnframt hvers eðlis og hversu háar þær greiðslur verða.**

Á ekki við _____

23. AÐRAR UMSÓKNIR EÐA LEYFI. **Afrit af leyfi stjórnar lífsýnasafns vegna notkunar lífsýna, leyfi yfirlæknis/-lækna vegna aðgangs að sjúkraskrám, leyfi annarra skráarhaldara (s.s. Krabbameinsskrár) og leyfi stofnunar fyrir framkvæmd rannsóknar skulu fylgja með umsókn, eftir því sem við á. Hafi umsóknin áður hlotið samþykki Siðaráðs Landlæknisembættisins eða annarrar siðanefndar skal afrit þess leyfis einnig fylgja. Hafi heimild leyfisveitenda ekki enn fengist, skal skrá dagsetningu umsóknar til viðkomandi aðila.**

JÁ _____Persónuvernd, dags. _____	JÁ _____Önnur siðanefnd, hver: _____
JÁ _____Lyfjastofnun, dags. _____	JÁ _____Lífsýnasafn, hvaða:_____
JÁ _____Geislavarnir ríkisins, dags. _____	JÁ _____Skráarhaldari, hvaða:_____
JÁ _____Stofnun, hvaða: _____	JÁ x____Yfirlæknir/-nar, hver(jir): /yfirljósmóðir á kvennasviði LSH Jón Hilmar Alfreðsson, Margrét I. Hallgrímsson

24. FYLGISKJÖL MEÐ UMSÓKN. **Starfságrip/ritaskrá ábyrgðarmanns (þar sem birtingar í ritrýndum tímaritum eru sérstaklega tilgreindar), svo og upplýsinga- og samþykkisblöð vegna þátttöku í rannsókninni skulu ávallt fylgja umsókn til Vísindasiðanefndar. ÖLL FYLGISKJÖL SKULU SEND Í ÞRÍRITI.**

___x___	Starfsferilsskrá ábyrgðarmanns	___x___	Nákvæmari rannsóknarlýsing(ar)
_____	Kynningarblað/-blöð	_____	Spurningalistar, fjöldi _____
___x___	Upplýsingablað/-blöð	_____	"Case Report Form"
___x___	Samþykkisblað/-blöð	___x___	Afrit af leyfum
_____	Önnur fylgiskjöl (hver?) _____		

25. ATHUGASEMDIR UMSÆKJENDA. Hér er hægt að koma á framfæri athugasemdum eða skýringum sem ekki komust fyrir annarsstaðar í umsókninni

Sótt var um leyfi fyrir rannsókninni til siðanefndar Landspítala-háskólasjúkrahús en þar sem verkefnið var skilgreint sem samstarfsverkefni milli stofnana, er umsókn nú send til Vísindasiðanefndar.

Rannsókn þessi er skilgreind sem námsverkefni og þar sem reglur Vísindasiðanefndar kveða á um að leiðbeinendur séu ábyrgðarmenn námsverkefna er ábyrgðarmaður hennar í þessari umsókn Sigríður Dúna Kristmundsdóttir, sem er íslenskur leiðbeinandi í doktorsnefnd en erlendir aðalleiðbeinendur geta ekki verið ábyrgðarmenn samkvæmt sömu reglum. Rannsakandi óskar hins vegar eftir undanþágu frá þessari reglu og að vera sjálfur skráður sem ábyrgðarmaður og einnig að upplýsinga- og samþykkisblöð til þátttakenda í rannsókninni verði undirrituð af honum, til rökstuðnings þessarar beiðni, sjá nánar lið 6 um verkaskiptingu, starfsferilsskrá rannsakanda og meðfylgjandi bréf.

VERÐI EINHVERJAR BREYTINGAR Á RANNSÓKNARÁÆTLUNINNI BER ÁBYRGÐARMANNI AÐ TILKYNNA ÞÆR ÁN TAFAR TIL VÍSINDASIÐANEFNDAR.

