Midwifery: A model of sustainable healthcare practice?

A thesis submitted in partial fulfilment of the requirements for the

Degree of Doctor of Philosophy in Education

In the University of Canterbury

by Lorna D Davies

University of Canterbury

College of Education, Health and Human Development

2017

Table of Contents

Acknowledgements

I have an extensive list of people that I would like to acknowledge. Firstly, I would like to thank the midwives who generously gave their time to meet with me and discuss their ideas about sustainability in healthcare practice. Without their involvement there would be no thesis. I would like to thank my supervisors, David Small and Sarah Lovell for their wisdom and guidance over the course of the last few years. I would also like to thank Anne Scott, Lee Thompson and Gillian Abel for your support in transforming a whimsical idea into a tangible form.

I offer my thanks to the many people who have encouraged and at times cajoled me to keep going when the going got tough. These include my wonderful colleagues at Ara, especially Mary Kensington and Rea Daellenbach who encouraged me to 'trust the process'. Special thanks to my 'agent provocateur' Sara Wickham, my spurring partner Ruth Martis, and to Claire McDonald who helped to give the focus groups shape and perspective and helped me with the initial coding. Thank you to my friends in the PhD group for the camaraderie and shared experiences, to my employers and managers at Ara Institute of Canterbury for honouring my endeavour with time, space and funding and to Health Workforce NZ for the funding awarded. There are many others, too numerous to include by name, but you know who you are and I extend my gratitude to you.

Thank you to my children for putting up with my grumpiness at times and having faith in me anyway. The person that I have to save my greatest appreciation for though, is Tom my husband, my best friend and my rock who kept me grounded throughout the process. I can never thank you enough for the love, support and absolute belief that I was able to do this, when I didn't believe it myself.

Finally I have to offer gratitude to the thesis itself. It has been both my comfort and my damnation during a tumultuous period of upheaval following the series of earthquakes in Christchurch. It has grown as I have regrown and I can now value the practices of research and writing up as mindful processes that have gifted me with both patience and tenacity.

Abstract

The global discourse around sustainability in healthcare has increased exponentially in the recent years. Sustainable healthcare has been defined as the long-term maintenance of health and wellbeing of the human population. However, there is a paucity of research around midwifery as a sustainable practice.

Using a qualitative research approach, I set out to establish what 'sustainability', in its broadest sense, meant to three groups of midwives practicing in the South Island of New Zealand. My aim was to define the term in relation to midwifery practice within the context of a caseload model and to determine whether sustainability was embraced as a concept of value in their work.

Within a series of focus groups, over a fourteen month period, using participatory action research as my methodological framework, I worked with purposefully selected midwives who represented a broad range of practice experience. Actor Network Theory (ANT) was used as a theoretical framework and analytical tool that enabled access to the networks via historical sources and from the data generated from the study.

Analysis of the data indicated that the midwives had an understanding of the tenets of environmental, economic and social sustainability and were able to relate the significance of these elements to their practice. However, their primary focus was on sustainability within the context of professionalism. Further analysis using ANT revealed a number of barriers that the midwives perceived as challenges to the sustainability of their professional identity and prohibited them from engaging with the broader tenets of sustainability within midwifery practice. It transpired that the hegemony of neoliberalism was instrumental in undermining the values of sustainability within the NZ midwifery context.

Neoliberalism makes its presence felt in multiple ways within the network, for instance in the concept of consumerism, in the materiality status of technology, in the semiotic nature of the nostalgia expressed by the midwives, and in the professional issues identified. These elements demonstrate that the barriers that impact on the professional identity of the midwives generate a 'siege' mentality, and it can be concluded that they prevent the midwives from engaging with the concept of sustainability in their practice.

Glossary

A Priori is a philosophical term used to define knowledge that is gained through deduction, rather than through empirical evidence

Actants rather than actors, is a term used to stress that material causes as well as human actors may be determinants of social interactions and outcomes.

Actor-network conveys the idea that the actant does not act on their own but under the influence of a complex network of material and semiotic influences.

Black boxes are configurations of human and non-human actants that have acquired a 'taken for granted' status.

Enrolment, is part of translation when roles are defined and actants formally accept and take on these roles

Generalized symmetry is the presumption that the material and semiotic components of networks are co-equal in importance.

Interessement in translation occurs when the primary actants recruit others to assume roles which accept the centrality of the primary actants role within the network

Intermediary that which transports meaning or force without transformation: defining its inputs is enough to define its outputs.

Mediators transform, translate, distort, and modify the meaning or the elements they are supposed to carry.

Mobilisation, is the element of translation that decrees which primary actors will assume a role of spokesperson for passive actants and aim to mobilise them to action.

Obligatory points of passage (OPP) are critical network channels. often designed by the primary actor to ensure communication must pass through his or her domain.

Problematisation the part of translation that defines the problem and identifies the relevant actants who, by defining the problem and a means of addressing it, are able to make themselves indispensible.

Punctualisation refers to the concept that the whole network is greater than the sum of its constituent parts.

Semiotics is the theory and study of communication and language in terms of signs and symbols.

Translation is the process of forming a network which occurs in the four moments or steps of problematization, interessement, enrolment and mobilisation.

Chapter 1. Motivation and Rationale for the Study

In an article conveying the crucial message of adopting a more sustainable way of living, Confino (2012) wrote "All the science in the world will not have the same impact without one moment of revelation". As an educator, I dream of facilitating this "moment of revelation", triggering a paradigm shift in the hearts and minds of the students who question why they are being encouraged to learn about sustainability as part of a Bachelor of Midwifery programme. Sometimes there is a breakthrough and I witness a visible shift in position. Confino goes on to say that when this happens "the experience is often so deep that it momentarily knocks the ego out of the way and what shines through is a sense of knowing in which ambivalence has no shelter." When this happens, it is a moment of magnitude indeed, but in truth it is a rare thing and more often what I encounter is confusion and self-conflict.

(Davies, 2014) Research Journal.

The existence of this place of ambivalence and a desire for my profession to experience such 'a moment' is what has driven me in this academic endeavour over the course of the last seven years. My thesis fundamentally explores the border lands between midwifery and sustainability and considers how the concept and the profession fare when they meet at the borderline. In this chapter I will set the stage by explaining what led me to pursue this line of enquiry for the purpose of my doctoral study; set out my aims and research questions and map out the shape of the terrain that forms the thesis.

Identifying a gap

As a lecturer in midwifery at Christchurch Polytechnic and Institute of Technology (CPIT) (rebranded Ara Institute of Canterbury in 2016) in Christchurch New Zealand, I was involved in the redevelopment of an undergraduate midwifery programme in collaboration with the School of Midwifery at Otago Polytechnic in Dunedin, New Zealand, between 2007-2008. Otago Polytechnic had decreed that the development of every new programme delivered by

the Institution was required to include a component of sustainability literacy[1]. As a result, the new midwifery curriculum was to embrace both a philosophical and practical inclusion of sustainability. The drive to include sustainability within courses and programmes offered by tertiary education is becoming increasingly common (Association of Teachers and Lecturers,(ATL) 2009); and is said to be recognition of the need for education that provides a clearer understanding of an ecological participatory worldview (Pairman 2010). Until recently discrete disciplinary models of learning and teaching have militated against attempts to implement interdisciplinary learning around complex issues such as sustainability (Steiner & Posch, 2006). However, an emerging focus on content related to sustainability in higher and tertiary education has led to a change in perspective and a more integrated approach in recent years (ATL, 2009; Jones, Selby, & Sterling, 2010).

As a result of having a long held interest in environmental issues, I was invited to take the lead in the development of the materials for a first year 5-credit course "Sustainability and the Midwife" and a third year course "Sustainable Midwifery Practice". The course materials for the first year course were categorized into three separate modules; 'Sustainability a Global Perspective'; 'Sustainable Healthcare' and 'Sustainability and Midwifery Practice'. The content in the third year course was focused on ensuring that students were prepared to sustain themselves and their own practice once registered as midwives and working in the field. The third year course content included exploring both international and local sustainable midwifery models, self-care, and setting up in self-employed practice. Whilst creating the materials, I became ever more interested in the idea of midwifery as a form of sustainable healthcare practice.   However, as I further delved into the field of sustainability in order to build up a repository of resources, it became evident that I may have stumbled upon 'unexplored territory'. After extensive searching, it became apparent that this was an area that had not been approached from a midwifery perspective. There was little indication

---

[1] See Chapter 10, p. 291 for definition

of any discourse around the subject area of midwifery and sustainability and a dearth of any research evidence within the broad midwifery literature[2].

The recognition that midwifery was not engaging, at least in a research context, with the intensifying discourse of sustainability, informed my decision to embark on my PhD. I questioned, would midwives be able to identify factors that related to them professionally within the broad framework of sustainability? Could professional identity serve as a cornerstone to support the values of sustainability within midwifery practice?

My overarching aim therefore was to establish midwives understanding of sustainability and to explore whether involvement in activity relating to sustainability might lead to practical and philosophical changes.

Guiding Questions

The central questions guiding the project were:

1. How do midwives view the concept of sustainability?
2. Do midwives relate to the concept of sustainability within their professional lives?
3. Could involvement in activity relating to sustainability lead to a change in practical and philosophical aspects of practice for participating midwives?

From an epistemological perspective, the study will draw from a range of different subject areas and disciplines in order to support the development of the thesis. These include: sociology, psychology, environmental science, and educational theory.

Context of the study

The scope of the study was limited to three group practices of midwives based in Canterbury, New Zealand and two individual interviews with a Māori midwife and a rural midwife respectively. It set out to explore their thoughts around the concept of sustainability in

---

[2] See Chapter 2, p. 31

relation to their scope of practice. The research also charts my own narrative around my aspirations to give sustainability a more significant profile in relation to midwifery practice. My study set out to ascertain whether active engagement with sustainability could lead to a change in practical and philosophical aspects of practice for midwives. The focus on research as a transformative process steered the proposed project towards Participatory Action Research (PAR) as the overarching methodological approach. However, as the study proceeded PAR became progressively more of an adjuvant process whilst Actor Network Theory (ANT), initially used as an analytical tool, grew to take on a much broader role in the thesis. I will discuss this evolution at length in Chapter 4.

Establishing my position as researcher

The personal and professional position that I approached the research from was that of a mother, a midwife, a midwifery lecturer, a feminist and an environmental activist. I will begin by contextualizing the study in order to identify how my own epistemological and ontological assumptions have influenced my position in relation to the work. I wrote my intellectual autobiography before considering anything else in relation to my research. I believe that it contributes to the rationale for the research and reflects the personal journey undertaken to arrive at the starting point for my work. In so doing it will help to establish a research paradigm. It therefore precedes the methodological and ethical principles which inform the study.

Contributing biographical Factors

I have personally endured[3] a long term 'relationship' with the concept of sustainability that dates back some thirty years to when my two children were very young. As with many women during pregnancy and in the early days of mothering, I gained a strong sense of the

---

[3] I have used the verb endure quite purposefully in this context. I consider that any in depth critique of the concept of sustainability is both personally, professionally and politically confronting.

magnitude of responsibility that comes with parenting. I began to consider what sort of world my children were going to grow up in and what the future held in store for them. At that time I read an article by journalist and social commentator, Jeremy Seabrook. The article claimed that although we claim a desire to leave a better world for our children, we are in fact plundering its resources and "squandering the substance in the pursuit of our here and now" (Seabrook, 1987, p. 20). It was my first introduction to the concept of climate change and it served as a catalyst. I felt that I had to take action and do something lest I fail my children in some way.

I acknowledge that my initial response to this 'epiphany' was an emotional reaction. However, from an epistemological perspective, emotion can be seen as a way of knowing the world (Game, 1997). We make sense of, and relate to, our physical, natural and social world within an emotional context. Thus emotion has epistemological significance because it is our emotions that allow us to really 'know' something; our intellect and cognition serve to inform this 'knowing'. This identification of the importance of sense of self encouraged me to both keep a journal and to write poetry and articles which, with hindsight, demonstrate an early exploration of reflective writing.

I was born in 1959 towards the end of the second wave of feminism. During the 1980s and early 1990s, as a member of a local women's health group, I was introduced to women's health issues through the lens of feminism. The group organised seminar events and I was fortunate to be able to meet and hear prominent speakers such as the psychoanalyst Susie Orbach, who exposed me to the realisation that the social subordination of women can become embodied in social relationships with food (Orbach, 1986). I had lived under the misapprehension that the menopause was a medical condition that required treatment until I heard Germaine Greer speak of this episode in a woman's life cycle as a social concept (Greer, 1991). The women's health group also established a free pregnancy testing service in a lower socio-economic district of the town, where women could not afford to pay for the privilege and frequently were unaware of what other services were on offer for them. My interest in gender inequalities in healthcare occurred at a time when social justice and the impact of social determinants of health were under scrutiny (Gray, 1982).

I became a social activist, joining the feminist organisation Women's Environmental Network UK, and as a member of that group I campaigned against 'women related' issues such as the environmental impact of using infant formula and disposable paper based products. I was drawn to the field of ecofeminism that explores a range of connections such as ethical, social, psychological and spiritual in relation to the domination and monopolisation of natural and human 'resources' and controlling power (Warren, 1997). I valued the philosophical intent of ecofeminism to pursue a culture which is life affirming rather than destructive. I had little insight into the disparities that divided the scholars of ecofeminism at that time, but it gave me drive and purpose and influenced my thinking.

My ensuing interest in maternity care led me into midwifery and I entered the profession in the late 1980s. I carried my 'sustainability'[4] learning with me and I found myself questioning many practices and assumptions relating to midwifery, pregnancy, childbirth and early parenthood. Sustainability as a word may not have featured in my vocabulary in the early days, but the subjects of ecology, equity and social justice were significant in shaping my own midwifery philosophy. Although a good grounding in social issues in maternity was presented within the programme, environmental concerns seemed to be largely ignored. I was disturbed to discover that a talk on infant feeding (including breastfeeding) was to be presented by a nutritionist employed by a company who manufactured breast milk substitute. My concern stemmed from an awareness that some of the companies producing breast milk substitutes held questionable environmental track records (Palmer, 2009). I sought out the somewhat meagre catalogue of materials that linked the political, economic and social implications of using infant formula over breastfeeding (Radford, 1991). It transpired that the issues of social justice and economics were once again linked with issues relating to gender.

---

[4] The word 'sustainability' was not widely used until the Brundtland Summit in 1987.

I had another baby in 1994 and became increasingly interested in parenting styles and practices from a personal perspective. I visited family members in Zimbabwe and discovered that babies in that sub-Saharan country remained with their mothers at all times and seemed to be constantly settled. This led me to explore co-sleeping as a concept. I discovered the work of anthropologist McKenna (McKenna, 1994), and physiologist Fleming (Fleming, 1994), who were producing research that tentatively supported the practice. I published an article on the subject (Davies, 1995), to learn that it was the first time that the subject had been broached from a positive position within midwifery journals. I felt that this sort of information needed to be shared more comprehensively with women but I did not have the skills to do this in the way that I felt was needed. As a result I decided to train as a childbirth educator. This encouraged me to explore the importance of human growth and development, and I developed a particular interest in attachment theory[5]. Although I had studied this earlier, I had a new and focused perspective. Alongside Piaget (1998) and Maslow, (2013), I read 'The Continuum Concept' where Liedloff (2004) argues that we are designed to occupy a specific ecological niche and in order to achieve a state of equilibrium and wellbeing, we need to inhabit the conditions that evolution has led us to expect. I appreciate the denunciations of the work as biological determinism (Bobel, 2010), but as a result of this work I began to consider the significant role of the midwife in establishing the mother baby relationship from a neuro-hormonal perspective. This understanding was to increase exponentially as a result of the spate of research that was undertaken in the next few decades. I authored an article for a more radical midwifery journal where I used ecology as a framework for midwifery (Davies, 1994).

I found that I had a natural affinity with teaching during my childbirth educator training and I looked towards midwifery education. I moved into the field of education and after

---

[5] *Attachment theory* was developed by John Bowlby and works around the belief that a strong emotional and physical *attachment* to at least one primary caregiver is critical to the individual in terms of personal development (Cassidy and Shaver 2008).

completing a postgraduate certificate in education, I commenced my MA in Women's Studies. Here, I was immersed in an interdisciplinary field of academic study that set out to examine gender as a social and cultural construct. On this programme I was introduced to relationships between power and gender and the resulting social inequalities. I became familiarised with a broad range of feminist writings and I was reacquainted with the concept of ecofeminism at the more conceptual level of theorists such as Plumwood,(2002) and Warren, (1997).   As I explored the work of these theorists, I found that I was constantly using midwifery practice as a frame of reference. Discourse about the physiological connection of birth and child care with nature and the debate around how patriarchal structures and paternalistic attitudes devalue and oppress both 'women' and 'nature' resonated within the context of my lived experience (Plumwood, 2002).

In 2000 I made the first of nine visits to The Farm Midwifery Center in Tennessee, the home of the acclaimed midwife, Ina May Gaskin, writer of 'Spiritual Midwifery' (Gaskin, 1978). Each year, with a colleague, I accompanied a group of twelve or so midwives to attend a workshop with the Farm midwives. The Farm was originally an intentional community established by a group of young hippies in the early 1970s. It has developed since to become a community that works as a cooperative with a strong ecological focus. The highlight of the trip was invariably the visit to a local Amish midwife. Observing the minimal impact lifestyle maintained by the Amish and hearing of the physiological approach to birth that resulted in surprisingly good outcomes was a truly humbling experience that had a profound effect on me. My visits to The Farm undoubtedly helped to shape my midwifery philosophy and practice and further fed into my interest in sustainability. I know that my experiences there were instrumental in my decision to move to New Zealand where I believed that I would be able to work within a framework of continuity and to be with woman in a holistic sense as an autonomous practitioner.

In 2005 I emigrated to New Zealand/Aotearoa with my family, not least because I coveted the midwifery model on offer there. I had viewed the re-establishment of midwifery in the early 1990s in New Zealand/Aotearoa with interest. My midwifery philosophy is strongly grounded

in a social model of care. I believe that midwifery care should be a primary care based wherever possible; that midwives should be autonomous practitioners; that every woman should be entitled to continuity of career during the childbirth experience and that she should be able to choose her midwife. Midwifery in New Zealand/Aotearoa appeared to embody my philosophy as a midwife. It is theorised that relationship is a significant factor in achieving wellbeing which would bestow a very important role upon the midwife stretching far beyond addressing the physical needs of the woman as defined by the medical model (Kirkham, 2010). The 'partnership model' was said to present a set of professional values where *"power differentials are acknowledged and actively shifted from the midwife to the childbearing woman"* (Pairman & Doneelan-Fernadez, 2006). These values were claimed to be founded on a 'new model of professionalism' based on feminist principles. To me it felt like New Zealand could provide an alluring synergistic fusion of feminism and midwifery.

Social Action and the Need for Change

Many of my own personal experiences outlined in the biographical account above, have left me with the prevailing conviction that social action can bring about change. The Women's Environmental Network prompted a change in attitudes and behaviours' even on the part of industry (Buckingham, 2010). The Farm midwives went on to steer changes in USA legislation that means that many USA states now recognise midwives as legitimate providers of care, albeit on a limited scale and often in difficult conditions (Craven, 2010; "The Big Push for Midwives", 2017). New Zealand midwives alongside consumers had spearheaded the renaissance of midwifery, a health field facing extinction as midwife activist Joan Donley expressed in her phrase "Are you Moas or Midwives" (Donley, 1988). I have been moulded by these experiences and I am an active player in the social context that I find myself within. Snook (2003) states that "the point of research is to improve the situation of human beings" (Snook, 2003, p. 73). My desire to produce research that makes a difference in a practical sense was strong. Such a desire is inevitably political by nature and therefore, the choice of topic for the thesis, the research paradigm, the choice of methodology and the conclusions elicited cannot be separated from my own background and experiences described. My own

socio-cultural values and beliefs are woven deeply into the fabric of the thesis. This meant that it was always going to have a strong reflexive element.

Mapping out the Thesis

The research described in the following chapters is set out in the following way:

- Chapter 2 contains a detailed discussion about the contested nature of sustainability, and the definitions of the concept are challenged and applied to both health care and midwifery specifically. It contextualises the direction and scope of the discussion with regard to sustainability and midwifery practice in the later chapters.
- In Chapter 3, the research methodology and methods are described, my position as researcher is declared, a research paradigm is established, and the research questions are explored. The methods used in order to generate data for the study are presented. It is also the chapter where the research questions are redefined. The complexities of engaging in participatory research are discussed in relation to the practicalities of carrying out the research.
- Chapter 4 introduces the theoretical framework and data analysis tool of Actor Network Theory (ANT) and provides a rationale for the decision to introduce it within the methodological context.
- Chapter 5 is a historical literature review of midwifery that demonstrates how the principles of ANT can be applied to demonstrate the relational aspects in a network and to explore the ever changing character of midwifery identity. It also serves to offer an understanding of the present midwifery situation in New Zealand/Aotearoa by exploring the past.
- Chapter 6 continues by outlining the more recent history of midwifery and discusses the impact of the ideology of neoliberalism on the reinstatement of midwifery in the 1990s as well as the ensuing professionalisation project generated by the profession. The chapter explores more contemporary midwifery practice and applies the theory

of ANT introduced in the last chapter. It demonstrates how relational elements influence change more than hierarchical theories.

- Chapter 7 presents the findings from the data relating to the broad concept of sustainability. Professional identity is raised around relationships with women and their whānau/family in addition to issues relating to environmental sustainability.

- Chapter 8 looks at the impact of consumerism on midwifery practice. The chapter explores the perceived impact that the concept of consumerism, with its focus on choice and risk, has had on the perception of professional identity of the midwives.

- Chapter 9 provides a concept analysis of nostalgia in order to analyse how this concept cloaks some interesting aspects of the perceived professional identity of the midwives.

- Chapter 10 considers the findings of the study in relation to a political milieu that has emerged recently in the field of maternity in New Zealand/Aotearoa and explores some of the strategies that may help to formalise an alliance between midwifery and sustainability.

Summary

The paucity of research around midwifery as a sustainable healthcare practice in a climate where the broad topic of sustainability is becoming increasingly important, would suggest that there is a significant need for an exploration of this topic. It is acknowledged that sustainability in a broad sense is a key health related issue. The medical profession for example, has published extensively on the significant global environmental threats to human health resulting from climate change (T. Burke 2012). As key players, healthcare workers are being advised to take on board the issues and are urged to take action on climate change in a drive to minimize these threats to human health (Femia & Werrell, 2015). However, within the healthcare and sustainability literature there seems to be a primary focus on the environmental and economic tenets of sustainability and less attention on social sustainability. The area of social sustainability would appear to fit well with the broadly accepted midwifery philosophy of pregnancy and birth as a normal event. Midwives working

within such a model of care are expected to employ a holistic approach which is believed to result in better socially related outcomes (Leap et al., 2010; Dahlberg and Aune, 2013). In New Zealand, the model of care is based around partnership, participation and protection (Pairman & Donellen-Fernandez, 2015) and is supported by codes of ethics, a midwifery philosophy of care, and standards for practice. This model would seem to support the principles of social sustainability such as equity, social justice and community capacity (Gilliland and Pairman 1995; Thompson 2004).

The thesis therefore set out to establish what understanding midwives in New Zealand/Aotearoa have around sustainability; whether involvement in activity relating to sustainability might lead to change in practical and philosophical aspects of practice for those participating; and whether professional identity could be a key player in leading midwives to a greater sense of engagement with the issues relating to sustainability.

Chapter 2. The Concept of Sustainability and its Place in Healthcare and Midwifery Practice

Introduction

A health care system can be viewed as a social microcosm and the definitions, principles and models that apply societally can often be superimposed on such subsystems. The sustainability discourse has been increasing exponentially in the last few years in health care, both in New Zealand/Aotearoa and in many other parts of the world. No concept stands in isolation and I recognise that it is not possible to view sustainability within healthcare as an actor on the stage alone. It is part of a complex tableau that introduces a range of other important players in the production that represents this context.

In this chapter therefore, I will present a conceptual analysis of the term 'sustainability', seeking a definition and a model/framework that encapsulates the quintessential qualities and values of the concept. I will consider how these apply to healthcare generally and midwifery specifically. This will help to contextualize the direction and scope of my discussion with regard to midwifery practice in the later chapters. I will also consider how the construct of sustainable development articulates with the broader construct of sustainability because this is pertinent to some of the discussion that will develop in the thesis. In later chapters, I will introduce some of the socio-political concepts associated with sustainability such as neoliberalism and individualism.

Defining sustainability

The term sustainability has an almost omnipresent status in many areas of contemporary life including healthcare, but it is a concept that has proven to be difficult to pin down in terms of definition (Colantonio, 2007). The all-encompassing nature of the concept means that no single framework is consistently useful, given the range of conservation needs in the natural world and the global range of societies and institutional structures (Vos, 2007). It is

stated that there are over a hundred different definitions (Marshall & Toffel, 2005). It has been suggested that the only consensus on sustainability is that there is no real shared universal understanding of what it really means and it is therefore a "constructively ambiguous" (Blewitt, 2014) "dialogue of values that defies consensual definition" (Ratner, 2004, p. 51).

Even the grammatical status of the word sustainability is complicated. For example, it is difficult to discuss in the abstract and is easier to use as an adjective (Daly, 2007). From a etymological perspective the word sustainability has evolved from the Latin 'sustinere', which means fundamentally 'the capacity to endure' (World Commission on Environment and Development (WCED), 1987). It could be questioned whether anything can be said to truly 'endure' when environments and species are in a continuous state of adaptability and evolution. However, although sustainability does not necessarily mean everlasting, it can be seen as a way of "asserting the value of longevity and intergenerational justice while recognising mortality and finitude"(Daly, 2007, p. 38).

The definition of sustainability that seems to be most universally employed and certainly the most commonly cited, was initially coined in 1987. The "Our Common Future" report , frequently referred to as the Brundtland Report[6], defined it as a concept that "meets the needs of the present without compromising the ability of future generations to meet their own needs"(WCED, 1987, p. 43). There are valid criticisms of the WCED definition, which is described as having limitations and contradictions and which I will analyse further within the chapter.

---

[6] Gro Harlem Brundtland was the Prime Minister of Norway when she was asked by the Secretary-General of the United Nations in December 1983 to establish and chair a special, independent commission to address the emerging problems resulting from a deterioration of the human environment and that of natural resources. The Commission was formally dissolved in December 1987.

Background to the notion of sustainability

In the last few decades, the notion of sustainability seems to have gained an ubiquitous status, but it is not a wholly new concept. The precursors of our modern notions of sustainability can be found dating back many centuries (Grober & Cunningham, 2012). There is evidence to suggest that aristocrats in the late 17th- and early 18th-century Europe began to fear that the plundering of natural resources may jeopardize the economy (Caradonna, 2014) and in 1798 the classical economist Malthus, suggested that natural constraints could curtail economic growth in his *Essay on the Principle of Population* (Malthus 1826). However, the modern concept of sustainability only began to gain momentum in the 1960s and 1970s with the word appearing as a noun in an English dictionary for the first time in 1972. This attention (which was initially almost exclusively ecologically focused) resulted from the work of environmentalists such as Rachel Carson (Carson, 1962) who alerted the world to the perils of unregulated agrochemical use and habitat destruction. This ecological focus was supported by an economic analysis when the need for an economic approach that recognized the limits of growth was introduced in the seminal text *Small is Beautiful* (Schumacher, 1973).

Sustainability, as an operative term within the sciences, emerged chiefly from concerns around issues relating to climate change in the late 1970s and 1980s. During the last forty to fifty years the demands on the world's natural resources have been excessive. The escalating utilization of oil, gas, coal, minerals, agricultural products, fresh water and other resources has been partnered with further trends such as the significant loss of biodiversity and growing levels of air pollution. There is ever more supporting evidence that, as a result of increasing CO_2 levels in the atmosphere, climate system change is now occurring and that weather patterns are noticeably changing (Hawken, 2007; McKibben, 2008; Moore- Lappé, 2011; Leining & White, 2015). There is also an increasing acceptance that that the change is anthropogenic which means that the effects are derived from human activities related to the factors outlined (Stern, 2007; Montgomery & Costello, 2012: Neumayer, 2013).

Tenets of sustainability

The World Commission on Environment and Development WCED (1987) definition of sustainability in "Our Common Future", was endorsed by the Rio Summit documents (Meakin, 1992). This served to augment the definition by agreeing that ecological, economic and social dimensions were the 'three pillars' of sustainability and the tripartite model of sustainability was generated. In spite of various attempts to refine this definition, these three dimensions have been broadly adopted within mainstream theory around sustainability, are referred to by many theorists and policy makers and have provided the framework for the Triple Bottom Line theory[7] (3BL) (Elkington, 1998). From an ethical perspective, the tenets are required to achieve the balanced pursuit of ecological health, social equity and justice and economic welfare. In order to convey the importance of the integrated nature of the elements, they have been represented in a number of ways, as 'pillars', (Figure 1) as interlocking circles (Figure 2), and as concentric circles (Figure 3).
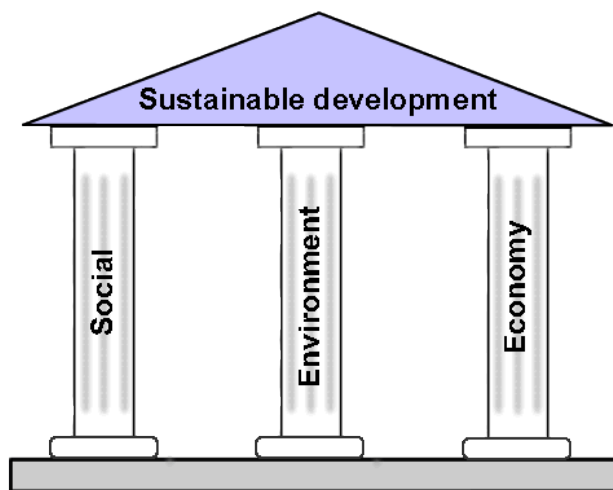
Figure 1: Three Pillars Model of Sustainability [8]

---

[7]The Triple Bottom Line (3BL) is a term coined by economist John Elkington (1998) which was introduced to assimilate the three tenets within a framework that could be utilized by businesses and organisations. 3BL set out to measure the financial, social and environmental performance of companies and corporations and it continues to be a central idea pervading business reporting, and business engagement with sustainability (Milne and Gray 2012).

[8] Source: http://www.sustainability-ed.org/pages/what3-1.htm
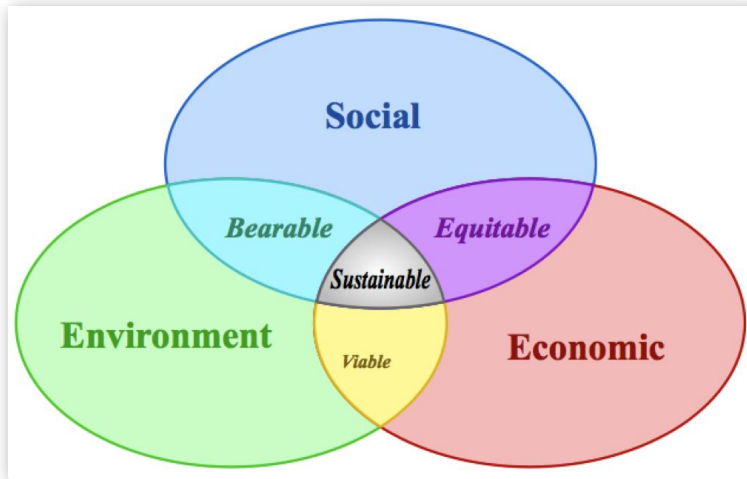
Figure 2: Conjoined Circles Sustainability Model[9]

The acceptance of the three pillars as equal 'partners' is based around the theory that although an ecologically stable and healthy environment is important in meeting human needs, if a society is committed to sustainability, the equally legitimate social and economic needs also necessitate the equivalent attention. Although the three components are viewed as discrete categories, or 'dimensions' within this model, the systems need to support one another in order to remain stable in the long term, if they are not to "jeopardise the achievements of civilization" (Littig & Grießler, 2005, p. 67).

Advocates of the 3BL framework of sustainability argue that organisations and institutions that support the principle of including a tripartite approach, will make decisions based on environmental protection and social justice as well as profit and economic returns. This should theoretically support a sustainable business ethic. It has certainly become increasingly common for companies and organisations to include terms such as 'eco-efficiency' and 'fair trade' in their business language and reports (Tullberg, 2012). Critics

---

[9] Source: http://humanhealthimpact.org/home/

however, argue that this is no more than 'shallow greening' or 'greenwash'[10] and that the triple bottom line approach serves primarily to perpetuate 'economism' and 'productivism' by promoting sustained economic growth (Milne & Gray, 2012). These are elements of a capitalist based economic system that ideologically cannot address the environmental and social tenets of sustainability because the primary motivation is profit driven. Consequently, the social and environmental needs are not considered to be equal to the economic. "The triple bottom line may in fact be a good old-fashioned single bottom line plus vague commitments to social and environmental concerns" (Norman & MacDonald, 2004, p. 256).

Weak and strong sustainability

This critique of the tripartite framework and its three strands, as the enabling of 'trading off' one tenet against the others, conceptualizes sustainability as a 'weak' model which permits and even welcomes trade-offs . Weak and strong are the two predominant conceptual approaches to sustainability. Proponents of weak sustainability assert that natural capital can be used as long as it is transformed into manufactured capital that is of equal value (Cabeza Gutés, 1996; Ang & Passel, 2012). In diagrammatic terms, weak sustainability presents the three tenets as either compartmentalised, (Figure 1) or overlapping (Figure 2). From an anthropocentric perspective the weak model approach reinforces the notion that nature and culture are dichotomous and can only be reconciled by the economy (Huckle, 2008; Forman, 2013). Anthropocentric theorists argue that humankind will ultimately be able to produce managerial and technological solutions to any environmental threat in order to maintain the sustainability of the economy and society. Norton (2005) argues that the WECD definition from 1987 supports the principle of weak sustainability and has proposed that this confusion has resulted in a conceptual framework which overvalues the power of economic sustainability to the detriment of environmental and social aspects. It is currently estimated that 80% of the world's resources are consumed by 20% of the world's population (Ott, 2014; Shah, 2014). Some critics therefore suggest that low-resource countries will not become

---

[10] 'Greenwashing' is the practice of making an unsubstantiated or misleading claim about the environmental benefits of a product, service or technology (Kahle & Gurel-Atay, 2015).

sustainable unless there is the requisite economic growth to bring them into line with western industrial countries and that this is an impracticable objective and a moral issue (Beckerman, 1992). French geographer and economist Sylvie Brunel (Brunel (2004) as cited in Lacroix & Stamatiou, 2007) states that the core ideas of sustainable development are a covert form of protectionism designed to maintain the status quo of the current capitalist economic model. Thus the three pillars of the sustainability 'industry' may exist only because they speak to externalities which can be easily measured and monetized. As a result, each of these pillars is effectively becoming its own 'industry' and there is little if any sense of integration. Whether the approach is weak or strong, pillars or circles, the primary emphasis currently rests squarely on global financial systems and the economy takes precedence above all other forms of sustainability (Neumayer, 2013; Ott, 2014).

Proponents of a strong approach to sustainability would argue that both Figure 1 and Figure 2 offer a fragmented and compartmentalised perspective that would, for example, fail to accept the consequences for externalities such as pollution produced in manufacturing. Strong sustainability advocates claim that society and the economy cannot survive outside of the natural environment and that that there are environmental functions that cannot be replicated by humans, such as sustaining the ozone layer (Neumayer, 2013). Non-anthropocentric or ecocentric theorists, argue that nature is not there to service the needs of the human population, and that it has an intrinsic value. The ecocentric perspective highlights that in a limited biophysical system such as the Earth, no subsystem can have unlimited growth without harming the other (social and environmental) systems (Jackson 2009; Read 2015). Although humans can utilize natural resources in order to survive, they have the potential to exceed what nature can provide and in the process to destroy the natural environment and with it the capacity to endure as a species (Spangenberg, Omann, & Hinterberger, 2002).

A sustainability model considered to be 'stronger' is represented in Figure 3 where the economy and society are constrained by environmental limits thus taking into consideration the costs of pollution as inclusive costs.
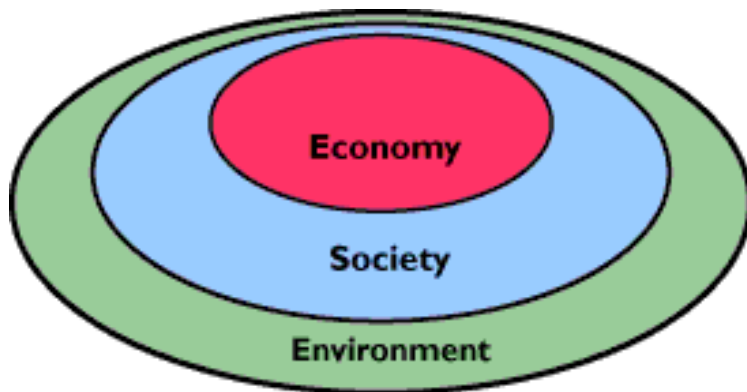
Figure 3: Concentric Model of Sustainability[11]

This ecocentric perspective has been criticized as failing to address how we should tackle the growing environmental crisis because it separates ecological problems from social problems thereby creating its own form of reductionism. Bookchin (1987) states that deep ecology is "vague, formless and often self-contradictory" (p. 3) and goes on to state that the proponents of deep ecology have been accused of disregarding the needs of humans with their ecocentric approach which is no better equipped to accommodate a holistic perspective than the weak models. It is additionally argued that there is no real effort to address how a more unifying process, that incorporates human needs within the natural framework approach will work. It has also been criticized for maintaining binary based associations defining 'good' and 'bad' behaviours that tend to create stalemate situations (Katz, Light, & Rothenberg, 2000).

Another major criticism of the tripartite models of sustainability is that they can reduce a complex human–environment interface that may include cultural, historical and institutional elements for example , into an all embracing 'social' category (Giddings, Hopwood, &

---

[11] Source http://www.sustainablecampus.cornell.edu/csi.cfm

O'Brien, 2002). There are conceptual frameworks that have been developed to accommodate this factor. The United Nations (UN) Commission on Sustainable Development (CSD) proposed that sustainability be measured in four dimensions to include the institutional dimension (UN Dept of Economic and Social Affairs, 2007). This relatively recent addition is largely related to international development applications where governments and agencies use the theory to highlight the need to include the existing pillars in building robust foundations for improvement (Gibson-Graham, 2008). It could however, be argued that this would portray institutional sustainability more as a vehicle to accommodate the framework of sustainability than a pillar within its own right. Seghezzo (2009) has developed a framework that includes five tenets. These include the three existing dimensions of environmental, social and economic, but additionally identifies a temporal dimension and a human dimension and suggests that this could facilitate integration to a more inclusive and holistic interpretation of sustainability by addressing the needs of community and individual sustainability. However on closer scrutiny it would appear that Seghezzo interprets the mainstream definition of social sustainability from an institutional perspective, that is used to inform social policy whereas others incorporate the human and temporal components as sub-categories of social sustainability (Colantonio, 2008).

An indigenous perspective

The compartmentalisation of the tripartite and other systems based models has proven to be challenging for indigenous communities[12] who often comprehend human and natural

---

[12] There are estimated to be some 400 million indigenous peoples worldwide residing in over 70 countries. They are viewed as distinct from those of the prevailing societies in which they live because they retain social, cultural, economic and political characteristics unique to their culture. A unique definition of indigenous has proved to be elusive because of the diversity of peoples and their culture. An understanding of the term has therefore been based on self-identification as enshrined in human rights documents. Indigenous groups are identified broadly by having; historical continuity with pre-colonial/settler societies; a strong link to territories and natural local environment; their own social, economic or political systems and language, culture and beliefs (Kamal, 2017).

21

communities as fully integrated (Dockry et al., 2015). These problems arise from distinctive ontological positions. A great deal of the mainstream debate about sustainable development has paid little heed to culturally defined specificity about what is sustainable (Redclift 2005). The indigenous perspective represents a holistic[13] worldview, borne of survival strategies developed over millennia. This has resulted in distinctly localised knowledge about the environment that supports both humans and other species. It is also intended to ensure that future generations have the same access to the earth's resources as their forbears. Following colonization the synergetic relationships that the indigenous peoples traditionally shared as part of nature was increasingly marginalized and the land rights of indigenous groups in diverse areas of the world overlooked in favour of escalating industrialization (Klein, 2014). Many indigenous groups still endeavour to build community that is aligned with the environment that they inhabit wherever possible (Capel, 2014).

Mātauranga Māori

In New Zealand/Aotearoa, Mātauranga Māori (the Māori worldview) has been defined as "the knowledge, comprehension, or understanding of everything visible and invisible existing in the universe"(Williams, 1989). In the contemporary world, the definition is usually extended to include: present-day, historic, local, and traditional knowledge; systems of knowledge transfer and storage; and the goals, aspirations and issues from a Māori perspective (Rei Millar, 2004). Figure 4 presents an example of a Māori sustainability model. The model of concentric circles (Figure 4) goes beyond the 'strong' sustainability model shown in Figure 3. Although it includes the social, economic and environmental tenets, these are strongly integrated not compartmentalised. The economy will not flourish without the wellbeing of the community which is supported by cultural identity. Beyond the social context there is a relationship with the land and the earth's resources. These relationships

---

[13] Holistic is described as characterized by the belief that the parts of something are intimately interconnected and explicable only by reference to the whole. The midwifery model in New Zealand/Aotearoa claims to be a holistic health profession.

are represented as both symbiotic and reciprocal. The model promotes a strong ethos of human relationships that are based upon participation and equity. This model is values-based as opposed to costs-based (Morgan, 2004).
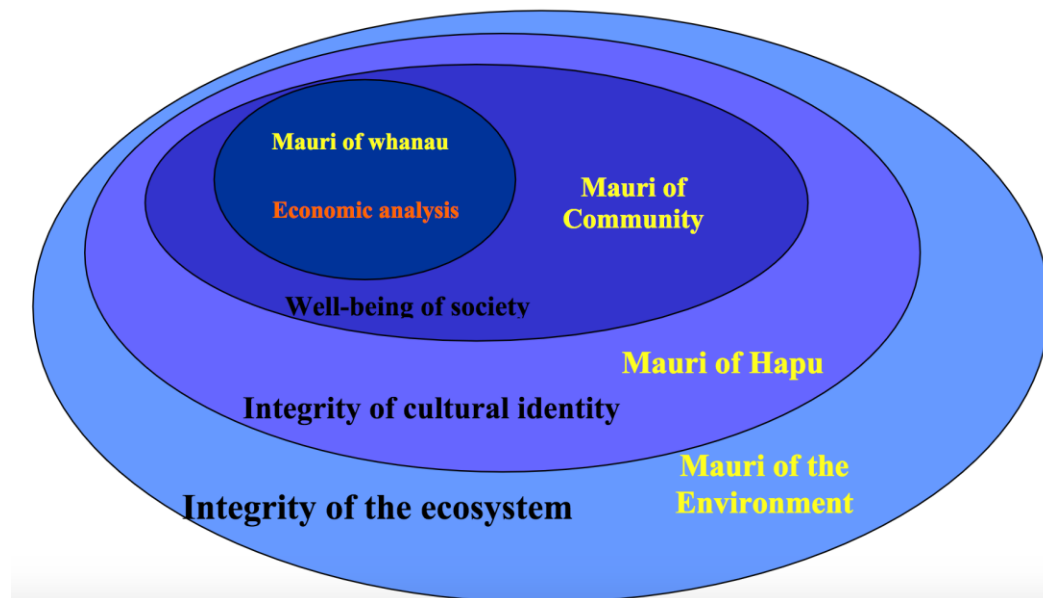
Figure 4. Mauri Model of Sustainability (Morgan 2004)

* Mauri is an energy which binds and animates all things in the physical world (Taonga, 2015a)

The stronger focus on the intrinsic value of a sustainable lifestyle based on a values based approach is expressed in the more holistic models of sustainability. The physical sciences can begin to assess human impacts on the natural world but they cannot provide an understanding of what social norms, values, beliefs, relationships, organisations and other social activities, drive social action and future developments in relation to those impacts (R. H. Moss et al. 2010). The focus on environmental and economic impact has tended to be commensurate with the more standardised indicators and definitions of the western post-industrial world (Mccool & Stankey, 2004; Haenn & Wilk, 2006). As a result of this reductionist approach there has been a neglect of consideration regarding how social systems can mitigate or militate against such effects (Lehtonen, 2004; Spangenberg, Omann & Hinterberger, 2002;, Tainter, 2006; Vallance et al., 2011) Historically many factors

have been used to militate against the acceptance of a more inclusive and integrated paradigm. Firstly, the dualistic construct of Western scientific theory[14] led us to view a traditional perspective as a counterpoint to a modern one and to consider traditional knowledge as fixed in the past (Blaser, Feit & McRae, 2004). Furthermore, Western scientific and development communities have viewed indigenous knowledge as a resource to be appropriated (Butler and Hinch 2007). However, Article 8 of the Convention on Biological Diversity (1992) urged governments and others to "…respect, preserve and maintain knowledge, innovations and practices of indigenous and local communities embodying traditional lifestyles relevant for the conservation and sustainable use of biological diversity…." (United Nations, 2017). Certainly, in the last decade the presence of traditional indigenous worldviews in relation to the effects of climate change and protection of biodiversity has increased exponentially. There are now many examples of projects in a variety of disciplines led by, or in collaboration with, indigenous academics and groups (Berkes, 2009; Green & Raygorodetsky, 2010; Alexander et al., 2011; Boillat & Berkes, 2013; Roosvall & Tegelberg, 2013; Birch, 2016; Ford et al., 2016)

Realistically though, any model can be considered to be a simplification of a complex reality and is therefore only ever going to be an incomplete approximation (Thai, Rahm & Coggburn, 2007) . Models do however, offer a starting point for addressing the 'wicked problems'[15] presented by something as all-encompassing as sustainability.

Capacity to Endure

During the last fifty years the demands on the world natural resources have been stretched beyond imagination, arguably challenging its capacity to endure. This has occurred as a result

---

[14] Western scientific theory also known as the positivist or empiricist paradigm is based on the dualistic notions of men of the Enlightenment, such as Descartes and Newton; the principles include determinism and reductionism, and the theory is claimed to be value free.

[15] 'Wicked problems' are social or cultural problems that are difficult or impossible to address because of incomplete or contradictory knowledge, the volume of opposing viewpoints, the large economic burden, and the interconnected nature of these problems with others (Hubbard, 2014).

of a rapidly 'developing' and globalized world. A series of social, political and economic developments including the flow of capital, changing regulatory trends, increasing consumerism, information transfer, improved technology and the movement of populations are just some of the factors that have altered our world dramatically particularly in the last half century (McMichael, Montgomery, & Costello, 2012a) (see Chapter 6). As a result of the high impact in such a relatively short period, our time in history has been labelled "The Great Acceleration" (Steffen et al., 2015). There is ever more supporting evidence that climate system change is indisputably occurring and that weather patterns are noticeably changing (Hawken, 2007; McKibben, 2010; Moore-Lappe, 2011; Pachauri & Meyer, 2014; Leining & White, 2015) . There is also an increasing acceptance that that the change is anthropogenic, principally as a result of the escalating use of fossil fuels, which means that the effects are almost without a doubt derived from human activity (McMichael, Montgomery, & Costello, 2012b). From a geological perspective, the epoch that we currently inhabit has come to be known as the 'Anthropocene Age' (Crutzen, 2002) which alludes to the impact of humankind on the earth's natural global systems.

The over utilization of oil, gas, coal, minerals, agricultural products, fresh water and other resources has been partnered with further worrying trends including a significant loss of biodiversity and an exponentially increasing global human population. In 1960 the worlds' population stood at 3 billion inhabitants; in 1985 it was just below 5 billion; in 2011, it passed the 7 billion mark. If the current trajectory continues, then the world will have to support between 9-10 billion people by 2050 (Dadax, 2017). Additionally, life expectancy has increased overall in most countries, which adds to the problems resulting from overuse of the earth's resources (Shaw, Horrace, & Vogel, 2005).

The possible impact of human influence on the climate system is clearly stated in the Synthesis Report of the Fifth Assessment Report from the Intergovernmental Panel on

Climate Change[16] (Pachauri & Meyer, 2014). The report unequivocally states that the future will be bleak for both human and natural systems unless urgent action is taken to stabilize atmospheric greenhouse gas concentrations. The report also indicates that substantial behavioural changes are required if we are to prevent irreparable, long-standing damage from climate change. To date this has been largely addressed by attempts to validate business accountability to society with regards to sustainability.

Sustainable Development

The three pillar and concentric circles models of sustainability introduced earlier in the chapter can be used to legitimise the concept of sustainable development. Since the WCED brought "sustainability" into political, corporate and academic spheres, approaches such as sustainable development and corporate social responsibility (CSR), have been introduced by the corporate business world and industry in a call for concerted efforts towards building a sustainable, resilient and inclusive future for the planet and its inhabitants (Crittenden et al., 2011)**.** The terms sustainability and sustainable development are often used interchangeably which can cloud attempts to clearly define both concepts. In brief, sustainability can be defined as the practice of reserving resources for future generations without any harm to the ecosystem whereas sustainable development can be viewed as an approach to economic planning that attempts to foster economic growth while preserving the quality of the environment for future generations (Robinson, 2004).

The concept of sustainable development is endorsed by many authors, who claim that its ambiguity allows for the development of creativity and power because it is not constrained by a prescriptive definition. "As a concept, its malleability allows it to remain an open,

---

[16] The *IPCC* is a scientific body under the auspices of the United Nations (UN). It reviews and assesses the most recent scientific, technical and socio-economic information produced worldwide relevant to the understanding of *climate change*. https://www.ipcc.ch/organization/organization.shtml

dynamic, and evolving idea that can be adapted to fit these very different situations and contexts across space and time" (Kates, Parris, & Leiserowitz, 2005, p. 55) They argue that the notion of sustainable development has enabled many diverse areas to flourish such as sustainable agriculture and sustainable cities. It has also enabled the initiating of common corporate standards in global organisations such as the UN. Norwegian Premier Gro Harlem Brundtland, herself stated that the environment was inseparable from human activity and attempts to isolate the natural world were politically naïve. She stressed the need to remove the idea of development from what she viewed as a limited focus associated with making the rich nations richer to something that could assist low income countries to increase their autonomy and self-sufficiency (WCED, 1987).

Sustainable Development as a concept has received a considerable share of criticism and its usefulness has been claimed to be limited as being too general (Tainter & Taylor, 2013). Redclift (2005) protests that the concept was adopted in policy circles without consensus "in the absence of agreement about a process that almost everybody thinks is desirable" (p. 213). Other critics argue that the notion of sustainable development is an oxymoronic concept that anyone can be redefined to fit any purpose. Like sustainability critics, they suggest that as a result the term is inconsequential and can be used to mask or to 'greenwash' injurious environmental or social activities (Daly, 1990; Newton, 2005). It is considered that the excessive consumption of resources is a misguided representation of "development." Linking the notion of development with "sustainable" simply misdirects us to believe that we can maintain a reliance on 'growth based' economies, yet still achieve a sustainable society. The simplicity of this approach is deceptive, and disguises fundamental ambiguity and contradictions. The concept has therefore been censured for being "subsumed under the dominant economic paradigm" (Banerjee, 2003, p. 165). Sustainable development has also been charged with using "vagueness as a smokescreen" to shield the fact that it allows big business to continue with its operations under the auspices of meeting the needs of future generations (Sharma & Starik, 2004). There are many examples of corporate companies that claim to have an ethos of sustainable development whilst continuing with a "business as usual" approach, including supermarket chains and fast food

companies. The New Zealand dairy farming industry has invited much adverse publicity for its apparent disregard for the degradation of the land and waterways as a result of a significant increase in dairy production in the last decade. This organisation has a web site where it claims that "Dairy farming in New Zealand aspires to sustainable development" and goes as far as to cite the WCED (1987) statement of "development that meets the needs of the present without compromising the ability of future generations to meet their own needs".

The notion of sustainable development has thus been accused of perpetuating poverty and furthering inequity and social injustice whilst cynically using the concept as a marketing tool. For all of the reasons above, it has been queried whether the concept of sustainable development serves only to distract us from authentic problems and possible solutions (Robinson, 2004). In spite of   the issues relating to inequity and social injustice, sustainable development has been used to ostensibly improve both the quality and delivery of health-care in New Zealand. This has been instigated here, as in the vast majority of OECD countries, by the introduction of a laissez faire market model within healthcare which will be addressed more comprehensively in Chapter 6.

Sustainability and Health Care

The many environmental and social changes that we are currently experiencing on a global scale can be attributed to the unprecedented interconnectedness and economic intensity of present-day human activity. These changes impact on human health in a number of ways that McMichael (2014) describes as:

> a syndrome, not a set of separate changes, that reflects the interrelated pressures, stresses, and tensions arising from an overly large world population, the pervasive and increasingly systemic environmental impact of many economic activities, urbanization, the spread of consumerism, and the widening gap between rich and poor both within and between countries. (p. 1335)

It is estimated that illness caused by poor sanitation or access to clean water supplies leads to

the deaths of millions each year in low resource countries. In high resource countries, the growth of non-communicable disease such as cardiovascular disease and cancer are at least in part blamed on consumption patterns and lifestyle (Baer & Singer, 2009; Goodman, 2013). Additionally, the effects of climate change[17] are predicted to have major ramifications for health care services and provision (McMichael, Montgomery, & Costello, 2012b). The Stern Report (Stern, 2007) had a limited impact by highlighting that failure to act on climate change was likely to have profound costs on human health.   As key players therefore, healthcare workers need to be prepared for such outcomes and also to take action to minimize these threats to human health. This can be achieved by using health education and health promotion strategies (Femia & Werrell, 2015) but also by lobbying for action on climate change (Burke, 2012).

Sustainable health organisations

In recent years, there has been a burgeoning of sustainable health organisations within many countries and health care systems. Organisations such as Ora Taiao (New Zealand Climate Change and Health Council) and the UK based Centre for Sustainable Healthcare have pledged to transform healthcare to ensure an alignment with sustainability objectives. The respected journals the British Medical Journal (since 2014, The BMJ) and The Lancet have published editions committed to advancing the climate change in health agenda. In July 2012 a session titled "Greening the Health Sector" was held at the Rio + 20 Summit in Brazil, which identified preserving the integrity of the environment as **the** "major determinant of human health and well-being". It is argued that the health of populations is dependent on a successfully transition to more sustainable ways of being.

---

[17] This would include climate related phenomena such as extreme weather events and natural disasters, food security issues and changing disease patterns as a result of changing weather patterns, and an increase in vectors such as malarial carrying mosquitos (Baer & Singer, 2009). Loss of land and livelihood and access to food and safe water would almost inevitably lead to security crises. For example, as those with refugee status attempt to find sanctuary in areas where subsistence is still possible, the potential for civil conflict would be great (Femia & Werrell, 2015).

> Human induced climate change is a reality, and one which threatens our biosphere
> and the global economy. It also poses a grave threat to our health and survival...
> Urgent action at national and international level is required to minimise emissions of
> greenhouse gases, while adaptive mechanisms are put in place to deal with those
> health consequences that are already unavoidable. (McMichael et al., 2012a)

Sustainable healthcare has been defined as the long-term maintenance of the health and
wellbeing of the human population (Bromley, 2008) and as "...a way of providing care that is
living and working within our means with regard to natural resources at its core" (Schroeder
et al., 2012). This is reassuring but the caveat is that this is frequently claimed to be
dependent on the determinants of sustainability defined within the tripartite models of
sustainability, such as healthy bio-physical environments, strong social structures and
effective economic frameworks (Swift, 2011;Guenther & Vittori, 2013; Amey, 2014;
Pachauri & Meyer, 2014).

A sustainable healthcare model

An example of this can be observed in the model produced by the Sustainable Development
Unit (SDU). This organisation, formed in 2008 in the UK, is a unit that informs health care
policy and provides education on sustainability. The unit aims to support the National Health
Service (NHS), public health, and social care to promote the development of environmental,
social and financial elements of sustainability (SDU 2015) (Figure 5).
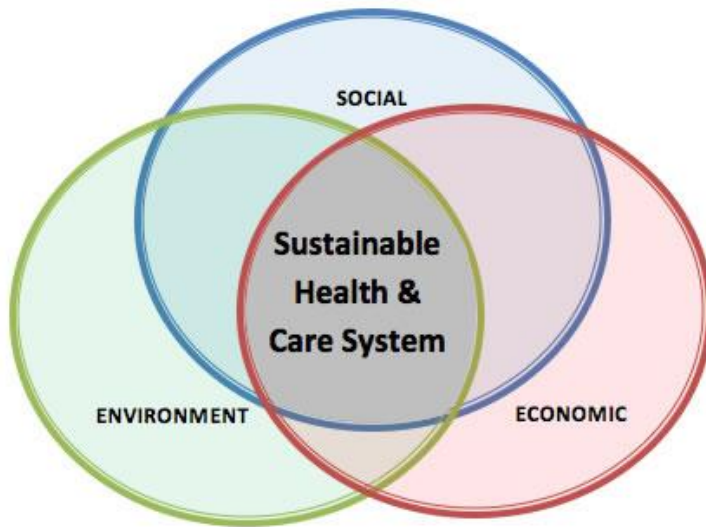
Figure 5: Sustainable Health and Care System Model[18]

As previously discussed within the chapter, when this tripartite model is applied generically, or more specifically to business and industry in the guise of sustainable development, it attracts criticism around serving the interests of a capitalist perspective. The triple bottom line model cannot be considered an integrated model in spite of the small central area of overlap. The tenets represent elements of an economic system that ideologically cannot address the environmental and social tenets because the primary motivation is profit driven. Although stressing the importance of vague socially related terms such as 'social value' and 'corporate citizenship' the Sustainable Development Unit ("Sustainable Development Unit" 2015), is primarily concerned with reducing carbon emissions and seemingly maintaining the current political status quo.

There has been further criticism that the broad response of health professionals to the challenge of sustainability has been fragmentary and reductionist, focused primarily on climate change and driven by public health. (McCartney & Hanlon, 2009; Hudson & Vissing,

---

[18] http://www.sduhealth.org.uk/images/whatis_diagram.jpg

2013). This has resulted in a marginalized effect that may discourage the participation of a broader range of health care professionals in any concerted collective effort to introduce a sustainability agenda into the broad frame of health-care.

In a report published in 2010 the World Health Organisation (WHO) stated that global health actors, including the WHO, had paid too little attention to social context and placed far too much emphasis on technology and the marketization of the healthcare sector (Evans, Elovainio, & Humphreys, 2010). The report outlined that the ascendency of neoliberal economic models had created hurdles for the instituting of social policy and action which had led to an increase in social inequality in healthcare in both wealthier and poorer nations. It has therefore been suggested that without acknowledging the significance of the social impacts of an ideology which is principally economically driven, we are in danger of losing our humanity (Solar & Irwin, 2010). Marxist critics view neoliberalism as a capitalist response aimed at restoring conditions for power and profit (Harvey, 2005). It is argued that this results in an ideological stronghold that creates political impotence, social and economic inequity and health and environmental problems (Harvey, 2005; Braedley & Luxton, 2010)

Hudson and Vissing (2013) argue that the concept of sustainable healthcare has been overgeneralized and has become little more than a buzzword that hides quite conflicting agendas. There is little if any discussion about the radical social and economic paradigm shifts that critics state are necessary in order to secure the future for humanity. Although addressing the issues relating to climate change is crucial, it can be argued that expecting this to happen within the current economic and social milieu is valueless (Littig & Grießler, 2005).

Sustainability and Midwifery

I have been unable to identify any groups attempting to establish a platform for a specific focus within the sphere of midwifery either in New Zealand/Aotearoa or further afield.

Midwives are member of groups such as Ora Taiao and are represented on groups such as the SDU but there is little indication that midwives are taking up an activist or lobbying stance. Additionally, as I determined in the introductory chapter, there is little evidence of serious academic exploration of the broad subject area of sustainability in relation to midwifery and a dearth of research evidence within the midwifery literature.

Literature search

Using a series of key words and phrases such as 'sustainability & midwifery'; 'ecology & midwifery'; 'ecological midwifery' and "sustainability and birth', I accessed a number of databases and text books. The search unearthed very few studies or articles relating to midwifery and sustainability. Those that did meet the keyword criteria can be loosely grouped into four separate camps. The first grouping was studies related to practice in third world or developing countries (de Souza et al., 1999; Wiley, 2002; Lucas, Goldschmidt, & Day, 2003; Argaw, Fanthahun, & Berhane, 2007). These studies were generally associated with primary health care services and their successes in curbing perinatal or maternal mortality rates. For example Argaw, Fanthahun and Berhane (2007) used a comparative cross sectional study to examine the effectiveness of community based reproductive health interventions in Ethiopia. The second group were concerned with midwives and 'sustaining self' in terms of avoiding burnout[19] within practice (Sandall, 1997). The two latter studies cited were evaluations of the continuity of care model in New Zealand and they both noted concern regarding the sustainability of case loading without good safeguards in place for the avoidance of burnout. The third group tended to use environmental frameworks for exploring a very specific subject area (Gold et al., 2001). These studies were primarily public health focused, examining the value of campaigns for issues such as the uptake of preconceptual folic acid and improving breastfeeding rates. Others were used to establish

---

[19] Burnout is described as "...a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do "people work" of some kind...emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level." (Maslach & Jackson (1986) as cited in Deery, 2003).

environmental predictors for subjects such as repeated adolescent pregnancy (Raneri & Wiemann, 2007). The final category were linked more to the effects of environmentally related issues on pregnancy. These included factors such as seafood contamination (Hibbeln, 2002), air pollution (Hansen, Barnett, & Pritchard, 2008), maternal exposure to severe adverse life events (Khashan et al., 2008), lead levels in water supplies (Hu et al. 2006), pharmacological drugs (Tullus & Burman, 1989) and low levels of various micronutrients (Costello & Osrin, 2003).

An updated review in 2017 using the same key words and terms, revealed that there had been a significant increase in the number of studies and articles citing the word sustainability . However, the focus remained on the sustainability of the profession or on self-sustainability in terms of self-care (Donald, 2014; McAra-Couper et al., 2014; Calvert, 2015; Hunter et al., 2016; Dixon et al., 2017). There was still no single study that viewed the broader issues of sustainability in relation to midwifery practice. The literature review therefore failed to elicit any type of framework to illustrate how midwifery values could be seen to articulate with the subject area of sustainability. It seemed that the principle of developing educational programmes to include sustainability may assist in achieving such an objective, but it would not address the question of what midwives practicing in the field know or feel about sustainability in relation to midwifery practice.

A natural alignment

Broadly speaking however, the profession has many features that align it with sustainability in a way that addresses the criticisms itemed in the previous paragraph regarding a narrow environmentally focused perspective.

Midwifery could be said to be grounded in a historically located tradition of sustainability. The longevity of the role serves to highlight the possibility that midwifery is the archetypal sustainable health care occupation and in this capacity midwifery has demonstrated a tenacity that has enabled it to survive as an entity in spite of considerable persecution and oppression (Towler and Bramall, 1986). The midwifery model supports a minimal

intervention (low tech, high touch) approach to childbirth. Midwives should be on the lower scale of resource use in healthcare by default if they are taking on their proposed role as guardian of normal birth using appropriate assessment tools and carrying out interventions only when required (Davis, 2004). Care across the spectrum during pregnancy, birth and the postnatal period should actually require very little in terms of resources in normal circumstances and accordingly should produce little waste (Martis, 2011). A low impact approach would essentially enable the midwife to role model a lower resource based, less exploitative way of parenting (Davies, 2011).

Holistic profession

 Midwifery has traditionally struggled with positioning within health care systems built around models of pathology and midwives have remonstrated that they are an atypical profession in healthcare (Lay, 2000). The midwifery model is claimed to be essentially aligned with the position of salutogenesis[20]   rather than pathogenesis (Downe, 2010). It therefore assimilates a holistic approach that incorporates social, cultural, spiritual and psychological as well as physiological elements, which aligns it with the indigenous models of sustainability. Pregnancy and birth are viewed as normal life events that should be situated within a social rather than a medical model (Kirkham, 2010; Miller & Wilkes, 2015). This again reduces the reliance on expensive health care resources. Home birth or even birthing at a midwifery led unit is demonstrated to cost considerably less than that of a hospital setting (Tracy 2011).

---

[20] Salutogenesis is a concept that was developed by medical sociologist Aaron Antonovsky (Antonovsky, 1987). The theory espouses that we should focus on the things that sustain health and well-being, as opposed to those that cause disease and illness. Antonovsky did not accept the tradition medical binary approach that separates health from illness and salutogenesis therefore creates a continuum relationship of health and wellbeing that is impacted by a range of factors including psychosocial as well as disease and illness.

Definitions of social sustainability notably include terms of relationality such as 'communities', 'relationships' and 'communication'(Barron & Gauntlett, 2002; McKenzie, 2004). Within a socially sited midwifery model, the midwife is expected to support the physical, psychosocial, cultural and spiritual wellbeing of the woman and her whānau; this holistic approach is believed to result in better outcomes (Pairman et al., 2015; Homer, 2016; Sandall et al., 2016). For example, a baby who is smaller than expected for the gestational age can usually be identified from a straightforward physical assessment of the mother and diligent monitoring (Gardosi et al., 2011). Any growth restriction may be the manifestation of a physical condition such as pre-eclampsia. However, there are other, sometimes complex reasons why a fetus should not be following a normal growth trajectory. If the midwife is aware of the broader psychosocial influences, including cultural and spiritual, she may be able to identify a range of factors that could affect the woman's emotional or psychological state of mind, which could consequently affect the growth of the fetus. These factors could include anything from domestic violence (Kendall-Tackett, 2007) and drug use (Behnke et al., 2013), to feeling unsupported or disconnected from the baby (Bolten et al., 2011; Bergman, 2014). With this knowledge, the midwife is in a position to work with the woman towards mitigating the problem/s by identifying an action plan that may or may not call upon the involvement of other referral agencies. Midwives by educating, encouraging, supporting and listening to women have the opportunity to assist women in building personal resilience and a sense of agency[21]. The most recent international definition of the midwife (ICM 2011a) would appear to support the principles of social sustainability such as equity, social justice and community capacity.

Conclusion

The challenge that the world currently faces is unprecedented in scope. It requires an essential shift in consciousness as well as in action. How we understand and experience our

---

[21] Agency refers to the subjective awareness when we are instigating, implementing, and controlling our decision making (Jeannerod and Pacherie, 2004)

relationship with nature impacts on our perspective of sustainability. In the western post-industrialised world, and increasingly in the emerging 'developing ' economies, humanity is regarded as separate from non-human nature and human potential and fulfilment is posited primarily in the realm of material gain. The ecosystems that sustain human life are viewed as an externality that provide a backdrop for rational exploitation to feed expanding economic growth. These cultural perceptions influence our social institutions and our political and economic practices. The prevalent western focussed epistemology has resulted in societal norms that ignore or undervalue other life forms in order to maximise short term human gain over long term systems stability. The earth and its components and processes are viewed in mechanistic terms ignoring the complexities of the ecological and social systems that humans are part of. The concept of 'sustainable development' purports to offer a bridge that it is claimed will satisfy both the anthropocentric needs of neoliberalism and the ecocentric needs of the environmental lobbyists. However, the introduction of the vague self contradictory concept of sustainable development may have served only to create confusion and to undermine public understanding of sustainability (Blewitt 2008).

Sustainability is about protecting the environment and achieving intra-generational and intergenerational equity and social justice. It would seem that the core values of the midwifery profession in New Zealand/Aoteaoa fundamentally align with this philosophical stance. For example Māori and other indigenous models of sustainability, viewed as sustainable models, are principally in accordance with these midwifery values. Therefore, theoretically at least, the sustainability movement could provide a framework for long held midwifery values that have been largely overlooked in contemporary healthcare practice (Davies, Daellenbach, & Kensington, 2011)

Chapter 3. Methodological Framework and Methods

Introduction

The methodology that I elected to use had to align with the initial goals of the project, which were to gain insight into midwives' understanding of sustainability and to establish whether involvement in activity relating to sustainability might lead to practical and philosophical changes. As outlined in Chapter 1, my personal and professional position reflected a feminist and emancipatory paradigm and I therefore commenced the project with the intention of employing Participatory Action Research. PAR is understood to represent both of these standpoints effectively as a methodology (McTaggart, 1999; Corbett, Francis, & Chapman, 2007; Harding, 1987; Jollands & Harmsworth, 2007; Kindon, Pain & Kesby, 2007; Barbera, 2008; Glasson, Chang & Bidewell, 2008; McIntyre, 2008; Walter, 2010a) and it therefore felt an appropriate fit for the study.

Participatory Action Research

In succinct terms, PAR can be described as an approach to social investigation, an educational process and a means of taking action to deal with a problem (Hall, 1981; Koch & Kralik, 2009). PAR is said to be a methodology with an intrinsic value system or axiology and a healthy respect for the existing knowledge and knowledge systems of the community of research (Walter, 2010a). The initiator of the PAR study will place these specific, localised values above others, thereby exhibiting a specific epistemology. I recognized the benefits of using this framework for the project and the deciding factor was the compatibility of PAR with the ontological and epistemological standpoints of my own area of midwifery, and with the broader context of sustainability.

In PAR, action is achieved through a reflective cycle where the participants become co-researchers, partners within the research process. Far from being passive participants they

are collaborators in a dynamic process. This is a consciousness raising process that creates educative theory and data. The participants play an active part in each stage of the process, from the determining of the direction that the research will take; through the data generation and the analysis stages; and continuing into the discussion, in terms of planning where to take the research from here. They also bring their own values and beliefs in to the field of inquiry which exerts influence on the study (McDonald, 2012). Power relations are critically examined which means that PAR has a critical and emancipatory function, facilitating the creation of theory through critical reflection of practice (Reason & Bradbury, 2006). Globally speaking, the actions undertaken are supposed to enable the participants to progress towards their goals. Consequently, the participants become partners or co-investigators in the research and enhance their own social and emotional wellbeing in the process (Smith & Romero, 2010).

Guiding principles

There were a number of guiding principles that served to galvanize my decision to select PAR as a methodology. These principles, discussed below, continued to inform my research practice beyond the confines of PAR, influencing the shape of the thesis. As I previously stated in relation to the choice of PAR, the design of the study and its components had to align with the epistemological and ontological philosophical stance of both midwifery and sustainability.

Research as a qualitative process

The study was always going to be a qualitative in design, because I wanted to gain a broader understanding and deeper insight into the way that midwives viewed and worked with the concept of sustainability and this called upon the employment of a qualitative approach. Qualitative research sets out to create meaning of human phenomena, by observing, recording, analysing and interpreting a range of methods and techniques (Walter, 2010). It is not intended to predict and control, but to describe and understand. Qualitative methods

and techniques have been described collectively as naturalistic and participatory methodologies that reveal authentic lived experiences of individuals and this is what I was hoping to achieve from the research.

Feminist Theory

It might be considered imprudent to produce a midwifery study that did not have a feminist focus for a number of reasons. Feminist research sets out to acknowledge and highlight the experiences and voices of women (Beckman, 2014), and explores ways to strengthen the ways in which women are able to live their lives (Gringeri, Wahab, & Anderson-Nathe, 2010). The philosophical standpoint of feminism is frequently at odds with the reductionist, rationalistic, positivist paradigm of traditional scientific knowledge that fuels a narrow masculine perspective (Harding, 1987). As part of a female dominated profession, midwives operate in a field that protects a uniquely female experience. Midwifery research is by default conducted for the benefit of childbearing women (either directly or indirectly) and is usually based around the contribution that midwives can make to meet the health needs of childbearing women (Wickham, 2006). Feminism with its emphasis on the empowerment of women and the support of women's control over their reproductive lives has therefore been utilized in many midwifery research studies (Fleming, 1994; Surtees, 2003; Adams & Bourgeault, 2004; Edwards, 2005; Barclay, 2008; Cooper, 2011;Walsh, Christianson & Stewart, 2015). In my thesis however, feminist theory will be drawn upon to inform the study by providing principles and a perspective from which to work rather than providing a specific method or methodology.

A feminist research epistemology acknowledges that there are many avenues to knowledge and diverse perspectives of reality. From the standpoint of sustainability, feminism has an additional focus. Ecofeminists draw parallels between the oppression of women and the exploitation of the Earth's resources and its appropriation by Western or Western-style economies (Diamond, 1990; Merchant, 1990; Mies & Shiva, 1993).

Reflexivity

Reflexivity is defined as a consciousness on the part of the researcher of the effect that their presence and their contribution has on the construction of meanings during the research process. Dowling (2006) describes reflexivity as a "poorly described and elusive" concept, but recognizes that it is an important development in the evolution of qualitative research that determines how the relationship between researcher and participant is effected during the research process. In critical reflexivity, the researcher demonstrates an enhanced level of perception of their own psychological, philosophical, and emotional states throughout the research experience that enables a profound understanding the personal and psychological state of others (Lincoln, 2011).

Reflexivity is said to assume a pivotal role in PAR (Robertson, 2000),as one of the major principles of PAR is the intention to contribute to an improvement in the "understanding, practice and social situation of participants and others" who are involved (McTaggart, 1991). This aim would by default require an element of reflexivity. Borg et al. (2012) note that "Reflexivity requires the researcher to be aware of themselves as the instrument of research. This is a particularly important issue for action researchers who are intimately involved with the subject of the research, the context in which it takes place, and others who may be stakeholders in that context." (p. 11). In this context the researchers are referring to action research; in PAR the participants are far more than 'subject', and this might suggest that reflexivity takes on an even greater significance.

Study Design and Methods

Ethics Approval

Ethics applications were made to the Ethics Research Committees' at CPIT and the University of Canterbury and were duly approved (Appendix E). Additionally, research ethics in New Zealand/Aotearoa requires that 'all health research conducted in the country is of relevance to Māori' and that consultation and consideration of Māori health issues are transparent. In response to this requirement, I consulted with Te Komiti Whakarite at Nga Ratonga Hauora Māori. Finally, I sought locality assessment agreement from the local Distric Health Board (DHB) as I was working with DHB employed midwives (Appendix D). This was initially a requirement of the national health ethical approval process that I undertook, but the requirement changed during the time of my application, rendering it unnecessary in my case (See Apppendix C) . Nonetheless, as I was using DHB time and location, it seemed appropriate to gain consent from the organisation.

Recruitment of the Midwives

I purposefully identified the midwives who participated in the research group meetings as potential group members. They were all New Zealand midwives registered with the Midwifery Council of New Zealand. The initial plan was to work within a contained geographical area on the South Island of New Zealand/Aotearoa in order to utilise a more sustainable approach by reducing the need for travel. I had intended to use the database of the local branch of the New Zealand College of Midwives to recruit midwifery practices. However, the February 22nd 2011 earthquake in Christchurch changed the landscape of the study both literally and metaphorically. The effects of the earthquake such as losing homes and migrating clients profoundly affected many of the Christchurch midwives, and it therefore seemed inappropriate to recruit in the way that was originally planned. As a result my recruitment strategy became more pragmatically focused. I chose to approach a Christchurch based urban midwifery group practice that I knew to be reasonably unaffected

by the event and I also contacted a group practice in a regional town in the South Island. Midwives in both of the practices were primarily concerned about the commitment of time. I felt that it was important to let them know the anticipated level and type of involvement from the outset, so that they were able to make a well informed decision about involvement. However, following reassurance that we could work around the unanticipated nature of midwifery, both practices agreed to participate. I additionally contacted a group of District Health Board (DHB) midwives working in a semi-rural primary maternity unit (PMU) and obtained their agreement to participate.

Each midwife was sent an information sheet (See Appendix A) along with an invitation to attend an initial meeting with the other members of their practice group to discuss issues relating to sustainability and midwifery practice. They were informed that they would be asked to consider something relating to sustainability that they would be able to introduce within their practice. The sheet also stated that over the course of an agreed time-frame, they would be requested to monitor the impact of their proposed action by recording their stories and identifying their observations and outcomes. It was suggested that this could be achieved in a number of media including a handwritten journal, an audio recording, blog format or others and that this could be carried out as often as you feel it to be necessary.

Profiling the midwives

I began my fieldwork by carrying out initial consultation and negotiation meetings with the three midwifery groupings where the information contained in the information sheet was reiterated and the signed (See Appendix B).

All of the midwives were either members of existing group practices or were colleagues within the same maternity facility. Two of the group practices were self-employed midwives who work as lead maternity carers (LMC's)[22] and the third were a group of midwives

---

[22] Lead Maternity carers (LMC's) provide maternity care for women in New Zealand. LMC's can be midwives, GPs with a diploma in obstetrics or obstetricians. LMCs are contracted through the Ministry of Health to provide

employed by a DHB who worked within a primary maternity unit (PMU) [23]. The two LMC practices each had four midwives working within the group and the primary unit was the source of five DHB midwives who expressed a desire to participate when approached by their manager. The midwives were all women and the majority were aged in their 40s and 50s which reflects the average age (47 years) of a midwife in New Zealand/ Aotearoa (NZCOM, 2012). In terms of ethnicity, eight of the midwives were New Zealand midwives of European origin, three were English and two were Irish. Eleven of the midwives had been trained as general nurses and two were 'direct entry'[24] midwives. The range of years in practice varied from 35 years to 5 years. Both practices were relatively well established (eight years and fifteen years) and many of the midwives from the primary unit had been working within the facility for over ten years.

In both the group practices and the PMU, the midwives were close colleagues who worked together and knew each other well within their groups. This offered the possibility of synergistic potential of the group described by Kitzinger and Barbour (1999), as there was a good chance that they already had well-formed relationships which would allow them to concentrate on the task in hand. However, there was the important consideration of the potential for pre-existing inter-relationship issues. I did consider interspersing midwives from different practices or settings at an early stage in the research. I thought that collaboration with others from outside of their principal working group may have dealt with any matters of unknown dynamic issues within the pre-existing groups. It may also have encouraged diversification and less 'group-think' (Krueger & Casey, 2009). There was also an issue that

---

a complete maternity service for the women who select them. The vast majority of women and their families choose a midwife as their LMC.

[23] A primary maternity unit is small community hospital maternity unit. It is generally staffed by midwives without direct medical support and is generally reserved for women who are considered to be low risk.

[24] A direct-entry midwife is educated in midwifery in a program or path that does not require any prior education or training as a nurse. All midwifery programmes in New Zealand are now provided at undergraduate level. Those entering from other health related disciplines can usually apply for cross-credit for some of the content but generally have to complete a three year programme of study (NZCOM, 2015)

with established groups, I was the outsider coming in, a factor that was effectively at odds with the idea of me being a co-researcher within the group. Having combined groups may have eliminated that aspect of the study as not all of the group's members would have known each other well, if at all in some cases, and my presence may have been less obvious as the outsider. However, on reflection, I envisioned that the responses from the practices may be quite diverse anyway; additionally each practice was likely to have its own sub-culture and the introduction of another sub-culture from outside that immediate group may have impacted on proceedings (Park, 2001). This impact may have resulted in positive outcomes, but I felt that as I was asking the groups to collectively introduce an action or intervention with which to take into practice, then pragmatically it would be easier to work within established groups where ideas were possibly more likely to be formulated within a social context that already existed. (Kitzinger & Barbour, 1999). Therefore, having weighed up the pros and cons, it was decided that the meetings should be held within discrete practice groupings rather than attempting to combine members of the practice groups. The midwives, who felt that logistically it would be easier to meet up within their own practices, endorsed this suggestion.

Research Group Meetings

I set out to co-generate data with the groups of midwives in the context of purposeful relationships. This approach was underpinned by my epistemological and methodological position as outlined both in this Chapter and in Chapter 1.   In the planning stages of the study I had hoped that we could create an enabling, egalitarian and safe environment within the research group meetings. I saw this as being in keeping with the principles enshrined in PAR around inclusiveness in the construction of knowledge (Koch and Kralik, 2009). However, the disruption inflicted upon the study by a series of earthquakes, meant that the groups had not been wholly involved in the formation of the study as I had hoped. I therefore recognized that we were going to have to consciously work at ensuring that we all felt a sense of 'investment' in the project. It therefore seemed appropriate to begin the process by

considering the name of the meetings and how they would operate. Within each of the groups, we agreed that we should consider them to be 'research group meetings' for the purposes of the study which allowed for us all to be involved as team members.

Research Group Meetings and Focus Groups

The design of the research group meetings embraced many of the broader characteristics of focus groups which are distinguished by their explicit use of group communication and interaction to generate data (Morgan & Scannell, 1998; Litosseliti, 2003; Krueger & Casey, 2009; Wilson, 2012). For example, the primary intention of focus group research is to create a setting where the attitudes, feelings, beliefs, experiences and reactions of those participating can be elicited. This is achieved in a way that would not be possible using methods such as one-to-one interviewing or surveys, because it capitalizes on the interaction within the group (Bloor, 2001; Krueger & Casey, 2009; Liamputtong, 2011; Wilson, 2012). There is suggestion that the focus group format has particular currency in midwifery research.   Deery (2003) suggests that focus groups have the potential to be a useful method to explore the views of midwives, "because they mirror the social organisation of midwifery practice that is dependent on a team approach and verbal communication" (p. 123). Perhaps most significantly the focus group is viewed as a platform to promote social action and initiate change, which, as previously identified, was my primary objective. (McTaggart, 1997; Kemmis & McTaggart, 1988; Minkler & Wallerstein, 2003 Burgess, 2006;)

Meetings

We agreed that we would meet on at least three occasions over a twelve month period at research group meetings for between 1 ½ -2 hours (see Figure 6).
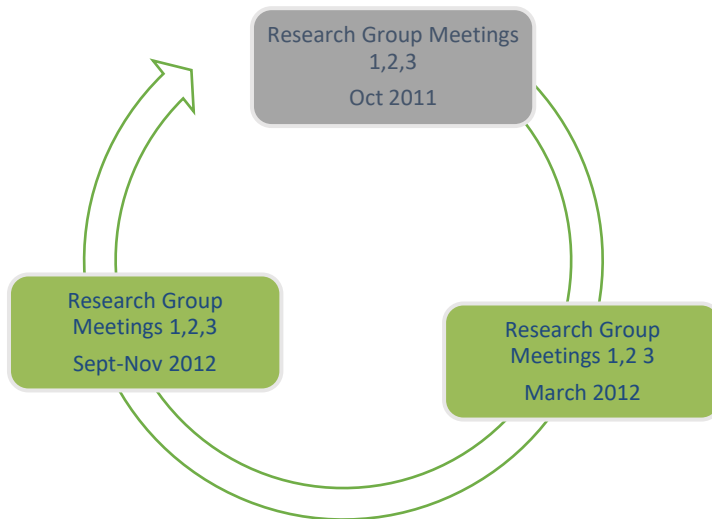
Figure 6 illustrates the placement of the components within the time frame of the study.

 We met in a variety of different venues that were determined by the midwives from the individual practices. These included clinic rooms, a hospital lounge, a rented room in a tertiary educational establishment and a home setting. It was important that the meetings were held in environments that were physically comfortable in terms of being warm and peaceful, as this was likely to enable the groups to relax into the meetings as quickly as possible (Litoselliti, 2003; Puchta & Potter, 2004).

Format and structure

During the introductory research group meetings, we explored the concept of sustainability, both in relation to us personally and within our sphere of practice. I was unaware of the level of understanding of the concept of sustainability on the part of the midwives prior to commencing the group meetings. It became apparent during these meetings that the level of knowledge was variable.

Although there were no question schedules, and the gatherings were very much an open discussion, there was in fact a degree of structure in order to 'signpost'[25] the meetings and to optimize the time available for productive discussion. This resulted from the preliminary discussions regarding their involvement in the project, where the midwives had expressed a desire to keep to strict time schedules in order to avoid time wasting. Accordingly, a structured activity at each meeting was scheduled, which it was hoped would provide impetus and motivation for action and in addition meet the temporal requirements of the groups(Koch & Kralik, 2006).

Visual Cues

During the first meeting, the midwives were introduced to a set of laminated cards that contained illustrations and statements related in some way to midwifery practice and sustainability. I was particularly keen to use visual cues in addition to verbal, as it is believed that images can be effectively used to expand ideas and encourage creative thought within a group dynamic setting (McDonagh-Philp, 2012). The cards that were designed to be used as catalysts for discussion, introduced the three accepted mainstream tenets of sustainability (see Chapter 2). The midwives considered the criteria on the cards in relation to the tenets and to midwifery practice. Many of the statements were adapted from the New Zealand College of Midwives Midwifery Standards for Practice (NZCOM, 2012) , The Midwifery Council of New Zealand Competencies for Entry to the Register of Midwives (MCNZ, 2008) and the NZCOM Code of Ethics (NZCOM, 2011). These documents encompass the professional framework for midwifery in New Zealand/ Aotearoa, which means that the ideas would have been familiar to practicing midwives. This was an important consideration as it has been suggested that if sustainability in healthcare is not firmly situated, then it can become little more than rhetoric as far as practitioners are concerned (Hanlon et al., 2012). Statements listed in Table 1 that were adapted from the professional framework documents

---

[25] The concept of sustainability is understood by many to be nebulous and the idea of signposting therefore is to offer some direction to the discussion in order to ensure that contributors are able to relate to the ideas and opinions of others within the group.

identified above, are asterisked to highlight this fact. The remaining statements are predominantly focused on the practicalities of resource management in midwifery practice as identified by Martis (2011). These were included to open up the discussion beyond the professional framework documents. During a literature search (see Chapter 2), I discovered that any research relating to sustainability in midwifery practice in New Zealand/Aotearoa concentrated almost exclusively on professional and practice related sustainability. I therefore hoped that the inclusion of criteria such as encouraging the use of reusable nappies and using alternative forms of transport would broaden the discussion to include an ecological perspective.

Table 1

Statements relating to midwifery practice and sustainability.