Staður:	**Dagsetning:**	**Undirskrift ábyrgðarmanns:**
Húsavík	**25. apríl 2004**	**f.h. Sigríðar Dúnu Kristmundsdóttur, Ólöf Ásta Ólafsdóttir**

Vinsamlegast sendið umsókn í tólf eintökum en fylgiskjöl í þríriti.
Grunnupplýsingar um rannsókn (eitt eintak) fylgi frumriti umsóknar.

Utánáskrift Vísindasiðanefndar:

Vísindasiðanefnd, Laugavegi 103, 105 Reykjavík.

Æskilegt er að umsóknin berist einnig, ásamt eins mörgum viðbótargögnum og mögulegt er, á rafrænu formi, annað hvort á disklingi eða verði send með tölvupósti á netfangið: visindasidanefnd@vsn.stjr.is

afrit

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afrit

Kynningarbréf og upplýst samþykki fyrir vísindarannsóknina:
Fæðingasögur og þekkingarþróun í ljósmóðurfræði

Rannsakandi: Ólöf Ásta Ólafsdóttir, lektor við Háskóla Íslands og forstöðumaður fræðasviðsins Ljósmóðurfræði og heilbrigði kvenna, Kvennasviði, Landspítala-háskólasjúkrahúss, sími 863 4623, netfang olofol@hi.is
Ábyrgðarmaður: Sigríður Dúna Kristmundsdóttir, prófessor við Háskóla Íslands, sími 5254508, netfang sduna@hi.is

Tilgangur rannsóknarinnar er safna fæðingarsögum til að skilgreina þekkingu ljósmæðra og hugmyndafræði um barneignir sem birtist í þeim. Einnig til þess að skoða barneignarþjónustu og val á fæðingarstað á Íslandi út frá menningarlegu sjónarhorni. Rannsóknaraðferðin er eigindleg (ethnography) og frásagnargreining (narrative analysis) er notuð við greiningu gagna. Frásagnargreining felur í sér að safna saman frásögnum af atburðum og aðstæðum sem þræddar eru saman í eina heild. Ný saga verður til sem innheldur margar frásagnir sem geta í þessu tilfelli verið eins konar hugmyndarammi um ljósmóðurstarfið. Sögunum er aðallega safnað í viðtölum við ljósmæður en einnig í fjölmiðlum og úr rituðu máli um reynslu kvenna og barneignir.
Í fyrsta hluta rannsóknarinnar sem var forrannsókn til að þróa rannsóknaraðferð var fæðingarsögum 8 ljósmæðra sem hafa unnið á landsbyggðinni frá árinu 1954 -2004 safnað í viðtölum og þær beðnar að rifja upp og segja frá atvikum eða aðstæðum sem hafa verið minnisverð, ánægjulegar eða erfiðar. Einnig var rætt um breytingar sem hafa orðið í starfi þeirra í hálfa öld ekki síst með tilliti til fæðingarstaðar.
Í öðrum hluta eru fæðingasögur 70 íslenskra kvenna sem komu út í bókinni *Konur með einn í útvíkkun fá enga samúð* í desember 2002 skoðaðar og fjallað um þær frá feminisku sjónarhorni með áherslu á orðræðu kvenna, menningu og upplifun af barneignar-þjónustunni.
Í þriðja hluta verður sögum safnað frá ljósmæðrum (15-20) með ólíkan bakgrunn sem hafa bæði starfað á landsbyggðinni og/ eða starfað í Reykjavík á fæðingardeild Kvennasviðs Landspítala-háskólasjúkrahúss. Niðurstöður úr fyrsta og öðrum hluta rannsóknarinnar eru notaðar til að þrengja rannsóknarefnið og til þróa næstu viðtöl þar sem aukin áhersla verður lögð á sögur sem endurspegla samband ljósmæðra við konur, faglegt öryggi, þekkingu og færni í starfi, ekki síst þegar frávik frá eðlilegu ferli fæðingar eru greind og bregðast þarf við á öruggan hátt.
Þekking í ljósmóðurfræði hefur fram að þessu verið byggð á reynslu í starfi en nám í ljósmóðurfræði fluttist á háskólastig og hófst við Háskóla Íslands árið 1996. Mikilvægt er að byggja upp rannsókna- og þekkingargrunn í ljósmóðurfræði og skoða hvernig ljósmóðurstarfið hefur þróast í íslensku samfélagi og menningu. Ein leið til þess er að nýta þann fjársjóð sem falinn er í fæðingarsögum. Engin sambærileg rannsókn hefur verið gerð á Íslandi og lítið um að fæðingarsögur séu skoðaðar með þessu hætti í rannsóknum erlendis. Niðurstöður þessarar rannsóknar ætti því ekki eingöngu að nýtast við við uppbyggingu rannsókna í ljósmóðurfræði á Íslandi heldur einnig vera innlegg í þekkingarþróun á alþjóðavísu.
Rannsóknin er unnin til doktorsgráðu í ljósmóðurfræði við Thames Valley University í London. Leiðbeinendur eru Lesley Page yfirljósmóður og Chris McCourt prófessor í félagsmannfræði. Íslenskur leiðbeinandi í doktorsnefnd er Sigríður Dúna Kristmundsdóttir, prófessor í mannfræði við Háskóla Íslands.