Holding regular practice meetings for sharing stories and information. *	Using alternative forms of transport to a car in your working life.
Having more 'me time'.	Involving family/whānau in midwifery care.*
Getting women to engage in outdoor activities.	Supporting and promoting breastfeeding wherever possible.*
Becoming a guest speaker for local schools and community groups. *	Supporting and promoting physiological birth.*
Being more reliant on technology.	Being less reliant on technology.
Providing opportunities for pregnant women to create friendships.*	Using alternative and complementary therapies.*
Encouraging the use of disposable nappies.	Discouraging the use of baby toiletries products.
Offering a preconceptual service. *	Encouraging the formation of postnatal groups.*
Teaching about nutrition in the childbearing period.*	Advocating the use of smoking cessation services.*
Enhancing the health status of the baby when the pregnancy is ongoing.*	Working in a collaborative and co-operative manner with other healthcare

professionals.*

Being an advocate for women who need help with social agencies. *

Respecting the customs, values and spiritual beliefs of women and their families/whānau.*

Hold information in confidence in order to protect the right to the privacy of the woman.*

Recognise Māori as tangata whenua of Aotearoa and honour the principals of partnership, protection and participation as an affirmation of the Treaty of Waitangi.*

Encourage public participation in the shaping of social policies and institutions.*

Advocate policies and legislation that promote social justice improved social conditions and a fairer sharing of the community's resources.*

Acknowledge the role and expertise of community groups in providing care and support for childbearing women.*

Support and sustain each other in your professional roles and actively nurture your own and others sense of self-worth.*

Ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women.*

Avoid the practice of receiving gifts and samples and of accepting sponsorship from commercial companies. *

Adapted from New Zealand College of Midwives Midwifery Standards for Practice, The Midwifery Council of New Zealand Competencies for Entry to the Register of Midwives and the NZCOM Code of Ethics.

The midwives were asked to arrange the cards across the room on an imaginary continuum of sustainability that ranged the criteria from irrelevant to highly significant when applied to midwifery practice. The activity generated a great deal of discussion and added further evidence to the commonly held belief that the concept of sustainability is subjective and diverse (Bell and Morse 2008).

Action/Intervention

The other 'road map' introduced during this first session which was intended to help the midwives to gain a sense of direction in the complex landscape of sustainability was the development of an action/intervention for each group. This action/intervention step is a key component of PAR. We agreed that this could be anything that the midwives felt to be relevant to sustainable midwifery practice, and that it could represent environmental, economic or social tenets of sustainability. PAR is a methodology primarily concerned with social change and the interventions are intended to encourage the practitioners to further examine the concept within the context of midwifery practice. Group 1 decided to introduce a book to keep minutes during practice meetings in order to sustain their practice by ensuring that things were not overlooked and that the practice members were kept informed if they were unable to attend. Group 2 was keen on establishing a 'grandmothers antenatal session'[26] which they viewed as a means of bringing the grandparent group up to date on some of the issues that were creating intergenerational confusion around childbearing. They hoped that this would lead to more sustainable outcomes, particularly around breastfeeding. Group 3 planned to look at designing their own cot cards[27] for babies in hospital as the current ones in use were sponsored by a disposable nappy company which they felt to be ecologically unsound.

During the second round of meetings, I invited the groups to brainstorm what factors that they felt would enable them to become more sustainable in midwifery practice and what they felt that the barriers to sustainable practice in midwifery to be.

<u>Emerging Challenges</u>

---

[26] Grandmothers antenatal sessions have proven to be very successful in some areas and have acted effectively as catalysts for change particularly in the area of breastfeeding (Polomeno 1999; Ingram, Johnson, & Hamid 2003).

[27] Cot cards are small cards attached to the baby's cot in hospital that contain information such as the baby's sex, name, weight and date, and time of birth.

The 'lineage' of PAR represents "a broad range of research approaches and epistemologies" (Jordan, 2009, p. 16) as well as a varied range of methods (McIntyre, 2008). It is not a fixed process but a responsive and dynamic research methodology which offers the potential for the unexpected (Tedmandson & Bannerjee, 2010). In this section of the Chapter I will present some of the challenges and analyse some of the reasons why PAR was not able to be fully operationalized as a methodological approach within the study, in the way that I had hoped that it would.

A Spectrum of Participation

The midwives were not involved in the initial planning process, because of the complicating factor of earthquakes and aftershocks. As a result I decided to locate the project within the continuum of the Schneider process, which is primarily consultative with a collaborative component (Schneider, 2010) and views participation along a continuum. This is illustrated below in Table 2

Schneider Model	
Advisory	Participants are invited to be part of a board or committee to represent the "stakeholder" group.
Consultation	Participants are regarded as having knowledge that may be valuable, but a primary researcher retains control of the project.
Collaboration	Participants collaborate with primary researcher in all aspects of the project, including identifying the research question, study design, data gathering and analysis, and dissemination of results.
Control	Participants lead the project by identifying the research question, the study design, and data gathering and analysis.

Table 2. *Adapted from Schneider (2010)*

I had introduced the midwives to the model believing that it would provide some structure for the process. I also hoped that it might enable the midwives to generate some areas for inquiry as phase 2 of the Schneider model is designed to encourage the research team to initiate their agreed action and observe and record their own and others experiences (Schneider, 2010). I suggested that the midwives might like to observe and record their experiences to share with the others within their groups. Although the midwives reflected well verbally on the processes during the research group meetings, they did not keep any form of journal, video diary or blog to reflect on their thoughts and actions during the data generation period as suggested by Kindon et al. (2007). The midwives were willing to receive copies of the transcripts in order to confirm the accuracy of content, and the preliminary findings were discussed with the groups; Russo (2012) suggests this is necessary in order to validate findings. However, it is argued by some PAR researchers that the data generated by the group should also be analysed in and by groups which means that the participants are participating as co-researchers in the process of analysis (Borg et al., 2012; Goeke & Kubanski, 2012). In the case of the midwives though, beyond confirming accuracy in the transcripts, the groups did not choose to participate as co-researchers showing little interest, for example, in verifying interpretation. This challenged my intention to use a PAR approach to evoke change. Interestingly, Kitzinger and Barbour (1999) suggest that research groups that are not self-originated will only be able to reflect on or monitor change effectively but will not be able to initiate it. Therefore, attempts to coax the midwives into working within a change agenda context may have been counterproductive as such action may have diluted the synergistic potential of the group interaction.

Participation with action/intervention

There was little active engagement with the action/interventions (cot-cards, grandmothers groups and practice minutes book) of the groups; on the whole they did not really take hold in terms of becoming a focus for social change. The grandmother's group was abandoned and a decision to develop a flyer to promote the practice was made, hence effecting a move

into the 'professional sustainability' camp[28]. Group 3 decided that the cot cards were in fact superfluous to 21st century parental needs[29] and decided to go a step further and eliminate the cot-cards from the primary unit. They did not however, go on to develop a further strategy, and the decision to abandon the idea of cot cards came reasonably early on in the project. The minutes book however, did go on to become an established practice for Group 1, but this could not be considered to be a move towards a more broadly focused sustainable profession.

Focus group vs research group meetings

Another issue was how the midwives viewed the concept of the focus group. The focus group is a method commonly used in midwifery research and most midwives are therefore likely to have preconceived ideas about how focus groups function (Steen & Roberts, 2011). Although the term 'research group meeting' had been addressed in the introductory information to the project, and in the initial meetings, I acknowledge that I used the term 'focus group' at times, as did the midwives in the group, which may with hindsight have contributed to the problem. I applied the term in good faith at the time as something that I felt that the midwives would be able to relate to. However, it is generally accepted that focus groups should be 'led' by a moderator (Barbour, 2008; Krueger & Casey, 2009) and I intended to use what I considered to be a less hierarchical approach in the form of 'research group meetings'. Harding (1989) argues that methodology is where feminism truly resides within a research paradigm, and that 'method' is a neutral entity, and simply a tool for data gathering. However, the research terms that we use communicate expectancy on the part of those involved (Crano, Burgoon, & Oskamp, 2001)and it may have been helpful if a consistent approach had been adhered to.

---

[28] This transfer became very apparent in the discussion that took place amongst the group.

[29] The midwives felt that the professionally prepared memorabilia available and access to digital film and photographs etc. had made the cot cards seem anachronistic.

I acknowledge that any decision making on the part of midwives relating to their level of involvement were valid and that that all of the resulting actions had excellent scope for analysis, but at the time I felt a sense of disillusionment. I believe that I was so focused on getting the methodology 'correct' that I did not allow myself to appreciate the foray into change that the midwives were undertaking at the time. I was asking them to take on a considerable amount of conceptual analysis of self and practice with regard to the subject area of sustainability, and my expectations were perhaps unrealistic. There is a belief that there is scope in such a group process to initiate changes in the thinking of those participating or in their understanding of the issues being addressed (Bergold & Thomas 2012). Chapters 7-9 demonstrate that there was indeed a shift in the thinking of the midwives, but it was not a shift in collective consciousness (Baum, MacDougall, & Smith, 2006) resulting in social action and it was not having a clearly identified impact on practice, at least at that time.

Positionality and power relations

The dynamics and the relationships between the individuals involved in the research group meetings undoubtedly influenced the way in which the meetings operated, and my own positionality certainly played a part in this. Goeke & Kubanski (2012) refer to the effect of the presence of a power differential within a PAR setting. Initially, I did not imagine that this would be the case when a group of women working within the same professional field were involved. From a feminist research perspective, it has been suggested that personal experience can be seen as an advantage to many projects and that by working on a project in which the researcher has a personal 'investment', they are enabled to merge the public and the private. Corbin, Dwyer, and Buckle, (2009) advocate that being an insider does not make for being any better or worse a researcher, just a different kind of researcher, and that as long as this is acknowledged and reflected on, it can add an additional dimension to the data.

However, I feel that the fact that I am a midwifery educator rather than a full time practicing midwife may have influenced behaviour within the groups. The ability of the 'academic' to meet the needs of the communities that they are purportedly 'partnered' with has been

challenged as a problematic state within any research process (Burgess, 2006). There was a sense that the groups were looking to me as the 'leader' of the project and as a result there was little sense of any real 'co-research' involvement, and more of a passive form of participation. It has been argued that researchers who choose to use PAR as a methodology cannot ignore the fact that power politics will always be prevalent when an 'outsider' is going into a setting, with the intention to make changes within a community (Daellenbach, 1999b). Alternatively, other writers consider that it is possible for power inequalities between the researcher and the co-researchers to be exposed and neutralized (Bannerjee & Tedmanson, 2010). I would additionally add that although I can be seen as having a 'leadership' role in the profession by virtue of being an educator (NZCOM, 2012), I still see myself very much as a regular member of the midwifery profession. I therefore believed that I would be more likely be seen as an 'insider' than an 'outsider'. However, it has been argued that as a researcher, it is not possible to take on the mantle of 'insider' and that it is necessary to accept a rule that requires duality as both insider and outsider (Brannick & Coghlan, 2007). For me personally this led to a degree of entanglement and role ambiguity.

> The moment the insider steps out from the inside, she is no longer a mere
> Insider (and vice versa). She necessarily looks in from the outside while also
> looking out from the inside... Not quite the same, not quite the other, she
> stands in that undetermined threshold place where she constantly drifts and out
> (Trinh, 1991, p. 74).

I felt that we had addressed this in the preliminary meetings of the study, when I had discussed my intended involvement as a co-researcher within the study. I had used the comparison of the concept of partnership within the midwifery model, where the woman and the midwife bring their own body of knowledge to the relationship to create a partnership where both parties contribute equally (Guilliland & Pairman, 2008). I recognize that this viewpoint has been challenged by some critics who claim that aiming for relationship rather than partnership is more pragmatic (Skinner, 1999a; Freeman, 2006), but still felt that it had an analogous value.

I used what I felt to be a reflexive, feminist approach with a strong recognition of my own values and beliefs (Hesse-Biber, 2011). For example, I attempted to maintain a subjective sense of my own social location by journaling and critically reflecting on the meetings with regard to my own part in the process as well as that of others. The establishment of the research group meetings was, as described, an attempt to create a flattened research method structure. The meetings were structured to initiate dialogue to encourage the flow of ideas. (Morgan, 1993; Rubin & Bellamy, 2012) A conversational style was standard in the groups (Fern, 2001) and I aimed to introduce a non-directive rather than a directive approach when introducing elements such as the cue cards, in an attempt to deflect from being cast as the moderator (Stewart, 2007). It is argued that using dialogue as a tool leads to structural openings for social change by creating the opportunity of a shared space for co-construction of meanings in an authentic and egalitarian space (Dutta, 2011) and I hoped that the research design would facilitate this space. However, aware of the possibility of the groups' losing focus, I recognized that there is was a need to give the meetings some shape and purpose. Consequently I utilized activities such as cue cards in order to stimulate discussion and use the time allocated most effectively, and it is possible that this could have been construed as guiding the process (Fern, 2001). As my research notes from the time demonstrate, there was a sense that the midwives continued to look to me as the leader of the project.

I have to acknowledge that as the study designer, I felt, I think justifiably, a considerable amount of responsibility for how it went. Sense (2006) describes this dilemma as trying "to drive the bus from the rear passenger seat – wanting to genuinely participate as a passenger but still wanting some degree of control over the destination"(p.1). Others describe the architect of a research study in PAR as a "transformative intellectual" (Guba and Lincoln (1994) as cited in Thompson & Perry, 2004, p. 405) or a change legitimizer (Goduscheit et al., 2008). These definitions point to a role that is inevitably different from those of the other group members. However the role and the positioning of this person would appear to be ambiguous and poorly addressed overall within the literature (Avison, Baskerville, & Myers, 2001). Sense (2006) suggests that a pragmatic approach is needed as some degree of

compromise will be required unless the project has sprung from a genuine grass roots ideological standpoint where the group collectively call for change. This might mean renouncing some of the idealistic emancipatory and transformative perspectives of PAR. It may be that an acceptance of disparity within the collective concept of participation would be a more realistic position.

Intra-relational dynamics

As discussed earlier in the chapter, the decision to work with established group practices was not undertaken lightly. Kitzenger (1995) has argued that using pre-established groups allows the generating of "naturally occurring data" within an authentic social context (p. 105). This proved to be the case to some extent and the group members were able to prompt the recall of shared experiences and to work together to resolve discrepancies around specific occurrences and events (Munday, 2006). However, whenever a group of individuals gather for a common purpose there is a group dynamic and with it the potential for group conflict, or at least for conflict between individuals within that group (Wheelan, 2005; Wittenbaum & Moreland, 2008). Within pre-formed groups where existing inter-relational dynamics are determined and the hierarchical structures and patterns of interaction established, both explicit and covert tensions may be present (Liamputtong, 2011). From both intrapersonal and interpersonal perspectives, the midwives were what would be classified a low-risk group for conflict potential, being essentially homogenous groups in terms of age, socio-economic status and gender (Stewart et al., 2007). However, researchers using a focus group type approach should only expect "homogeneity in background and not homogeneity in attitudes" (Morgan, 1986, p. 48). Just because the midwives shared a practice, it did not follow that they would similarly share common values, beliefs and a practice based philosophy. Varying attitudes, even between people who know each other well can lead to conflict (Litoseletti, 2003; Puchta & Potter, 2004; Krueger & Casey, 2009). It transpired that significant tensions were present between some group members. The presence of inherent conflict within one of

the groups in particular, created a series of challenges during the research group meetings and almost certainly impacted on the ability or willingness of some the midwives to fully engage as co-researchers within the project.

Time Keeping

The issue of temporality was another area of challenge within the research group meetings. The need for a clearly defined time frame for meetings in research is well documented (Kitzenger, 1995; Bloor et al., 2001; Barbour, 2007; Liamputtong, 2011) I have also already discussed that time management in the meetings was important to the midwives. However, with hindsight, an urgency to settle the midwives into the meeting as quickly as possible was possibly counter-productive. This sense of temporal awareness on my part featured throughout the data generation and collection process and may have contributed to the challenges presented with relation to PAR within the research group meetings.

Call the Midwife

Midwives work with a considerable amount of uncertainty in their working lives, with the call to a birth or other unanticipated event always a phone call away (Leap & Pairman, 2010). I was expecting this to impact on attendance at the meetings that we negotiated, but not in the way that it transpired . I thought that they may not turn up because of having to be at a birth, or be called away to a birth during the meeting, but there were actually only two occasions when the midwives were not all able to be present within their discrete LMC groups. However, both of these happened to be the first meetings for the groups concerned.

Of the five DHB midwives who attended the initial meeting, one resigned from her employment with the DHB after the first meeting and another went on extended leave after the second meeting. Another midwife therefore joined the group to replace those missing and this change in dynamic almost certainly had some impact. It is identified that a consistent approach in group membership is important in PAR in order to maximize shared understanding and to increase a sense of ownership within the group (Krueger & Casey,

2009). If the midwives had missed the introductory session, then it could be argued that they may have been disadvantaged in terms of how they perceived the concept, which may have been different from that of their peers. In order to mitigate that possibility, I ensured that those who were unable to attend were sent a copy of the transcript so that they were able to gain some insight into how their colleagues had discussed the concept of sustainability. I did 'check in' with those who were latecomers to make sure that they felt comfortable in picking up the conversation having not been privy to the previous discussion and they responded favourably. My understanding is that at least some of them had also been updated by their colleagues about what was discussed during the meetings, although clearly this may have differed from the original discussion by virtue of personal recount and interpretation.

Reluctant Champions?

There is a sense of urgency in much of the literature around sustainability. For example, it is argued that the need for transition to more sustainable societies is 'critical'(UNESCO, 2009; Ferrar-Balas et al., 2010; Palma et al., 2011), and that a stronger presence of awareness of sustainability in a broad range of professional practices including education and health is 'essential' (Boyle, 1999; Jones et al., 2012). A principal driving force on my part was to provide a canvas for change in midwifery and I saw my research framework as the easel for the canvas. I imagined that if I provided an opportunity for midwives to initiate sustainability measures within their own practice, then they would become 'champions for the cause'. (Caldwell, 2003). However, as Kotter (1996) surmises, research and experience suggest that some of our change efforts toward a more sustainable world will work, many will not, or at least not perhaps in the way that we might imagine that they will.

On reflection, although the process did not work in the way that I had originally anticipated, this does not mean that it was not a worthwhile endeavour. I have been able to make meaning from my own positionality within the process and to generate some valuable and informative data from the discourse emerging from the research group meetings. The

midwives actively chose not to participate as fully fledged co-researchers and this was ultimately their decision. As such they were still actively engaged in the PAR process albeit in a self-determined and modified way.

An Agenda for Change

Dahlen (2006) suggests that midwifery is a deeply political arena and that midwives must be change agents by virtue of working in the area of women's health. "…everything we do to women, the way care is structured and delivered, impacts on women and their babies" (p.5). The sphere of maternity care is certainly one of perpetual change and midwives are often at the forefront of facilitating the change endeavouring to ensure that change is both positive and sustainable (Brodie, 2002). However, any deliberate introduction of a change agenda carries the possibility of challenging long held values and beliefs (Ratner, 2004; Marshall & Toffel, 2005; De vries & Petersen, 2009). Consequently this may result in disruptive change to the ways that individuals see and work within the world. This may entail a 'leap-of-faith' on the part of at least some of those involved.

Having been a long term advocate for the benefits of more sustainable ways of being and doing, I acknowledge that I hold long term ideological beliefs and I that cast myself in the role of 'change agent' when I set out to undertake this thesis. If I am to be honest with myself, I believed that I would be able to communicate a sense of the need to change to more sustainable ways of being to the midwives in the group and then work with them to translate this into action. I imagined that by participating In a PAR study they might be motivated to adopt the innovative ideas generated and to promote and disseminate them. I felt that a group of people who are connected to one another (such as the midwives in the research groups) would be more likely to be a socially cohesive unit, which would lead to greater levels of support and a shared understanding (Battilana & Casciaro, 2013) thus further strengthening the possibility of change.

On reflection I can see that I was adopting a simplified approach to a complex situation fraught with wicked problems. In reality the aspiration to act as a catalyst for change in a socio-political context is deeply embedded in identity involving core values and sense of self (Ratner, 2004; Marshall & Toffel, 2005; Harre et al., 2009) and my hope of effecting an agenda of change was not borne out in the way that I had perhaps naïvely anticipated. As previously noted, the desire to craft this thesis came from my own strong ideological roots that are identified in my intellectual autobiography. Although the data generated from the research group meetings was rich and offered good insight into how the midwives viewed sustainability, it did not serve my deeply held need to establish a way in which change might be initiated within my profession. During the data generation phase of the process, I found myself becomingly increasingly discouraged by the reluctance of the groups to fully participate in the way that I had hoped that they would. Although the midwives who 'participated' in the study were willing to offer their time and thoughts within the research group meetings, they were unable or unwilling to take on a greater level of participation as co-researchers.

My use of PAR as a methodology was intended to facilitate change. The term 'action' in research indicates that the research is designed to contribute to change efforts or accompany action by those involved. The reality from the outset was that the design could never have been PAR in its purest sense, and was always going to be at best a methodological hybrid, because unlike the original PAR studies, this was not a grass roots response to a perceived problem within midwifery practice on the part of those involved. PAR had emerged from a research tradition, where oppressed groups were encouraged to use the methodology for emancipatory purposes and to achieve empowerment (Susman & Evered, 1978; Calhoun & Karaganis, 2001; Fals-Borda, 2001). Having explored the methodology at length, I now recognize that the reluctance of the groups to fully participate is not an uncommon event within this methodological sphere and frustrations relating to the full participation of those who are recruits rather instigators can create methodological problems within PAR projects (Bergold & Thomas, 2012; Goeke & Kubanski, 2012).

From reflection to reflexivity.

What helped me to make meaning from this emerging state of affairs was the fact that as the data gathering proceeded, I found that I was personally moving beyond the territory of reflection and further into the realms of reflexivity. It may be useful at this point to further distinguish between reflection and reflexivity which are sometimes used interchangeably. Reflection[30] is described as a component of learning and thinking. We reflect in order to learn something, or we learn as a result of reflecting, and the term 'reflective learning' emphasises the intention to learn from current or prior experience" Reflection promotes self-questioning and thoughtful consideration on one's experience by connecting practice or experience with theory. (Schon, 1987; Moon, 2004). Reflecting on practice is said to be a deliberate activity that has structure and methods that can be learned (Jasper, 2003; Moon, 2004). There are many models that are used to create a framework for reflective learning such as those of Gibbs (1988) and Mezirow (1990). Reflexivity in contrast is said to include an additional layer of internalisation, whereby the learner is fundamentally changed as a result of experience in addition to its intrinsic learning value. (Hibbert & Cunliffe, 2013).

I found it difficult at times to extricate my midwifery self from my researcher self, and both from my personal self. I found the work of the German philosopher Hans-Georg Gadamer (Gadamer, 1976) to be useful in this context. In his work around hermeneutics, Gadamer promoted the idea that a person cannot be separated from their own historical and cultural environment and the fusion of the existing values and biases from this reality with the values of other 'cultures' that enable an individual to create knowledge. I feel that my sense of

---

[30] Reflection is seen as a tool used to facilitate change and is prevalent in health care practice and education. Midwives are encouraged to work within a framework of reflective practice. Reflective practice is incorporated into the vast majority of contemporary midwifery curricula in New Zealand and other countries, and the midwife is encouraged to examine their practice with a view to making changes for the future where necessary (Polomeno, 1999). Midwives use reflection for addressing clinical situations at practice meetings, raising issues within their biennial Midwifery Standards Review, and for other areas within their working lives.

reflexivity developed as I found myself questioning my own attitudes, assumptions and biases whilst grappling with the complexity of my role in relation to the others in the team.

Data Recording

The data gathering procedures took place over a 12 month period in total. All of the meetings were digitally recorded and the recording was transcribed verbatim by a professional transcriber who had signed a confidentiality contract. I listened carefully to the recordings before delivering for transcribing in order to gain immediate clarification and recall of the conversations and the contexts and made notes at that stage. This note expansion approach is said to help to retain the significant points of the discussion concisely (Bertrand et al., 1992). In order to ensure the accuracy of the data, once returned from the transcriber, I read the texts myself again in the knowledge that a slight grammatical error can change the meaning perceived from the content (Boyzatis, 1998). Finally the transcripts were sent out to the group members for verification. This offered the midwives the opportunity to check the accuracy of the previous discussion and for them to respond to and clarify either individually or as a practice. They made some typographical and grammatical corrections, but this was something that they did individually, never collaboratively. The group members were invited to comment on interpretation, but none of the group members commented directly on interpretation.

Data Analysis

The data used for the study included eleven transcriptions which represented 28 hours of recorded interviews. It also included my research journal entries and spontaneous non-recorded interviews and memos that were generated over the course of the fieldwork stage of the study.

Once the amended transcripts had been returned by the midwives, I chose to eliminate what I considered to be extraneous information and to incorporate relevant field notes into the transcription.   I acknowledge that this does not fulfil the philosophical ideal of participation of PAR at all levels including data analysis (Bergold & Thomas, 2012). I appreciate that when the process includes this step, the research 'partners' are enabled to gain insight into the background of their own and other members viewpoints creating what has been described as an "Ethic of Voice" (Riecken et al., 2005). However, in my study, as I have already reported, the midwives were not really interested in moving beyond the accuracy stage of the transcript process. I returned again to the Schneider model and conceded that I had been unable to reach beyond the consultation level where participants are regarded as having knowledge that may be valuable but I retained the overall control by making decisions about what should be retained or eliminated (Schneider, 2010).

The process of analysis was therefore not fully inclusive within the framework of PAR, but the midwives seemed to be satisfied with this arrangement, so in principle it was a consensual and collaborative decision.

Analytical method

I chose to use Thematic Analysis (TA) in order to identify, analyse and report patterns emerging from the data as well as to interpret various aspects of the work . I recognise that Thematic Analysis is sometimes reproached for lacking sophistication as a method, but it can be countered that the theoretical framework chosen by the researcher will inform the use of TA (Braun & Clarke, 2014). Having used PAR which is a methodology without a prescribed analytical element in the way of 'branded' methods such as grounded theory (Strauss & Corbin, 1998), or interpretive phenomenological analysis (Heidegger, 1998), I needed an analytical method that was flexible and inclusive. One of the strengths of TA is that it can be used to analyse almost all forms of qualitative data (Boyatzis, 1998; Braun & Clarke, 2014). Additionally, TA is described as the most common and the simplest form of analysis in qualitative research (Javadi & Zarea, 2016). and at the point of making the decision, I had not completely discounted the possibility of further involvement on the part of the participating

midwives and Thematic Analysis would have been easier for novice co-researchers to comprehend than a method such as discourse analysis.

Braun and Clarke (2006) state that TA can be used as an essentialist/realist method, reporting meanings, experiences and the realities of the research participants, or as a constructionist method that explores the way in which the experiences, realities and meanings are the effects of a range of discourses operating within society. My use of TA is best described as 'contextualist' which sits midway between the essentialist and the constructivist positions. It acknowledges the way that the participants make meaning of their experience and how the broader social context impacts on that meaning whilst maintaining focus on the material and other limits of reality. In this way TA can be used to reflect reality whilst simultaneously clarifying that reality (Javadi & Zarea, 2016). A data driven inductive analytic approach is recommended for less structured data gathering such as focus groups. (Fereday & Muir-Cochrane, 2006).

Themes and Sub-themes

By following the framework developed by (Braun & Clarke, 2006; 2014) the dataset was coded manually, identifying interesting features of the data across the entire data set, and relevant data extracts were collected. I decided not to use a computerized programme for the process in the belief that a manual method would allow greater immersion in the process which would enable greater familiarization. These codes and collated data were then examined to identify potential themes. The themes were then reviewed and redefined where necessary and named. A thematic map of the analysis was created.

The themes that emerged from the analysis were as follows:
1. The role of the midwife
2. Rapidly changing world
3. Consumerism
4. Sustainability

Both themes and sub-themes can be seen in Figure 7.
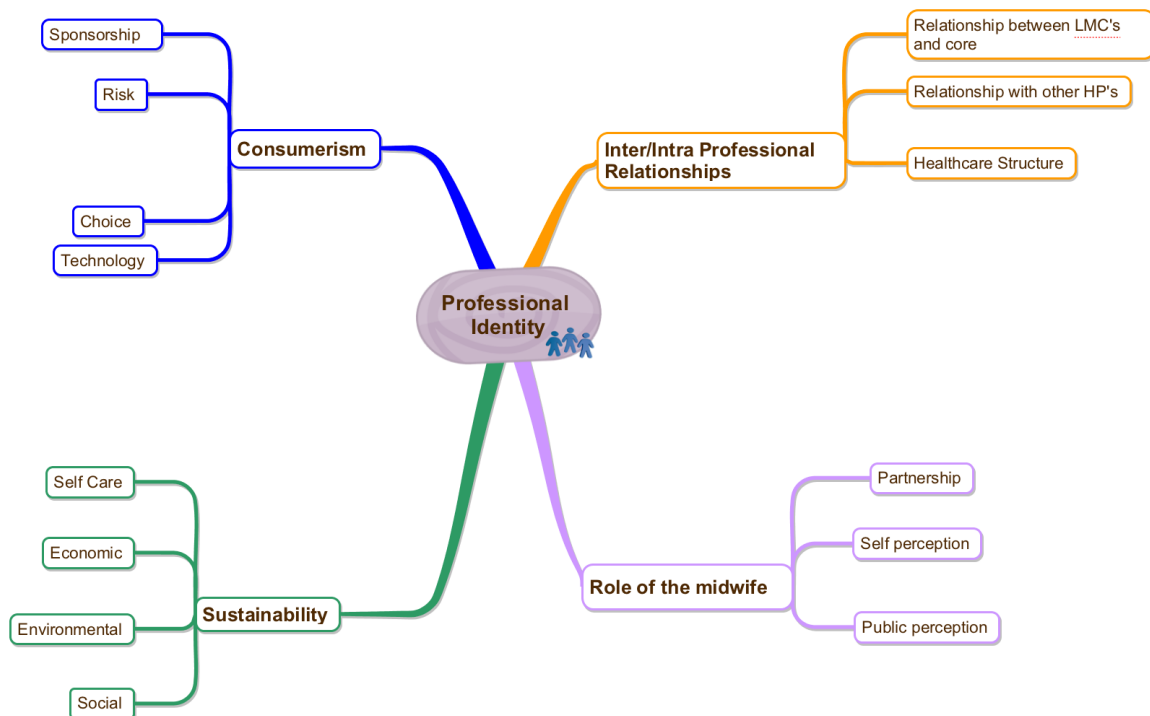
Figure 7: Themes and sub-themes

A feature of an inductive approach is that the participants may not go where the researcher anticipates that they will go (Anderson, 2010) and during this stage of the analysis it became apparent that the broad concept of sustainability was of far less consequence to the midwives than professional identity. This was the pivotal theme in the data and was seen in almost every issue raised by the midwives. Professional identity was used to relate to how the midwives interpreted both their role and responsibilities particularly in relation to the role of the midwife. Professional identity was raised in discussion around both intra- and inter-professional relationships as well as those with women and their whānau/family. Professional identity also featured in much of the discussion around factors relating to sustainability often around why changes would be difficult to implement. My philosophical standpoint as a researcher with an interest in feminist and emancipatory theory, led me to reflect on this change of direction. My overarching interpretation of the initial thematic analysis of the data was that it seemed that the factors that that were preventing the

midwives from engaging with sustainability, were possibly the same as those that they felt challenged their professional identity and thereby the sustainability of the midwifery profession. My thesis had evolved from the intended focus and the original questions had in many ways been addressed. However the midwives had inadvertently provided an impetus to continue and explore further their perceptions around their professional identity and the professional sustainability of midwifery practice.

A Change in Direction

From the data that had been produced it was necessary to decide what was going to be useful in terms of informing the new direction of the research and what was superfluous. In order to achieve this I had to redefine the goals of the research. The goals of the research had become focused on professional identity and the questions were reframed to:

1. What factors contribute to the professional identity of midwifery ?
2. What factors impact on the professional sustainability of midwives in New Zealand/ Aotearoa?

Thematic analysis is said to have "limited interpretative power beyond mere description if it is not used within an existing theoretical framework that anchors the analytic claims that are made" (Braun & Clarke, 2006, p. 97). I recognized that in order to analyse the data satisfactorily, I had to utilize a theoretical framework that would ensure that the analysis was broad enough to encompass the diverse range of entities that appeared to be contributing to the complex interplay of influences linked with the sustainability of professional identity for the midwives in the research groups.

I had been introduced to Actor Network Theory (ANT) as a theory that addresses the co-evolution of inter-actants in the network by using the process known as 'translation' to demonstrate how ANT driven results connect with the existing knowledge of the network

(Dankert, 2011). ANT calls upon a translation process to determine how the actants are associating and forming the networks in which they function. The translation process can be used to investigate phenomena. Within the framework the focus is not on the actants themselves but on the relationships that they form within the network. In Chapter 4 I will introduce the concept of ANT before continuing to demonstrate how it was used to explore the data.

Conclusion

In this chapter I introduced the methodology of PAR and deliberated on why it did not work within my study in the way that I had anticipated. I considered the methods utilised, and explored whether they may have contributed to this outcome. I also outlined the reflexive stance that I had adopted. Analysis of the data would reveal that the inability of the midwives to engage fully with the subject of sustainability was more complex than I had originally foreseen. On reflection, I recognize that my initial response to what I perceived to be a lack of commitment to participate on the part of the midwives, was solipsistic. I deduced that PAR had not worked as effectively as it might because I had not fully considered intrinsic factors such as power differentials, time commitments and other factors. That is not to say that these factors did not contribute to the less than optimal articulation of methodology with participant engagement, but I assumed that these factors had militated independently to prevent the midwives being able to offer complete involvement in the study. I had been so busy focusing on the matter of sustainability that I had not initially recognized some of the other discourses that were emerging during the data generation process. However, as I began to draw on the salient themes and sub-themes during the data analysis, a different narrative began to emerge and the possibility that there were other extrinsic factors at play transpired. I required an analysis schemata that would enable a social critique on a much larger scale than I had originally imagined. I was to find this in the shape of Actor Network Theory.

Chapter 4. Actor Network Theory – a Change in Focus

Introduction

I recognized that in order to analyse the data satisfactorily, I had to utilize a framework for analysis that was broad enough to encompass the diverse range of entities that appeared to be contributing to the complex interplay of influence linked with the sustainability of professional identity for the midwives in the research groups.

I was initially drawn to both assemblage thinking and Actor Network Theory (ANT). Both have been identified as useful for "enabling rich analyses of contexts" (Fenwick & Edwards, 2010, p. 4). It is stated that these theoretical standpoints can both be seen as part of a paradigmatic shift from the "language, representation and discourse concepts of the 1990s, to the heterogeneous, networking and materiality focus of the early twenty first century" (Müller, 2015, p. 29). Both Assemblage Theory and Actor-Network Theory can be used in a variety of different ways as concept, ethos and descriptor. This diversity means that neither can be exclusively owned by any one research tradition. There are commonalities in how they are deployed however, and this gives insight into how they can be used. They are both frequently used to exemplify complexity, emergence and indeterminacy within a range of different fields of research (Anderson & McFarlane, 2011). The strongest link between the two has to be, however, that they both emphasise that what goes on in the world shapes it, and not the other way round (Heeks & Stanforth, 2013).   Müller (2015) describes the emergence of ANT and other assemblage theories as a "return to a concern for materiality", and a move away from the "language, representation and discourse concepts." (p. 28). However, this does not exclude these elements from a network.

Having explored both concepts, I eventually elected to work primarily with ANT because although it has many parallels with assemblage theory, is more empirical in its approach and has been refined through a range of concrete real world situations (Müller 2015a). ANT has

been appropriated and adapted by many academic fields, including sociology (e.g Mützel 2009), anthropology (e.g. Oppenheim 2007a) and international relations (e.g. Barry 2013).

Actor Network Theory

Broadly viewed as an affiliate of the anti-essentialist movement , ANT was formulated within the field of science and technology studies (STS) in the 1980s using a strongly ethnographic focused approach. It evolved from the work of Bruno Latour (Latour, 1986; 1992; 1993; 1996; 1999a; 1999b; 2005) and Michel Callon (Callon, 1986a; 1986b; 1987) at the Ecole de Mines in Paris and was refined later by the British theorist John Law (Law, 1992a; 1992b; 2002; 2007). Described as a "systematic way to bring out infrastructure that is usually left out of the "heroic" accounts of scientific and technological achievements" (Goguen 1998) ANT set out to acknowledge the importance of parts played by both subjects and objects in scientific research. Although the theory is influenced by the radicalization of sociology of science and technology propounded by Kuhn (1970) and Bloor (1983), it contains elements from a broad range of intellectual traditions including Foucauldian perspectives on power and knowledge and the philosophical teachings of Michel Serres (Cressman, 2009; Cresswell, Worth, & Sheikh, 2010). Latour (2005a) speaks of the work of Gabriel Tarde as an "early ancestor" of ANT because he used more of an inductive method to of explanation in his work pulling on what might be considered to the less important micro detail to create a macro portrayal of the world. From its roots in Science and Technology studies (STS), ANT has been appropriated and adapted by many academic fields subsequently, including sociology, anthropology and international relations.

In their network theory, Latour, Callon and Law, developed a language that does not distinguish between humans and non-humans, the subjective and the objective (Fenwick & Edwards, 2010). ANT treats both of these elements as 'hybrid entities' that are part of social networks designed to analyse situations where separation of the individual components is problematic (Callon, 1997, p. 3). In enunciating the character of non-human agency, ANT unravels any division between the semiotics of modern binaries such as society and nature, agency and structure, content and context, micro and macro and human and non-human

(Ritzer & Ryan, 2011; Banks, 2016). Everything is society and society is everything. The 'actor'[31] in ANT is therefore firmly heterogeneous and the term includes individual as well as collectivities of humans; non-humans including animals, technology and documents and intangible elements such as concepts and institutions.

The inclusion of both subjects and objects as actants has challenged both the fields of scientific research for its relativist positioning, and the social science fields, where it was claimed to be positivist in its approach by stating that that scientific facts exist independently of human activity (Ritzer & Ryan, 2011). The latter argument has led to a debate that challenges the limits and meanings of social constructivism (Callon & Latour, 1992). However, ANT can be seen to differ from social constructivism, which sets out to uncover the ways in which individuals and groups participate in the construction of their perceived social reality. ANT includes more than human perception and emphasizes the significance of material objects in the construction of knowledge.

ANT has equally been held to account for its inclusion of the word 'theory'. This criticism has been levelled, not least, by the originators of the 'theory'. Theories generally are used to explain why something happens and fit within a testable, predictable and explanatory model. ANT conversely focuses on how associations are made and transfigure (Latour, 2005). As identified above, even the originators of the theory have frequently revised aspects of the approach using a wide range of alternative titles including, the sociology of translations, (Callon, 1986a); the sociology of associations (Latour, 2005); actant-rhizome[32] ontology

---

[31] Latour has expressed misgiving about the use of the term 'actor' and has used the term actant as an alternative because 'actor' suggests a human entity whereas actant can more readily accommodate non-humans as an unfamiliar term (Latour, 1996) It has also been suggested that the word actant also effects a shift from the entity that is the origin of the action to the action itself (Dankert, 2011).

[32] In botanical terms a rhizome is a continuously growing horizontal underground stem which puts out lateral shoots and roots at intervals. Deleuze & Guattari (1987), the initiators of assemblage theory use the terms

(Latour, 2005) Co-Word Analysis (Callon, Rip, & Law, 1986) and enrolment theory (Ritzer & Ryan, 2011). The alleged confusion created by ANT at one stage led to the founding theorists to call for an end to ANT as an approach. It was claimed that it had been adapted and translated by so many that it had altered into something else. In the words of Latour (1999b) "...there are four things that do not work with actor-network theory; the word actor, the word network, the word theory and the hyphen! Four nails in the coffin."(p. 15). Latour now takes the stance that ANT is "a name that is so awkward, so confusing, so meaningless that it deserves to be kept" (Latour, 2005, p. 9). Gad and Jensen (2010), argue that ANT is only considered a theoretical perspective because it is wrongly assumed that it always arrives at the same conclusion. That is, no matter what the area of enquiry, the purpose is to establish that actants are enmeshed in networks. They continue to suggest that far from this being the case, the ethos of ANT is to not to apply any presuppositions, and that such assumption eschews the ANT principle of no priori assumption.

It is now, however, broadly accepted that whether it is referred to as a theory or method, the approach is often usefully employed as a range of practices rather than a concrete set of concepts. Cressman (2009) describes it as a frustrating paradigm because it cannot be pinned down to a "catch all theory that can be universally applied." (p. 3). However, this could be viewed as bestowing a radical quality that can lead to the reconsideration of taken for granted ideas (Ponti, 2011). In this light, the non-specific nature of ANT can be viewed as a positive feature that allows researchers to observe in detail how relations among people, groups, things, institutions, and concepts are created, maintained and transformed over time without being entirely prescriptive.

Ontological and Epistemological Positioning

"rhizome" and "rhizomatic" to describe theory and research that includes the principles of connectivity, heterogeneity, multiplicity, regeneration and anti-genealogy.

73

ANT is said to have its own ontological and epistemological positions as a result of considering the world as existing as networks (Law, 1992). Philosophically ANT does not sit comfortably with either modernism or post-modernism. Supporters of ANT argue that reality itself does not exist intrinsically as such, but the construction of reality is achieved through the interplay of the actants within the network (Callon, 1987; Latour, 1999b; Latour, 2007). ANT views all factors, human and non-human, as actants that promote the implementation of action. In order to attend to the need to treat both human and non-human actants equitably, the principles of agnosticism, generalized symmetry and free association are used (Callon, 1986b). These three principles decree that there should be no distinction between the social, conceptual, natural and technological by demanding analytical impartiality of both human and non-human entities (agnosticism); the use of an abstract and neutral vocabulary, such as the use of the term 'actant' (Generalised Symmetry) and the exclusion and rejection of assumptions between the entities (Free Association) (Tatnall & Gilding, 1999). In following these three principles, ANT is theoretically free from a binary perspective and can examine non-human actants and their relationship with humans without bias . "The human is not a constitutional pole to be opposed to that of the non-human. The two expressions 'humans' and 'nonhumans' are belated results that no longer suffice to designate the other dimension" (Latour, 1993, p. 137) Purposeful action and intentionality may not be properties of objects, but they are also not properties of humans either. They are properties of institutions [collectives of humans and non-humans], apparatuses, or what Foucault called dispositifs (Latour, 1999a, p. 192).

However, the suggestion of ANT as a non-hierarchical or flat ontology has led to fierce opposition to the notion that objects potentially have power over humans, which has been interpreted as challenging the concept of human agency. (Dankert, 2011). It has led to ANT being described as a post-human concept by suggesting that non-human objects such as technologies and concepts have the potential to shape social interactions as much as their human counterparts, thus ostensibly granting them agency (Cressman, 2009; Kipnis, 2015). Latour (1999a) however, insists that there is a marked difference between human and non-human agency and that an actant cannot take action alone as it is reliant on its relationships

with other actants in the network in order to effect action and change. Latour (1999b) continues to explain that there is also a difference between 'objects' and 'things'. An object brings to mind stability as something that does not change, such as a table or a hat. However, a 'thing' presents a more abstract construct that is less stable than an object and capable of change. This could include a legal act, or a political ideology for example. The important thing is that nothing in the network has an a priori [33] relevance, and consequently presumptions cannot be made.   This position accentuates the radical position of ANT in relation to classical sociology which assumes humans to be of greater importance than objects or things. As a result, ANT can be seen to present a new way of questioning reality and even of re-conceptualizing what reality is and in so doing it is argued has created a new ontological position (Cordella & Shaikh, 2006).