Kæra ljósmóðir !

Mig langar til að biðja þig að taka þátt í þriðja hluta rannsóknar minnar um fæðingarsögur og þekkingarþróun í ljósmóðurfræði sem er lýst hér að ofan. Þátttaka þín felst í óformlegu opnu samtali þar sem við ræðum reynslu þína í ljósmóðurstarfi. Í viðtalinu bið ég þig um að segja mér fæðingasögur sem hafa haft áhrif hvernig þín faglega færni hefur þróast, segja frá atvikum eða atburðum sem eru þér finnst á einhvern hátt hafa staðið upp úr og verið lærdómsríkir. Ég er sérstaklega að leita eftir sögum þar sem reynt hefur á faglega færni og kunnáttu t.d. þegar grunur vaknar og frávik verða frá eðlilegu fæðingarferli og þegar "akút" vandamál koma upp sem bregðast þar við á fljótan og öruggan hátt, en einnig reynslusögur þegar " allt gekk vel". Ég hef líka áhuga á að ræða sérstaklega reynslu þína af samkiptum við konur, hvernig tengsl og samband þitt við konur þróast og hvaða áhrif þau hafa á þig í starfi.
Ég lít svo á að ljósmæðurnar sem segja mér sögur séu meðrannsakandur þar sem í gegnum samræður er verið að skoða og skilgreina faglega færni í starfi, hugmyndaramma ljósmóðurfræðinnar og félagsleg og menningarleg áhrif. Í samtalinu gefst tækifæri til að íhuga og koma sjónarmiðjum og starfsreynslu á framfæri sem getur verið styrkjandi bæði faglega og persónulega.
Viðtalið, sem tekur 1-2 klukkustundir verður tekið upp á segulband og vélritað frá orði til orðs. Hin rituðu gögn verða geymd á vísum stað á skrifstofu rannsakanda og eru merkt með bókstaf og nafni sem er ekki hið rétta og geta bæði gengið á íslensku og ensku (dæmi: R- Rosa) segulbönd eru merkt og geymd á sama hátt. Listi yfir þátttakendur og merki þeirra eru geymd sér í læstri hyrslu. Upptökum verður eytt að rannsókn lokinni. Fyllsta trúnaðar verður gætt varðandi þar sem kemur fram í viðtölum og tekið skal fram að frjálst er að hafna þátttöku eða hætta í rannsókn á hvaða stigi sem er án útskýringa, einnig er að sjálfsögðu hægt að neitað svara spurningum eða ræða ákveðin efnisatriði sem koma upp. Þar sem verið er að gagna afla gagna frá heilbrigðisstarfsmönnum sem hafa starfað eða starfa á Kvennasviði Landspítala- háskólasjúkrahúss og persónulegir atburðir skjólstæðinga þeirra koma við sögu er sótt um leyfi til að framkvæma rannsóknina til Vísindasiðanefndar. Til að að trúnaðar sé gætt við skjólstæðinga eru þátttakendur undir nafnleynd og í samræmi við þagnarskyldu heilbrigðisstarfsmanna er áhersla lögð á að í frásögnum sé ekki fjallað um fólk undir nafni og staðir ekki nafngreindir. Þetta er einnig haft í huga við birtingu niðurstaðna/frásagna í ræðu og riti. Verði gerð undantekning á þessu verður það gert með samþykki viðkomandi aðila.