The Network

In addition to his concern with the use of the term 'actor', Latour also critiqued the use of the word 'network' which he felt was open to misunderstanding as a static grid like structure rather than an ever evolving dynamic process (Latour, 1996). He argues that the notion of networks has localised the universal and suggests that the 'work' component of the term had become foregrounded and that 'worknet' may be a better option (Latour, 2010). It is important to stress that the actants themselves do not constitute the network. Actants enter into networked relationships which then "define them, name them and provide them with substance, action, intention and subjectivity" (Ritzer & Ryan, 2011, p. 1). The actants in a network acquire the form that they do as a result of their interaction with one another. This supports the no a priori essence of ANT as the actants only derive their form via the networks. Additionally, the actants themselves are amalgamations of symbolically endowed

---

[33] A Priori is a philosophical term that is used in several different ways. In this context the term is used to define knowledge that is gained through deduction, rather than through empirical evidence (Landaur & Rowlands, 2001)

identities, relations and inscriptions that are also networks themselves, and which can be located within other diverse networks. This liberal and democratic approach resulting from an ANT approach has vexed some critics who accuse it of being so liberal that "it has no other………it has made itself into a 'final' final vocabulary" (Lee & Brown, 1994, p. 774)

The anti-dualism and anti-determinist nature of ANT is said to lead to accounts that are descriptive rather than analytical (Law,2007). Latour (1996) dismisses this by stating that in ANT, the researcher has to follow the actions of the actants and strive to avoid inflicting generalized and abstract values on what they are analysing. Following the actants, sometimes referred to as analytical tracing (Oppenheim, 2007a) is the primary operational principle of ANT. It is a confusing precept because of the potential number of actants within a given network including those who may appear or disappear before a final network is achieved (Cressman, 2009). Because of this the network builders are generally the primary actants to be followed. This is achieved by establishing a point of origin and then investigating who and what the network builders are in the network, how they became part of the network and how interests are interpreted (Fenwick & Edwards, 2010). The associations or links between the actants must be followed because they are the effects of power that leads to change. Therefore, connection alone is not enough, the actants need to be actively engaged in the network, working to maintain and create order as part of a collective existence. As long as the actants continue to interact, the actant network will externally at least appear stable (Fenwick & Edwards, 2010).

Translation

Networks can be intensely dynamic and inherently volatile, with new actants being enrolled into the network and ensuing jostling for position (Law, 1994). This process is referred to as 'translation' and frequently involves a displacement of an actant from one status to another (Callon, 1986a). It is considered to be a core concept within ANT and as such led Latour to call for a change in the name of the theory to a 'sociology of translation' (Latour, 1996). Translation describes what happens when the entities come together and connect, changing form as a result. This can occur as a result of the action of one or sometimes more of the

actants reinterpreting or relocating the interests or even the identity of those in the assemblage in order to align the interests of these other actants with their own (Garrety, 2013). If actants have not been translated or translated themselves, then they are not part of the actor-network (Ritzer & Ryan, 2011)

Horowitz (2012) describes translation as "an attempt to define and control others" (p. 809). ANT proponents deny this accusation relating to power arguing that powerful elements in networks are contingent and temporary and in many conventional senses they have little power. (Law, 1992; Fenwick & Edwards, 2010). Furthermore, powerless entities can be become empowered by forming networks. Supporters of ANT theory additionally argue that ANT can help us to understand who is excluded in networks, why they are excluded and how networks might be developed that run counter to dominant hegemonies (Fenwick & Edwards, 2010). Interestingly, Law (1992) advocates that ANT is simultaneously "all about power" (p. 387), but that "that notion of power should be abandoned" (p.278) because power can effectively be seen as composed within a network and not exerted. Additionally, far from being something that occurs in isolation, translation creates ripple effects or 'chains of translation' (Latour, 1987a)where thoughts, behaviours, actions, and effects are carried from actant to actant with each adding an element of their own to the sequence. However, the components can be can be stabilised when the entities that make up the network are realigned.

Such alignment are stated to result from the completion of the four stages of translation which are problematisation, interessment, enrolment, and mobilisation. During problematization the actants identify what constitutes a problem, resolve to solve it and define the critical actants.   Different actants may perceive different issues of concern within the same situation at this point and ANT acknowledges plurality of viewpoints. However, consensus must be achieved and the focus of ANT is then to identify issues that all of the actants will sign up to address. At this point, a concept that Callon (1986a) developed called the obligatory passage points (OPP) becomes activated. The OPP is effectively the gateway into collective action and allows some actants to become more powerful in their capacity to

translate other actants. Some OPP's may exist as 'centres of calculation' that have to be negotiated by the actants in order to satisfy the interests that have been attributed to them by the primary actant (Gulson, Clarke, & Petersen, 2015). They may be regulatory bodies, senior managers, or other individual or collective actants that are nodes within the network and bring together other actants as resources. These enable the actants to mobilize extensive networks. Once they have persuaded or coerced other actants to support and follow their lead, the interessement stage of the process is activated. In enrolment, these critical actants grant qualities to and motivate other actants to establish roles that will change the network (Tatnall & Gilding, 1999). During mobilisation, the emerging network gains further endorsement as it becomes more durable which can potentially lead to the establishment of irreversible translations. This occurs when it becomes untenable to return to a point where there are any alternative positions (Callon, 1986a). ANT serves to explore how the connections came to be and what sustains them and what leads to change. It includes the examining of negotiations, forces, resistances and exclusions that are at play in micro interactions. Translation is the process that generates ordering effects such as devices, agents, institutions or organisations (Fenwick & Edwards, 2010). The process of translation is very important in the context of midwifery as it is principally what has kept midwifery alive in many contexts at many times in history. This will be examined in depth in a number of further chapters.

Punctualisation, Intermediaries and Mediators

When translation has succeeded the network actants are mobilised to assume a particular role and perform in a certain way (Saldanha, 2003). Following translation, and once a degree of stability has been achieved, the complex networks of ANT are said to disappear from view. The complex assemblages are "replaced by the action itself and the seemingly simple author of that action" (Law, 1992, p. 385) This is known as punctualisation or 'black boxing'. The 'black boxes' are configurations of human and non-human actants that have acquired a 'taken for granted' status. That is, even though a network of heterogeneous entities lies behind

everything, the individual entities are also made up from networks and "the reality is infinite" (Callon, 1987, p. 93). However, networks are to a greater or lesser degree unreliable and can become unstable at any time. The entry of new actants, the exiting of existing actants as well as rearrangements of alliances can lead to black boxes being opened and their contents reconsidered (Latour, 1999a).

ANT places a high level of significance on what are referred to as intermediaries and mediators. These are entities that move throughout a network where they carry out specific tasks that act to create a degree of stability within the network. Intermediaries operate by relocating the power of another actant without transforming it. Examples of intermediaries are documents or financial resources. These entities can be used to maintain social order, but conversely can be used to destabilize the same. They facilitate connection between groups of actants but can be ignored and undermined without creating major shifts (Oppenheim, 2007). They are therefore viewed as passive elements (Pyyhtinen & Tamminen, 2011). Mediators on the other hand are active entities. They are said to shape the 'social' "making it bifurcate in unexpected ways" working through "flows of translations" (Latour, 2005, p. 202). Within this milieu, translation is viewed as a range of processes that include negotiation, calculation, arbitration and even acts of violence. Any act where the actant takes it upon themselves to act as the spokesperson for another, either with their support or otherwise. According to Latour and Callon (1981), if an actor speaks of 'us' they are actually transforming other actants into a singular state of being of which the 'translator' becomes the representative.

ANT within the context of my study

Although ANT is becoming more visible in health related research, I discovered that there are very few existing studies that have used ANT for researching issues relating to midwifery practice. I did manage to locate a limited number of sources such as the thesis produced by Jette Clausen, a Danish Professor of Midwifery, who used ANT within the context of STS to

explore relational aspects of technologies such as epidurals and fetal monitors within the birthing environment (Clausen, 2010). Another example is the work of midwife Christine Kenney, (Kenney, 2009) who used ANT in her 2009 doctoral thesis to explore miscarriage, combining ANT with other theoretical approaches. However, Kenney's work is the only example of a New Zealand study that I have been able to locate that has any direct application to midwifery practice.

The central actants that I identified to follow in the network emerging from my research are midwives. I appreciate that this decision could be levelled as a subjective one, that is one of me imposing the worldview of myself as researcher on the analytical process. It can be countered, however, that ANT requires a high level of reflexivity on the part of the researcher (Cowan, Morgan, & Mcdermont, 2009; Cresswell, Worth & Sheikh, 2010; Sheehan, 2011). Additionally, I have stated my positionality at length in earlier chapters and I fully acknowledge that this is one world view of many that might be extrapolated from the network. Additionally, action does not necessarily originate in the actor that is seen to act. Action is the consequence of the actions (or translations) of other actants that may be co-located in time and space with the entity followed or may result as a consequence of events that are distant in time and space (Latour, 2005, p. 44).

The Complexity of the Network

In spite of a dearth of evidence of ANT within my sphere of practice, as I gained familiarity with it, ANT seemed to present a valid tool for framing the analysis of the data generated (Gad & Jensen 2010). There are a number of reasons why this was the case.

Firstly, complexity is broadly recognized to be an integral feature of maternity services and in the delivery of midwifery care, both at a local level (Guilliland & Pairman, 2010; Skinner & Foureur, 2010; Davis & Walker, 2013) and more globally (Lankshear, Ettorre, & Mason, 2005; Mander & Murphy-Lawless, 2013). This complexity creates an elaborate interweaving of

relationships that can make it difficult to locate specific issues relating to midwives, because midwifery is essentially tied up with other players in the tableau of maternity services (Skinner & Dahlen, 2015). This status reflects the essence of ANT which describes the interaction of groups of 'actants' who have sought to define their position within a complexity of networks (Callon, 1999; Ritzer & Ryan, 2011). I therefore felt that ANT could provide a useful lens for exploring the non-linear pattern that the associations within my data had identified and offer a framework that would facilitate insight into how midwives played into, or were affected by, the complexity in relation to other actants. This was a pragmatic response to dealing what felt like a wicked problem in terms of the complexity, albeit on a micro level.

Objective and subjective actants within the network.

I also reasoned, from what the midwives had discussed, that although human relationships were viewed as instrumental in the perceived professional identity of the midwives, there were other significant entities that were non-human in form. These included, for example, policies and protocols, technologies, political ideology, and history. The domain of midwifery is and always has been, fluid and dynamic. Historically, midwifery has shifted from one position to another, from a state of autonomy to one of subjugation, and this reshaping has been influenced by the presence of a wide range of non-human objects (Ehrenreich & English, 1973; Donnison, 1988). These 'objective' actants have been influential in how midwives viewed their world and have played an active role in the networks occupied by the midwives. Bennett (2009) asserts that "humans need nonhumans to function more than nonhumans need humans" (p. 151-2). What this suggests within an ANT context, is that although humans instigate and mediate some of the actions of non-humans, virtually all human action is mediated by objects, not other humans. The texts, policies, legal documents and financial resources in the network play important roles. They encourage stability, facilitate mediation between actants and enable the connection and maintenance of groups of actants within the network. Conversely, there are times when they are able to

www.manaraa.com

manipulate meaning or to transform the elements that they are supposed to be supporting within the network of relations (Oppenheim, 2007; Pyyhtinen & Tamminen, 2011). The midwives referred to the impact of technology, for example, as a mediator with the ability to change things considerably within the system, whilst the impact of legislation had mediated a change that played into the hands of the midwives and gave them greater power.

Issues of Power

This leads into the third reason why I felt that ANT was an appropriate tool for analysis. The issue of power, particularly patriarchal power is pervasive in contemporary midwifery practice in New Zealand/Aotearoa as it is in other western healthcare settings. The existence of power relationships and the need to manage these disparities therefore is a strong theme within the literature associated with the sociology of midwifery (Edwards, 2004; Skinner & Dahlen, 2015). The vested interests of midwifery, medicine, obstetrics and institutions, compete to define concepts such as risk and safety within a range of diverse value and belief systems (Symon, 2000; Skinner & Foureur 2010). The issue of power is also present in the relationship between the midwife and the women who access midwifery care. The rhetoric of equality within what is deemed to be a collaborative relationship centering around the notion of partnership, is a central focus of academic attention in midwifery in New Zealand/Aotearoa (Freeman, Timperley, & Adair, 2004; Pairman, 2005).

The work of Foucault on the construction of power, truth and knowledge has been frequently cited in midwifery research and used as a model for analytical purposes in many studies (Brown, 2002;Fahy, 2002; Surtees, 2003; Davis & Walker, 2013). Although ANT shares a Foucauldian micro-sociological perspective, there are marked differences in the two approaches. Foucault describes power as diffuse and omnipresent, something that is not a structure or a possession. The dispositif, is a term used by Foucault that refers to collection of institutions, groups and discourses that are viewed as disparate; they are not networked entities even though they do serve to create a state of normalization within a social context (Foucault, 1978). In ANT, power is created within a relational context as the result of the struggle for order within the network (Law 1992).

82

Within the perspective of ANT, the analysis of power becomes the study of associations. ANT is concerned with understanding how networks overcome resistance; reinforce their position; stabilise into a state of consistency; systematize juxtaposing elements; translate network elements; dissuade actants from pursuing their own interests; enrol new actants into the network; grant attributes and inspire actants; become progressively transferable and useful; and how they become functionally imperative (Callon, 1986a; 1986b; Latour, 1996; 2005a; Law, 2007). Power cannot be viewed as possession but as a consequence of the number of entities that are networked, and it is generated in in a relational and distributed way that results from ordering struggles. Interestingly in his later writings, Foucault plotted an ascending analysis of power in order to explain how an event reaches a conclusion and then moves on (Foucault, 1980). In this light, Foucault speculated that power, far from being homogenous, was in fact networked (Pyyhtinen & Tamminen, 2011).

The possibility of using ANT, instead of the more obvious Foucauldian route, to follow power relations within the context of maternity care felt inciting and innovative. Through the lens of ANT, the connections between the actants influence outcomes such as power relations. Those who are powerful, do not necessarily 'hold the power' in an assumed manner, but they are able to enrol, persuade and procure the support of others into associations on terms that allow these initial actants to represent the interests of others (Latour, 2005a). This seemed to offer an original and critical version of power that acknowledges actants and discourses and the differential scale on which power functions (Murdoch & Marsden, 1995). I was surprised that ANT had not been used more as a theory or analytical tool to explore and unravel the complex threads of the networks occupied by midwives.

Controversies within the Network

Finally, ANT makes connections between controversies (Latour, 2005; Venturini, 2010). Controversies are complex phenomena and can be seen as situations where disagreement

83

arises (Coser & Larsen, 1976). Dewey (1922) once described controversy as something that "stirs us to observation and memory. It instigates to invention. It shocks us out of our sheep-like passivity, and sets us at noting and contriving. ...Conflict is a sine qua non of reflection and ingenuity" (p. 300). This statement resonated and motivated me. The actants cannot ignore each other and have to engage and the controversy ends when a compromise that enables things to return to normal or to re-establish in a different form. In ANT, controversies occur when the most heterogeneous of relationships are formed and they display the social[34] at its most dynamic (Venturini, 2010). New conflicts may emerge and old opponents become allies. Latour devised and taught a didactic version of ANT in the form of a system that he named the cartography of controversy (Venturini, 2010) . This practice involves taking a controversy and using different perspectives to explore the root and development of the controversy. The idea is not to come up with a solution for the issues, but to bring in as many actants as possible so that there is a strong range of perspectives to support decision making around controversial subject areas. It theoretically allows for co-construction and sharing of a well-established history of controversy, from the fate of the 'witches' in the Malleus Malefacarum (Ehrenreich, 1973), to the challenge of the male midwife in the eighteenth century (Shelton, 2012) through to the reported drunken debauchery of the lay midwives in Victorian Britain (Phillips, 2007). In contemporary New Zealand/Aotearoa, there is a continuing presence of controversy within the working lives of midwives, such as the filing of a court action claiming a breach of gender rules with regard to equal pay (Bayer, 2015) or the proposals to return newly qualified midwives to hospital instead of community-based practice (Ryan, 2016). ANT therefore offered a way of issue mapping within the framework of the cartography of controversy that could offer insight.

A Degree of Uncertainty

By its embracing of uncertainty, following the actants in their assembling of the social, and providing a way of making meaning from the mapping of controversy, ANT appeared to

---

[34] In this context I refer to social in the manner of Latour who uses the word to refer to the "trail of associations between heterogeneous elements."

provide a valuable analytical tool for examining the current landscape of midwifery practice in New Zealand/Aotearoa. However in spite of its appeal, there were factors that led me to question the validity of turning towards actor network theory. From a philosophical position, the consideration of using ANT felt like a departure from the feminist stance that I had initially fostered within the methodological framework of PAR. PAR is a social research practice guided by the principles and values of participation and empowerment (Kemmis, McTaggart & Nixon, 2013). It holds a philosophy of inclusivity and the value of engaging in the research process is seen to benefit the users and the stakeholders of the research(Cargo & Mercer, 2008). ANT demands a more recursive approach where the intention of the researcher is to explore the changing nature of the relationships and associations (Greenhalgh & Stones, 2010). Inclusivity is not a given and entities who do not contribute to the network are duly excluded. However, it can be argued that PAR does interconnect with ANT as it is a way of making meaning from a specific social world by working with the actants who inhabit it in order to explore, construct, and develop theories that can become shared theory as a result of the combination of different frames of reference and expertise of the participants (Rhodes, 2009). Andersen et al. (2015) suggest that participants in any form of action research are network configurations anyway, which would invalidate such concerns. Lastly, as ANT allows for diversity in its application, PAR is equally diverse with its methods and uses a pluralistic epistemological approach (Reason & Bradbury, 2006). This flexibility should allow for articulation and even fusion between the two.

Feminism and ANT

Feminism and ANT also appear to represent conflicting theoretical and intellectual traditions that have the potential to challenge each other on many fronts. The movements emerged from historical, political and intellectual traditions that are markedly different. Feminist scholarship evolved from a socio-political tradition that was primarily focused on eliminating gender inequality and was built on the theoretical traditions of Marxism, existentialism and psychoanalytical theories. ANT developed primarily from the post-structural and constructivist movements (Quinlan, 2014). Some feminists have criticized ANT for dismissing

basic social factors as gender, race and class which they claim renders it impotent in any endeavor to challenge the power of patriarchy, racism and oligarchy (Harding, 1987).

However, comparisons are to be found between the two. Like ANT, feminist theory is extremely diverse. It is made up of many distinct empirical, theoretical and methodological approaches. It is not in any way shape or form a 'unified' tradition of thought and practice (Quinlan, 2014). Some feminist theorists, for example, have drawn heavily on post-structuralism and constructivism (Mohanty, 1988; Haraway, 1991; Butler, 2004). Additionally, feminist scholars have explored the place of ANT within a feminist research context to see if a fusion of theory is practicable and indeed useful. In spite of her criticism, Harding (2008) still acknowledges that that feminist scholarship and ANT may learn from one another. Cyborg theorist Donna Haraway has openly acknowledged that actor-network theory has been liberating for her, particularly in relation to the argument that agency is not necessarily a trait specific to humans (Penley, Ross, & Haraway 1990). In response, Latour has stressed that a hybrid socio-technical status bridges the relationship between humans and non-humans. This is a viewpoint that strongly identifies with the cyborg society portrayed by Haraway. Additionally, in spite of the fact that ANT has been criticized for its disregard of gender (Wajcman, 2000) and its propensity for creating power inequalities (Star, 1990) it could be argued that the multiplicity of entities involved in a network provides the potential to both identify and address gender issues that may have been masked in other research contexts.

ANT and Sustainability

ANT possesses an additional focus within the milieu of my study because it can be argued that it is well sited within the context of sustainability (Newton, 2002). It articulates with the concept of ecologies, and can be used to expose factors that may impact on or even obliterate ecosystems (Bennet, 2004). It offers us the opportunity to rethink our involvement in the world as human beings by acknowledging that we impact on non-human actants and that they impact on us. The paradigm of sustainability can challenge deep-seated elements that form our realities on many levels. The ever increasing complexity of our current lives

governed by technological advancement and globalization alongside shifting demographic patterns and the threat of climate change, means that past events and ways of doing and being cannot be assumed or applied. (Garrety, 2013; Latour, 2010; Law & Hassard 1999). Latour (1993) argues that science and politics have never been separate. For example the extent of climate change or the question of when human life commences, leads to the unavoidable politicizing of scientific territory.

ANT as a tool for analysis

Having introduced ANT in some depth, it would be judicious to return to the consideration of the applied use of ANT as a tool for analysis of the data which I introduced in the last chapter. I have to acknowledge that I did have some initial concerns. My methodological choice of PAR meant that I was already an active member within all of the collective groups of midwives and that I had played an active part in the process of data gathering. This decreed that I was an actant in the network myself as a researcher/group member, albeit standing slightly apart from the group (Sheehan, 2011). I was unsure how this would work in practice with ANT. The no a priori principle of ANT left me concerned that over-familiarity with the field could prove to be a barrier by preventing me from really hearing what my colleagues had to say.

I could rationalise a response to these concerns. I recognized that the situation required a reflexive approach that would enable me to critically analyse my own position. An awareness and acknowledgement of my own social and ideological location influenced by my biographical characteristics such as my class, race and gender remained important in a relational sense (I. Hay, 2015). Additionally, insight into my own formative experiences, including my insider knowledge of the world of midwifery, were significant with regard to how I would relate to the findings of the research from this new perspective. Reflexivity has been described as a natural component of ANT as reflexivity is relational and the fundamental principle of ANT is relationality, which should have ameliorated my concerns.

However, although the use of a reflexive approach offered some solace, it did not feel enough of a compass to guide me. I knew that I had set out to be my authentic self in the relationships with the midwives and had considered my insider/outsider status as discussed earlier in the chapter. I justified that my presence in the research network formed a relational aspect within the ANT process and accepted that this may have had an effect on how data were structured, but in spite of this rationalization, I still felt lost on the edge of the network without a map to guide me.

I returned to the literature to explore further how I could make the process fit within the dynamic and live context of my study and emerged reassured. The realisation that ANT should really be considered as a "set of sensitivities" rather than a "narrow set of fixed principles and applications" (Müller, 2015, p. 66) helped in that reassurance. The 'post'-ANT approach fostered by Annemarie Mol was also helpful by advising, "do not think of it [ANT] as a scheme or a system, think of it as a kaleidoscope" (Mol, 2010, p. 61). Mol also advocates that neither the researcher or the researched need to be neutralized for new knowledge to be generated. The researcher is able to interpret understanding obtained through scholarship and empirical study whilst simultaneously functioning within the network alongside the other actants (Mol, 2010). ANT is an active and transformative entity learned in practice from those other players in the field and a fundamental principle of ANT is that the presumptions and categorizations of the researcher should not be permitted to control the descriptions generated. Gad and Jensen (2010) write that "the researcher must be open-minded with respect to what counts as observation, and careful in description because local actants, in the first instance, are believed to know their own practices best" (p.76). I was able to return to the analysis with a renewed and enhanced understanding of ANT and as a result I was able to include what I feel to be a pertinent ANT led approach with reflexive translations of my findings.

Accessing the network

The other valuable support that I found in the literature was a framework in the shape of the four questions posed by feminist ANT proponent Quinlan (2014) that helped to provide a smooth access route into the data from the perspective of ANT. The questions are as follows:

1. Which actants should we follow?
2. Where do we start the analysis?
3. What can we see when we begin to follow the actants?
4. What about the politics?

Summary

During the course of the project, ANT served as both an analytical tool and a theoretical framework for the study. Although feminism continued to inform the project development with a focus on power and gender issues, ANT took on a central role as a "diaspora that overlaps with other intellectual traditions". (Law, 2007, p. 2) In ANT the theory is embedded and extended in empirically grounded practices and this application was vital in the progress of my study.

Chapter 5. Following the Actants (1) - A Historical Journey

Introduction

In order to understand the present, we must trace the paths taken from the past. This means that we are less likely to introduce assumptions about the linear nature of history.   My analysis using ANT will therefore begin in the midwifery stories of yesteryear. Marland and Rafferty (2002) debate that the history of midwifery has frequently been presented as a "moral fable in which midwives struggle towards or from the teleological goals of increasing technology, the hospital and the professionalisation of childbirth", but they go on to state that "more subtle forces are at work"(p. 3). I was interested to know what these other forces might be and I turned to ANT and Quinlan's questions introduced in Chapter 3, to assist me in this endeavour.

Using Quinlan's Framework

Which Actants to Follow?

In response to Quinlan's first question, which actants should we follow, perhaps not surprisingly, the central actants that I chose to follow in the network were midwives. I recognize that I have a significant affinity with the area of my research, as a midwife, and I appreciate therefore that this decision could be levelled as a subjective one; that is one of me imposing the worldview of myself as researcher on the analytical process. As determined in Chapter 4 ANT requires a high level of reflexivity on the part of the researcher (Cowan, Morgan & Mcdermont, 2009; Cresswell, Worth & Sheikh, 2010; Sheehan, 2011). Additionally, I have stated my positionality at length in Chapters 1, 2 and 3 and I fully acknowledge that this is one world view of many that might be extrapolated from the network. Action does not necessarily originate in the actant that is seen to act. Action is the consequence of the actions (or translations) of other actants that may be co-located in time and space with the

entity followed or may result as a consequence of events that are distant in time and space (Latour, 2005a). Feminist critics have claimed that ANT focuses on the voices and interests of the powerful within a network, suggesting that midwives are an oppressed group (Star, 1990). Certainly from a feminist perspective, midwives have at times been presented as a marginalized and oppressed group (Kirkham, 1999; Lay, 2000; Mander & Fleming, 2002: Cooper, 2011; Yuill, 2012) However, it would be fair to say that this could not be said to be the case in New Zealand/Aotearoa where midwives have taken a centre stage position; that is not to say, however, that patriarchal attitudes do not still prevail (Simmonds, 2011). Star (1990) challenges ANT researchers to pay attention to the marginal actant and to assess what happens to the actor-network as a result. By using ANT and following midwives I hope to achieve what Latour (2005) describes as granting a group " the ability to make up their own theories of what the social is made of" (p. 1).

Starting the Analysis

It is advocated that we are all products of our unique historical and cultural backgrounds and that our past informs our worldview both individually and collectively (Moon, 2008). The past offers an extensive evidential base for the review and analysis of how societies and communities and groups within it function. History can also help to trace the development of identity (Liu & Hilton, 2005), which is a key feature within the analysis of my study. Historical data can provide the key to how groups were formed and how they have evolved from a genealogical perspective (Liu & Hilton, 2005). The way in which a group represents its history will shape its sense of identity by acknowledging a sense of what it has been, what it is seen to be now and what it is felt that it should be. Such representations influence the way that groups relate to other groups and to current socio-cultural and political issues (Liu & Hilton, 2005). Defining the group within a contemporary context diminishes this when compared with the opportunity of crafting an understanding of identity based on a rich historical past (Moon, 2008). However, this line of reasoning is countered by Correia and Rosenkranz (2015) who consider that starting in the present and looking into the past may lead to bias and create a distorted understanding of the subject area under scrutiny.

In response to this latter argument, the tool of reflexivity is offered as a counterpoint. My use of a reflexive approach is considered at length in Chapter 3. The use of reflexivity as a tool for establishing the contextual environment is of particular significance when undertaking analysis of secondary level data such as historical documents and reports (Moon, 2008). Unlike my position as insider/outsider in the contemporary world of the focus groups, I found myself the outsider/insider when it came to looking back to the world of my forebears, in the form of the midwives of the past. Although I could theoretically relate to many of the practices of the women who had come before me, there was a sense of studying the unfamiliar, which can be a "barrier to identifying disguised and subtle expressions of themes" (Berger 2015). As a quasi 'stranger' to many of the historical cultures under scrutiny, I needed to consider how my contemporary values and beliefs could influence my interpretation of any given historical situation. It is additionally argued that ANT can be utilized mindfully as a tool for enhancing reflexivity by following the actants and allowing the data to determine the analysis and the direction of the research (Sheehan, 2011). Ruming (2009) suggests that the researcher is also an actor in the network by virtue of researching the network, such is the dynamic process of ANT. By using a reflexive approach in ANT terms, it is possible to negotiate the relations and relationships that present in the exploration of the historical landscape. This is not simply a matter of gaining insight in to the dynamism of the relationships under observation but also the discursive socio-cultural exchanges, which may offer greater insight into positions within networks. Latour (1996) describes reflexivity within the context of ANT as such:

> Reflexivity is not a "problem", a stumbling block along the path to knowledge, the prison in which all enterprises would be locked, it is the land of opportunity at last opened for actors. (p. 13).

Following the Actants

The third question that Quinlan asks is, what happens when we start to follow the actants? As identified, I decided to begin by following the actants in a temporal sense, by exploring the history of midwifery. The historical context can offer a rich foraging ground in relation to the emergence of the professional identity of the midwife and it would be problematic to

consider such analysis without including an evaluation of past events. I will therefore endeavour to provide a historical interpretation, in order to locate the development of midwifery practice within the context of ANT in both temporal and spatial terms. My aim in doing this is to situate the contemporary 'professional' position of midwifery in New Zealand/Aotearoa. I will discuss the construct of professional identity which can briefly be described as the professional self-concept of the individual based on their attributes, values, beliefs, and experiences (Ibarra, 1999; Slay & Smith, 2011) in greater depth in Chapter 6. The historical context is never easy to validate as reliable evidence may be limited, biased and difficult to authenticate. As a result it can be speculative and therefore open to misinterpretation and this applies to the history of midwifery as much as other areas (Allotey, 2011). In ANT, Latour invites us to utilize a number of features that enable us to transport data from other times and places to trace the actants of that time and place. One such feature is the immutable mobile (Latour, 1987b; 1992; 2005a). This is a technique that enables the assembling data about events or things from the past without the need for the object itself to be present. Documentation such as historical records can be used to facilitate the transport of data across temporal and spatial terrain. However, this thesis is not primarily concerned with historic research, and the analysis of primary historical data in the form of archival records, letters and diaries will not be undertaken. I will instead be drawing upon a range of reliable sources in from the available literature in an attempt to make meaning from the networks of action from the past that provide the backdrop to current midwifery practice and its perceived issues.

Finally the historical landscape offers an opportunity to reveal the narrative of midwifery. Law (2007) is emphatic that ANT is an approach that is limited as an abstract concept, and strongly grounded in empiricism. "Knowledge lies in exemplars and words are never enough"(p. 2). The use of ANT within a historical context therefore can provide a means of telling stories of complexities and multiplicities (Law & Mol, 2002) and the history of midwifery is rife with such. The chronicled history of midwifery has a temporal scale of millennia, but midwifery as a profession only has a temporal scale of decades. For many centuries, the networks of midwives have been reportedly constructed, deconstructed and reconstructed in a vast range of time and settings. As a result, midwives have had to

reconfigure identity on numerous occasions in order to survive as an entity. These network changes are part of the history that has contributed to the current professional status of midwives in New Zealand/Aotearoa. For ease of purpose, I have chosen to primarily work with a chronological approach in order to introduce the networks of midwifery from a variety of ages past. Although I recognize this to a be a linear approach, that may feel at odds with the networking processes of ANT, I will narrow things down by introducing a variety of networks within this chronological framework.

What about the Politics?

A Masculinist Socio-cultural Context

The final question posed by Quinlan is "What about the politics?" A literature review of the history of midwifery soon reveals that it is associated strongly with the concept of patriarchy and frequently viewed from a feminist perspective (Donnison, 1988; Papps & Olssen, 1997; Fleming, 1998; Banks, 1999; Lay, 2000; Bannerji, 2001; Surtees, 2003; Biggs, 2004; Phillips, 2007; Guilliland & Pairman, 2010;). It has been convincingly argued that midwifery has been situated within a masculinist socio-cultural context for millennia (Davis & Walker, 2010). Issues relating to power relations and gender are rarely far from the central focus in any academic discourse relating to midwifery and this applies to the analysis of the historical narrative of the profession as much as analysis of contemporary practice. For many centuries it has been argued that midwifery has reflected the gendered power relations of a masculinist socio-cultural professional context (Pringle, 1989). A feminist approach involves a starting point around the oppression and marginalisation of women and others who have less power in society. In feminist standpoint theory, for example, the oppressed groups would be able to view the processes that lead to oppression in a way that more privileged and generally patriarchal groups, are unable to do. This viewpoint has been referred to as 'looking from below (Harding, 2008). However, it is countered that by using ANT, the researcher is not limited to a perspective from below and that being marginalised can privilege the researcher with multiple locations (Quinlan, 2014). ANT offers the opportunity to view how a network

itself can become, for some time at least, stable and cohesive. Additionally, making assumptions about who or what is a marginalised group is making a priori decisions about the status quo of that group, whereas ANT is about following the actants within the network without a priori assumptions (Latour). Law (2012) points out that philosophical standpoints, epistemology and ontology are treated as "a source of possible insights" that inform analysis rather than guide it. He continues by saying that if we do this then these conceptual matters become "a set of specificities, a collection of possible resources, an aid to thinking and a set of sensitising suggestions." (p.5).

Challenging the hegemony of patriarchy

There are many accounts of historical instances where midwives have challenged the hegemony of patriarchy. The Athenian, Agnodice, is reported to have battled with male physicians to establish women's rights to support reproductive health and childbirth in the networks of ancient Greece. Agnodice, commonly referred to as the 'midwife of Greece', along with a small number of other women is alleged to have been allowed access to the School of Medicine established by Hippocrates. Here they learned about matters pertaining to female reproduction. After the death of Hippocrates, other doctors discovered that Agnodice and her peers held knowledge about inducing abortion and contraception. Fearing such knowledge, the authorities introduced the death penalty for any woman found practising either medicine or midwifery. Agnodice fought back by taking on a male identity and thus went on to prove that women were as capable if not more so than male doctors at ensuring safe birth practices and that women preferred to be under the attendance of a woman to a man during birth (Towler & Bramall 1986; Phillips, 2007). Seventeenth century English midwives such as Cellier and Sharpe, who will be discussed in greater detail later in the chapter, were impassioned and articulate activists, who attempted to ensure that women held their position in the birthing room by exposing contradictions and instabilities in the existing system (Phillips, 2007). However, in these cases, as in other historical episodes populated by midwives, by assuming marginality and neglecting to explore the networks where these midwives were located, we are losing an opportunity to see why marginality has occurred, and if, that this is indeed the case (Quinlan, 2014). That said, I do not set out to

95

polarize feminism and ANT in the historical context. Rather I see them as complimentary approaches that may help to offer some alternative perspective.

As a woman and midwife, I hold an ontological perspective that is strongly aligned with feminism and for all of the reasons outlined in Chapter 1, I firmly define myself as a feminist. As I established in the previous chapter, feminist research methodologies and ANT can be synergistic. This appreciation however, does require the researcher to become more circumspect and this is aided by an attitude of curiosity and a reflexive approach. Feminist theory and ANT both draw attention to important dimensions of historical interpretation, and using an ANT lens may support or even enhance that of feminist viewpoints on the positioning of midwives in history.

The world's oldest caring profession

Midwifery is an ancient tradition that long pre-dates contemporary definitions of a 'professional'. Women have relied on other women to help them birth for millennia and midwifery is commonly referred to as the "world's oldest caring profession" (Davis, 2004; Teijlingen, Lowis, McCaffery & Porter, 2004). Pre-historical societies were seen to revere the feminine including female reproduction and in particular, birth (Towler & Bramall, 1986). Within ancient 'networks' where nature was honoured and natural forces deified, the binary perspective of human and nature as separate entities would not have been prevalent (Kay, 2014). Women were viewed as having a particularly strong affinity with nature and the word "mother" is still used in many cultures as a referral to deity such as Pachamamma in Inca folklore and Papatūānuku in Māori tradition (Selin, 1997). Consequently, it could be imagined that the birth attendant/midwife would generally have been viewed as an esteemed and respected member of her[35] community/network. Traditionally in nearly all

---

[35] I use the gender related terms 'her' and 'she' figuratively as it would seem that although the majority of birth attendants were and continue to be women, there are some accounts of male birth attendants in some cultural settings throughout history. Towler and Bramall (1986), for example, suggest that men were frequently birth attendants until about 6000 BC and men were recognized as active participants in some Māori iwi (Best, 1906).

societies, the representation of the midwife is that of a village woman who learned her trade by attending the births of family and neighbours within the immediate community and skills and knowledge were handed down inter-generationally (Towler & Bramall, 1986; Papps & Olssen, 1997). There are exceptions, the Hittite midwives for example, who were members of a Bronze age civilisation, gave midwives the status of 'high priestess'(Bryce, 2002). In either case, village woman or high priestess, the role of midwife has been traditionally cast alongside that of healer, a role that has been reported to include the activities of a counsellor, herbalist, pharmacist, abortionist and others (Garratt, 2001). Midwives have even been referred to as the 'people doctors' because they did not have formal education but were recognised as having their own body of knowledge in regards to healing and birthing (Ehrenreich & English, 1973). Interestingly, this notion of an inclusive and clearly defined ontology is something that contemporary midwifery is grappling to achieve, whilst managing an eclectic body of knowledge, that has been 'loaned' from a range of disciplines (Lane, 2002; Davis-Floyd, 2014).

However, although archaeological artefacts have been presented to offer a sketchy history of childbirth in prehistory, the availability of evidence from this era is in fact extremely limited (Beausang, 2000). It has therefore been argued that our knowledge and understanding of early childbirth and the role of the midwife is romanticized and mythical and that the simplified vision of the early role and work of the midwife is mere conjecture (Eller, 2011; Radcliffe, 1947). We do know however that the networks of the early midwife would have been very local, comprised of those within, or who interfaced with, the tribe or village of the actants, even when the actants were nomadic tribes people. ANT theorists have made the point that networks are non-distinguishable as micro or macro, global or local. Networks regardless of size, time or place introduce elements from other places and times and these can never, logistically, be fully visible to either actant or researcher (Oppenheim, 2007b) . A small localised network can prove to be as complex as a large globalised one and therefore networks can seldom be assumed to be simple. Latour (1999) cited in Müller, (2015a). argues that contexts flow locally through networks and all networks are made up of local interactions anyway, in the sense that we connect as one entity with another

Medieval Midwifery

Feminist historical accounts of the medieval period present the midwife as a subjugated member of society who was prevented from becoming medically qualified (Garratt, 2001) and deterred from gaining the professional standing that the male physician was able to enjoy (Ehrenreich & English, 1973). Ehrenreich and English state that midwives were subjected to oppression and discrimination by agencies and institutions that served to exclude them from the early prototypes of professional education and organisations. For example, midwives were forbidden from access to the emerging institution of the university, and this excluded them from formalizing their position within the realm of medicine. The apprenticeship model of midwifery could possibly have justified its presence within the emerging trades' guild movement[36] during the 13th and 14th centuries. However, midwives as a group were barred from entry of the organisations, although a few gained entry under the auspices of the barber-surgeons[37] collective (Towler & Bramall, 1986). The Roman Catholic Church was an active participant in much of this opposition, as was the State[38]

---

[36] Trades guilds were organisations established to regulate craft production in Medieval Europe. They were different from trade unions, as they represented the interests of both craft-masters and less skilled workers whereas modern unions emerged to serve the interests of the workers (Ogilvie, 2011).

[37] Barber –surgeons were 'tradesmen' not doctors. They were adept in the use of using instruments for a variety of purposes (Towler and Bramall 1986). The Barber-Surgeons had originally been a London Livery service. The two functions eventually separated into clearly differentiated trades by the mid-18th century

(Schnorrenberg, 1981).

[38] This resulted from a number of events occurring in Medieval Europe including the introduction of new political structures such as feudal monarchies; new agricultural practices that allowed for a surplus of food leading to population growth; and increasing urbanization. The migration from rural to urban setting led to an emphasis on movable property and the introduction of the need for contracts and the resolution of disputes which initiated a reliance on written law. The study and practice of Canon or Roman Law was encouraged by the Roman Catholic Church and the value of this was also recognised by kings and citizens who were trying win

which was synonymous with the Church at this time. The Church governed the universities, who ran the medical schools and many doctors were therefore clerics. The Church was also influential in the establishment and administration of the trades guilds (Ridgway 2002). They appeared to represent a world that was increasingly taking on a regulatory purpose and a sense of civic/ecclesiastical coalescence and order. Powerful religious ritual and ceremony are intermediaries that circulate through a network and perform certain functions (Ritzer & Ryan, 2011). In the medieval setting under scrutiny these were used to dictate the allocation of power and control.

The tradition of Churching

The tradition of 'churching' after childbirth is one such example of how such entities within the network of childbirth functioned, in ANT terms, as mediators, to retain control over birthing women and in doing so constrained the activity of midwives and the development of midwifery. From the 11th century or thereabouts, following childbirth, the mother was confined for some forty days (and for longer if she had borne a daughter) within her family home and was forbidden from appearing in public until she had received a blessing from the local clergyman to 'purify' her (Cressy, 1993). Midwives conversely, were associated with the unpredictable natural world (in the form of childbirth), a domain that juxtaposed with the 'morally superior' male cultural activities that were offered within the church and universities. (Spretnak, 1996; Merchant, 2006). The physical experiences of birth and lactation were construed as feral and erratic (Griffin, 1978). This position did not align with the prevailing desire to construct a sense of orderliness and control on the part of the church and state.

Granting of Privileges

---

freedom from feudal rule. As a result of these and other less significant but nonetheless important factors, the law, church and universities became tightly interwoven (Janin, 2008).

From a feminist perspective, there is little question that the Christian religions held a strong and hold over communities, including midwives. Some theorists propose that the granting of privileges to midwives, such as education and licensing[39], served to provide greater control on the part of the church (Ridgway, 2002; Teijlingen, Lowis, McCaffery & Porter, 2004). It was a means of ensuring that the patriarchy were able to use monitoring and surveillance for a group of women who wielded power within their communities. The reality remained that the blame for the fragility of the human condition was still firmly pinned onto women. The opposing positions of the two women that Christianity used to shape ideas about birth namely Mary the mother of Jesus and the mother of original sin, Eve, served to cause conflict and confusion in the minds of the fatalistic God fearing medieval communities around the matter of childbirth. In countering the claim that churching of women was an act of sanctity, it has been claimed that it was actually a ritual focused on the impurity and sin of women who need to undergo spiritual cleansing in order to purge them of the effects of pregnancy and birth. It therefore reinforced a focus on sin and contamination can be seen to date back to the 'original sin' of Eve in the Christian tradition (Niebrzydowski, 2011).

Insertion of the divides

Avoiding the insertion of divides is how Latour (1987) describes "insertions in continuities that make the subject appear mysterious and without origins"(Bonner, Chiasson & Gopal, 2009) One such form of divide is the rhetorical separation of humans (subjects) from nature (objects) where humans are separated into distinct and separate units that are allegedly able to function independently of other actants as a result of their activity (Banks, 1999). According to feminist scholars, the ecclesiastic and academic worlds used the divide between 'order' and 'untamed' in order to position midwives as capricious and in need of taming (Garratt, 2001). Midwifery was thus largely denied a place within the network of church, universities and guilds. It seems that the attempts of midwives to enter this patriarchal

---

[39] In England the midwife's duties were incorporated into the oath she swore under the licensing system operated through the Church of England under an Act of 1512.

network at some level, be it academic or as a trades guild, led to activity within the network to quell this possibility.

Chains of association

Actor-Network Theory offers the researcher an opportunity to view a plurality of perspectives and a complexity that can belie a more focused perspective. Chains of association are used as a way of dissolving the nature/culture division, which helps to mitigate against a reliance on a binary approach. The resulting 'translation' and the ostracizing of midwives would suggest that other (patriarchal) actants were united by 'enrolment' to support their individual and diverse aims. However, whilst following the midwives and focusing on chains of association, alternative constructions begin to emerge and take shape. There are many aspects of historical evidence from this period that would demonstrate that the positioning of midwives within the medieval networks of Europe was not strictly one of marginalization at all times by any means. In relational terms there were stronger and weaker links in the chain. Midwives can be seen to have held respect from their communities and were even provided with kudos by the Church (Goldsmith, 1984). Many midwives served their communities in what can be termed as a semi-official capacity, and this was rewarded by special privileges such as a tax exempt status within their community (Minkowski, 1992). It would seem that the barring of midwives from the patriarchal organisations such as the Church and the Guilds were matched by the prohibition of men including doctors from the birthing environment which was seen exclusively as women's territory and the only secular space that men could not inhabit (Beausang, 2000). Although it is suggested that the doctors who were emerging from the newly formed universities at this point in history were not interested in childbirth and would not have viewed it as a medical area of interest anyway. Medicine for them was an intellectual pursuit whereas birthing women required manual skills (Minkowski, 1992).

Midwifery privilege

Notwithstanding, midwives also could claim to hold a unique body of knowledge that by contemporary standards would suggest an understanding of how the body worked during labour and birth. For example, Medieval midwives seemed to understand how best to facilitate birth by introducing technologies such as birthing chairs to aid their craft (Fee, Brown & Beatty, 2003). In addition to their herbs and other folk medicines, they used intermediaries in the form of semi-precious stones such as jet stone and amulets, and prayer rolls[40]. Far from being viewed with disapproval by the Roman Catholic Church, these entities which gave comfort and support to women in labour were viewed as 'gifts from God', natural objects with special properties. They did not hold demonic agency, but were accepted as a form of natural magic. ANT works on the precept that many relations are both material and semiotic and these material objects represented influential signs and symbols that were interpreted by the receivers (Shiga, 2007). Midwives believed that if their practical help did not work then God would step in and assist and therefore incantations, prayer and religious images played a significant role in the toolkit of the medieval midwife. Faith was used as a means of overcoming fear. Perhaps most surprising of all is that, because of the strictly female code of the domain, midwives were granted the right to surgically remove a live fetus from a dead mother. They were also the only lay members of society to be granted the right to perform the sacrament of baptism for a baby who was not expected to survive for long following birth. (Marland & Rafferty, 2002). This can be viewed as a pragmatic move on the part of the church, where the fatalistic reality was that almost half of all babies would reach childhood and the need to 'save their souls' was of paramount importance to society. Nonetheless, this sanction granted midwives a unique societal status. With regard to the ritual of churching of women, some writers have claimed that the separation of women from her community during the perinatal period has universal application[41], and that the practice

---

[40] Prayer rolls were manuscripts that contained biblical visual images and verbal inscriptions.

[41] The Chinese month is another example

was about the veneration of the mother figure, a religious rite of passage and a social event (Knodel, 1997).

The Burning Times

According to Ehrenreich and English (1973), the midwife as an 'agent of reproduction' was stated by many clerics in the Christian tradition to be contaminated by association, with the 'sinning' of women resulting from the actions of Eve. As a result, between the late 15th and 17th centuries midwives and women healers became the target of witch hunting. (Towler & Bramall, 1986) The infamous historical period, sometimes referred to as "The Burning Times" (MacOg, 2013), offers an illuminating historical expression of the ANT translation concept, as developed by (Callon, 1986b). It illustrates how the role of both subjects and objects within a network translate the concept of agency as less a fixed property of certain agencies to become more of a distributional process "through which knowledge and action come to be embodied by a collective of humans and artefacts" (Shiga, 2007, p. 40).

In the problematization element of the translation process, one of the actants makes itself indispensable to others by using a variety of strategies and devices of interessement[42]. There are any number of reasons why this should take place, for example, in order to build a power base, or as an attempt to secure the place of the actant who feels under threat within the network. Strategies used may include, persuasion, force and even seduction, but the important point is that these approaches are used to engage, coerce or cajole the other actants into the programme of action. It has long been propositioned that the persecution of midwives as witches was instigated and executed by the Roman Catholic Church. It is claimed by the clerics that midwives were performing morally questionable acts such as examining unmarried women alleging rape, or supporting women accused of attempting to

---

[42] The interessement phase of a translation process, is synonymous with the word 'interposition'. It is the phase used to strengthen the association between actors, and support the structure of the network (Latour, 1992).

end their pregnancy, or of committing infanticide, and this held them personally to moral account by the Church. (Purkiss, 1996).

A crisis of faith

 In fact, it is highly unlikely if not impossible that the Church alone could have taken action against midwives. A crisis of faith was sweeping Europe, a crisis that had emerged as a result of the social impacts of a series of famines and plague and even more significantly, from the bourgeoning Protestant religious movements which served to threaten the position of Catholicism as the incontrovertible moral authority (Ehrenreich & English, 1973). It is therefore argued that the Church had far less influence over the witch trials than was commonly believed (Harley, 1990; Briggs, 1998).   The moment of problematization, the recognition that the 'witches' could deflect from a church in crisis, occurred at a time when profound social and economic dislocations were taking place amongst the small scattered fiefdoms as Europe moved towards larger and centralized ruling units (Minkowski, 1992). In addition, the European Reformation[43] was leading the way for marked societal change. At that time the Roman Catholic Church was still able to mobilise significant economic, social, cultural and religious authority by decreeing who was a witch, and then to offering to counter the harmful influences of witch craft. The fear of witch craft and supernatural powers created a perceived threat to the other network players such as the courts, the nobility and the villagers who had used the services of midwives. Their fear encouraged allegiance to the actant that they believed could deal with the problem. This was effectively a way of dealing with both the dissident group and the perceived threat (which may have been considered a real threat) simultaneously. By persuading the others, that these women

---

[43] The Reformation was a sixteenth century movement from which the protestant churches originated. The Reformation is one of the most profound processes of change in Europe of the sixteenth century. Intense criticism of the Church of Rome led by the pope resulted in various reformation currents and the formation of several Protestant church reformations. The critical views of the religious sphere deeply impacted the spiritual, social, and cultural terrain, as well as upon the political sphere.

were in fact witches and held supernatural powers, the primary mover won the attention and increasingly the support of the other actants.

Neighbourly disputes

Interessement is the 'locking in' or gaining the interest of the other actants in the network. This stage is followed by enrolment where the midwives are ostracized and a galvanizing of the collective strength of the other actants ensues. The greater the perceived magnitude of the threat, the more powerful the reformed network becomes and the greater stability it achieves, for some time at least (Krieger & Belliger, 2014). The importance of the enrolment of the other key actants in the network cannot be understated. For example, most courts were secular at the time of the trials and so the Church would have needed the commitment of the judiciary system. Briggs (1998) argues that the witch hunts were frequently local events instigated by neighbourly disputes more than for religious ideology, but again, the initial problematization, interessement and enrolment ensured that there was unification. In the case of the burning times, all of the actants came together, the church in crisis, social disputes around land rights, and the development of the printing press.

The Malleus Maleficarum

Actants can become powerful or vulnerable through the introduction of inanimate objects that serve as subject extensions. The introduction of the early printing press delivered a potent actant into the network. (Dolan, 2013). The Malleus Malefacarum[44] printed in 1486 was a treatise on the prosecution of witches that stated that "No one does more harm to the Catholic Church than midwives" (Kramer & Sprenger (1486) quoted in Banks, 1999; p. 30). The introduction of printing at this time indisputably helped to shape and disseminate the targeting of midwives as witches. The process of translation tends to simplify entities by

---

[44] The Malleus Maleficarum was written by two eminent ecclesiastical scholars in 1486. The treatise was condemned by the Catholic Church in 1490 but the invention of printing in 1455 by Gutenberg, just as the fervour of witch hunting was mounted, enabled the dissemination of the Malleus Maleficarum throughout Europe and for several centuries (Broedel, 2003).

creating associations and Callon (1986) suggests that if a translation is successful then the principal actant, who initially instigated the action, "speaks for others but in its own language" (p.26).

It has been argued that the focus on midwives detracts from the belief that many of those executed were not midwives and that many were men (Briggs, 1998). Additionally, the estimated numbers vary from tens of thousands to over a million women over a period of two or more centuries (Purkiss, 1996). Some critics go as far as to suggest that the 'holocaust of women' is a fabrication of radical feminism (Reid, 2006). Nonetheless, in spite of incomplete verification, there is evidence to suggest that midwives were specifically targeted, in some cases by the church, and were brought to trial and were punished as a result (Purkiss, 1996). Harley (1990) suggests that the true history of midwifery has been deflected by the 'midwife as witch myth' that he argues is an unfounded stereotype and "an obstacle to serious study of the history of midwives, women's health and the relationship between popular medicine and religion" (p. 1).

The Age of Enlightenment

The Age of Enlightenment is another epoch in history that can be usefully employed to track the development of the identity of the midwife using an actor network approach to trace the movement of midwives at this time. This period, which gained full momentum in the latter decades of the 17th century, is presented as a dramatic and far-reaching evaluation of the nature and aims of philosophy, politics and religion (Knights, 2010). The Enlightenment is the era that introduced the concept of dualism. Plato had propagated a clear distinction between mind and body in the Hellenistic[45] period, viewing the mind as a non-physical substance (Bos, 2002). Descartes developed this concept further and identified the mind with consciousness

---

[45] Hellenistic civilization represents the zenith of Greek influence in the ancient world from 323 BC to about 146 BC.(Knights, 2010).

that set it apart from the brain as the root source of intelligence. 'Cartesian' dualism is presented as a paradigm of order/reason built around a linear, reductionist, predictable and deterministic world view. It is based around the laws of physics (as they were understood at that time) and was believed to offer absolute certainty (Edelstein, 2010; Knights, 2010). This worldview helped to develop the early concept of modern science, as a universal value free system of knowledge, able to draw objective conclusions about life and the universe (Duncan, 2000; Blaxter, 2010; Mehta, 2011).

The principles of this binary approach were applied to support a mechanistic and reductionist view of the human body and facilitated the bio-medical model of health which is a rationalistic and scientific approach to health and illness. (Davis-Floyd, 1997). This approach provides the framework for the dominant model of disease in Western society today. It encourages a focus on the physical determinants of health thereby excluding the social, psychological, cultural, spiritual and behavioural dimensions of illness. As a result, medicine made significant developments throughout the period of the Enlightenment. The changes emphasized an empirical approach to medicine and a clinical focus on medical training (Schnorrenberg, 1981). The biomedical model is said to promote a western male orientated and patriarchal worldview that radical feminists have stated encourages the 'naturalising' of women and 'culturing' of men which became the accepted standard of development for Western capitalism and industrialization during the Enlightenment (Mies & Shiva, 1993). Feminist theorist Susan Bordo (1986), has described the Enlightenment as a "flight from the feminine" (p. 441) when men began to use scientific discourse as a means to take control over reproduction and childbirth thus reinforcing the male/female binary argument.

ANT and the Binary Perspective

ANT does not endorse the concept of a binary dualistic perspective, which is viewed as an insertion of a divide. Latour (1993) argues that the hallmark of 'modernity' is the rhetorical separation of nature (objects) from society (subjects). He suggests this is an illusion that we have created with discourse and that any such separation is meaningless. As alluded to earlier in the chapter, ANT can be viewed as an attempt to overcome the artificial boundaries between culture and nature (Dolwick, 2009). Actants in the seamless nature/culture space

created by ANT accept the contribution of the non-human objects that are necessary for the maintenance and operation of networks. In his book Reassembling the Social (Latour, 2005a) asks us to consider culture and nature as "two *collectors* that were invented together largely for polemical reasons, in the 17th century." (p. 110). Latour is suggesting that the Enlightenment philosophers were limiting us to discussing our perceptions of non-human actants as objects without an ability to independently contribute to the network, or arguably to assume agency.   ANT on the other hand embraces the links between actants regardless of human or non-human status and recreates the entities within a given network in many forms of hybridity. This hybrid approach may assist the researcher and their audience in viewing the developments in the birthing room of the period through an alternative lens.

The Man-Midwife

The Enlightenment is also referred to as the period that spawned governmentality and greater levels of regulatory process.   By the 18th century, the medical fraternity were replacing the church as signatories in the licensing of midwives, ostensibly placing midwives under the direct control of medicine (Teijlingen et al., 2004).   At first glance the binary of gender division, midwives vs medical men, does appear to be the key driver in the development of maternity care within the networks of childbirth during this period. Although most women continued to be attended in labour and birth by traditional midwives, an increasing number of wealthier women were turning to the newly established role of the man-midwife throughout the 17th and 18th centuries (Marland, 2005; Phillips, 2007). The man-midwife was essentially a barber-surgeon specialising in childbirth (Eccles, 1982). The entry of men into the arena of childbirth is seen as a substantive event in the history of childbirth where records demonstrate a 'sex differential' between male (medical) and female (lay-midwife) accoucheurs[46]. Cody (1999) debates that the introduction of the man-midwife had even greater ramifications societally, providing a metaphor for the broader societal shifts that were occurring in areas such as the family and within the professions. "...once

---

[46] Accoucheur is a French word that describes a person who assists during childbirth, especially an obstetrician.

men believed they had conquered the world of birth, reproduction could operate as an objective reference point within the natural world and even social relations"(p. 23)

The birth of obstetrics

Male midwives certainly appeared to have a number of advantages over their female counterparts. They were much more likely to have the privilege of education, and they used publication extensively to increase their standing, broaden their influence and create a credible professional identity (Allotey, 2011). It is also alleged that they used their masculine standing to influence the husbands of the women they attended (Cody, 1999). However, like all surgeons, men-midwives were considered less prestigious than physicians as they trained within an apprenticeship model and in England they did not have to attend university (Towler & Bramall, 1986; Williams, 1997). Interestingly, in Scotland and in other parts of Europe, men-midwives were expected to attend university as a medical student from the time of the introduction of men-midwives (Schnorrenberg, 1981) . The title 'obstetrics', from the Latin term 'obstetrix'[47], is first recorded in 1828 in a move that was a deliberate attempt to dissociate from midwifery, an occupation synonymous with women (Schnorrenberg, 1981), although it was still not commonly used until the early decades of the 20th century (De Lee, 1934). However, the term "midwifery" continued to be commonly used for some time and the study of the subject of midwifery became a compulsory component of medical education in 1866 in the UK with parallel developments in other European countries. The College of Obstetricians in London and the American Board of Obstetrics and Gynaecology in the USA, were not instituted until 1929 and 1930 respectively (Drife, 2002).

Some historians believe that the stereotyping of the role of the midwife during this time may have encouraged a departure from the historical reality and that midwives were far from

---

[47] The word obstetrix' stems from the word 'obstare' meaning 'to stand before'. It was considered to be a more academic term than the Anglo-Saxon 'midwyf' which means 'with woman'. Midwives have frequently drawn attention to the origins of the two words to distinguish the major philosophical difference between the two roles (D'Cruz, Jacobs, & Schoo, 2009).

being simple village women, who fell victim to the emergence of the male accoucheur (Evenden, 2000). It is claimed that many midwives were seen as having higher social status than other members of her community and were given powers beyond the remit of their midwifery practice, including leading investigations of sexual impropriety and acting in the capacity of expert witness from the early 17th century (Thomas, 2009). Thomas also states that the terms used to describe the work of the midwife demonstrates that the women were "placed in the same conceptual category as work done by men" and that "many testimonials referred to midwifery as an 'office', a term usually reserved for positions held by men"(p. 123).

Turf wars and the introduction of forceps

The two groups embarked on what have been described as the 'turf wars' that arguably went on to influence the politics of the birthing room for centuries to come (Barclay 2008). However, it should be noted that the 'turf wars' were also fought between the different branches of the medical profession which contested the feminist line of reasoning that this was primarily a gender issue (Tobin, 2001). The issue of which group should take control of childbirth during the 17th and 18th centuries veiled a deeper epistemological question relating to whose knowledge and skills counted at an authoritative level. This period represents an early step towards a more contemporary model of professionalism which includes an expectation of 'expert' (medical) rather than folk (midwifery) knowledge (Phillips, 2007).

Harley (1990) proposes that the increasing wealth in London society provided women with choices that they embraced, and that this primarily facilitated the emergence of the male midwife. However, Dunn (1995) argues that the prestige resulting from the development of a specialised body of knowledge relating to the introduction of obstetrical instruments such as forceps was probably a stronger influence. The introduction of obstetric instruments within the network of childbirth actants during this time had a significant impact on the network and on the identity of the midwife. Early childbirth technologies, such as forceps proved to be influential actants within the network. The introduction of forceps was kept secret for more than a century in order to prevent midwives gaining access to the skills

required to use them as such a technological advancement was seen as requiring greater "knowledge and skill in its use than could be expected of a midwife" (Johnson, 1952, p. 30). The forceps were carried around in a box carried by two men to offer the impression that a larger item than a pair of forceps was contained, and those present in the birthing room (including the mother) were blindfolded to prevent any information leaving the environment (Towler & Bramall, 1986). The kudos enjoyed by the technological actant of forceps is a strong illustration of the material and semiotic power of non-human actants in a network. The forceps represented power and intrigue. They impacted significantly on the status of midwives and it is argued that, in many ways, this form of technology enabled men-midwives to stake their claim to practice in the birthing room[48]. A further form of technology that continued to forge influence was the printed word. The growth of male-midwifery is largely attributed to the availability of accoucheurs' such as Päre, whose writings in the vernacular rather that the traditional Latin encouraged the enrolment of men in the field (Teijlingen et al., 2004).

In spite of the growth in numbers, however, men-midwives did have to deal with a range of significant problems. The recorded maternal mortality rate associated with their increasing presence leads Shelton (2012) to seriously challenge the legitimacy of the man-midwife as either an ethical or competent practitioner, viewing practitioners as self-promoting opportunists who exploited a niche without considering the ramifications on making hospital confinement fashionable and leading to many deaths from puerperal fever. Shelton (2012) is particularly critical of the many deaths that were caused by men-midwives, "1 million human deaths were connected to man-midwifery initiatives of the 18th century. In simple terms, those deaths arose from dismantling the pre-1730 structure of maternal home-care provided by trained midwives" (p. 723).

---

[48] There is some evidence that a few women midwives were introduced to the use of forceps, but it seems that these were the exception rather than the rule (Drife, 2002).

Early indications of autonomy

Allotey (2011) has detected that manuscripts and other writings from this period suggest that midwives may have forfeited their stake to the medical man's claim to superior knowledge and skill in cases of problematic cases in childbirth. The men-midwives certainly canvassed to establish a niche as the suitable practitioners for dealing with difficult birthing situations (Dunn, 1995). Chamberlen, one of the early proponents of forceps use, wrote that calling a man to assist at a difficult birth did not serve to discredit a midwife but was a responsible action(Phillips, 2007). This suggests that there may have been genuine social concern on his and the part of other male accoucheurs'. However, it may also have been an attempt at manipulating the midwives such as Elizabeth Cellier, Jane Sharpe and others who were campaigning at that time to establish a College of Midwives and to establish independent regulation (Ridgway, 2002). These women may have been led to believe that concession could be viewed as an act of compromise and a necessary part of the negotiation required to obtain legislation for midwifery. In this way these 18th century midwives were aiming to ensure the continuation of midwifery as an independent profession (Ehrenreich and English, 1973; Donnison, 1977; Marland,2005). In her historical account of Scottish midwives however, (Fleming, 1998) suggests that the relatively high levels of autonomy of the midwives in the 18th century, who were also skilled businesswomen, was enjoyed because of the "lack of specific professional standards" (p. 45). The increasing medicalisation and commercialism that the men-midwives brought about did appear to take its toll on the business woman midwife though. A marked decline in employment of midwives can be traced throughout the latter decades of the 18th and into the 19th century, amongst the middle classes at least, as they continued to shift towards the technology and lying-in hospital care promoted by the men-midwives. Poorer uneducated women continued to serve their equally poor and uneducated communities {Citation}.

Modernism

For the next century or so, the status quo was maintained within the network, which was largely punctualised, whilst men-midwives garnered greater status and network support in their transferral to obstetrics. In the mid to late 19th century in Britain, a new actant entered the network of childbirth, bringing with it further destabilizing of the network and thus creating a new phase of translation. Destabilized networks occur when networks are adjusting to a consequential restructuring of power relations that is triggered by a shift in the beliefs on which they were founded: the introduction of new information, policy changes, technological progression, or the introduction or departure of human players (Callon, 1986b). In this particular case, all of the above components transpired to create a shift in power relations that had marked effects on midwifery as an entity.

This historical period was a time of social reform and there was a move to formally organise the emerging occupation of nursing by a group of socially influential and politically informed women. Unlike midwifery, nursing has no ancient tradition to call upon as a frame of reference for the profession. That is not to say that women in a social capacity did not attend to the health needs of their own family and community throughout history (Hawkins, 2010), but nursing as an occupational entity did not really emerge until the mid-19th century (Abel-Smith, 1960).

The precursors of modern nursing in medieval Europe are to be found in the history of religious orders where nuns and other ecclesiastical representatives devoted their lives to waiting on the sick in servitude to God (Maggs, 1983). It is believed that this influence of holy order emerged in the hierarchical structure and language of the brand of nursing established by the likes of Florence Nightingale. Terms such as a senior nurse being referred to as 'Sister' and the wearing of headwear not dissimilar to the nun's wimple, mirror these origins. This heritage may also have been instrumental in creating an idealized perception of the ministering `Nursing Saint' resulting from the charitable aspect of the early reformers work. (Beatrice, 1998).

Nursing – a new profession

The world's first school of nursing was opened by Florence Nightingale at St. Thomas' Hospital in London in 1860 where young middle class women were trained as nurses and midwives (as a branch of nursing), and were grounded in the pre-war feminist movement that was characterised by suffrage, social purity [49] and eugenics [50] (Helmstadter & Godden, 2011). This organised elite group engaged with professionalisation as a means of advancing the standard of practice in both nursing and midwifery. However, these members of the first wave of the feminist movement did not recognize midwives as equal to nurses. Midwives were viewed as uneducated working class women with little in common with the middle class suffragettes (Yuill, 2012). Midwives now found themselves in a position where they were not only challenged by the doctors preserve of 'healing' but by the nurses task of 'caring' (Ehrenreich & English, 1973). In spite of disagreements with both the Church, State and the medical profession, the midwife had essentially been an autonomous practitioner, working independently to help women in childbirth, and her work had been primarily determined by the needs of the women she served (Donnison, 1977; Thomas, 2009). The role and identity of the midwife did not fit comfortably with either the Christian moral

---

[49] The social purity of the Western nursing movement in the late 19th century was built around the principles of Christian morality and opposed those activities that were deemed to be immoral, such as prostitution and the partaking of alcohol (Egan & Hawkes, 2007).

[50] The concept of eugenics began to garner public support in the late 1900s as a scientifically valid argument for "improving human stock by giving the more suitable races or stock a better chance of prevailing speedily over the less suitable" (Galton. 1883, p. 765). During this time the study of eugenics became viewed as a necessary part of nursing. The idea was that nurses would monitor poverty by supervising workhouses and poorhouses. In many ways the eugenic activity was little more than public health measures (Gastaldo & Holmes, 1999). However, it was eventually enacted in legislation as a means of detaining those in society who demonstrated mental deficiency, which was a broad definition which included alcoholics, prostitutes, unmarried mothers, people with learning difficulties, and the disabled. Midwives, who at this time were a branch of nursing, were actively encouraged by doctors to adopt what was felt to be an ethical stand as eugenicists (Berghs, 2006).

114

idealism of nursing or with the university educated requirements of male doctors. University education had become a pre-requisite for medicine by the mid-19th century (Beatrice, 1998).

A social reform agenda

(Stanley 2012) suggests that the growing confusion around the role of the midwife is captured well in the characterisation of Charles Dickens' Sairey Gamp published in 1844. In this novel, Gamp, the midwife, is presented as having a twofold profession by assimilating midwifery with caring for the sick and laying out the dead. The midwife is referred to as both the monthly nurse[51] and the midwife. Gamp also portrayed a common public perception of the midwife as an uneducated and lazy alcoholic who endangered the lives of both mothers and babies. Again, the technology of print was being used as an agent to influence public and professional opinion. This can be seen as a political ploy used to justify bringing midwifery under the jurisdiction of nursing (Towler & Bramall, 1986). Until this point, midwives had learned their trade within an apprenticeship, but those who had established an institutionalised nursing training now fought for a similar approach for midwifery, with qualified nurses being offered a shortened course in midwifery (Hawkins, 2010). The social reform agenda formed by doctors, parliamentarians and the Church amongst others, is an important conceptual actant within the network at this time. Social reform had gathered momentum in the latter decades of the 19th century and there was a series of legislative measures relating to infant and maternal health[52].

An Obligatory Passage Point

---

[51] A monthly nurse is reported to be a type of `maternity aide' who was employed alongside the midwife by wealthy families in the 16th and 17th centuries. In Dickens representation however, she was depicted as the assistant to the male physician in the newly introduced lying-in hospitals. (Stanley, 2012).

[52] The maternal and child health movement was fuelled by the combination of stubbornly high infant mortality rates and declining fertility; poor standards of education and hygiene among the working classes were blamed (Reid, 2012).

This series of events led to the ANT position of obligatory passage point (OPP) which occurs when the actant achieve their interest as defined by the most powerful actant in the network (Callon, 1987). Medicine, as the translator or macro actant in the network had aligned with the neophyte vocation of nursing and used the development of social control to achieve their objective of bringing midwives into the fold and under the surveillance of medical practitioners. A range of regulatory tools and legislation acted within an intermediary and mediatory context and helped to destabilise the power that was viewed as vested in midwives (Borsay & Hunter 2012). The Midwives Act was legislated under the auspices of eliminating the employment of illiterate and untrained midwives who were said to be responsible for dangerous and unsanitary practices and instead to establish a new breed of professional, middle-class midwife who would engender middle class values of self-reliance and respectability amongst the working class mothers. Heagarty, (1996) argues that the supervision system introduced as a layer of surveillance of midwives was oppressive and gave further control to the medical profession by requiring medical aid to be present for all but the most normal of births. There is however, the slightest suggestion of a 'betrayal' which in ANT terms means that the actants don't abide by the agreements (translations) achieved by their representatives (Rhodes 2009). Reid, (2012)suggests that the social profile of practicing midwives actually changed little in the first three decades of the century in the UK with the Act serving to have less of an impact on how midwives practiced than how doctors perceived them.

Midwifery in early settler New Zealand/ Aotearoa

From an Anglo-centric perspective, the parallels between New Zealand/Aotearoa and England following the period of European colonization in the 19th Century are manifold. As a British colony, the history of regulated midwifery in New Zealand/ Aotearoa in the late 19th and early 20th century followed an almost identical trajectory to that in England at that time. The same human actants can be identified as the same groups as can the intermediaries and mediators in the form of texts, policy documents and legislation and the inscription power of

those who supported or opposed the intermediary impact. However, such socio-political congruence was shaped at considerable cost to the indigenous network of the residing population of Māori in Aotearoa, who in the time honoured history of colonialism, became the marginalized group within network. Once again, the concept of 'translation' is central to the process when ANT is used for analytical processing. Translation involves the reinterpreting/displacing, of the interests, and even the identities of other actants in the network in order to align the interest of that actant with their own which results as a one group gaining control over another leading to a state of punctualization (Law, 1992).

A Māori World View

The punctualization that takes place following colonization has particular relevance to ANT with regard to the hypothesis that objects may possess agency. ANT theorists advocate that there are interlocking referential chains of objects and subjects, humans and non-humans, and that the actants within these chains acknowledge mutual benefits and effects (Latour 1987b). Indigenous perceptions of what and who contributes to a society, are very different to those supposed by Euro-Western cultures. Watts (2013) speaks of indigenous agency as being situated within what she refers to as a "Place-Thought" framework[53], whereas within a Euro-Western context, agency is sited firmly within an epistemological-ontological framework. To Māori and other indigenous cultures, the land, rivers, mountains, seas and all the earths inhabitants are sentient, and connected. This belief resonates with the concept of 'chains of translation' introduced by Latour where the thoughts, behaviours actions and effects are transferred from actant to actant whether human or non-human. As this occurs, each adds an element of their own to the sequence. Ecosystems have ethical structures where all life forms are respected, and non-humans are viewed as active members of society.

---

[53] Watts is referring to the mythic concept of "Sky Woman', an Anishinaabe 'Earth Mother' cosmological figure who falls from the sky and lies on the back of a turtle. She creates land and becomes land. Place-thought is a manifestation of her ability to communicate with animals, water and other life forms. As a result she becomes the foundation of all future societies and the decision maker of how living entities will function upon her.

The agency owned by place can be seen within indigenous societies as similar to the agency owned by humans. When the agency of non-human materiality is threatened, human agency is similarly threatened (Watts, 2013). As a result of this worldview there is a deep spiritual connection to the land which is embedded in Māori creation stories (Mikaere, 1994). This cosmological narrative emphasizes the importance of the wahine in sustaining whakapapa (Pere, 1997). Consequently Māori women held significant status, acknowledged as the bearers of past, present and future generations (Simmonds, 2011).

Misappropriation and misrepresentation

Following the period of British colonization in the latter half of the eighteenth century, however, the effects of colonization resulted in the misappropriation and misrepresentation of Māori forms of knowledge whilst western notions and ideologies were imposed on the indigenous people (Simmonds, 2011). The metaphysical power of childbearing Māori women was trampled by Western theory and philosophy. Their traditional knowledge and their strength embodied in the tapu of the whare tangata[54] was dishonoured. Shame associated with reproduction was only acquired once Māori women had been taught shame by Victorian, Christian mores incarnated in attitudes subscribing to the inferiority of women, and the dirty and dangerous nature of women's bodies and sexuality (Mikaere, 1994). The colonial influence of Europeans was to cast considerable influence on the Māori way of birth (Fleming, 1998) and in early 20th century New Zealand/Aotearoa, politicians and social reformers were to accuse the anthropologist, Elsdon Best of romanticizing Māori childbirth practices within his writings (Papps and Olssen 1997). This may or may not have held some element of truth but Elsdon Best, himself a product of the colonial ruling class, stated in his ethnographic accounts that wahine were "…passive and resistant to the dominant male" (p. 97) thus aligning with the colonial historical perspective of female inferiority that it is argued was advocated by most colonial ethnographic reports (Buckley & Gottlieb, 1988). This is

---

[54] The perceived strength of the connection between Māori spirituality and childbearing is illustrated in the language where words frequently have both a sacred and an everyday translation. Whanau means family and to give birth; hapu means sub-tribe and pregnant; whenua means land and placenta and whare tangata, which means house of humanity, can also mean uterus (Pere, 1997).

118

something which is vehemently contested by Māori feminist theorists (Mikaere, 1994; Pere, 1997).

During the 19th Century, Māori women were systematically disconnected from their extensive whānau support as they became increasingly urbanized as a result of land confiscation (Cook, 2012). This marginalisation of Māori women's reproductive processes had profound effects on their childbirth practices (Simmonds, 2011). Māori women were isolated from their traditional communities and they also lost their tohunga[55] and knowledge of traditional medicine, which impacted on the provision of Māori birth attendants (Cook, 2012). From the arrival of the early settlers in the first half of the 19th century until the early years of the 20th century both Pākehā and, increasingly, Māori women were served predominantly by lay midwives who had been apprenticed to other midwives. However, doctors became more instrumental in the training of midwives and immigrant midwives were increasingly influencing the system by the training that they had received overseas, usually in the UK and generally from nurse training. The Midwives Act of 1904 in New Zealand followed closely the passing of the English Midwives Act of 1902 and they were not dissimilar in constitution. Both Acts were passed to establish state control of midwives by regulating their practice and in both countries midwives now found their education and their regulation fell under the jurisdiction of both medicine and nursing (Papps & Olssen, 1997; Fleming, 1998; Stojanovic, 2008). An obligatory passing point (OPP) had been effected in Aotearoa as well as in the "Mother Country".

Population Politics

In ANT, any actant unsuccessful in sustaining themselves as a link in a chain is said to disappear. This is because nothing has reality or form outside the enactment of relations within the network (Law, 2007).In order to ensure endurance therefore, from the perspective

---

[55] Tohunga is an expert practitioner of a skill or art.

of a marginalized group, this might mean aligning with the stronger voices in the network. Conversely, the actant could aim to strengthen its ties with more established network actants. There is no clear indication of which of these two possibilities was influential in winning the support of the new breed of midwives in New Zealand/Aotearoa in the late years of the 19th and early years of the 20th century. Either way it would seem that the road to professional status for midwifery was paved to some degree by the development of a eugenics based ideology that mobilised the network of reproduction at this time .

In the late 1800s, infant welfare had become an issue of national concern in both England and New Zealand as fears were expressed about the physical 'efficiency of the populations'. (Papps & Olssen, 1997; Marland & Rafferty,2002). This trend is cited as an issue of global concern in the late 19th and early 20th century (Bashford & Levine, 2010). A primary concern for eugenicists was to prevent racial deterioration. It was believed that producing 'better' people by removing the weaker elements of society would serve to improve society (Bashford & Levine, 2010). In New Zealand/Aotearoa, the relatively small population of the country and a decreasing birth rate amongst the settlers, gave rise to eugenic beliefs directed primarily, though not exclusively[56] at Māori. Inscripted in Hansard by parliamentary debate, and mobilized by many actants including doctors, nurses and midwives, eugenic belief gained momentum as a response to racism and achieved capacity as an ideology with the establishment of Eugenic Societies that advocated the sterilization of those considered deviant, in a similar manner to that observed in the UK (Tolerton, 2017).

Ironically it may have been the Māori birth practices that supported lower levels of infant and maternal mortality, as earlier in the settlement period, a commonly held view of childbirth in Māori communities was that it was "much less problem prone than European childbirth practices" (Papps & Olssen, 1997, p. 102). These racist attitudes permeated the white public

---

[56] Others who were targetted included Chinese, unmarried women, 'mental defectives'criminals and other 'deviants' (Bashford and Levine 2010)

consciousness from Seddon, the Prime Minister, through to the general European settler population (Ballantyne & Moloughney, 2006).

In 1904 a Royal Commission was set up to investigate the fall in the white birth rate in Australia and New Zealand. The findings of the commission confirmed both a fall in birth rates in the middle classes and a high infant mortality rate in the poorer white communities[57]. The traditional or lay midwives (many of whom were Māori) were blamed for the high maternal and infant mortality rates which allowed British trained nurse Grace Neill, who was employed as the Assistant Inspector of Hospitals, to lobby for the training and regulating of midwives (MacDonald, 2000). One of Neil's stated aims was to make childbirth more attractive for "preferred breeders, the respectable wives of working men"(Macdonald, 2000, p. 469). Neill won the support of the Prime Minister Seddon and her successful campaigning led to the passing of the 1904 Midwives Act. This legislation redefined the role of the midwife from 'handywoman' to registered health practitioner and established midwifery training establishments, and state run maternity hospitals (Mein -Smith, 1986; Stojanovic, 2008; Clarke, 2012).

Regulation of Midwifery

The early decades of the 20th century demonstrates a flurry of activity within a network that had reassembled from a midwifery network to a larger maternity network to incorporate the new actant groups upon the 'stage'. The registration of midwives resulted in midwives being placed under the control of both the medical and nursing professions, as the criteria for registration were dictated by the central health authorities and as such had to be agreed by

---

[57] The birth rate declined from the 1840s when the birth rate is recorded at 6.5-7 live births per woman to 2.1 live births per woman in the 1930s. There were a number of social factors that contributed, including the fact that women were marrying later and more did not marry at all compared to the mid-19th century. Paid employment opportunities for women also increased (Taonga, 2014b).

both the chief medical and chief nursing officers (Fleming, 1998). Both professions saw midwifery as a threat to their authority (Papps & Olssen, 1997). In 1909 a Trained Nurses Association was formed and those midwives with a nursing qualification were encouraged to take membership. It was felt that because both professions had relatively small numbers, one national combined organisation would be better placed to serve the interests of both professions. This also made sense geographically; communities were widely distributed throughout the country and communications systems were limited, which made centralization a pragmatic decision. This relationship was legislated in the 1925 Nurses & Midwives Registration Act. The Act created a Board that was comprised of two doctors (the Director General of Health & a registered medical practitioner), two nurses (the Director Division of Nursing & a registered nurse) and one midwife (who was recommended by the New Zealand Trained Nurses Association). The Board was granted the responsibility for the education and registration of nurses and midwives (Pairman, 2005).

Traditional midwives, many of whom were Māori wahine, were transmuted into 'untrained midwives' and they were only allowed to register if they could persuade the Board that their experience was valid and that they were competent, regardless of their years of experience. As a result, different classifications of registration were issued, Class A signified women who had been trained in a recognized programme in New Zealand/Aotearoa or overseas, and Class B covered the untrained who were proven to be of good character and had practiced for at least three years (Stojanovic, 2008a).

Nurses and Midwives Registration Act 1925

The 1925 Nurses and Midwives Registration Act of 1925 offers a good example of how the introduction of a non-human entity, a mediator, which in this particular case is a legal act, can play a significant and independent role in the network. This Act may have been designed by humans and legislated by humans, but serves as an independent mediator in influencing and altering the network. Networks require interaction, movement and process and this calls upon an intercessor to initiate and sustain the action. Decisions are made based on the connections between actants and the content they are dealing with. The mediator in the

form of legislative action provides the medium for wiring and firing between the other actants.

Midwife and Maternity Nurse

As a result of the Nurses and Midwives Registration Act 1925 two classes of maternity practitioners, the midwife and the maternity nurse, were established. The merger of the two occupations resulted in the discontinuation of midwifery specific education (Gilkison, Giddings & Smythe, 2013). This was the first of many concessions of midwifery to the stronger voice of nursing. Maternity nurse training was extended from 12 months to 18 months and birth was transferred from the small maternity hospitals to public hospitals. Midwives were becoming increasingly concerned about the influence of nursing over what they considered to be their territory (Stojanovic, 2008). Joan Donley, one of the founder members of the New Zealand College of Midwives, highlights the vulnerability of midwives engulfed in an organisation that did not have the interests of midwives at heart, but had been facilitated by the direct impact of the legal intervention in the form of the 1925 Act. She also felt that the profession was being used as a political pawn in an impasse between nursing and medicine.

> Politically, however, the incorporation of midwives into the nurses' organisation strengthened the nursing profession at the same time as it effectively eliminated midwives as a pressure group that could be used in future political manoeuvres, e.g. by the doctors if that suited their interests. (Donley, 1986. p. 95)

Increasing Medicalisation of Childbirth

Another mediator, the Social Security Act 1938 introduced universally accessible maternity care at no cost for all women in New Zealand/Aotearoa. This arrangement included an expectation that the woman would birth in hospital, but that she could select her choice of doctor. This Act effected what Stojanovic (2008a) describes as "the 'coup de grace' for the autonomous midwife" (p. 57), as women were lured into an increasingly medicalised

maternity service under the care of obstetricians and General Practitioners. The scope of midwifery practice continued to be seriously curtailed throughout the twentieth century as a result of increasing medicalisation within the field of childbirth (Stojanovic, 2008). This 'coup de grace' was equally evident in many other western countries such as Australia, UK and the USA where the medical professions were exerting increasing power in the field of obstetrics (Teijlingen et al., 2004). In New Zealand/Aotearoa Doris Gordon, an obstetrician who formed the Obstetric Society of New Zealand, was leading a campaign to establish a Postgraduate School of Obstetrics with its own Chair (Papps and Olssen, 1997). Like Grace Neill, Gordon promulgated the safe motherhood message by condemning the practices of midwives which she deemed to be unsafe. Interestingly, she used the first wave feminist arguments around women's rights in advocating the right to choose a hospital birth. This supported her endeavours to establish obstetrics firmly at the forefront of maternity provision (Fleming, 1998).

Gordon's aspirations reflected an ever growing acceptance of obstetrics as authoritative knowledge along with an intensifying medicalisation of childbirth in the latter half of the twentieth century. Intervention in childbirth was creating a reliance on technology on the part of both those delivering maternity care and those receiving it. This hegemony seriously challenged not just the autonomy of the midwife, but the very identity of midwifery (Fleming, 1998).

A Maternity Services Committee was established in 1960 to advise the Minister of Health on matters relating to maternity care. This committee of ten doctors and four nurse/midwives, claimed to be a professional committee representing all of the professional stakeholder groups as well as the voices of the women of New Zealand/ Aotearoa. There were no domiciliary midwives on the committee and no lay members (Papps & Olssen, 1997). At this time women were increasingly birthing in specialist obstetric units, although many were accessing GP led maternity hospitals. The number of domiciliary midwives was rapidly

decreasing and most midwives were employed as assistants to obstetricians or General Practioner's (GP's). [58]

The Nurses Act 1971

In 1971, the Nurses Act (1971) removed the statutory rights of midwives to practice autonomously. However, the preceding stages of translation had ensured an insidious process of erosion that made the action feel like an inevitability. The passing of the Act consequently provoked little response on the part of midwives and it was, almost without exception, accepted that New Zealand midwifery had now become a highly stratified branch of nursing (Gilliland & Pairman, 2010). Women were cared for antenatally and in the intrapartum period by their General Practitioner or an obstetrician and hospitalization was all but enforced. The 1971 Nurses Act served to ensure that midwives could only work under the authority of a medical practitioner, thus maternity nurses would deliver 'care' during labour but would relinquish care to the obstetrician at the time that birth was imminent. This model was at variance with the newly established International Confederation of Midwives' definition of a midwife (ICM 1972)[59]. Midwives in New Zealand/Aotearoa now had no

---

[58] in 1971 only twenty four women delivered under domiciliary midwifery care.

[59] International Confederation of Midwives Definition of a Midwife. 1972.
Qualifications: A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

 Types of Care: The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. http://www.ucs.mun.ca/~pherbert/number1.html

specific education and were not deemed responsible enough to conduct births without the presence of a medical practitioner (Gilkinson et al., 2013). There were however, a very small number of 'domiciliary midwives'[60] who provided care for women throughout their pregnancy, birth and puerperium in the community, although these midwives still had to practice under the supervision of the equally small number of doctors who would support them (Guilliland & Pairman, 2010). There were several attempts to curb the practice of the domiciliary midwives in the late 1970s and early 1980s such as attempting to place them under the control of the Obstetrics Standards Review Committees (1983) but the Domiciliary Midwives Society (DMS) continued to counter this opposition and maintained their right to practice homebirth and continuity of care.

In 1983 the Nurses Amendment Bill proposed that all domiciliary midwives should be nurses. The bill also proposed that nurses without midwifery training should be able to provide care for women in labour (Guilliland & Pairman, 2010). The medicalisation and nursification of midwifery (Hendry, 2003) was all but complete and a 'black boxing' (albeit contingent) of the network achieved.