Bestu kveðjur Ólöf Ásta

Kynningarbréf og upplýst samþykki fyrir þessari rannsókn eru í tvíriti og þú munt halda eftir eintaki til upplýsinga um í hverju þátttaka felst.

Mér hefur verið kynnt eðli og umfang þessarar vísindarannsóknar og ég er samþykk þátttöku.

Undirskrift þátttakanda

Undirskrift rannsakanda.

Ef þú hefur spurningar um rétt þinn sem þátttakandi í þessari vísindarannsókn eða vilt hætta þátttöku í rannsókninni getur þú snúið þér til Vísindasiðanefndar Laugavegi 103, 105 Reykjavík. Netfang: visindasidanefnd@vsn.stjr.is

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Kæru ljósmæður

Húsavík 3. desember 2004

Efni: Kynning á markmiðum fagrýnihóps ljósmæðra sem er hluti af upplýsingasöfnun og greiningu gagna í rannsókninni: Fæðingarsögur og þekkingarþróun í ljómóðurfræði: Ljósmóðurstarf á Íslandi 1954-2004,

Eins og þið vitið hef ég kallað saman nokkrar ljósmæður til að vera í fagrýnihópi, til að fjalla um hluta af niðurstöðum rannsóknar minnar um fæðingarsögur og þekkingarþróun í ljósmóðurfræði og ljósmóðurstarf á Íslandi 1954-2004. Mig langar að þakka ykkur öllum fyrir að vilja taka þátt. Hér á eftir eru stutt kynning á rannsókninni og tilganginum með fagrýnihópnum.

Tilgangur rannsóknarinnar er skoða fæðingarsögur og skilgreina þekkingu ljósmæðra og hugmyndafræði um barneignir sem birtist í þeim. Ennfremur að skoða hvernig barneignarþjónusta á Íslandi hefur þróast út frá menningarlegu sjónarhorni á árunum 1954-2004 sérstaklega með tilliti til fæðingarstaðar. Rannsóknin miðar einnig að því að skoða gildi fæðingarsagna í þekkingarþróun og skilgreina hvernig ljósmæður segja frá, með það fyrir augum að þróa frásagnarmáta og sögugerðir til að miðla þekkingu ljósmæðra.

Rannsóknaraðferðin er eigindleg og mannfræðileg og byggir á söguaðferð eða frásagnargreiningu. Með því að velja og segja ákveðnar sögur hafa ljósmæður komið hugmyndum á framfæri, lýst félagslegum og menningarlegum breytingum, sagt frá aðstæðum og á hvaða forsendum þær vinna. Ljósmæðurnar íhuga starfið, ræða atvik sem hafa haft áhrif, skýra aðstæður og meta atburðarásina. Í gegnum frásögnina hafa skilaboð ljósmæðra ákveðinn tilgang og þess vegna er hægt að líta á sögur þeirra sem fræðilegan hugmyndaramma rannsóknarinnar, sem ætlað er að sýna ljósmóðurstarfið í nýju ljósi til að þróa og birta grunn ljósmóðurþekkingar.