Conclusion

In this chapter, a review of the historical literature was utilized to broaden the research lens whilst exploring the historical relational positionality of midwifery within networks. The intention was to shed some light on the contemporary perceived professional role of the midwife by looking to the past for guidance. The central metaphor of ANT is that of a province of competing social forces and strategies that are recurrently shifting with alliances

---

Locations for Practise: A midwife may practise in any setting including the home, community, hospitals, clinics, or health units

[60] Domiciliary midwives continued to provide homebirth and care in the community throughout the 1970s and 1980s. They received payment directly from women and took only what women could afford which meant that their work was hard and poorly paid (Gilliland & Pairman, 2010).

being formed and dissolved. By introducing some of the key actants and their relationships within these historically sited networks, the dynamic and power laden perspectives of life within the historical milieus of childbirth have been presented; power and contestation have been observed. Although the epistemological and ontological assumptions of feminist theory are very different to the no a-priori, a-moral approach of Actor-Network Theory, the two perspectives have given a balance to the analysis of the evolving nature of the role and identity of the midwife. Feminist theory has enabled the development of subtle analyses of subjectivity and meaning in relation to the action within the ANT framework, whilst the renunciation of fixed social status and hierarchy in ANT have enabled a greater analytical insight into the moral and ethical dimensions of the historiography. The result is a more circumspect viewing of the development of midwifery as a profession from a prehistoric era through to the post-industrial world of the late 20th century.

Chapter 6. Following the Actants (2) The Neoliberal and Professionalisation Projects

Introduction

By the early 1980s midwifery in New Zealand/ Aotearoa was at a marked nadir in its history. If we follow the midwives within the birthing territory of New Zealand/ Aotearoa in the early 1980s we may view them as a largely subjugated and disempowered group of health workers. The medicalisation and nursification of midwifery (Stojanovic, 2008) was all but complete and a punctualization of the network seemed inevitable. However, the provisional nature of networks means that the potential for change and further repositioning is omnipresent. By stepping back and taking a longer range view of the broader sociopolitical landscape of the time, it becomes apparent that there were occurrences taking place within the network that meant that any 'black boxing' of the network was merely contingent.

In Actor-Network Theory, Latour (2005) claims that we find numerous, competing accounts about what generates hierarchical structures, inequity and relations of domination. He states that non-human elements in the network are not only fully engaged and operational actors, but that they are "what explains the contrasted landscape we started with, the overarching powers of society, the huge asymmetries, the crushing exercise of power" (p. 72). ANT exposes the social forces that are acting upon one another at any given time, to create conflict and reform within a network. The actants who construct the assemblage are also being mediated by the network. In this way, the midwives and the supporting groups were not the movement directly, but were operating within the context of a global paradigm shift that enabled the changes to occur. The actant is acting within a network which is simultaneously acting and therefore the actants are moving targets of multiple agencies (Latour, 1993). In this chapter I will begin to track the movements of the actants in the network by exploring the sociopolitical backdrop to the inter-professional battle surrounding the axiomatic life event of birth that was playing out in New Zealand/Aotearoa in the final

decades of the 20th century and the first decades of the 21st century. Once again I am identifying the primary actants as midwives.

Social Experiment to Neoliberal Experiment

In the decades following the second world war, New Zealand/Aotearoa was viewed as the social laboratory of the Western world in terms of social welfare provision (Peters & Marshall, 2002). However the inauguration of neoliberalism in the 1970s and 1980s was to facilitate a move in New Zealand/Aotearoa from a "welfare to a contract state" (Levine, 2009, p. 163) and this was to have far reaching effects on society, including the health care system.

Neoliberalism

Neoliberalism is the progeny of the theory of classical liberalism of the 19th century, but it is possible to date back a forerunner of classical liberalism to the period of the Enlightenment in the 17th century. Classical liberalism operated on the basis that the more political freedom a society has, the higher degree of economic freedom is necessary. The theory focused on anti-regulation, privatization, and devolution of the state in addressing social issues and was used by the British and other imperialist nations to justify capitalism at home and colonialism overseas (Harvey, 2005; Birch & Mykhnenko, 2010; Bockman, 2013).

From the 1940s to the 1970s Keynes's economic theory[61] had been widely applied in post war Europe and the USA. However, the application of Keynsian theory started to lose favour

---

[61] Keynes, a British economist, challenged the theory of the free market as an economic strategy for providing full employment. He proposed that every worker who wanted a job could have one as long as the wage demands of workers was flexible. The main tenet of the Keynsian argument centred on aggregate demand. This is measured as total spending by all sectors from households to governments. Keynes additionally asserted that free markets do not have self-balancing mechanisms that could lead to full employment. Keynsian economics

by the 1970s as a result of a series of constructed global economic crises which facilitated the emergence of the concept of neoliberalism. Neoliberalism, and particularly its monetary policies, were adopted by leaders such as Reagan in the United States and Thatcher in the UK, in order to foster political opposition to state interventionism in favour of free market reform policies (Harvey, 2005). This persuasive economic theory and ideological conviction rapidly gained global political and economic approval and support, convincing bureaucrats, businesses and governments that social welfare models were inefficient and that private markets were more cost-effective and efficacious in terms of taxation. Laissez-faire capitalism was hailed as promoting human wellbeing (Kotz, 2015) and personal freedom (Harvey, 2005). Improved efficiency would be achieved by: limiting redistributive taxation, privatization of the previously state owned services, a shift in welfare policy towards entrepreneurship and philanthropy, and the corporatization of higher education and health services (Boas & Gans-Morse, 2009; Thorsen, 2011; Bockman, 2013a)

Defining Neoliberalism

Depending on the context, neoliberalism is viewed as a hegemonic political ideological discourse, a policy paradigm, and a well-defined form of governmentality (Larner, 2000). Critics of neoliberalism maintain that its policies are a façade that provide a smoke screen for the use of the political state by wealthy individuals and corporations to enable them to effectively increase their share of valued resources in a global society (Harvey, 2005; Birch & Mykhnenko, 2010; Wilkinson & Pickett, 2010; Klein, 2014) and to enforce a "general regulation of society by the market" (Foucault, 2008, p. 145).

By removing state intervention, neoliberalism is said to provide a counterbalance to the advance of state oppression. By eradicating any centralized control of economic activities, economic power is detached from political power, and the one can serve to offset the other. Therefore, it is claimed that neoliberalism can be legitimately presented as a defender of the

---

are therefore reliant on government intervention using policies that aspire to achieve full employment and price stability (Jahan, Mahmud, & Papageorgiou, 2014).

less economically privileged, while intervention on the part of the state is seen as the root cause of poverty (Craig & Porter, 2006). Those who promote this view hold that the world's poor have been victim to inept and predacious over-regulating governments who have kept the underprivileged in a state of oppression (W. G. Moss, 2008). This interpretation of neoliberalism is viewed as an 'inclusive' liberalism, in which market liberalism co-exists with policies that promote opportunity, empowerment, and security; while still market-led, the emphasis is on partnerships and good governance (Porter & Craig, 2004). This view is supported by the theory of trickle-down economics,[62] a theory that in simple terms works on the premise that by decreasing tax rates for corporations and investors, the production in an economy overall will increase. This theory has been critiqued extensively and critics claim that this economic doctrine has led to an inequitable distribution of wealth (Fuentes-Nieva & Galasso, 2014).

Neoliberalism as an International Movement

In New Zealand/Aotearoa, the dismantling of the welfare state was instigated by a Labour administration, led by David Lange in the mid-1980s at a rapid rate and with what has been described as unusually coherent (Hood, Rothstein & Baldwin, 2001). Interestingly, both Margaret Thatcher and Ronald Reagan had been elected on a mandate of encouraging a free market economic and political approach, whereas in New Zealand/Aotearoa, the Labour government had failed to allude to such sweeping change in their manifesto for election (D. Small, 2016). Neoliberalism was established as the dominant paradigm of public policy and citizens were redefined as consumers of now competitive services and the rights of citizens redefined as consumer rights. The financial system was deregulated, tax rates were slashed, government subsidies were reduced or eliminated and state ownership repealed. In spite of what appeared to be a departure from the traditional values of the Labour Party, the administration claimed to be upholding these values. In 1988 the Labour government led by

---

[62] The economic policies of the Reagan administration were based on the trickle-down theory. It contrasts with Keynsian theory (Hood, Rothstein, & Baldwin, 2001).

Lange, proposed the introduction of a flat rate of taxation regardless of income level. New Zealand/Aotearoa, which was said to have inspired Aneurin Bevan, the Labour Health Minister in the UK, by being in the forefront of social change internationally, was now reported as becoming the first post welfare state (Walker, 1994).

The Marxist critic David Harvey (Harvey (2005), describes neoliberalism as "a cumulative 'moving map' of regulatory institutionalized practices"(p. 88) and it has been argued that the neoliberal experiment in New Zealand/Aotearoa (as in other similar countries) has travelled through several divergent phases . The first wave, referred to by Peck & Tickell (2002), as the roll-back, can be seen as the introduction of the neoliberal agenda in the 1980s. This period represents "the active destruction or discreditation of Keynesian-welfarist and social-collectivist institutions" (p. 384) as the state retreated from many areas of economic productivity, but continued to attempt to preserve the integrity of the welfare and social aspirations that are associated with social democracy. In the 1990s (the roll-out) the marketization was more thorough and ruthless and was accompanied by the introduction of a neo-conservative element with regard to policies and programmes related to social policy. It is described as "the purposeful construction and consolidation of neoliberalised state forms, modes of governance, and regulatory relations" (Peck & Tickell, 2002, p. 384). In the third phase, often referred to as the 'Third Way' in the late 1990s an ethos of 'partnership' emerged where the discourses of 'social inclusion' and social investment were placed alongside the more apparent components of neoliberalism such as market activation, contractualism and economic globalization. New Zealand critic Louise Humpage (Humpage, 2014), refers to a more recent 'roll-over' where the acceptance of the neoliberal agenda and the economic crisis of 2008 has enabled a further wave of retrenchment, placing even greater focus on social policy than the early roll back and roll out phases.

Individualism

The concept of individualism is central to neoliberalism and is the ideological lived reality of most western industrialised nations (Eagleton-Pierce, 2016). Individualism is the social theory that champions the moral worth of the individual and is a key component of the neoliberal

ideological standpoint (D. Watts, 2014). Neoliberalism appears to operate on the premise that humans will generally act independently of others and that they will put their own interests before those of others and their environment. In human terms this is viewed as a very new development (Heron, 2008). As the late UK Prime Minister, Margaret Thatcher, advocated,

> there is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first. It's our duty to look after ourselves (Thatcher, 1987 as cited in (Willetts (1992), pp. 47-48)

Under neoliberal policies, personal responsibility is emphasized and the state withdraws to various degrees from welfare provision including the responsibility for providing healthcare, public education and social services. The individual is held responsible for their own well-being and self-management. Beck & Beck-Gernsheim, (2002) describe how citizens are forced to become entrepreneurs in their own lives, managing choices within a highly volatile world and taking individual responsibility for their failures. If culture and consumer choice are viewed as inseparable then consumerism represents the opportunity to exercise true individuality (Holzer, 2006). However, the freedom that is achievable is dependent on many preconditions. For example, if someone does not have enough food to survive, or is in poor health, or living in oppressed circumstances, then freedom of choice means little. Therefore from a humanitarian perspective, an equitable provision of basic services is essential and will need to be provided at state level (E. Lewis, 2015)

It has been suggested that an entrenched allegiance to individualism in western democratic countries has led to a major emphasis on individual achievement and self-fulfilment (Murphy-Lawless 2011). Neoliberalism is blamed for interfering with social unity, which occurs when people connect in social organisations, clubs and associations. This emphasis on the individual has led to a state of confusion between our roles as consumers and as citizens and it has even been questioned whether neoliberalism really has a concept of citizenship (Voet & Voet, 1998). McChesney (2008) observes "Instead of citizens, it produces consumers. Instead of communities, it produces shopping malls. The net result is an atomized

society of disengaged individuals who feel demoralized and socially powerless". (p. 286).
Bauman (2013) argues that individualism has changed identity from what would have been
considered as a 'given' into what could be thought of as a 'task.' "This has led to the
disassociation of how we view ourselves as standing within a community into what he
describes as "compulsive and obligatory self-determination" (Bauman, 2013, p. 32). This is
coupled with the idea that success lies in the hands of the individual regardless of social
inequality. This it is said has led to an increase in uncertainty, insecurity and risk averse
behaviour.

Western individualism is also confused with the notion of autonomy and independence
(Eckersley, 2006). Autonomy is defined by Eckersley as "the ability to act according to our
internalized values and beliefs" (p. 312), whereas independence is defined as not being
reliant on or influenced by others. This could be interpreted as 'thinking of ourselves' instead
of 'thinking for ourselves' (Eckersley, 2006). If this assumption is based in reality, it could
result in people being disconnected, not only from one another but also from the
environment that they inhabit. The net result being communities who are unengaged with
the things that contribute to and affect their lives. Without this sense of common purpose
and public spirit , our democratic rights become less guaranteed. We are so caught up in our
own attempts to meet our individual needs that we can lose focus on what our economies
and our governments are up to. This ostensibly places our democratic rights as citizens at
risk (Chomsky, 1999).

Actor-Network Theory and Neoliberalism

The behemoth scale of the concept of neoliberalism in its different guises has permeated
almost every facet of life in New Zealand/Aotearoa. However, from an ANT perspective,
Latour & Callon (1981) insist that no fully formed notion of neoliberalism or any other grand
narrative truly exists. The pair discuss addressing micro-macro relations in dynamic but not in
evolutionary terms. They argue that micro-actants effectively grow to macro size but that this
is not as a result of social learning, but of relationality. They describe the 'big Leviathan' (in
this case neoliberalism) as an actant that the critic has to treat as no lesser or greater than

other actants in the network, and then trace its associations rather than treating neoliberalism as though it was a macro-structure against which other things are understood. The concept of any grand narrative therefore, is only the sum of its parts and if we try to analyse a unitary overarching system, we may find ourselves working with a 'monster' that we feel that we can never overcome.

There is only neoliberalism after all of the actants are traced and the networking is established. This recognition enables a shifting of focus to particular practices or processes or agencies.

> To summarise, macro-actors are micro-actors seated on top of many leaky black boxes, They are neither larger, nor more complex than micro-actors; on the contrary they are of the same size and is we shall see, they are in fact simpler than micro actors….Macro-actors are no more complex than micro-actors otherwise they would not have grown to macro proportions. (Latour & Callon, 1981)

Neoliberalism and the Health Care System in New Zealand/Aotearoa

Under the auspices of the economic reforms popularly known as 'Rogernomics' (with reference to Labour Finance Minister, Roger Douglas), the impact of the restructured health service during the early years of the neoliberal project was extensive (C. Hay, 1998). This move to the ideological stance of neoliberalism from the traditional political left effected a move from a 'public good'[63] system funded and provided by the state, to a 'managerial' system framed within a business market model. The establishment of a system that aimed to provide free healthcare to all citizens at the point of access (Social Security Act 1938), was replaced with a drive for reduced governmental intervention in healthcare, less centralised governance of healthcare, greater private provision, and the ethos of a competitive market

---

[63] Public goods are goods that are both non-excludable and non-rivalrous. This means that individuals cannot be effectively excluded from use and where use by one individual does not reduce availability to others (Cowen, 2008).

place. This shift was designed to provide greater focus on rationalisation of services and a drive for improved efficiency and value for money, whilst at the same time allegedly increasing public choice and democratizing health care governance (Coburn, 2006).

The devolution of the administration of the public health service led to a decentralization of power and a limiting of the jurisdiction of the Department of Health. The Area Health Boards Act (1983 No 134) was carried forward within a neoliberal framework by the Labour administration providing the establishment of 14 Area Health Boards that assumed public health responsibility, leaving the Department of Health with a diminished level of responsibility. The governance of the public health system had become a New Public Management (NPM) model[64]. Prior to this there was no requirement for performance orientated targets as long as the health facilities remained within budget.

New Public Management and Managerialism

The language of the New Public Management (NPM) structures in healthcare governance demonstrated an allegiance with neoclassical economics and words such as efficiency, performance, accountability, choice, consumer and responsiveness, highlighted consumer sovereignty (Lewis & Moran, 1998). This language endorsed the commercial focus of health and the model of 'managed competition' was adopted (Hendry, 2003). A neoliberal ideology views citizens primarily as rational consumers of public goods and health care, viewed as a commodity, becomes one of these 'goods'.

The introduction of 'managerialism' brought with it changes in authority and accountability in the management of services with managers functioning as independent arbitrators in service delivery (McIntyre, Francis & Chapman, 2011). When factors such as risk management strategies, strategic planning, cost benefit analyses, and performance based

---

[64] The NPM model represented an attempt to apply business-like approach to areas of the public sector
 (Barnett et al., 2009).

targets are taken from the world of commerce and industry they create market based behaviour within these public based facilities. Health care workers are no longer viewed as public servants but as "self-interested actors responsible to the market and contributing to the monetary success of slimmed down state enterprises"(Steger & Roy, 2010: 12-13). A neoliberal approach is focused almost wholly on economic growth and there is little if any acknowledgement of the connections and dependencies that exist between participative democracy, sustainability, social equity, and economic growth (McGregor, 2001).

Consumerism

Consumerism' which is discussed further in Chapter 8, is a central discourse within the framework of corporate governance and when the principles are applied to health services, consumer choice and individual autonomy assume centrality (McIntyre et al., 2011). By eschewing the notion of 'public good' and fostering a culture of individualism within health care, neoliberalism has been charged with altering the culture of the health care workplace to the detriment of health care workers and patients. "This seriously reflects the preoccupation of neoliberalism with consumerism and the acquisition of goods, and neglects to address society's caring role" (Horton, 2007, p. 3). This evolution has been said to have led to changes in ownership of knowledge with a focus on partnership between the provider (health professional) and the recipient (consumer), something that is viewed by many as a positive development. Neoliberalism in healthcare has been bestowed with empowering users of the service, creating cost-consciousness in the use of state resources and challenging the paternalistic tradition of the medical profession (Fitzsimons, 2000). There is evidence that consumer participation can lead to improved health care provision in some countries, but in New Zealand/Aotearoa a genuine resolve to create a seamless public health system/consumer interface was never fully effected (Coney, 2004). The infrastructure for increased participation does not seem to have been coordinated effectively, leaving the state without a strong national consumer voice or a systematic way of networking and information sharing. Meanwhile, Government and health agencies were unable to communicate efficiently with the groups in the consumer sector thereby reducing opportunities for such

groups to participate in decision making and policy development within healthcare (Coney, 2004).

A Pre-existing Issue

Many theorists, policy makers and non-governmental agencies (NGOs) have argued that the health service reforms were necessary, if not essential (Crampton & Starfield, 2004). It is even suggested that the changes, far from being radical, were merely steps in an evolutionary process and that attempts to initiate change had been present long before the 1980s neoliberal revolution. In the decades leading to this wave of reform, reports of inconsistencies in health care quality and inequality in access to health care services were claimed to be creating public and political concern (Gauld, 2008). This was a time when social medicine/public health was being condemned internationally for being expensive and unsustainable (Easton, 2002) and there is no doubt that the shape of health needs was changing. For example, the leading causes of death had shifted from infectious diseases, such as tuberculosis and cholera, to non-communicable diseases such as heart disease and cancer. This was also an era where the public were being introduced to a range of medical technologies and an increasing market of pharmaceuticals of which they saw the benefits.

A further perspective suggests that the health system established in the 1930s was far less progressive and comprehensive than it was ever claimed to be (Bassett, 1998) and that the changes introduced were never going to disestablish what could be considered to be a stable entity. This argument suggests that the vision of a free health system with universal access was never fully realised because of ongoing disputes between the medical establishment and governments. An example cited is that GP's persistently resisted a move to a totally publicly funded model which they viewed as an obstacle to their entrepreneurial activities and income (Easton, 2001). Gauld (2009) debates that this particular social experiment had in fact eventuated as a compromise between a two-fold mix of public and private health care subsidised by a series of measures collectively presented as the General Medical Services (GMS) benefits.

A Nexus – Women need Midwives and Midwives need Women [65]

This landscape of shifting societal values and the altering framework of healthcare at this time provided the backdrop for the development of activity in the network of maternity care. As the midwives in the 1970s and early 1980s had been fighting for their existence, the ideology of neoliberalism had been emerging. Specific elements of the neoliberal agenda were to provide the midwives with social and political ammunition that would enable them to end the punctualization that had rendered them disenfranchised as a profession for so many years. The 1983 Amendment to the Nurses Act could ostensibly have represented the demise of midwifery. However, it served instead as a watershed, an obligatory passing point (OPP) refashioning the landscape of maternity by initiating a process of translation that was to have far-reaching effects.

 The enrolment of actants in networks is never a neutral event. It involves the setting or re-establishment of boundaries in order to grant agency to others. The decades following the attempted disestablishment of midwifery depicts an extremely dynamic period of activity as actants jostled for space, connection, recognition, engagement, and acceptance within the network. The midwives and their allies gained power and strength using a range of enrolment strategies to engineer the creation of a range of obligatory passage points that were to ensure a new and more robust placement in the territory of maternity care.   In the early 1980s frustration was giving rise to increasing politicisation in the midwifery community which may have pre-empted a move into a problematization phase within the network. However, other events within other actant groups were stirring simultaneously. The problematization phase of the translation process in ANT is one where one of the actants renders itself imperative to the others by using a variety of strategies to ensure enrolment.

---

[65] The collaborative political activity described in this section, led the New Zealand College of Midwives to define the relationship between the midwifery profession and maternity consumer groups as 'partnership' and the slogan 'women need midwives and midwives need women' was coined (Donley, 1986).

However, Latour (2005) in 'We have never been modern', states that the 'chicken' and the 'egg' are separate static objects, ,'egg-chickens' or 'chicken-eggs', an argument that eliminates the need for a 'which came first' dialectic. Action within the network does not necessarily emerge from the entity that is observed to act, but may occur as a consequence of the action of other co-located actants (Latour 2005).   It may be that the midwives induced the consumer groups into action or ,conversely, it may have been the birth activists that initiated the action. The potential for multi-agency activity is omnipresent within the network.

A Changing Landscape

The midwifery section of the New Zealand Nurses Association (NZNA) was formed in 1969 by a group of hospital based midwives who had formed a specialist interest group in order to publicly signify their separate status from that of nursing. By the mid-1980s a diminishing number of midwives in practice and a rising birth rate challenged a service struggling to manage the increase in demand for its amenities and facilities (Surtees, 2003b). The service on offer was viewed as both inadequate and inappropriate, and this was particularly acute in rural areas (Hendry, 2003). To compound this problem, nurses were unwilling to undertake the one year midwifery course on offer without funding. Consequently, there were very few midwives registering in the midwifery programmes in the early 1980s (Hendry, 2003). As a result of the unrest, some midwives forged political alliances in order to win support, or lobbied individual MP's (Guilliland & Pairman, 2010).

Simultaneously, the marginalized domiciliary midwives introduced in Chapter 6 were continuing to provide a continuity of care model to women who employed their services. The proposal by the Maternity Services Committee to bring them under the jurisdiction of the Obstetric Standards Review Committee was vehemently opposed by the Domiciliary Midwives Society (DMS). This Society was formed in 1981 and headed by the activist midwife Joan Donley. This group held onto their conviction that women deserved more than increasing medicalisation and determinedly maintained their right to practice homebirth and continuity of care (Guilliland & Pairman, 2010).

The alliance between women and midwives

The midwives drew closer to a position of critical mass as another actant assemblage, in the form of an alliance of users of maternity services, threw their support behind the increasingly unified midwives. Influenced by the second wave of feminism, this collective were spurred into action to challenge the authoritative knowledge of medicine and to question why their rights in relation to childbirth were being ignored (Papps & Olssen, 1997). Surtees, (2003) states that the second wave of feminism in New Zealand/Aotearoa encompassed a robust analysis of the medicalisation of the female body that included political wrangling "over the contested terrain of women's bodies with regard to reproductive choices and fertility and abortion debates" (p. 29). This extended to birth territory in terms of choice of birth place and who should attend a labouring and birthing woman (Daellenbach, 1999b). During the 1950s childbirth educators had been aiming to empower women with antenatal education and had established the organisation, Parent Centre. Finally, the Homebirth Association in New Zealand/Aotearoa was formed in 1980. The supporters of the Home Birth Association formed the "Save the Midwives" consumer group ,which along with a small group of hospital based and domiciliary midwives, worked to seek a way of re-establishing midwifery (Papps & Olsen, 1997; Guilliland & Pairman, 2010).

A definitive period of interessement (Callon, 1986a) was now engaging as the aligning groups moved closer together, collectively placing them in a far stronger position to support the restructuring of the network. The factions united to form a nexus between midwifery and women's consumer groups. The combined forces in this largely female collective, led to the development of a shared vision for the future of the provision of maternity care. The counter actions of the medical profession, such as producing a publication condemning homebirth as being unsafe for babies, only served to fuel the debate and increase the visibility of the Home Birth Association, and by association the midwives who supported and assisted with the practice (Fleming, 1994). The pro-midwifery lobby organised themselves strategically to raise the profile of midwifery and to expose what they saw as the poor and dictatorial provision of maternity care (Guilliland & Pairman, 2010). This activity ranged from

141

speaking at appropriate meetings to lobbying politicians. In 1988 the NZNO[66] Midwives section group went on to establish the New Zealand College of Midwives, "as a separate professional forum ...that provided a focus for midwifery to reclaim its identity." (Pairman, 2005, p. 52). This effectively freed the midwives in the College to intensify the drive towards an independent profession. Midwives who had not been particularly politically aware or active, were suddenly working in regional groups to promote midwifery as a viable alternative to the mainstream obstetrically focused norm of the time (Fleming, 1994). All of these actions contributed to maintaining a coherent and enhanced sense of professional identity and to galvanize the belief that change was needed (Guilliland & Pairman, 2010). The network was in full militating force at this time with enrolment in a powerful and productive phase for the midwives.

The Medical Profession and other Actants

At this time other key players in the network were struggling to contend with the changes that were rapidly redefining their position. When the first Labour Administration took power in the post war era the medical profession was well placed to wield its authority. The government relied on the profession to provide the public with the latest medical knowledge that offered credence to the political management of the economy and social wellbeing. This gave doctors a considerable power base on which to work and negotiate the best deal for their profession. In secondary care, the funding that had flowed into the hospital sector during the aspirational age of social welfare had equally served to increase the power of the

---

[66] The NZNA later became the NZNO

medical establishment and to encourage professional expansionism[67] and medical imperialism[68]. However, the advent of neoliberalism, along with changing societal expectations, altered the standing of the medical profession wherever it fostered influence.

The reining in of medicine

It was argued by some politicians that the welfare states established within a Keynsian framework had given the medical profession too much power under the protection of the state. The healthcare systems under neoliberal governments, however, worked to eradicate the 'nanny state' ethos' encouraging and rewarding an individualistic, competitive and entrepreneurial approach that did not initially sit well with the conservative medical profession. This demanded radical decentralization and a user pays approach for all except the most indigent members of society.   By offering patients (who were now consumers) the right to inclusion in decision making around their treatments and therapies, the neoliberal values of modern consumerism seriously challenged medical hegemony (McIntyre et al., 2011). The oligopolistic practices of doctors were contested as the reforms turned them into providers of care, positioned to meet the needs of the 'consumer'. The 1986 Commerce Act (New Zealand Government, 1986) which enabled doctors to advertise for the first time, is an example of the changing role and expectations of the medical profession occurring at this time. (Barnett & Kearns, 1996). Another example was the introduction of clinics that were funded by corporate health care services; these interrupted the longstanding unwritten agreement preventing competition between medical practitioners (J. D. Bell & Fay, 1991).

It has been countered that medicine been subjected to a gradual process of erosion for several decades as a result of a changing more globalized world and economic impacts .

---

[67] Professional expansionism is described as a deliberate attempt to increase the privileges and rewards of members within a professional group (Rothman, 1979).

[68] As Zola (1983) states "medicalisation is a process whereby more and more of everyday life has come under medical dominion, influence and supervision" (p. 295). This could be applied to the incursion of medicine into the domain of childbirth, which had traditionally been addressed as a social rather than a medical event.

Other critics have countered that neoliberalisation in the healthcare setting is not necessarily opposed to medical dominance and that the neoliberal values of choice and partnership are no more than rhetoric offering justification for the continuing hegemony of medicine over healthcare (Benoit et al., 2005) In spite of this variance in perspective, it is generally agreed that there was a slow change in the perceived traditional role of the doctor as an altruistic healer into an expert within a specific area of medicine. These changes can be seen to align with objectives more related to consumerism (K. Lane, 2006; Sandall et al., 2009). The consumerist approach to healthcare was also inevitably beginning to change the way that the public viewed medical practitioners. What had once been a service was becoming an 'industry' as the health care discourse shifted from considerations of equity to those of efficiency. Meanwhile the new health consumers began to 'shop' around to find the right doctor/treatment/ therapy (Barnett & Kearns, 1996).

The Cartwright Inquiry

A further highly publicised event illustrates how the increasingly powerful voice of consumerism was working to alter the previously deferential public perception of the medical profession. The Cartwright Inquiry (1988) followed a public scandal around the treatment of cervical cancer patients at a leading Auckland hospital. This was viewed by many as an affront to women's health care provision. Feminist activists and women's groups combined to campaign on the grounds that such paternalistic attitudes and behaviours could no longer be tolerated. The Inquiry, which led to the public discrediting of Dr Herbert Green, and a broader admonishment of the hospital based health care system, led to unprecedented reforms in the health care system by protecting patient rights with legislation. It established a model of accountability to patients, through the establishment of the Health and Disability Commissioner, that gained international attention. This incident militated women's groups further to demand greater rights over their bodies and greater involvement in decisions regarding their health (Coney, 1988) and thus helped to fortify the case for greater involvement of midwives in the women's health care sphere of maternity. More recently the Inquiry has been held to account and suggestions have been levelled that the adverse effects on the women involved were exaggerated and that the recommendations

from the Enquiry in fact made little contribution to changes that were already in process within medicine and patient rights (Bryder, 2013). These claims, however, have been refuted and the Cartwright Inquiry is still generally viewed as a watershed moment in terms of patient rights in New Zealand/Aotearoa (Mccredie et al., 2010).

The Might of Political Will

Within the context of ANT, any successful process of translation is reliant on durability (Law, 2007). Thoughts and actions may be worthy and even valid, but they have limited power. In order to build a strong and resilient network that can sustain relations between the entities inhabiting it, durable materials such as a built environment or a text format are required. The Cartwright Report can be considered to be one such stabilizing material entity, an intermediary that contributed to the evolving power base of the midwives in the 1980s. Another, the Nurses Amendment Act (DoH 1990), came about as a result of the enrolment of a major actant in the network with a determination to change the face of maternity care. The MP Helen Clark, who held the office of Minister of Health for the incumbent Labour government between 1987-1989, had established a strong relationship with the midwives and consumers, who had lobbied her for several years. She claimed to understand the issues and expressed concerns about women's health more generally. Clark recognized that maternity services and midwives were key players in providing women with alternatives to the existing status quo in maternity service provision (Abel, 1997). It was Clark in 1989 who proposed an amendment of the existing Nurses Act 1977, which could be more rapidly expedited than a "laborious and time-consuming full review of the Nurses Act"(Guilliland & Pairman, 2010, p. 31), in order to introduce the changes that she agreed were necessary. Simultaneously, Clark set out to explore the potential for the introduction of midwifery education programmes that precluded the need for a nursing qualification.

The Nurses Amendment Bill was introduced to Parliament by Clark during its first reading in November 1989 and was mandated in law as the Nurses Amendment Act on 22nd August 1990. This Act mediated a very important obligatory passage point (OPP) within the network

of maternity care by granting the midwives the capacity to translate other actants in a variety of chains of translation. In many ways, the events that were to unfold created some unanticipated alliances and some unexpected losses within the existing status quo of the network.

Ninety nine submissions were received in the consultation period of the Act, and submissions fell into two broad categories: "those supporting the Bill and indicating brief reasons for that support, and those supporting the principle of autonomy for midwives but raising specific concerns" (Mander and Fleming 2013: p. 6). The submissions represented an eclectic selection of organisations and groups with a broad range of opinions about the proposal. Those expressing greatest concerns came primarily from medical bodies such as the New Zealand College of Obstetricians and Gynaecologists (RNZCOG) whose members were concerned that "midwifery care was not safe without medical involvement" (Guilliland & Pairman, 2010; p. 36), although in principle they did not appear to be wholly opposed to the introduction of midwifery as an autonomous profession (Exton, 2008). The New Zealand Medical Women's Association and the National Council of Women of New Zealand voiced concerns about the decision being a cost reducing exercise (Exton, 2008). Some midwives were also in opposition to the proposal suggesting that not all midwives interests were being met (Guilliland & Pairman, 2010). The New Zealand Nurses Association, to which a considerable number of midwives belonged at the time, was wholly supportive of the severance of midwifery from nursing at this time. Yet the regulatory body representing nursing, The Nursing Council, was vehemently opposed to the idea of direct entry midwifery education and lobbied the Department of Health (unsuccessfully) to retain midwifery education under the jurisdiction of nurse education (Exton, 2008). From a feminist perspective, it could be argued that these female gendered groups were all, in different ways, victims of decades if not centuries of patriarchal oppression. It is theorized that oppression can be perpetuated by the oppressed when the oppressors divide them and pit them against one another to the benefit of those in the oppressing roles (Matheson & Bobay, 2007).

From an ANT perspective this varying range of responses is wholly representative of the heterogeneous nature of networks where nothing is ever quite as it seems, binary division does not exist, and there is no such thing as homogeneity. Within a relatively short time period, the 'nodes' would reposition and previous adversaries quite possibly become allies, and vice versa. Certain actant groups may even be forced to leave the network, as was almost the case with midwives in earlier years. The differences in the network are "less interesting than the complete chain along which actions are distributed" (Latour, 1992, p. 243). Key actants within the various groups were able to draw on cultural understandings around the nature of childbirth and the relationships of those engaged in the sphere of practice.

The Passing of the Act

The ensuing remodelling of midwifery following the Amendments to the Nursing Act (1990) was designed around the 'Partnership Model'. This model aimed to ensure that the delivery of care was a collaborative affair, with women claiming ownership of the process (MoH, 2007). This far reaching reform introduced a system that would enable midwives to work within a framework of continuity[69] (Guilliland & Pairman, 1995; Abel, 1997). Midwives were to be acknowledged as experts regarding normal birth and were effectively mandated to practice to the complete capacity of their role as defined within the Midwifery Scope of Practice[70]. This enabled them to assume full responsibility for providing care for women

---

[69] The Continuity of care model had been recognized as a way to forward the provision of maternity care internationally at this time. For example, the report 'Changing Childbirth' (Dept of Health, 1993), that resulted from the work of an Expert Maternity Group that included women using maternity services as well as health professionals, made demands for continuity of care in addition to choice in type of care and place of birth.

[70] The midwifery scope of practice states that "the midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn. The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral, midwives provide midwifery care in

throughout the antenatal, intrapartum and postnatal periods (MOH, 2007). They could also order laboratory tests, make referrals for ultrasound and obstetric consultation as well as prescribe prescription drugs within the parameters of the Midwifery Scope of Practice. These non-human entities conferred greater power and therefore status to the midwives, strengthening their position within the network.   The legislation supporting this process gave midwives in New Zealand/Aotearoa long awaited autonomy (Guilliland & Pairman, 1995). The fee-for-service[71] payment which had been privileged by GP's for many years was now available to midwives who could provide care 'independently'[72], or in a shared arrangement with a GP or obstetrician (Tully 1999). The Act opened the door to what was an almost exclusively women's domain, which was to set a global precedence with a state-funded maternity continuity of care model, direct entry midwifery education, and eventually its own regulatory authority.

A feminist narrative of magnitude

---

collaboration with other health professionals. Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being. The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides. The Competencies for Entry to the Register provide details of the skills, knowledge and attitudes expected of a midwife to work within the Midwifery Scope of Practice. Whereas the Midwifery Scope of Practice provides the broad boundaries of midwifery practice, the Competencies provide the detail of how a registered midwife is expected to practise and what she is expected to be capable of doing (Midwifery Council of New Zealand, 2010b)

[71] Fee-for-service (FFS) is a payment model where health care services are unbundled and paid for separately. Therefore the more treatments provided the greater the earnings.

[72] I use the term 'independent' with caution as in recent years the midwifery profession has been attempting to get the public to view midwives as part of an integrated maternity service. Midwives were never truly independent in New Zealand Aotearoa anyway as the term independent is legitimately reserved for those who work outside of any public health care service such as those offered in the UK or USA (Wickham, 2009).

On the surface this sequence of events appears to represent a feminist narrative of magnitude. An oppressed group of midwives, supported by women's groups and organisations largely managed by women and championed by a progressive female politician, re-establishing the midwife within a mainstream healthcare context. In working together, the midwives and women had created a hubris for a midwife-consumer relationship which was to provide the nexus for the 'partnership model' that was to become the defining philosophical and practical focus of the midwifery model of the future (Fleming, 1996). However, as identified, the unfolding of events that opened the 'window of opportunity' was in many ways serendipitous and multiplicitous, involving a great deal more than simply feminist intent. The resurgence of midwifery as an autonomous healthcare profession was also aided by amongst other things, the political drive for efficient delivery and financing of services and issues of consumer choice that were the lynch pins of the market-led reforms. The Nurses Amendment Bill may have contributed to the rapidly emerging ideology of neoliberalism in maternity care, thereby assisting the commitment of the proponents of neoliberalism to open up the market place and to break professional monopolies in healthcare, as much as it met the needs of the feminist agenda (Daellenbach, 1999b).

Neoliberalism a Paradoxical Ally

There is no doubt that many were supportive of the midwives who wanted to "regain their identity as midwives rather than nurses and control over their midwifery practice" (Pairman, 2005). However, as Marx, once stated, the problem with perspective is that the development of society cannot be explained by viewing history as a product of a unitary set of values and beliefs (Marx & Engels, 1970).

Throughout the 1980s a drive to improve the 'major deficiencies' related to the provision of healthcare had led to Treasury analysts arguing that the health service would not become more efficient until such time that the delivery of service was devolved to competing providers which it was believed would improve delivery of care and broaden consumer choice (Tully, 1999). At the time that the Amendments to the Nurses Act were underway,

changes were being made to social security and social service provisions that were to change the assistance available, changes ostensibly to create greater self-reliance on the part of the individual and a reduced dependency on the state. When Helen Clark made the opening address at the New Zealand College of Midwives Conference in 1990 she stated that,

> When I became Minister of Health last year, I had the opportunity to do something about the injustice which I consider the loss of autonomy for midwives to be. …I discovered surprising allies. Even the Treasury could see merit in increased autonomy. And if we look at the problem from the perspective of those officials who have been charged by Government with reviewing restrictions on practice which are in essence anti-competitive, there is certainly a strong argument to be mounted against the monopoly of registered medical practitioners in taking full responsibility for the supervision of childbirth" (Clark, 1990, pp. 2-3).

Clark's argument (which had a clear focus on competition and the market), was that the granting of autonomy to midwives would decrease costs in maternity services, appended with the intention to provide a woman centred approach that would offer choices in childbirth. This type of rhetoric was a signal to maternity services to become more consumer-orientated. It was an approach ideologically aligned with neoliberalism (Daellenbach, 1999b).

Although the construction of gender, based on 'partnership' was used by both midwives and consumer groups as a discursive means of introducing radical reforms into maternity care, the choices that women now had were not just about gender but were also determined by the sweeping socio-political changes of the time (J. McAra-Couper, Jones & Smythe, 2012). It would seem that both the feminist driven initiative that allegedly re-instated midwifery in New Zealand/ Aotearoa and the hegemonic model of neoliberalism were, if not amalgamating, then being capitalized upon as a means to an end. The discourse of the new midwifery profession can be seen to bear testimony to this quasi 'fusion'. Fraser poses the question, "Was it mere coincidence that second-wave feminism and neoliberalism prospered in tandem? Or was there some perverse, subterranean elective affinity between them?" (Fraser, 2009, p. 108).

The Emergence of a New Midwifery

Although the allegiance between midwifery and neoliberalism did not necessarily represent a state of convergence within the network, it facilitated a translation that enabled midwives to realize a set of networked possibilities that created a change in status quo that represented a strong degree of (possible) irreversibility[73]. Within this translation process, the midwives braced their position by utilising "professionalism as an indicator of an independent profession"(Banks, 2007).

The National Government that replaced the fouth Labour administration in 1990, was to take neoliberalism even closer to its ideological imaginings by decreasing state intervention even further and increasing reliance on the mechanisms of the market. The policies introduced in the Health Service during this administration set out to improve both efficiency of, and access to, provision of care (Humpage, 2014). A move from curative to a preventative approach in healthcare was encouraged and this was to be achieved by placing greater responsibility on consumers by using the concept of individualism to foster a culture of self-help (Upton, 1991).

In 1993 a series of further health sector reforms were introduced. The Department of Health became the more streamlined Ministry of Health; the Social Security Act 1964 (NZ Government, 2017) was repealed and replaced by the Health and Disabilities Services Act 1993 (NZ Government, 2017); Four Regional Health Authorities' (RHA's) were formed and these purchased services from both public/private and non- profit providers; the existing 14

---

[73] The concept of irreversibility illustrates how translations within actor-networks are made durable and how they can overcome attacks from contesting translations (Callon, 1986b). The extent of irreversibility is dependent on whether it is possible to return to a point where a translation was only one among many and also the extent to which that particular translation determines subsequent translations. In reality, in ANT terms, every example of irreversibility must be pre-empted with 'possible'.

Area Health Boards were re-configured into 23 Crown Health Enterprises (CHE's) governed by a board of directors and managed by a Chief Executive (the CHE's were expected to compete for funding, structured as for-profit organisations and subject to regular company law); and the public health services were dismantled and the Public Health Commission, a separate public health purchasing agency, was established.

The District Health Authories(DHA's) set out the terms and conditions that the RHA's had to use to purchase maternity services from midwives, GPS and obstetricians. The neoliberal schema and its economic subsidiary of capitalism had provided the midwives with an opportunity for utilising the intermediary of market competition with the opposing actant groups in the network. Midwives were now private providers, able to offer a totally state funded service that was universally available at no direct cost to women.

Self-employed business women

According to Guilliland and Pairman (2010) midwives could now "utilise their full scope of practice according to the needs of women, rather than according to priorities of hospitals or the needs of employers" (p. 240). Women, as well as midwives, were granted autonomy in their maternity experience and encouraged to make choices around matters such as place of birth and pain relief in labour. However, as well as being given the opportunity to promote the broad principles of a feminism, the midwives were now self-employed business women who could foster entrepreneurial aspirations in the changing and highly complex field of health care provision. The 1990 Act triggered a significant departure of midwives from the hospital sector. The midwives in hospital lamented the significant reduction in their ability to practice their scope with normal pregnancy birth and post-partum period. When GP's had been involved, their attendance during labour and birth tended to be short-lived as the hospital midwives would monitor the labour and call for the GP as the birth became imminent. The new breed of self-employed midwives attended for the labour and birth and this impacted on the degree of involvement and consequently the job satisfaction of the

hospital based midwives who saw the advantages of working independently (M. Banks, 2007). This addition to the self-employed workforce meant that there was greater market competition between the providers. Midwives were now not only in competition with their medical adversaries, but also with each other, heightening the quasi-market position of providers of maternity care. Guilliland and Pairman (2010) defend this outcome by claiming that it was necessary for a self-employed model to be initiated in order to expedite change to enable midwives to utilise their full scope of practice. They assert that midwifery autonomy would not have been achieved if midwives had remained employed by CHE's.