Rannsóknaráætlun var lögð fyrir Vísindasiðanefnd sem taldi hana ekki leyfisskylda. Þar sem við erum að ræða persónulegum atburði skjólstæðinga ljósmæðra og gæta þarf trúnaðar eru þátttakendur undir nafnleynd og áhersla lögð á að í frásögnum sé ekki fjallað um fólk undir nafni og staðir nafngreindir. Sérstaklega verður þetta haft í huga við birtingu niðurstaðna í ræðu og riti. Á fagrýnifundinum vil ég taka fram að þar ríkir þagnarskylda og einnig að ykkur er að sjálfsögðu frjálst að hætta án útskýringa og neita að svara spurningum eða ræða ákveðin efnisatriði sem koma upp

Nú hefur fæðingasögum ljósmæðra verið safnað frá breiðum sjónarhóli í 16 einstaklingsviðtölum en einnig úr fjölmiðlum og í umhverfinu. Eftir því sem rannsóknarferlið hefur mótast og viðfangsefnið þrengst hefur áhersla verið lögð á frásagnir ljósmæðra um samband við konur, hvernig tengsl milli þeirra þróast og hvaða áhrif þau hafa á þróun þekkingar í starfi. Ennfremur að skilgreina mismunandi þekkingarform sem ljósmæður nota í starfi með áherslu á huglæga eða innsæis þekkingu, hvað hún felur í sér og hvernig hún hefur áhrif á faglegt öryggi í ljósmóðurstarfi.

Ég lít á ljósmæður sem taka þátt í þessari rannsókn sem meðrannsakandur þar sem í samræðum okkar erum við að skoða og skilgreina faglega færni í starfi, hugmyndaramma ljósmóðurfræðinnar, félagsleg og menningarleg áhrif. Í fagrýnihópinn hafa eins og í rannsókninni almennt verið valdar ljósmæður með mismunandi bakgrunn hvað varðar aldur, menntun, starfsreynslu á mismunandi fæðingarstöðum, kennslu- og rannsóknareynslu.

Markmiðið með þessari fagrýni er safna fleiri sögum eða upplýsingum sem innifela ofangreinda þætti **þ.e. huglæga eða innsæis þekkingu, samband ljósmæðra og kvenna og faglegt öryggi,** og ennfremur að bera undir ykkur hluta af rannsóknarniðurstöðum sem kynntar verða á fundinum og ræða hvort reynsla ykkar er sambærileg eða ólík. Jafnframt munum við, ef tími gefst til ræða hlutverk sagna í starfi ljósmæðra, hvernig sögur eru notaðar, hvenær og hvernig.

Gert er ráð fyrir að fagrýnifundurinn taki um það bil tvær klukkustundir og verða samræður teknar upp á segulband og vélritaðar. Aðstoðarmaður minn verður Steinunn Blöndal ljósmóðurnemi á 2. ári og mun lokaverkefni hennar til embættisprófs að hluta til byggja á niðurstöðum fagrýnihópsins.

Fagrýnifundurinn er haldinn fimmtudaginn 9. desember kl. 16.30 í Eirbergi í fundarherbergi rannsóknarstofnunar á 2. hæð.

Hlakka til að sjá ykkur

Kær kveðja

Ólöf Ásta

APPENDIX 2 a -Approvals for conducting the study from the The National Bioethics Committiee (NBC)

APPENDIX 2 b -Approvals for conducting the study from the Landspitali University Hospital

APPENDIX 2 c -Notification and confirmation of the Data Protection Authority

AFRIT 2a

Háskóli Íslands,
félagsvísindadeild
Sigríður Dúna Kristmundsdóttir, prófessor
Odda v/Sturlugötu
101 Reykjavík

VÍSINDASIÐANEFND
Laugavegur 103, 105 Reykjavík,
Sími: 551 7100, Bréfsími: 551 1444
netfang: visindasidanefnd@vsn.stjr.is

Reykjavík 4. maí 2004
Tilvísun: VSNb2004040020/03-07/BH/--

Varðar: 04-055-afg Fæðingasögur og þekkingarþróun í ljósmóðurfræði.

Á fundi sínum 04.05.2004 fjallaði Vísindasiðanefnd um umsókn þína dags. 25.04.2004, vegna ofangreindrar rannsóknaráætlunar. Meðumsækjandi þinn er Ólöf Ásta Ólafsdóttir, lektor og doktorsnemi við Thames Valley University, en rannsóknin er doktorsverkefni hennar.