Turf wars and matters of finance

The 'turf wars' between doctors and midwives (Henaghan, 2012), that took place in the 1990s were reminiscent of the turf wars discussed in Chapter 5 during the 16th Century between the midwives and the men-midwives/barber surgeons, with the exception that many GP's were now women. Gender related issues feature strongly in both and the weightier epistemological questions relating to whose knowledge and skills counted at an authoritative level was still a powerful argument in the 1990s. However, at this time there was an important additional focus on matters of finance, a mediator that added another dimension within the network, and a factor that was purportedly present to assist the midwives in the climate of enhancing cost-effectiveness and efficiency. However, in addition to having greater autonomy in a primary care based, self-employed capacity and carrying a case-load, there were personal financial advantages for midwives over their hospital based colleagues at that time[74].

The Nurses Amendment Act enabled midwives to access the same maternity benefits fee

---

[74] In New Zealand there is no mandated minimum or maximum caseload size. Although NZCOM have always advocated that 40-60 women is probably a reasonable caseload for a full time midwife (Calvert, 2015).

schedule as doctors[75]. This was furthered by a review of the Maternity Benefits Scheme by the Department of Health in 1992 where a decision was made to pay an hourly rate for care in labour. As midwives were spending considerably longer periods of time with labouring and birthing women, the tribunal outcome inevitably weighed in favour of midwives. The NZMA threatened a judicial review and eventually four Regional Health Authorities assumed responsibility for a project on maternity services that set out to create an integrated maternity services framework. This would eventually lead to the important development of minimum service specifications for maternity in the form of the 1996 Section 51 Notice. Many GP's chose to abandon obstetric provision at this time and there was continuing conflict between the providers. The ending of the monopoly of the medical fraternity over childbirth in the context of the market based reforms gave midwives opportunities that they would almost certainly not have been privileged to have without the advent of neoliberalism, with midwives increasingly able to take advantage of the ideology of competition and choice. (Tully, Daellenbach, & Guilliland, 1998, p. 48).

From training to education

The concept of the market place also pervaded the education and educational experience of midwives. Midwifery training[76] (which was only available to nurses) had already moved from the field of health service delivery into tertiary education following the Carpenter Report of 1971(Gilkinson, 2013). Throughout the 1980s and 1990s the institutions offering midwifery training were in the throes of their own neoliberalisation. This action demonstrates how the chain of translation in Actor-Network Theory is acted out within the network at a meta-level, with the narrative of neoliberalism in health connecting with the same ideological

---

[75] The fee-for-service was claimed from the Department of Health as part of the Maternity Benefits Scheme introduced by the Department of Health and not directly from the users of the service.

[76] The words training and educating are frequently used interchangeably with reference to healthcare practice. However, although both can be used within preparation for practice, there are distinct differences that should be addressed. Training gives the skills to do something rather than know something. Education provides the theory. This is important in the consideration of the development of a profession (Freidson, 2001)

methodology within an educational context. Student midwives were now additionally required to self-fund their education, which reinforced their need to become 'business women' as many now had to find the optimal means of repaying their student loans (Surtees, 2003b). The first direct entry midwifery programme offering a Diploma level course was established at AUT in 1992 and it was followed shortly afterwards by a Bachelor of Midwifery at Otago Polytechnic. Gilkinson (2013) suggests that the New Zealand tertiary sector was following an international trend where education is commoditised and regarded as "an economic industry"(p. 21).

Section 51 and the introduction of the LMC

Although they had increased their presence within the network, the positioning of midwives remained tenuous and contingent. Throughout the first half of the 1990s the midwives had to remain vigilant as other actants jostled to reclaim what they considered to be their rightful positions and reinstate their own interests. Under Section 51 of the Health and Disability Services Act 1993, which came into effect in July 1996, maternity care funding was reformed to a fixed-fee-system[77] instead of the previous fee-for-service payment. The negotiations that took place to implement the Notice between the RHA's, providers, consumers and CHE representatives were lengthy, contentious and at times rancorous. The inter-professional rivalry was heated and highly public with media taking full advantage of the drama unfolding in their reporting (Tully, 1999).

Section 51 fortified the position of the midwives with the introduction of the Lead Maternity Carer (LMC). Guilliland, (1999) refers to the introduction of the LMC as the recommencement of autonomous practice for midwives. The LMC, who was to be either a midwife, a GP, or an obstetrician, was expected to provide full provision of care, throughout the pregnancy, intrapartum, and postnatal period. LMC's were to be paid for care in a modular format inclusive of episodes of care. The module fees were seen as a means of

---

[77] A fixed fee system is a pricing structure that charges a single fixed fee for a service regardless of usage.

cost-cutting on the part of policy makers[78] (Bryder 2014) and thus met opposition from many different groups. It was however, the proposal of a continuity of care model coveted by many midwives, that was the major cause of contention. Midwives, unlike GP's (their chief competitors in the market), were in a position to provide a comprehensive package of care throughout the childbirth continuum. Direct entry midwifery education was already preparing students to be practitioners who could provide continuity of care (Surtees, 2003). The NZMA rejected the Section 51 Notice and a number of GP's chose to boycott the scheme whilst others began charging women for their services outside the remit of Section 51. The College of Midwives found itself facing criticism from doctors, and also from members of their own profession. In spite of the placations from NZCOM that this was a temporary but necessary measure on the journey to autonomy, many midwives were disappointed by the payment specifications which they saw as impacting on their income. Guilliland, as the CE of NZCOM, urged members of the College to support the philosophy underlining Section 51 as a means to achieve complete autonomy by providing 'equal pay for equal work (Surtees, 2003). Meanwhile the doctors established a Joint Maternity Working Party, which excluded midwives. It was suspected that the RHA's were working with the doctors to develop a proposal to alter the current specifications to favour their members more by bringing back the fee-for-service payment model as well as other introductions that would give favour to doctors. After considerable and lengthy political wrangling, in June 1997 the NZMA notified its membership that it must decide to accept or reject the Section 51 Notice. Rejection would mean being unable to claim payment for any maternity service provided. A compromise was eventually reached that meant that doctors would receive a specified birth fee but they remained in opposition to the capped modular fee on offer. The College of Midwives in turn opposed the specified birth fee. Nonetheless, in February 1998, a compromise was achieved and a new Section 51 Advice Notice was issued to take effect from March 1st 1998.

---

[78] For example dealing with the issue of 'over-servicing', where if the woman had appointed more than one caregiver, such as a GP and a midwife, both could claim payment on the existing payment schedule. Under the auspices of Section 51, the primary carer was required to subcontract individual tasks if shared care was selected.

156

Guidelines for Referral

The dealings evolving in the last few years of the 20th and the early 21st century demonstrate a tangible shift in the focus of midwives, but also those of the other human actants. The fighting on the political battleground appeared to move closer to the negotiating table and there was an increasing emphasis on improving the quality of maternity care within the legislative framework. For example, in 1997 a major achievement was grasped with the publication of the Guidelines for Referral to Obstetric and Related Specialist Medical Services[79]. The implementation of the guidelines was not without challenge as they were frequently used as 'policy' or 'rules' which precluded the rights of the woman to be involved in the decision making processes. However, the guidelines were reviewed again in 1999 with a stronger consumer input and in 2000 the guidelines were attached to the Section 88 Maternity Notice following the passing of the Public Health and Disability Act (2000). In addition to providing the referral guidelines, Section 88 specifies all aspects of services to be provided by LMC's; identifies quality indicators and processes; sets out prices and payment rates; specifies generic access to hospital facilities; and provides claim form templates (MoH, 2007).

Midwifery Council of New Zealand and Regulatory Requirements

In September 2004 the Midwifery Council of New Zealand assumed regulatory responsibility for midwives as it was handed over from the Nursing Council of New Zealand. This action followed the passing of the Health Practitioners Competence Assurance Act (HPCAA) (MoH,

---

[79] The guidelines were the result of three years of consultation and negotiation between RANZCOG, NZMA, RNZGP and the Paediatric Society as well as the NZCOM and RHA's. What began as a "risk list approach to maternity care" (Guilliland and Pairman 2010) was shaped into an evidence informed list of criteria that would constitute referral with informed consent explicitly included. This document represented a significant step forward in terms of inter-professional collaboration.

2003) exactly a year earlier in September 2003[80]. Section 11 of the Act states that the Act is "...responsible for the protection of the health and safety of women and babies during the childbirth process by providing mechanisms to ensure that midwives are competent and fit to practise midwifery". In accordance with the HPCAA, the MCNZ was required to define the midwifery scope of practice and to establish the requirements for practice. They also developed a set of core competencies that every midwife would be required to meet in order to register as a midwife in New Zealand/Aotearoa. With the establishment of its own regulatory body, the final structures were put in place to fully ratify autonomous midwifery practice in New Zealand/Aotearoa. The HPCAA (2003) replaced the Nurses Act (MoH, 1977) and the amendments of other pieces of health professional regulatory legislation[81] in order to position midwifery on an equal footing with other health professions. Once again the positioning of the players within the network conspired to make this happen and the status was conferred in an opportune manner, as the events leading to the passing of the HPCAA had provided a framework for the regulation of many groups of health practitioners including midwives.

---

[80] The primary purpose of the Act is public safety public which is achieved by ensuring that all health practitioners are competent and fit to practise their professions. This aim is supported by the following mechanisms:

- Scopes of practice describe and define the boundaries of each profession.
- Professional competence has to be proven in order to register as a health practitioner.
- Evidence of continuing professional competence is required when a health practitioner applies for a practising certificate in order to be able to continue to practise.
- A Regulatory Authority can suspend a practitioner's practising certificate, impose conditions on a scope of practice or alter a practitioner's scope of practice. (Ministry of Health, 2015.)

[81] Medicines Act 1981

Medicines Regulations 1984

Misuse of Drugs Act 1975

Misuse of Drugs Regulations 1977

Privacy Act 1993

Health Information Privacy Code 1994

Accident Compensation Act 2001

Scope of Practice

Once the regulatory body was in situ, the Midwifery Scope of Practice was introduced in 2004 after a period of consultation with stakeholders, including consumer and medical groups. The Scope of Practice provided the legal definition of midwifery practice where midwives are expected "to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn"(para.1)[82] All midwives were now enforced to be registered for practice with MCNZ. They had to hold an Annual Practising Certificate (APC) and had to submit a declaration of meeting MCNZ requirements to practice and this meant meeting the competencies for practice decreed by the MCNZ[83]. In accordance with section 41 of the HPCAA, midwives were now mandated by the MCNZ to demonstrate sustained competence by completing a recertification programme over a three year period[84] In 2008 MCNZ

---

[82] This means that midwives must retain the ability to work across the scope and be able to demonstrate this as part of their recertification requirements.

[83] The Competencies for Entry to the Register are:

Competency One:

The midwife works in partnership with the woman/wahine throughout the maternity experience

Competency Two:

The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care

Competency Three:

The midwife promotes practices that enhance the health of the woman/wahine and her family/whānau and which encourage their participation in her health care

Competency Four:

The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care

[84] Over a three year period participants are required to:

- Make a declaration of competence to practise within the Midwifery Scope of Practice
- Competently practise across all areas of the Scope
- Maintain a professional portfolio

introduced amendments to the educational requirements of midwives. In order to be deemed competent to practice across the Scope of Practice, midwifery students had to compete a programme of education approved by MCNZ and pass the Midwifery Council Midwifery Examination[85]. From 2007 all graduating midwives were expected to complete a government funded Midwifery First Year in Practice (MFYP) Programme[86] and this became a compulsory requirement in 2014.

The Trojan Analogy

In the vernacular of ANT, the lid on the black box was closed a little further as midwives in New Zealand/Aotearoa were conferred as autonomous and independent health care professionals, with their own regulatory body and their own regulatory requirements. The network of maternity care during the turbulent years in the run up to the HPCAA is a very clear example of the self-serving nature of actants within the network. In spite of the fact that the underlying political intent of neoliberalism seemed far removed from the declared socialist feminist principles, the midwives utilized the ideology of neoliberalism to ensure an effective translation could occur. The narrative of the Wooden Horse of Troy is an analogous

---

    o   Complete all compulsory education including

    o   A two hour adult CPR session annually

    o   two hour neonatal resuscitation session annually

    o   A two day technical skills workshop once every three years

    o   A four hour breastfeeding workshop once every three years

- Complete a minimum of 50 points of elective education and professional activity
- Participate in a Midwifery Standards Review (MSR)

[85] During a three year degree programme the students have to complete a minimum of 4800 hours with 50 % in practice and at least 40% in midwifery related theory. They also have to undertake a designated number of antenatal and postnatal checks, labour and birth care and newborn assessment. The must also participate in the care of at least 40 women experiencing complications during the childbirth continuum.

[86] This includes a mentoring component, practice component and educational component as well as an extended Midwifery Standards Review process.

means of framing the events that unfolded to secure the position of the midwives in the face of the long term resistance of the medical, nursing and other groups[87]. Whether they were primarily manoeuvring with intent or simply employing a serendipitous opportunity, the midwives successfully engaged with a figurative Trojan Horse in the shape of the neoliberal project in order to transfigure the network at the time. Midwifery had used the might of neoliberalism to achieve its own end and in so doing had broken the medical monopoly over childbirth in the competitive market oriented domain of maternity care in this new epoch. However, although the midwives may have emerged as the 'victors', they remained circumspect, still concerned that at the first opportunity the doctors would disenfranchise midwifery and attempt a return to the former status quo in the form of another chain of translation (Guilliland & Pairman 2010). Midwifery could not permit this hard won battle to be lost again and, as their position strengthened, they ostensibly retreated to some extent from the neoliberal project to give their full attention to the 'professionalisation project' (Pairman, 2005) as the next strategic step in the punctualization of their near[88] hegemonic stance in the network of normal childbirth. However, yet again the confounding nature of the web effect that creates networks was to draw the concepts of neoliberalism, feminism and professionalism into the affray as related, rather than wholly different, concepts.

The Professionalisation Project

---

[87] The story of the Trojan horse is one of stratagem and opportunism. In the story, enshrined in the poem by Virgil, after a unproductive siege of many years, the Greeks built a colossal wooden horse and hid an elite group of warriors inside it. The remainder of the Greeks pulled away leaving the horse at the gates of the city and the Trojans pulled it into their walled city as an emblem of victory. Whilst the citizens of Troy were sleeping, however, the warriors inside crept from the horse and opened the gates to allow the remainder of the Greek army access. The Greeks then entered the city of Troy and conquered it.

[88] Latour (2005) is critical of the concept of hegemony as being too often "confused with a postmodern emphasis on the critique of the 'Great Narratives' and Eurocentric standpoint" (p. 11). He therefore challenges the whole notion of a hegemonic standpoint as a virtual and contingent phenomenon.

The flurry of regulatory action that occurred in the period following the inauguration of the MCNZ, as outlined in the previous pages, was providing the metaphorical roof for the professional abode of midwifery that the members had been building for some decades. In so doing they were further securing their hard fought position, now using the concept of professionalism as a mediator, to further influence the relationships within the network and to reshape the network boundaries again. The aspiration to win professional status and thus gain professional autonomy, was in many ways the driving force of the midwives and the desired professional identity of midwifery was viewed as an important factor in the reconfiguring of the network. In her doctoral thesis, Pairman (2005) acknowledges that the move towards the professionalisation of midwifery was intentional and strategic.

Professionalism, which refers to the internalisation of the values and practices of the profession by its members (Freidson, 1994), is said to create a means of articulating standards, competencies and ethics. It is also the means by which an occupational group keeps its social contract with society (Belar, 2013). It was important for the midwives to be able to articulate a clear sense of professional identity in order to gain kudos and maintain credibility. Professionalisation was therefore a key strategy in operational terms and professionalism a lynchpin in maintaining the tenure of midwifery in the network of maternity services.

Defining Professionalism

Professionalism is a concept that is contextual, provisional and not easy to define (Fox, 1992; Englund, 1996; Hargreaves & Goodson, 1996; Evetts, 2011). As Freidson (1994) states, "much of the debate about professionalism is clouded by unstated assumptions and inconsistent and incomplete usages" (p, 169). Nonetheless, it is generally accepted that professional

groups have body of knowledge and skills that demonstrate a level of expertise[89] or competence[90] that is societally endorsed and where they gain financial reward from the application of this knowledge (Freidson, 1994; Fournier, 1999; Tully, 1999; Timmons, 2011;Evetts, 2013).

Characteristics of Professional Groups

The definition above can be further broken down into elements that are generally accepted to signify 'professional'. These include: autonomy, specialised theoretical knowledge, the existence of professional norms, competitive selection procedures, specialised education and credentials, altruism based around a code of conduct and ethics, a regulatory framework, a disciplinary system to deal with those who break standards, public recognition and trust, and lifetime careers (Andersen & Pedersen, 2012) . However, this list of characteristics is subject to change according to contextual and societal need. For example, self-regulation is not carried out in the same way that it was in New Zealand/Aotearoa in the wake of the Cartwright Report discussed on p 138. In principle the professional bodies do still self-regulate, but the reforms of the Health and Disability Act (1994) and the HPCA Act (2003) have led to the introduction of a co-regulatory model with more lay participation and external monitoring (Patterson, 2010).

Evetts (2013) suggests that the line between profession and occupation is now less defined than ever and that any analysis of either needs to be performed with regard to the other as they share many common characteristics. The question of which occupational group qualifies as a profession is wide open to dispute with some researchers shying away from

---

[89] Ehrenreich and English (1973) point out that expertise has traditionally been confused with professionalism which they claim is a misleading assumption. However, Fournier (1999) suggests that although expertise is not synonymous with professionalism, it partly acquires its authority through professionalism.

[90] The term competence is often broadly used for representing knowledge, skill, attitudes and the experience required to fulfil a certain role (Butler, Fraser, & Murphy, 2008)

offering a definition of profession, preferring to list what they consider to be relevant occupational/professional groups (Aldridge & Evetts 2003). For example, (Freidson, 1988) suggested that such a specific definition of profession based around ideology justifies inequity in the status and social closure between occupations.

A Brief Theoretical History of Professionalism

Much of the analysis of professionalism and professionalisation is presented from a 'power' perspective. The earlier sociological views of professionalism were largely viewed from a functionalist perspective, represented in the work of Durkheim (1997), where the professions were viewed as entities that embodied strong social values and so would perform as respected intermediaries between the population and the state, thus giving them considerable status and control. This categorisation of professionalism, often referred to as 'classical professionalism', is generally used to describe the 'original' status professions of divinity, law and medicine (Hughes, 1963). These groups, who eventually granted entry to other occupations such as accountancy and engineering, were granted legitimacy by the jurisdiction to license and regulate the entry to the profession and the activities of their members. Freidson (1994) viewed the professions as a pivotal, apolitical mechanism within society and accredited those working within these professions with having altruistic notions of 'service'. It was assumed that such 'service' was sanctioned by society, free from ideology and accepted as being of mutual benefit to the practitioner and the client/patient (Tully, 1999).

Post professionalism

A 'post-professionalism' perspective emerged in the 1970s reflecting a major shift as sociological conflict theory began to play an active role. Additionally, professional individuals and groups were being subjected to claims of incompetence and corruption which undermined public faith (Saks, 2015). The theorists now turned to Neo-Weberian and Marxist theory, which focused on hierarchies and power structures, to present a critique of the

classical version of professionalism (Larson, 1977; Evetts, 2011).   A neo-Weberian analysis of professionalism is centred on market conditions and how professions exploit expertise to gain social and financial benefits (Larson 1977).   Neo-Weberians theorise that professions were institutionalized and monopolistic and that members used the cloak of professionalism in order to protect and enhance their power base (Grossman, 2004).   This Marxist, Neo-Weberian 'power approach' position challenged the existing status quo of classical professionalism, claiming it to be an Anglo-American hegemonic perspective and that some professional groups were self-serving and elitist (Larson, 1977; Freidson, 1970; 1988).

New Forms of Professionalism

In the last few decades, significant socio-political changes resulting from a range of phenomena including the rise of neoliberalism, gender transformations in the workplace and changing societal expectations, have led changes in what would constitute 'professional'. Societal developments have encroached on the traditional perspectives of professionalism, with many professions finding occupational control of their work and discretionary decision making increasing difficult to maintain and sustain (Evetts, 2012). Members of professional occupations have shifted into organisational employment and large commercial companies where it is more difficult to maintain a strong degree of occupational control. This has been compounded with the introduction of public/private structures in the form of   PPP's[91] and a call for the professionalisation of roles in the voluntary sector in the shape of charities and non-governmental organisations (NGOs) (Langer & Schrőer 2011)[92].

These changes have led to the rise of different brands of professionalism such as bureaucratic or organisational professionalism, which is based around managerialism and the so-called "new professionalism". Regulation is externalised and target setting and performance review play an important part in the framework. New Professionalism (NP) is

---

[91] See page 130

[92] See page 247 in Chapter 9

the most recent contender in the professionalism stakes and it has been adopted by many occupations within the public service sector. New professionalism been heralded as a horizontal rather than a hierarchical form of professionalism with shared values and accountability and a collaborative stance between professional groups. NP is typified by client education and empowerment, ongoing reflection on practice, partnership, choice, emotional intelligence, collaboration, and patient/client centred care. Light (2010) argues that new professionalism is couched (in large part) in terms of three central criteria. A shift from a training and licence model of accountability to a competency/performance based model; a move away from self-regulated trust towards a form of informed trust based on standards competency and performance; and a new team approach model of professional work. These changes are said to herald "a systematic attempt to further embed principles of buyer-dominance into the field of statutory health care" and of exchanging autonomy for accountability (Saks, 2015). Somewhat ironically, it would appear that at the time that midwives were re/claiming autonomy, there was a move away from this towards public accountability.

Professions and occupations

The midwives in New Zealand/Aotearoa had sought to progress from 'occupation' to 'profession'. They observed obstetrics, as a branch of medicine and therefore part of a 'status profession', being used as a yardstick against which the other health related occupations in maternity care were measured in terms of importance and public standing (R. J. Surtees 2003b). In the years preceding the re-establishment of midwifery practice in New Zealand, midwives, like nurses, teachers, and social workers, were classified as semi-professional workers. The work of these semi-professional groups was perceived to be less autonomous than the work of the higher status professions; these latter professions were deemed to be more exacting in terms of gaining entry, thus demonstrating strong occupational closure (Abbott, 1988). However, as early as 1963, Hughes was suggesting that the differences between professions and occupations were differences of degree rather than kind. Likewise Freidson (1994) identifies the notion of profession as being entirely synonymous with occupation, based on the reference to specialized work for which one is

remunerated. Although the idea that only traditional professions carry out expert work associated with a specific epistemological and ontological foundation continued to pervade the common perceptions of what constituted professional, the gates were certainly opening to allow through a much broader range of professions.

Each occupational/professional group had its own vested interest and interpretation. It is speculated that this is because the concept of professionalism did not develop as a homogenous system, but resulted from different trade groups going through their own processes to reach their own idea of professionalism, irrespective of their relationship with other occupational groups (Freidson, 2001). Proponents of ANT would argue that this was unlikely because in actor-network theory, everything is relational (Callon, 1986a; Law, 2011). Yet the viewpoint that the need of a secure and privileged place in the evolving economic world of capitalism had led middle class occupational groups to seek professional status (Freidson, 1976) appears to fit comfortably within an ANT framework . This action resulted in the establishment of credentialing and training institutions thus bringing the market into line with the process of professionalisation (Freidson, 1983).

 Hafferty, (2006) describes professionalism as a "zero sum game" (p. 193). That is, in order for one group to attain or increase professional status, the gains of one group needs to be compensated by the losses of others. This at first glance could be applied to the state of play in maternity care over the ages, with the on-going reshaping between the various actants resulting in territorial disputes termed as 'turf wars'. However, again, this perspective suggests an acceptance of a hierarchical approach, that is, power being exerted over one group by another. In ANT the changing state is seen as resulting from relational activity within the network that leads to the transformation of hybrid collectives into coherent networks (Callon, 1986b). Any re-shaping of the network is achieved by "funnelling, reframing or mediating the concerns of several actors into a narrower passage point" (Duim, Ren, & Jóhannesson, 2012, p. 235), and an advocate/mediator defines the identities of the actants. This consequence is evident in the territory of maternity care provision in Aotearoa during the tempestuous years of the re-establishment of midwifery as a profession, where

167

the significant mediating presence was the concept of neoliberalism and the enrolment of the groups that utilised the ideology.

A New Professionalism for Midwives

"The central tenet of New Zealand's midwifery professional identity is that midwifery is the partnership between women and midwives" (Pairman & Donellen-Fernandez, 2015, p. 275).

During the renaissance of midwifery in New Zealand/Aotearoa from the 1970s onwards, midwives purposefully reconstructed their collective role as a professional practice by using the concept of partnership (Guilliland & Pairman, 1995a; Tully, 1999; Pairman, 2005). From the early days when the activist midwives and consumer groups combined forces in an endeavour to usurp the powerful mandate of the medical profession, the concept of partnership was mooted and it was given primacy after 1990 when the partnership model as defined[93] by Guilliland and Pairman (1995) was published in the first Midwives Handbook for practice (NZCOM, 1990). The midwives viewed 'new professionalism' as a model that could provide a legitimate professional framework to build capability to articulate their value and their contribution to health care and society as a whole (Guilliland, 1999).

Professionalisation as a gendered concept

---

[93] The defining features of the partnership model were:-

- pregnancy and childbirth are normal life events.
- midwifery's primary professional role is with women experiencing a normal pregnancy, labour, birth and postnatal period.
- Midwifery provides women with continuity of caregiver throughout her childbearing experience.
- Midwifery is woman centred (Guilliland & Pairman, 1995a).

Evetts (2013) argues that professionalisation and professionalism are historically gendered concepts. She proposes that the part played by neoliberalism is an important reason for the increase in the stature of certain occupational groups; that the ideology has led to unprecedented opportunities for specific female-dominant occupational groups such as midwives and social workers. The willingness of the midwives to take on the façade of the free market in order to compete with GP's and obstetricians within the sphere of maternity care was viewed enthusiastically by the professional administrators and bureaucrats in the Department of Health. The midwives held the capacity to challenge the monopoly of the medical profession and it was therefore in the interests of the Department of Health managers to take on a mediation role and support the strengthening of the position of midwifery in the network. Kutinova (2008) states that the government at this time financially favoured midwives over doctors in the field of maternity care. This argument is based around the belief that the state is requisite in order to licence professions and will only recognise a profession when it suits their purposes (Abbott, 1988; Larson, 1977). However, this was not about power in a traditional hierarchical sense but was concerned with the relational interests of quite disparate groups. At the time that the midwifery professionalisation project (Pairman, 2005) was being planned, some feminist scholars urged a cautionary approach in the claiming of professionalism (Davies 1996; Dillabough, 1999; Glazer, 1990). Davies (1996) wrote that the specific historical and cultural construction that was based on male values fit uneasily with the newer and more feminized professions.

Unlike other groups, such as teachers and social workers who had adopted the concept[94] (Hargreaves, 1994), the midwives unsurprisingly chose to utilise the theory within the context of a feminist framework. Pairman (2005) describes the model of midwifery in New Zealand/Aotearoa as a "new form of professionalism whereby a partnership is formed between the woman and the midwife" (p. 65). The 'new' professionalism was to purportedly lead to a state of equity and reciprocity between midwife and woman within the relationship

---

[94] New professionalism is recognized to have garnered particular interest amongst practitioner workers within the public service sector (Evetts, 2011)

with both viewed as "making contributions that are essential to a successful relationship and to positive outcomes for the mother and her baby"(Pairman, 2005, p. 14).

New professionalism or de-professionalising?

The concept of "new professionalism' has been held to account by many and critics have suggested that it is a cosmetic exercise and even a 'road block' in the process of genuine professionalisation. (Timmons, 2011). The concept of new professionalism with a focus on commercialism and quality has inevitably been aligned with neoliberalism and marketization (Evetts, 2011). It has been proposed that the liberalising meaning of professionalisation and its offerings of autonomy has altered its position to be even more focussed on regulation and accountability (Hoyle and Wallace, 2005; Timmons, 2011). This has led some theorists to suggest that 'new professionalism' is more akin to a de-professionalisation process and has even been hijacked as a form of occupational control (Muzio & Kirkpatrick, 2011). Evetts (2013) views professionalism as an ideology of controls used to "Convince, cajole and persuade employees, practitioners and other workers to perform and behave in ways in which the organisation or institution deem to be appropriate, effective and efficient" (p. 411).

The concept of new professionalism in midwifery would seem to be comprised of a hybrid blend of liberal feminism and neoliberalism. Evolving from the perspective of a woman-centred ethic of care it embraces values such as individual choice and autonomy that allow women to 'choose' to be healthy and productive, whilst also leading to a reduction in demands of the state as women govern themselves and each other.

Surtees (2003) suggests that the wider networks of disciplinary and professionalised power, surveillance and (self) regulation are the tools of an overarching neoliberal approach to health care in New Zealand/Aotearoa. The ideological premise of partnership as a feminist concept can equally be applied to the rhetoric of 'inclusive' neoliberalism, when it extols the use of policies that promote opportunity, empowerment, and security. Whilst still market-led, the emphasis is on partnerships and good governance. However, this, it has been

suggested, is a form of 'wolf in sheep's clothing', that seeks to "re-embed and legitimate a liberal social and economic order" (Porter & Craig 2004), without addressing the true causes of social injustice and inequality. The neoliberal project was closely aligned with the concept of partnership and this was particularly so in healthcare with a focus on partnership between the provider and the consumer. It could therefore be construed that neoliberalism and feminism had found another point of synergy in the domain of the professionalising of midwifery.

The contemporary midwifery professional identity

Professional identity is recognized to be a tenuous concept, but is considered to be a vital component in the success of a profession (Remley & Herlihy, 2013). It can perhaps best be defined as a form of self-concept based around one's profession that is constructed from values, beliefs, attributes, motivation and experiences (Ibarra, 1999a). This is often convoluted by the potential for conflict between the personal and professional identity of the individual. This is addressed in some professions including midwifery by applying professional codes of conduct and codes of ethics that offers some guidance in terms of acknowledging and working with this (Midwifery Council of New Zealand, 2010a). Additionally, many health related undergraduate programmes, including midwifery, aim to help students to become aware of their self-identity by exploring the sociopolitical and cultural influences that have shaped who they are and to explore how they articulate with professional values and behaviour. This education is delivered under the auspices of the auspices of 'Cultural Competence'[95] (Pairman, 2010).   Remley and Herihy (2010) found that individuals with a well-defined sense of professional identity felt a sense of pride in being a

---

[95] Cultural competence is integrated into the Midwifery Council of New Zealand competencies for entry to the register of midwives. Cultural competence for midwives requires the application of the principles of cultural safety to the midwifery partnership. Cultural safety is the effective midwifery care of women by midwives who have undertaken a process of self-reflection on their own cultural identity and recognise the impact of their own culture on their practice (Midwifery Council of New Zealand, 2012).

member of that profession and were able to communicate a strong sense of belonging. However, the caveat is that a sense of collective self-esteem seems to be central to the professional identity of the individual (Crocker & Luhtanen, 2003). Ergo, if the profession does not have a strong sense of professional identity, then the individual members of the group will not either.

Currently the professional identity of the midwife in New Zealand/Aotearoa is a complex and multi-dimensional construct affected by externally derived influences such as social identity and professional relationships. My analysis of past events unveils a broad range of midwifery 'identities' that surface and retract according to what is happening within the broader social context at the time. Within the confines of the European historical context this identity would include wise women, healers, witches, business wen, and nurses. In a more contemporary setting the discourses of professionalism and professionalisation can be viewed as a means of creating identity (Evetts, 2013). However, such classification serves to simplify what is essentially a complex issue, as midwifery identity, like any other identity, needs to be viewed as a discursive practice, a fluid process of knowledge and skills formation that has altered in character considerably over time and space, crossing the borders of rigid definition (Read & Bartkowski, 2000). In the contemporary sphere of practice, professional behaviour may present because it is a performative element of the identity. Identities are what we do. Professional identity may be reinforced by performance; doing what is expected of a professional can make people feel more professional. Surtees (2003) agrees that there are an abundance of midwifery identities that are constructed according to time and place and as a result midwifery, "develops as part of, and in accordance with, the dominant and prevailing discourses around economic, cultural, social and political regimes of power within which it is embedded" (p. 27).

Conclusion

One of the criticisms of ANT by feminists is that it marginalises oppressed groups such as women (Wajcman, 2000). In the case of the midwives, it would seem that the marginalised

group became, for a while at least, the triumphant conquerors. It remains unclear as to whether this was a well planned and executed campaign or simply a serendipitous and fortuitous series of events that gave midwives in New Zealand/Aotearoa a window of opportunity to take action and stake their claim as the primary actants in the field of maternity care. ANT has been defined as a theoretical approach that is useful for "exploring messiness" (Law, 2004, p. 4). It neither claims to offer a framework for certainty or a methodological rule book for studying associations (Latour, 2005b). Law(2004) instead advocates that ANT is a "Toolkit for telling interesting stories" (p. 1). In this chapter, the messiness is at times overwhelming and the narrative compelling. By establishing a connection and opening a dialogue between the provinces of ANT, neoliberalism, feminism and professionalism, I have been able to rummage through the artefacts and comb through the debris in the field of maternity care in the final decades of the last century and the early years of the current century in a way that has facilitated a new perspective. The re-establishment of midwifery once enshrined in legislation, signalled a period of black boxing that was to last effectively to the present-day setting. At its 'closure' the black box was seriously "leaky", with the macro-actant of neoliberalism sitting on top of the box observing the changing shape of the tableau created by the actants within the 'box'.

Chapter 7. Sustainability and Midwifery Practice

Latour (2005) advocates that in order to follow actants the network has to provide evidence of preceding activity which can be researched and recorded. As I established in Chapter 4, in ANT no network stands alone without existing connection, and networks can therefore be vast and incalculable (Latour, 1996). The network is only ever the by-product of an earlier existing network or networks. The vestige of prior activity is evident from previous flows of translation, controversies, contradictions, energy, and movement that can be traced by the researcher (Dolwick, 2009). In the previous chapters, the historical networks populated with midwives paved the way for this by establishing who and what were the actants in the network of maternity that enabled midwifery to either flourish or flounder. This means that the analysis of the current social habitus of the midwives in New Zealand/Aotearoa is sited within a chronological continuum. Therefore the commencement of the analysis will involve locating the existing position of the midwives in the network both in relation to the issues pertaining to sustainability and in the actions of, and their interactions with, the other actants assembled around them. In this chapter I will present the findings from the data relating to the broad concept of sustainability.

Environmental Sustainability and Midwifery Practice

As discussed in Chapter 3, during the initial round of focus groups I introduced the question of what the midwives considered sustainability to be and asked them how they would define the concept. I wanted to ascertain their level of understanding of sustainability in order to establish a benchmark. The question of what they perceived sustainability to be was delivered in a non-specific and conversational manner, in order to elicit an impartial response. They displayed an initial reticence to attempt any comprehensive definition, but when they did contribute they unanimously linked the term with issues relating to the environment and climate change.

> Jane (1): *I think ecologically-friendly lifestyles, trying to maintain the planet for future generations, that kind of thing.*
>
> Alice (1): *Yeah, climate change and the green theme sort of thing.*
>
> Wanda (2): *Using renewable resources and not having too much waste.*
>
> Sally (2): *...energy in and energy out - ways to work with that, ways to care for the environment, ways to not waste and not damage.*
>
> Terrie (2): *I would have seen it as the impact on our environment and climate change.*

This response on the part of the midwives is probably less than surprising. It is well documented that efforts to inform the public about sustainability have traditionally concentrated on the provision of scientifically sound information in the form of reporting climate change effects for example, as a means to educate and change behaviour (Lorenzi & Whitmarch 2007). This message is likely to fail to inform without the inclusion of societal values, personal experience, and other contextual factors (Irwin & Wynne, 2003). However, that is not to say that the midwives did not apply those broader societal elements, but just that they did not recognise them as being related to sustainability in a societal context.

Waste in Practice

The midwives' discussions covered a broad spectrum of subject areas relating to environmental sustainability including clinical equipment, transport, clinical waste, nutrition, pharmaceuticals, breastfeeding, and baby equipment. There seemed to be a genuine intent on their part to find more sustainable ways of being and doing within the context of their sphere of practice. The midwives were reasonably aware of the benefits of a more proactive approach to carbon reduction within healthcare at both local and global levels. For example, one of the midwives expressed concern about the volume of paper based materials used in practice and the waste generated. All of the paper that we currently use is really, really wasteful. Leaflets, brochures, pamphlets. Whatever happened to the paperless society? (Sally :2)

Interestingly, the NZCOM owned Midwifery and Maternity Providers Organisation (MMPO)[96] and other commercially operated midwifery management systems available for LMC are used extensively as online practice management packages. This creates its own challenges in terms of emissions, but does reduce the need for a paper based system. Some of the LMC midwives were also introducing online access to materials for their clients or providing them with laminated copies of leaflets and articles that they returned at the end of care in order to reduce waste.

> Jane: *You get them back off women.*
>
> Amber: *I get them back and reuse them again.*
>
> Patricia: *So do I. As often as I can. And I've set up an introductory folder for my women so when I do that book in visit it's got lots of the major ones like you do on that first care plan with health and disability. I've just got them all in a clear file say to them if they want to keep a copy that's fine just fill it out and I'll just replace it. And then I find they don't sort of get so sort of dog eared and munted and fall out the folder. And some things I've started to laminate just as an easy thing just to get them to read whilst you're working and marking notes.*

The comment from Sally, about paper waste represents the views of an employed midwife from a culture where paperwork is reported as impacting on satisfactory levels of care. The perception of an inability to provide adequate care is said to be contributing to individuals leaving the profession (Writes, 2017; Youngson, 2014; Byrom & Downe, 2014). This increasing need to document every element of clinical care is said to be a response to the encroachment of risk management in healthcare (Skinner, 2011) which will be explored in detail in Chapter 8. Yet it is argued that open and explicit collaborative working and training amongst health care professionals is a more effective way of instituting a culture of safety

---

[96] The MMPO was established by NZCOM in 1997 to provide the LMC midwives with a practice management package.

(Amalberti et al., 2005). A situation where risk focused practices took priority over both consideration of sustainable resource management and relationships at the interface of practice were not uncommon in the discussions.

The construction of barriers

There was a sense of dissonance that appeared to stem from the frustration of being "a very small cog in a very big wheel" (Jess: 3) and this in turn would result in the construction of barriers. Although they were able to identify practices that were wasteful and unsustainable, they were also able to provide an equally broad range of reasons why making changes would be difficult. For example, during a discussion on reusable versus disposable nappies, although they agreed that reusable were preferable to disposable in terms of the environment, the midwives presented a number of reasons for the popularity of disposable including convenience, hygiene, ease of use, and time saving,

> Betty (2): *Women just don't have the time these days. They just don't want to know.*
> Wanda (2): *The thing with those too is what happens to the plastic, cause it's made into…*
> Sally (2): *It's the pulp they take out isn't it, but the plastic is still a problem and we can't do anything about that.*

In spite of their concerns regarding environmental issues related to resource management in practice, more often than not, the midwives expressed a sense of resignation at what they perceived as their inability to effect change. This sense of resignation resulted from an acknowledgement of their role in supporting women and recognising the constraints that their clients face, but also the lack of commitment by manufacturers to make more sustainable products.

In a discussion about baby wipes, which they considered to be a resource intensive product, the suggestion of using old sheets for making rags to use instead of baby wipes was raised.

177

Helen (3): *We used to tear up old sheets and use them for baby wipes. You know sometimes I think oh you know, I don't know that we could go back to that really.*

No going back

This idea of "not going back" can be seen to be linked to efficient use of time or the widespread embrace of a disposable society, but it could also be associated with the idea of progress, a notion that dates back to the Enlightenment (See Chapter 5). The idea of progress hinges on an assumption that quality of human life is constantly improved by economic development driven by the application of science and technology (Bordo, 1986). The idea of progress is also linked to professionalism. The evolution of midwifery to professional status has, by default, bestowed the midwife with the label of 'expert' (see Chapter 6). The midwife could have a role in advocating for the use of more sustainable products, but there is a perception that this could be a step backwards for their professional aspirations. In this context, the midwife as expert is expected to identify hindrances that slow or neutralise progress (Larson & Larson, 1979). Therefore "going back" is simply not an option.

 The notion of "no going back" was also evident when it came to discussing the issue of transport, where one of the midwives, although acknowledging the carbon emissions associated with car use, felt prompted to justify her choice of transport.

Jane (1):- *The problem is your homebirth kit is actually quite cumbersome and quite heavy. And we are supposed to have that with us 24/7. How would you put that on a bike?*

While the midwives recognised the benefits of working in alternative ways, such as practising locally, they were quick to identify the implications this could have on their caseloads and potential to offer continuity of care. Such practices quickly ruled out alternative ways of working as the quotes below illustrate.

Patricia (1): *It would be lovely to work more locally….in the beginning I said I really want to keep to the west side of town if I could but it was very hard to say no when you've got people right across the other side of town or further north. You know you've got at*

least an hour's drive to get to them and it's just thinking more logically with that sustainability. It is hard and I have said that also when your women then refer you, you do get clients from the other side of town. So as much as it's like the ideal to yes it would be nice to work in your area it's just not workable when you get referrals through word of mouth and you don't want to turn those away. Or women move.

Alice (1): *And return clients.*[97]

Patricia(1): *And return clients.*

Alice (1): *Move out of town.*

Patricia(1): *So it does sound nice but I can see why logistically it's not possible Jane; I think it doesn't work, it wouldn't work for us because of the way we work.*

This discussion could be seen to reflect the theory behind weak and strong sustainability introduced in Chapter 2, the two predominant conceptual approaches to sustainability which permit, and even welcome, trade-offs between tenets (Ott, 2003; Neumayer, 2013). Proponents of weak sustainability assert that natural capital[98] can be used with impunity as long as it is transformed into manufactured capital that is of equal value (Cabeza Gutés, 1996; Ang & Passel, 2012). In this context the use of a car for practice purposes would be

---

[97] Return clients are those requesting the service of the same midwife for subsequent babies.

[98] The language that is used to describe offset such as social 'capital' is interesting and offers some insight into the weight of importance placed upon the tenets of sustainability. Economic metaphors are commonly used to describe the multifaceted relationship between the environment and human well-being. However, the word 'capital' has strong associations with the world of economics and notably with capitalism (Smith & Kulynych, 2002). It would seem that the environment is viewed as a capital stock that provides utility benefits to humankind in the shape of ecosystem services (Ang & Passel, 2012). Smith and Kulynych (2002) express concern that academics like Putnam (2000) and Bourdieu (1985), who developed the concept of social capital, are negligent because in so doing they are helping to maintain oppressive class, status and power relations. They suggest that the word 'capital' in all of its manifestations constitutes elements of power and therefore cannot represent a concept, which symbolizes inclusivity, equity and justice.

justified. From an anthropocentric[99] perspective the weak models reinforce the notion that nature and culture are dichotomous and can only be reconciled by the economy (Huckle, 2008; Forman, 2013).   The field of environmental ethics states that an anthropocentric position leads us to ignore the obligations that we have concerning the natural environment and to justify our attitudes and behaviours relating to things such as using more than one car or heavy meat consumption. The midwives clearly do have a line of reasoning in terms of the need to transport equipment or having to attend to a birthing woman in the middle of the night. However, the intransigent position of this group was that there was effectively no other way to work as a community based midwife which would sit within the weak model perspective of sustainability. This is certainly not a trait that is specific to one group and is a broad based trend.