Tilgangur rannsóknarinnar er safna fæðingarsögum og skilgreina þekkingu ljósmæðra og hugmyndafræði um barneignir sem birtist í þeim. Einnig til þess að skoða barneignarþjónustu og val á fæðingarstað á Íslandi út frá menningarlegu sjónarhorni. Rannsóknaraðferðin er eigindleg og frásagnargreining (narrative analysis) er notuð við greiningu gagna.

Ekki er ljóst við hversu marga þátttakendur verður rætt en gera má ráð fyrir u.þ.b. 15-20 viðtölum í viðbót við viðtöl úr forrannsókn. Val á úrtaki miðast við þægindaúrtak auk sjálfboðaliða og ákveðinna aðila sem rannsakandi hefur í huga.

Rannsakandi leitar sjálfur eftir samþykki þátttakenda, auglýsir eftir sjálfboðaliðum á Kvennadeild LSH og leggur fyrir upplýsingabréf og samþykkiseyðublað.

Vísindasiðanefnd hefur farið vandlega yfir rannsóknaráætlunina og telur hana ekki vera leyfisskylda. Framkvæmd rannsóknarinnar byggist á viðtölum við ljósmæður um almenna reynslu sína af starfinu auk ópersónugreinanlegra frásagna þeirra af einstökum tilvikum. Það er skilingur nefndarinnar að ekki sé verið að kanna heilsufarsupplýsingar einstaklinga og heldur ekki rætt um einstök sjúkratilfelli þannig að að þau verði persónugreinanleg, enda teldist það brot á þagnarskyldu. Vísindasiðanefnd telur rannsóknina því ekki tilheyra þeim vettvangi sem hún starfar á, en áréttar að þagnarskylda og reglur um meðferð persónuupplýsinga séu virt í rannsókninni.

Rannsakendum er velkomið að hafa samband við nefndina hafi þeir önnur rök eða sjónarmið sem þeir óska eftir að koma á framfæri.

F.h. Vísindasiðanefndar,
með kveðju,
Björn Guðbjörnsson, formaður

LANDSPÍTALI
HÁSKÓLASJÚKRAHÚS

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Ólöf Ásta Ólafsdóttir
lektor við Háskóla Íslands
forstöðumaður fræðasviðs Ljósmóðurfræði og heilbrigði kvenna

17.03.2004

Efni: Leyfi til að framkvæma rannsóknina : Fæðingarsögur og þekkingarþróun í ljósmóðurfræði, annar hluti.

Ágæta Ólöf Ásta

Undirritaðir sviðsstjórar kvennasviðs hafa lesið yfir upplýsingar um rannsókn þína. Sviðsstjórar gera enga athugasemd við form og inntak þessarar rannsóknar og heimila fyrir sitt leyti að rannsóknin verði gerð. Leyfið er háð tilkynningar til Persónuverndar.

Við óskum þér góðs gengis með framkvæmd rannsóknarinnar

Margrét I. Hallgrímsson

Margrét I. Hallgrímsson
sviðsstjóri/yfirljósmóðir

Jón Hilmar Alfreðsson

Jón Hilmar Alfreðsson
sviðsstjóri/yfirlæknir

2C

Ólöf Ásta Ólafsdóttir

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veffang: personuvernd.is

Reykjavík 4. júlí 2006
Tilvísun: S3007/2006/ HS/-

Hér með staðfestist að Persónuvernd hefur móttekið tilkynningu í yðar nafni um vinnslu persónuupplýsinga. Tilkynningin er nr. S3007/2006 og fylgir afrit hennar hjálagt.

Allar tilkynningar sem berast Persónuvernd birtast sjálfkrafa á heimasíðu stofnunarinnar. Tekið skal fram að með móttöku og birtingu tilkynninga hefur engin afstaða verið tekin af hálfu Persónuverndar um efni þeirra.

Virðingarfyllst,

Hrund Sig.

Hrund Sigurðardóttir