Adhering to the rules

The group discussion promoted analysis of the taken-for-granted ways of practising that implicitly aligned best practice with unsustainable products. For example, disposable instruments and other medically related commodities are in common use in most western healthcare settings and the midwives felt uncomfortable about this:

Gemma (3): *We need sterility for some things and yet we have this enormous amount of packaging and I find it a waste.*
Sarah (3): *and all of these syringes for oral stuff, you know the oral syringes that 99% of the time are chucked out.*

Wanda (2): *There's not a lot of instruments that are used out of a pack is there?*
Helen (2): *How do you mean?*

---

[99] Anthropocentric means viewing and interpreting everything in terms of human experience and values or as regarding human beings as the central factor in the universe.

Wanda (2): *Well if you're having a normal birth here, I know that we provide four instruments and you will often only use one.*

Betty (2): *and then they all get thrown out don't they? It's terrible.*

There has been some debate in the last decade or so around the use of disposable stainless steel medical instruments, such as the scissors and clamps found in 'perineal suture packs' (Adler et al., 2005). These were introduced in the belief that they would reduce cross-contamination of blood borne diseases, although studies have suggested that this is not yet affirmative and the environmental impact of such disposable products is also contentious (Obasi et al., 2009; Ibbotson et al., 2013). A 'cradle to grave' approach takes into account the energy used in extracting and transporting the raw materials as well as the production, distribution and disposal of the product. Finally, whilst there is inconsistency in the literature in terms of cost benefit analysis in relation to disposable versus reusable; disposable equipment does appear overall to increase costs. (Martis, 2011).

One midwife was vexed by what she perceived to be a cultural acceptance of waste in healthcare and yet accepted the use of disposable instruments as a 'rule'. *"It is really difficult, I mean we are in an industry where disposables are the rule"* Melanie (3). The midwife's referral to the 'rule' is an interesting one and may result from an assumption that this is an area that falls under DHB policy. The fact that it is accepted as a rule by the midwife perhaps reflects the power that policies have on the workforce in maternity care. As Burrows (2004) states, "policies are not tablets of stone and can be changed by discussion and negotiation". (p.374)Yet in this case it would seem that it is easier to defend the status quo than consider how relevant that policy is.

Knowledge relating to cost-benefits from a life-cycle analysis would not be considered within the domain of midwifery practice generally, but perhaps the higher echelons of health care management with purchasing power should be, especially when the economic benefits of using reusable instruments make it viable to encourage more socially just purchasing

practices. This example demonstrates the importance of sustainability literacy[100] within the healthcare setting at all levels. There is a bioethical dimension around the allocation of healthcare resources, where important questions such as who gets what, and who decides, or how do we measure outcomes; personal choice or a more objective understanding are used to guide decisions around allocation (Kluge, 2007; Scheunemann & White, 2011). However the converting of health care systems into market places which demand the rationalising of goods and services has promoted the introduction of targeting efficiency and cost control purchasing. Allocation decisions hinge primarily on economic value with little consideration given to the questions of sustainability, such as whether resources are renewable or not, or the ethical aspects of the life-cycle costs of the product.

Barriers to Engagement[101]

I have considered at length why the midwives, although able to recognise the need for consideration of the impact of environmental degradation and to even generate some means of introducing measures within their own work place, were unable to engage more comprehensively. It may be that the magnitude of these environmental effects are quite simply incomprehensible.

It is understood that the wicked problems generated and the scale of the issues faced by the threat of climate change and loss of biodiversity, etc. can lead to a sense of being overwhelmed and

---

[100] See page 278

[101] The term ''engagement'' in this instance is taken to mean a personal state of connection with issues relating to sustainability such as climate change in contrast to engagement solely as a process of public participation in policy making. This approach is comprised of cognitive, affective and behavioural aspects. In other words, it is not enough for people to know about climate change in order to be engaged; they also need to care about the issue and be motivated and able to take action.

even debilitate individuals (Grothmann & Patt, 2005). Behavioural psychologists working in this area state that numerous barriers exist that prevent people from engaging in action. The sense that it is futile because it is too late to influence climate change outcomes is not an uncommon response (Lovelock, 2007). The multiple and conflicting information around the issues is another barrier that can lead from confusion at one end of the spectrum to cynicism and non-engagement at the other (Russill & Nyssa, 2009). There is a further belief that because others are too selfish to take responsibility that there is little point in even trying to make a difference, or that 'others' are primarily responsible; these 'others' could be industry, the government, or other countries (Lorenzoni, Nicholson-Cole, & Whitmarsh, 2007). Many people perceive climate change as a distant threat that is superseded by shorter term individualistic priorities (Wiseman, Williamson, & Fritze, 2010) A low level of self-efficacy means that people do not feel that the things that they can employ in their everyday life will actually make a difference. (Whitmarsh, Lorenzoni, & O'Neill 2012)

Even where there is acceptance of the environmental issues, this does not necessarily bring about action. Lorenzoni et al (2007) claim that although the literature on understanding of climate change suggests a widespread awareness of the issues and general concern, there is little evidence to suggest much effort to change behaviours.

A solution based focus

The midwives did seem to become more solution focused as the meetings progressed. For example they began to explore alternatives to the energy intensive production, distribution and disposal of transitory clinical items.

> Gemma (3): *Maybe we should get our own steriliser [like dentists do] and start you know autoclaving things, I don't know. We use sterile instruments for home birth.*

> Melanie (3): *For urinalysis, I give them a pottle at booking and tell them to wash it and use it again.*

183

One of the midwives expressed frustration at the pressure that she felt was placed on parents to buy expensive material goods for their baby and stated that she advised/told them *"You don't need to buy all of that stuff. You can buy most of it second hand you don't need to buy everything new"* Alice (1)

This more proactive stance might suggest a shift in attitude resulting from having some time between our meetings in which to reflect on some of the issues at stake, as well as the opportunity to consider these bigger questions around sustainability in relation to practice. However, it is suggested that knowledge alone is not enough to motivate behavioural changes relating to threats from environmental devastation and changes in attitudes and behaviour require extensive cognitive processes and a genuine desire for change. (Moser & Boykoff, 2013). Lorenzoni et al. (2007) suggest that cognitive, affective and behavioural changes are all required in order to win engagement with the sociopolitical issue of climate change. This means that "it is not enough for people to know about climate change in order to be engaged; they also need to care about it, be motivated and able to take action" (Lorenzoni, Nicholson-Cole, & Whitmarsh, 2007, p. 306). Introducing the conversation and raising consciousness amongst the groups may have been enough to prompt greater consideration and even a shift in thinking on the part of the midwives. Success in increasing awareness is dependent on an understanding of what will encourage people to participate in change (Swim et al., 2011) which was one of the motivating factors for the initiation of the study.

Social sustainability

The place that the midwives held within their communities of childbearing women and families demonstrates their greatest strength (Davies, Daellenbach & Kensington, 2011). The most recent international definition of the midwife (ICM 2011) supports the major principles of social sustainability in the form of equity, social justice and community capacity (ICM, 2011a). As part of their role, midwives are expected to work to safeguard the health

and wellbeing of new families with health promotion and education strategies. By informing and empowering the woman and her family during this crucial phase in the growth of the baby and their family, the midwife can be seen to be helping to sustain the hugely significant societal unit of the family. This is a significant contribution to public health. Yet the midwives found it harder to grasp the concept of social sustainability in relation to midwifery practice in New Zealand/Aotearoa than the tenets of environmentalism. In spite of this, their conversations demonstrated that social sustainability was a crucially important determinant in their working lives.

What sustains midwives in practice

Social sustainability is considered to be less easy to measure than economic growth or environmental impact and is also felt to be the weakest pillar when it comes to its analytical and theoretical underpinnings (Lehtonen, 2004). A definition of social sustainability would also appear to be elusive (Collantonio, 2008). Definitions of sustainability generally relate to the environment and the economy and a social aspect is perceived principally as a means of promoting the message of environmental or economic sustainability (McKenzie, 2004) This subsequently impacts on the development of a socially inclusive policy approach around sustainability (Adebowale, 2002).

There has been a flurry of research activity in the last few years exploring what sustains the practice of midwives in New Zealand/Aotearoa This work has found that developing reciprocal relationships with women is crucial to the midwifery model of care and that this is consistent with a number of international studies (Benjamin, Walsh, & Taub 2001; Huber & Sandall, 2009; Dahlberg & Aune, 2013; Forster et al., 2016). These studies are supported by the responses of the midwives in my study who place a high value on the midwife/mother relationships that they foster, as demonstrated in the quotes below.

Gemma (3): *it's all about the relationship that you have with the woman and getting that right.*

Amber (1): *And even when you look after return clients[102], you have that relationship from their first time, especially if they've been complicated or they've had some sadness, they don't have to explain themselves, and as I was saying they just carry on that relationship don't they?*

It is well documented that when provision of care is placed within a continuity of care model, the evidence demonstrates a range of positive outcomes in terms of greater physical, psychological and emotional wellbeing as well as a cost saving effect (Hunter et al., 2008; Homer, Brodie, & Leap, 2008; Huber & Sandall, 2009; Tracy et al., 2013; Sandall et al., 2013). Within the continuity model, the midwife is expected to share information and to acknowledge the woman's autonomy in her own life and respect the decisions that the woman makes for her childbearing experience (NZCOM, 2005; Grigg & Tracy, 2013). Partnership is seen as pivotal to the midwifery model "The notion of partnership has become part of our identity as midwives in New Zealand " (Pairman, 1998, p. 6).

Midwife/Whānau Relationships

The midwives conveyed the importance of involving the partner and the family/whānau of the women; this is important for a number of reasons. Establishing a relationship with the significant others in the life of the women gives the midwife the opportunity to assess a number of factors. For example, this might include the level of support that the woman has,

> Sarah (3): *I think it is important to get to know the father, because that has such a bearing how the woman acts and reacts and worries that she might have like is there money coming in or is he going to be there for those important times, not you know*

---

[102] A return client is a woman who is using the same midwife for subsequent pregnancies.

for some of the meetings, the visits as well as the support afterwards and stuff like that.

or to identify any additional support that might be required with regard to the health and wellbeing of the other family members.

> Jane (1): *A woman came with her mother, who I had cared for….. and there was all this discussion about all these other people, kids in the family that I had contact with, Joseph was having his hips fixed and stuff like that …….we did eventually get to her pregnancy but the rest was important for them to discuss……….and the only reason that is the case is that I know the family so well.*

The importance of encouraging the involvement and support of the father of the baby, as well as other family members where possible, when a new family member is expected, has been well documented across a multi-disciplinaryfield (Rini et al., 2006; Doucet, 2006; Orr, 2004; Deave & Johnson, 2008;Barker, 2011). The presence of the father in a loving and synchronous relationship that is fostered during pregnancy helps to support the mother/baby 'niche' (Doucet, 2006; Buckley, 2015). It is also identified that midwives who are emotionally connected to their clients understand the importance of wider family and social support (Cook & Loomis, 2012; Hunter & Warren, 2014). The personal attention that a midwife in a continuity of care model is able to offer the woman and her significant others, enables her to resolve fears and concerns and develops trusting and nurturing relationships among family members (Huber & Sandall, 2009; Dahlberg & Aune, 2013; Forster et al., 2016). Niven (2013) states that midwives who are able to capitalize on such social connection offer "respect, compassion and reassurance; the giving of information, the provision of choice, the acknowledgement of concerns and the sharing of joys and sorrows" (p.3). These are values and actions that were also demonstrated by the midwives in the focus groups during our discussions.

Protecting, promoting and preserving the mother/baby dyad

Continuing from the relationships forged with women, their partners and their families, the midwives expressed a strong desire to facilitate a birthing experience for women that is positive and life enhancing. The midwives viewed their role very much as that of "guardian of normal birth" and this was a key feature of their perceived midwifery identity. The origin of the phrase "guardian of normal birth" is unclear, but midwives have described themselves as such for many years (Fahy, Foureur, & Hastie, 2008). NZCOM claims that "normal birth provides the most favourable outcome in terms of physical and emotional wellbeing to the majority of women and their babies" (NZCOM, 2017), and this premise is certainly increasingly supported by the international literature (Dixon et al., 2011; ACNM, MANA & NACPM, 2012; Olsen & Clausen, 2012; Conesa Ferrer et al., 2016; Cumberledge, 2016). Defining the term normal in relation to birth is not straightforward as it is influenced by whoever is defining 'normal' and what is considered to be intervention (Anderson, 2003).The word physiological is probably therefore a better description semantically speaking. According to Downe (2017) the literature supports a belief that the majority of women globally do want to have physiological birth[103]. Schaab (2007) states that "The midwife supports natural processes as they unfold uniquely in each emergence of new life and promotes the autonomy of both mother and child in the birthing processes"(p. 35). Certainly a drive to protect, promote and preserve normal physiological birth seems to evolve from a desire to strengthen the mother/baby dyad on the part of the midwives. All expressed a common philosophical approach to midwifery in that birth is fundamentally a normal physiological event in keeping with the international definitions and the Midwifery Scope of Practice here in New Zealand/Aotearoa. When asked what a sustainable practice would look like, one of the midwives in Group 2 responded spontaneously with "promoting physiological birth". The midwives extol what they perceive as the empowering benefits of physiological birth for the woman and her family/whānau,

Alice (1): *It [physiological birth] shows women that they can do, like they actually have the power to..... [pause] If they can go through birth, they can actually do anything.*
Jane (1): *Yes, it improves people's self-esteem and their cohesiveness as a family.*

---

[103] This information is part of a qualitative systematic review which is currently awaiting publication in BJOG.

www.manaraa.com

Terrie (2) *Its empowering the woman really, physiological birth isn't it? When she knows that she is able to do it, she sees the results of it, that encourages her to make decisions with her child as time goes by.*

It has been proposed that the eco-niche[104] of the mother-baby relationship provides the habitat for the prototype of all relationships for that individual infant (Odent, 1999; Leclère et al., 2014). The midwives regarded the protecting and supporting of the mother-baby dyad throughout the childbirth continuum of being of paramount importance.

Alice (1): *That initial you know falling in love with their baby just gets them through those weeks when they're very vulnerable.*

However, beyond the immediate mother/baby dyad, they viewed the importance of creating a space for a woman to have a positive experience across the continuum of childbirth as having greater significance than the immediate family environment. It is well documented that early attachment is likely to lead to greater ability of the individual to form relationships throughout life (Grossmann & Waters 2006; Horst, 2011). It is theorised that the ability to forge relationships is a significant factor in achieving wellbeing and that people who readily form relationships are generally happier and healthier (Layard, 2011; Wood, Tesser, & Holmes, 2013; Gewirtz, Kurtines, & Lamb 2013) Therapeutic relationships based on strong relational foundations are believed to enhance healing and reduce pain and suffering (Youngson, 2014b). The midwives demonstrated a strong appreciation of this link to both short and long term health benefits to communities and society.

> Lorna (3): *There is a statement, I don't know it's from, about physiological birth being low tech, high touch.*

---

[104] An econiche is defined as the particular area within a habitat occupied by an organism. A species niche includes the physical environment to which it has become adapted (Online Encyclopedia, 2011). This definition could therefore be considered to be well applied to the status of the mother-baby dyad where the mother provides a complete ecosystem to provide everything required by the newborn for survival within a closed loop feedback system.

Sarah (3): *That's lovely, I would agree with that.*

Gemma (3):, *if you're looking at midwifery and women and birthing then you want the whole community and the whole nation to be a part of that and to own it as well.*

Sarah (3): *and support the ideals of normality.*

Naomi: *And we all, we're becoming increasingly aware that pregnancy and birth are far more important in terms of the individual's health and wellbeing as they go through their lives than we'd previously thought that it was. Protecting physiological birth is going to be of enormous financial impact to an individual country but I don't think they [government] see that…. you know if you're looking at women who have ended up with a very highly managed birth whether its, whether it was predictable or preventable or not you can see how that impacts on the woman's immediate health, the baby's immediate health, the breastfeeding relationship.*

Facilitating normal physiological birth also gave the midwives an immense amount of satisfaction connecting them with the woman and with their own value system as a midwife. As Gemma (3) stated *"it [physiological birth] encompasses everything that midwives do.*

Social Connector

Gladwell (2006) identifies a role based on personality type that he describes as the 'social connector'. Connectors, according to Gladwell, are people within a community who embrace a networking role. They make it their business to engage with others across a range of social, professional, cultural and economic circles and connect people with others. The midwife as social connector acts as a catalyst in the network by negotiating the partnership with the woman, encouraging active involvement of the woman's partner or her family members and facilitating the eco-niche of the mother/baby dyad.

Social sustainability is generally defined with reference to community, communication and relationships (Barron & Gauntlett, 2002; McKenzie, 2004). The midwives in the study also

demonstrate a significant role in connecting with women (and their significant family members) as well as with others in the network.   This is achieved in a number of different ways that may promote relationships and assist women in establishing their own new network of friends and support.

Not my role

Generally speaking, the midwives did not see themselves as connectors in a formal sense. They did not view organising groups during the antenatal or postnatal period as part of their scope of practice *"I think it's not really my role. I think I'm better at one on one role than in a group"* Alice (1).

Or that it was too time consuming:

Jane (1): *I don't mind doing the group education stuff but it does involve a lot of preparation and a lot of work and quite frankly it's easier to leave it to somebody else.*

However they did see themselves as acting as ad hoc social 'negotiators' with women from their caseload.

> Alice (1): *As far as this goes though, providing them opportunities to create friendships, I've had two women who were in the same cul-de-sac but didn't know each other were pregnant. So to each one I said to them, "I know someone in your street," without saying who it was, "who is pregnant too, would you like me to tell you about them and would I…" and both of them said, "Yeah, that would be great." I got both their permission. So you've got that privacy issue as well, and they've become best of friends which is really nice.*
>
> Jane (1): *Yeah. But I also definitely do it with people that I realise don't know anyone else who's pregnant or have no family support or what have you, so if there's someone who has either a similar pregnancy complication or comes from the same culture or lives in the same street or in the same area or what have you, I'll often say to each of them, to the one who doesn't know anyone "Would you like me to find someone that*

you can talk with or whatever," and then I'll say to the woman who I've chosen to
approach to talk to them, *"I'm wondering if you can help me, I've got this woman who
doesn't know anyone and she's from your country and would you be interested in
meeting with her,"* and stuff, and I don't think I've ever had anybody say no".

The exception to the group facilitation norm was the suggestion of creating 'grandmothers antenatal sessions' by the midwives in Group 3. This idea evolved from a belief that the mothers of pregnant women are influential in the decision making of their daughters/ daughters in-law when it relates to their childbirth experience. However there is evidence to suggest that the information given is often based on anecdotal experience and practice has changed considerably since they were birthing their babies a few decades ago. The changes have occurred for a number of reasons other than the re-establishment of midwifery including: other societal changes, such as less deference for authority; an increased research agenda in maternity care that has led to an evidence based approach to care; and shorter stays of postnatal care in hospitals and maternity units.

> Melanie (3): *Their mothers or grandmothers say you need an obstetrician, and the GPs do the same, and the GPs will refer them and not to us, even halfway through a pregnancy they will say oh now go to the obstetrician. And it is about the historical practice of midwifery and obstetrics, when the grandmothers were having their children it was seen as an improvement that you should go in to hospital and have the benefit of medical care. And I think culturally we've just got to work against that and in order to sustain good midwifery here.*

The idea of grandmothers groups did not ultimately translate into practice, but the will to make community based connections to improve outcomes was evident.

The DHB midwives, expressed some discouragement about the fact that women had developed a tendency to remain in their rooms during their postnatal stay in hospital and

the following discussion ensued that emphasized the role of the midwife in engineering social engagement.

.

> Terrie (2): *People have become more isolated and they shut their doors and they want to be in the room behind shut doors all the time.*
>
> Sally (2): *We could ask them to have their lunches in the kitchen.*
>
> Betty (2): *There's nothing wrong with that. And I tell you, when you do get them down here, three in an evening feeding their babies with them, it's wonderful because you'll get your experienced multip and your two little primips and they are just sucking up the knowledge.*

Community Relationships.

There has been an element of caution directed at the 'one to one' midwifery model as fostering 'exclusivity' within the mother/midwife relationship, fuelled by the belief that it could ostensibly lead to a dependency within the relationship (Downe, 1997; Allen et al., 1996). However my study suggests that the relationship of the midwife with the community could be construed as an extension of the primary relationship with the women and as a means of augmenting necessary support for the midwives at times.

> Melanie (3): *And that comes I think with the growing relationship between a midwife and the community she serves. Sarah and Jess are very well known in this area and have loyal client bases that have used them for the second generation. And that, having those sort of midwives in the practice does help to sustain the practice through the leaner times. If something bad happens to a midwife the reputation that she has with the community around her is a cushion and a support and a guard.*

The discourse of Melanie above is slightly defensive and does not feel unlike the days when domiciliary midwives were reliant on the home-birthing women in their communities to support their practice. The imagery of 'leaner' times feeds into the 'profession under siege' theme identified further in the chapter.

The DHB midwives do not have the privilege of continuity of care experienced by the LMC midwives. However, they did have a strong focus on, and connection with, the local community and they reflected on the involvement of their community with gratitude and pride. The reciprocity highlighted in the mother/midwife relationship discussion is therefore mirrored in a broader community context.

> Sally (2): *The support that is required to keep a little place like this going, that the community help is really important...We had a maintenance guy here and I was saying look we've got furniture that needs a little bit of TLC rather than throwing it out it needs refurbishing and he said well that's what the old guys who belong to ****** do, they take the old furniture and they give it a good going over and put it back into service again. So between us we are looking at getting a Friends group up and running again.*

> Claire (2): *So, developing a really close bond with this group would be one of those things that could actually create grass roots support.*
> Wanda (2): *That's right and when we've already got a maternity unit here and it's established and people know about it.*

Again there is an element of pulling in community support for a time when it might be needed by building social capacity. Social capacity, refers to an aggregate of social relationships, formed from networks, groups, communities, organisations or individuals. It facilitates collective action taken to improve upon quality of life and represents the connective value of the community and the norms of reciprocity that are created. These norms include trust and cooperation. The greater level of trust within a community of any kind, the greater the likelihood of cooperation (Lovell, 2009; Parker & Larsen, 2010)

The findings laid out in this chapter relating to social sustainability would appear to support those of other studies in that the professional identity of the midwife is strongly grounded in

194

relationships with women during the childbirth continuum (Hunter et al., 2008; McAra-Couper et al., 2014; Crowther et al., 2016; Hunter et al., 2016) . The role of social connector in this context encompasses many of the tenets of professionalism identified in Chapter 6. The social connector role embraces the midwifery philosophy which is grounded in partnership. The building of relationships ostensibly provides autonomy not just for the midwife but also for the women (Edwards, 2005). This would appear to be so within the continuity of care model with the LMC's but is also evident within the sphere of the DHB midwives in the primary birthing unit.   Relationships form an important factor in the competencies for practice which are listed in Chapter 6. Although the requirement to establish partnership within the midwife/mother relationship is primarily sited in Competency 1[105] the principles can be applied to the other Competencies. Pairman and Donellen-Fernandez (2015) talk about the relationships being the "medium through which midwifery is practiced"(p. 385) and if the success of the profession is balanced on relationship building with a client group, then midwifery could be viewed as a strong socially sustainable healthcare profession.

Blurring the lines between social sustainability and the social sustainability of a profession

In spite of a healthy gathering of data relating to both environmental and social sustainability and the alignment to midwifery, the issue of professional identity that I had originally imagined would provide a cornerstone on which to support the values of sustainability within midwifery practice, seemed to be the primary and core concern of the midwives with whom I talked.   Professional identity was raised in discussion around relationships with women and their whānau/family. Professional identity also featured in much of the discussion around factors relating to environmental sustainability, often around why changes would be difficult to implement.

---

[105] The midwife works in partnership with the woman/wahine throughout the maternity experience.

In the last twenty-five to thirty years, midwifery has developed as a profession in many western-based healthcare systems and this has led to the concept of midwifery professional identity becoming a key focus in midwifery research, education and practice (Larsson, 2009). There are many reasons for this evolution including organisational changes, changing societal needs and demands, and the increasing presence of evidence based practice (Surtees, 2003; Bryson & Deery, 2010; Lane, 2012). There are now eighty-eight countries that have national midwifery organisations and midwifery is generally accepted as an autonomous profession (ICM, 2012). More specifically, in New Zealand/Aotearoa, as I identified in Chapter 6, the professionalizing of midwifery was a primary objective of midwifery leaders in the years following their re-establishment, which accorded it a high relevance factor for the midwives in my study.

The sustainability of models of midwifery care in New Zealand and in other similar high-resource countries has appeared as an area of research interest in recent years (Wakelin & Skinner, 2007; Young, 2011; Sandall et al., 2013; Tracy et al., 2013; Donald, 2014; McAra-Couper et al., 2014). It may be that this trend had influenced the midwives in both their interpretation and application of sustainability. Professional identity was used to relate to how the midwives interpreted both their role and responsibilities.

Professional Identity

Burke and Reitzes (1981) describe identity as being "like a compass helping us steer a course of interaction in a sea of social meaning"(p. 91). They speak of identity as a social product defined by the naming of, and locating in, social categories where interaction with others occurs, and as a reference point that enables us to assess the implication of our own and other's behaviours (Burke & Reitzes, 1981). Identity provides us with purpose and behavioural guidance which can lead to aspects of psychological well-being such as self-esteem and self-worth (Serpe & Stryker, 2011). Within a professional or occupational context, identity enables the individual to categorise themselves within a specific work related role (Serpe & Stryker, 2011). Professional identity is shaped in collaboration with others creating a social sense of unity or cohesion within the profession. Tajfel and Turner

(1979) define a group identity as a collection of individuals who perceive themselves to be part of the same social category, who share some emotional involvement in this common definition, and who achieve some degree of social consensus about the evaluation of their group and its membership. It has been suggested that effective functioning of a professional group is reliant on this cohesion. Likewise a sense of group fragmentation of dissonance can impact on the group identity, leading to a loss of locus of control, stress and stress related illness (Larsson, Aldegarmann, & Aarts, 2009).

Midwifery Identity

Figure 7 depicts the ways in which the midwives in the study defined their identity as midwife within the data.
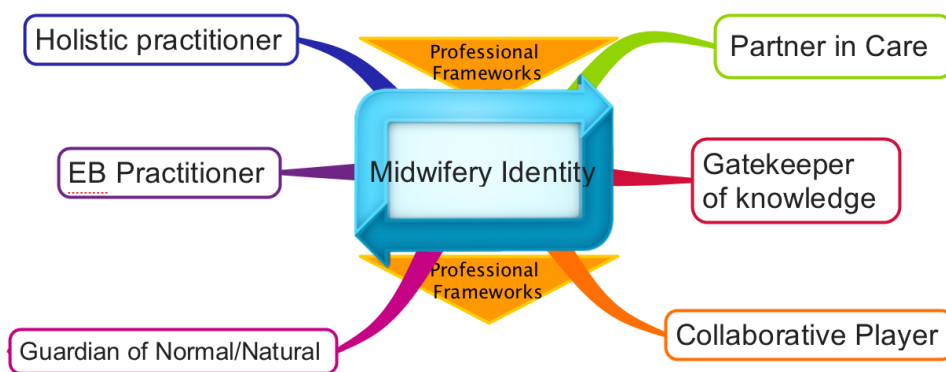
Figure 7. The tenets of midwifery as identified by the midwives.

They viewed their legitimised professional identity as enshrined within the frameworks for practice.[106]

In many ways the midwives viewed themselves in a positive manner as holistic and evidence

---

[106] The midwifery profession in New Zealand has developed a number of inter-related frameworks that express the values, beliefs, standards and practice of midwifery. These frameworks include theories of midwifery partnership, cultural safety, the midwifery philosophy, scope of practice and competencies, ethical statements, and practice standards. The informing documents include Standards for Practice, Competencies for Entry to the Register of Midwives, Cultural Competence, Midwifery Code of Ethics, and Turanga Kaupapa. Together these frameworks guide midwifery practice and articulate the profession's expectations of its members.

197

based (EB) practitioners who worked in partnership with women, and collaboratively with other health professionals. A strong component of identity expressed across all three groups was that of 'guardian of normal birth' which was addressed earlier in the chapter.

The midwives also gave a strong message that they saw themselves as being a powerful group.

> Jane (1): *We're [midwives] very strong here [in NZ]. And we also have a huge role internationally.*
>
> Amber (1): *I think because we've become independent practitioners, like we can…*
>
> Alice (1): *We're autonomous practitioners.*

In a comparative data study by Crowther et al. (2016) that took a study from New Zealand/ Aotearoa (McAra-Couper et al., 2014) and equated it with one from the UK (Hunter & Warren, 2014), the authors state that "the joy of midwifery manifested in the way that midwives described their pride and passion...they felt their work contributed to society...making a difference to individuals and society was core"(p. 43). This sentiment was echoed in the words of the midwives in the focus groups. When the midwives spoke about their relationships with women and their families there was generally a sense of elation that was not necessarily evident in other aspects of their work. This presented as a strong sense of pride and job satisfaction.

> Helen (3): *Respecting the customs, values and spiritual beliefs of women and their families is so important in serving their needs.   I think that is just part of midwifery. It's being a midwife, that's what we are and that's what we do all of the time.*

> Amber (1): *We hold a special place in people's hearts don't we, we really do.*

The word 'serving' is an interesting one here, and is somewhat anachronistic. 'Serving' is not a commonly observed concept in current healthcare settings (although ironically we still refer

to a health service), as it does not sit well within the framework of 'professionalism' (Walsh, 2010).   The term servitude is viewed as a tool of hierarchical oppression, consigned to the annals of history. However, Myskim (2011) argues that at a societal level the concept of service is "a fundamental reality of human existence but currently a neglected value"(p. 3). She suggests that an ethic of care and service could assist in "achieving the twin goals of human wellbeing and global sustainability that our future demands" (p. 3) by creating cultures of care and altruism. Oddly the words 'care' and 'caring' are used in an objectified way in the 'giving of midwifery care', or 'care has been handed over to' rather than in an affective way such as 'I care for the woman'.

Reciprocity

In the context of an ethical approach, service should not imply power imbalance, but sharing of power in a relationship; midwives generally viewed their relationships with women within partnership as a mutually reciprocal one leading to shared meanings, shared control and openness (Pairman, 1998).

> Sarah (3): *It's not just talking about the woman and her experiences, it's also about sharing a little bit of ourselves as well because if we don't share anything about ourselves we can't expect women to share about themselves and that is part of the relationship.*

This midwife shows a high level of empathy in her discourse that one would imagine would forge a sound professional relationship in most cases. Likewise Alice (1) demonstrates good interpersonal skills and emotional intelligence in her comment, *" I think it's harder though when someone's different to you, you know, you don't really know their beliefs very well, but that's a matter of just saying that to the woman too."*

In this case the midwife chose to ask women directly what their needs were in relation to their values, an approach advocated by Benn (1999).

However, another midwife felt that it was not always a reciprocal relationship:

> Gemma (3): *The number of women that I have met and you seem to know everything about them and their dog and they've not asked you one question that you can answer, they don't know if you have got children, they don't how old you are, do you know what I mean?*

This led Gemma to question the meaning of the partnership model. Likewise Sarah expressed an occasion when the notion of partnership appeared to elude her:

Sarah (3): *They expect us to go and see them a lot and an example of that is a woman yesterday; I was supposed to go and see somebody else so I was going to drop a form off to her and she texts and then we had a birth and so I couldn't go and I changed the appointment. And she said to me, she texts me yesterday, fortunately just before I left to say you're just going to drop a form off aren't you? I said well actually no I'm not coming ¾ of an hour away to drop a form off so I went home and I faxed it through sort of thing. But you know the expectation is that I would go down and drop a form off, that's ¾ of an hour driving.*

This aspect of reciprocity will be explored in more depth in Chapter 9 where the question of intergenerational differences will be considered.

A critique of the Partnership Model

Although the partnership model was viewed positively overall by the midwives it has not escaped critique.   Skinner (1999) wrote a candid paper in 1999 where she challenged whether partnership was a realistic expectation for midwives other than with women who were educated, middle-class and Pākehā. She questioned whether the word 'relationship' would be more fitting than partnership. She continued by suggesting that the endeavour to create a partnership based on equality could lead to frustration, self-doubt and even burn-

out for some midwives. In a study a few years later, Freeman (2006) concluded that a power differential was inescapable in the midwife/mother relationship but that women and midwives were still able to achieve partnership without having to achieve 'equality' in decision making. Benn (1999) responded to Skinner's work advocating that the issue rests on how we define partnership and that the key to making partnership work lies in communicating what it is and what it means very clearly to women. Daellenbach (1999) also shared a consumer perspective in response to the work of Skinner and stated that although she agreed that the term was problematic, it was important to recognize that the term, like so many others has "multiple, shifting and contextualised meaning" which makes finding any one definition problematic. She suggested that we use a flexible approach to defining partnership that is based around what the woman defines as partnership.

More recently a number of international and New Zealand studies and publications have supported the importance of continuity of carer for the reciprocity and emotional sustenance that it offers for both midwives and women (Wakelin & Skinner, 2007; Hunter et al., 2008; McCourt & Stevens, 2008; McAra-Couper et al., 2014; Leap et al., 2011). The establishment of authentic relationship in the mother/midwife connection is now viewed as a crucial factor, not just in improving maternity outcomes but in protecting against burnout in practice. Midwives have indicated that impaired relationship building can lead to them leaving the profession (Hunter et al., 2008; Huber & Sandall, 2009; Kirkham, 2010).

Professional Friend

Although the interface with clients is episodic in character, the length of contact with women is frequently of a greater duration than most health service encounters, and midwives take on the mantle of 'professional friend' (Walsh, 1999; Pairman, 2010;) within a context of continuity. Pairman (1998) advises that 'professional friendship' is different from more generic friendships because there is a professional purpose and a temporally regulated

character to the relationship. She also claims that this character is intrinsic to the model of midwifery care in NZ as it is a way of ensuring that women's views are heard and understood when the trappings of professional detachment are placed to one side. The value of 'professional friendship' within continuity of care has been validated by a number of studies (Hunter et al., 2008; Foster & Lasser, 2010) and this was reinforced in some of the comments made by the midwives in the focus groups.

> Melanie (3): *The sense where the professional partnership and the sense of friendship and family you know I'm going to a naming ceremony next month through a woman who I've delivered two of her four children. I'm sitting now waiting for a third child to arrive in a family where I've been there for the birth of both previous children. I would feel disappointed, upset and hurt if I'm not there at that family event because I feel that in this context I'm part of their family.*

There remain questions around the matter of co-dependency within a close professional 'friendship' and the time framed nature of the relationship is an area that requires further investigation in relation to the establishment of boundaries and the discontinuation of the relationship (Walsh, 1999; McAra-Couper et al., 2014). Nonetheless, the midwives clearly established strong reciprocal trusting relationships with the women that made them feel respected and valued.

It transpired from analysis of the data, that there were many hurdles that impacted on the midwives' sense of professional well-being and identity. Discussions with women around antenatal screening, for example, was considered to be taking excessive amounts of time that could be used more productively for other information sharing. The reported increasing use of technologies, such as ultrasonography and caesarean section were seen as areas that encroached on their role at times. The concept of risk was said to be dominating the sphere of maternity care provision and impacting on the traditional role of the midwife as 'guardian of normal'.

The sustainability of the profession

The ways in which the midwives interpreted the concept of sustainability with regard to professional identity was diverse. The range of responses that resulted from the discussions were framed within a number of different contexts, with some of the midwives extending this concept to include sustaining self (self-care), *"being able to work in a healthy way and keep going with working in a healthy way"* (Alice:1) and avoiding burnout *"To me it means not burning out"* (Terrie:2). It has been speculated that burnout has been an issue in midwifery practice for some years now and especially in self-employed practice (Young, 2011; Donald, 2014), and the reality of this was raised by Guilliland during a radio interview on RNZ (Ryan; 2017).

For one midwife, the issue rested on being able to continue working within the model of midwifery care in New Zealand/Aotearoa that currently exists.

Jane (1): *It means to me sort of longevity in your chosen profession, like essentially to a midwife it means that I should be able to be working as a self-employed midwife for the next however many years until I choose no longer to work there.*

Another perspective was offered by one of the midwives who felt that preserving the role of the midwife as 'guardian of normal birth', was a key factor in professional sustainability. Gemma (3): *...it's sustainable for families, for midwives and the community to promote physiological birth instead of technology so that it's out there politically and socially...it encompasses everything that midwives do and if we don't sustain that, then we are just little medical solders.*

The fundamental concern of this midwife was that if midwives do not promote birth within the context of a social based life event rather than a bio-medical oriented occurrence, then midwifery autonomy will be lost to the medicalisation of childbirth. This concern speaks to

the historical tensions between midwifery autonomy and biomedical dominance discussed in Chapter 6.

A midwife based in a rural practice who was finding juggling the requirements of practice with the requirements of a personal life challenging, expressed:

Naomi (KI 1): *When we talk about sustainability in midwifery and I think 'what's sustainability?' I immediately think about 'for how long can we continue to do this'?*

This comment contrasts with that of urban midwife Jane (1) above, who defines sustainability as being able to work as long as she chooses. Naomi (KI 1) spoke at length about how difficult it was to manage a rural caseload within the constraints of the funding system and without what she felt to be a reasonable degree of understanding from urban colleagues. To her, sustainability was very much about surviving at a professional level and had little to do with choice. The issue of the sustainability of rural midwifery practice in Aotearoa has been acknowledged and to some extent measures have been taken to address the problems that rural midwives face. Nonetheless, this midwife continued to view the demands of her work largely as unsustainable.

Survival

The use of the word survival is not infrequent in the data, appearing in a number of contexts such as the one below.

> Betty (2): *Sometimes it feels like an exercise in survival here. It would be lovely to have the time to think about how we could manage resources more efficiently and things, but you don't get a chance to come up and take air some days.*

Betty then comes us with a suggestion for improving both efficiency and the sustainability of normal birth.

> Betty (2): *I mean, ultimate sustainability would be for the DHB to employ an osteopath to turn all the OP babies on primips and cut the caesarean section rate by half.*

Wanda (2): *That's not gonna happen they don't believe in osteopaths.*

In this conversation between Betty and Wanda, they can be seen to be aligning themselves with professionals outside of the biomedical model and there is suggestion that this could be key to the sustainability of normal birth. However, the caveat is there is no funding to support this.

Or relating to breastfeeding as a sustainable practice:

Sally(2): *...another sort of idea in terms of sustainability was actually to have more breastfeeding input. But yeah, it takes a lot of time…*
Betty (2): *But again, our DHB or PHOs don't see this as a priority for health prevention and so the money is not coming.*
Wanda (2): *There's no money for it.*

In the discussion relating to breastfeeding there is also criticism of a lack of funding. However, there is an apparent acceptance of this, and no further discussion about whether they, the midwives could possibly play a part in attempting to improve the normal birth and breastfeeding rates in these cases.

Sally (2): *What we do now is based on years and years of other people writing policies and doing stuff that we are actually able to be here, working here at a midwifery unit Somehow this midwifery, you know, "protecting the rights" that was dear old Karen and Joan.*

Sally speaks affectionately of the midwifery leaders who led the activity that resulted in the re-establishment of midwifery as a profession and recognises that it took considerable time and effort for the changes to take place. However, even this safeguarding of the professional status in legal and regulatory terms was recognised as tenuous.

Sally(2) : *And I guess we have got to have the legislation to be able to allow midwives to practice as we do so we don't have those politics and things behind us then we will go backwards and things might change again.*

This underlying sense of uncertainty about both their current and future role and practice created a world weary feeling.

Melanie (3): *It's very wearisome having to constantly demand to be taken seriously, always having to prove that you have the right to be treated as a professional person. Gets weary doesn't it?*

There were many comments about complexity and the changing world in which they were practising. There was a sense that the midwives did not have the time or the energy to expend on what they viewed as additional responsibility in the shape of the broad tenets of sustainability when they saw themselves as actors in a complex maternity system that allowed little time for any kind of peripheral thought or activity .

Amber (1): *It's [midwifery] very time consuming…, I see our role and our philosophy as a practice, what we actually do, is the best that we can for the individual woman that's in front of us, and it's different for everybody because that's individualised care. We don't just look after teams, we don't just look after people with IVF, we look after people who do homebirths, and want epidurals, they want to birth in the primary units as well as birthing in the hospital….*

Profession under Siege

An unsettling concern about working under pressure was accompanied by the sense that the participants viewed their role as being under threat on some level and this was expressed in the areas of conflict that they identified. The exercising of power in the political landscape of midwifery, largely focussed on the patriarchal power and the medicalisation of childbirth has been explored in depth in the midwifery literature (Mander & Fleming, 2002; Surtees, 2003: Edwards, 2005; Davis & Walker, 2012) and is discussed further throughout

this thesis. However, the perceived barriers identified by the midwives, were complex and multi-factorial. 'Profession under siege' is a term that is found in the literature on the sociology of professions and examples of the trend can be found concerning doctors (Bellah, 1997; Waal, Malik, & Bhugra, 2010), psychologists (Olsen Murray, 2001), dentists (Barzun, 1979), nurses (Ward, 2013), teachers (Cohen, Higgins, & Ambrose, 2008), social workers, and others. The thrust of the debate is that the notion of what constitutes 'professional' for these different groups is in some way under threat. The reasons suggested for this phenomenon do vary within contexts, but aspects such as funding changes, modernising of public and health services, political imperatives and public expectations are often cited (Waal, Malik, & Bhugra, 2010).

Conclusion

Although there was a professed interest in the association between midwifery practice and the broader tenets of economic, environmental and social sustainability, for much of the time such a nexus was not viewed as tenable or even relevant by the midwives. Many of the attempts to consider how these broader tenets could be brought into effect went unheeded and when discussion did tentatively step into the territory of sustainability 'in' rather than 'of' practice, barriers would emerge that would suppress the discussion.

Identity in its broadest sense is a relational concept that is constantly changing and shifting according to the cultural and sociopolitical context and the associated reformation of networks. The role of the midwife therefore can be viewed as ever evolving and changing within contexts that are themselves dynamic. This relational aspect suggests that midwifery cannot be self-sustaining as an entity because midwives are predictably reliant on their interactions with the other actants on the stage of maternity care provision. I recognised that I needed to re-enter the network via the data to further establish the actants that were contributing to the current status quo within the maternity care setting and perhaps preventing the midwives from engaging with issues relating to sustainability more generally.

Chapter 8. The Red Herring of Choice and the Illusion of Risk Control

The previous chapter concluded that the midwives place considerable worth on the building and maintaining of relationships with their clients and a positive perception of professional identity is firmly embroiled within these relationships. However, in reality these relationships, although strong, represent only a small element of a large network of significant complexity. Within the ANT methodology, concepts and technologies are seen to have the capacity to frame social connections and interactions as much as human actants (Cressman, 2009: Kipnis, 2015). Within the network of maternity services there are many other actants, human, material, conceptual, and semiotic, that have substantial impact on the professional identity and working practices of midwives. These include technology, birth settings, the media and even earthquakes. One conceptual actant that figures extensively within the data, pulling most of the other actants into its path as it flows through the network, is the concept of consumerism. In this chapter I explore the perceived impact that the concept of consumerism in a broad sense, focused on choice and its counterpart of risk, has had on the midwives, and consider the effects on the perception of their professional identity.

As discussed in Chapter 6, over the course of the last century, childbirth has become increasingly medicalised as a result of political, cultural and societal influences that have redefined pregnancy, labour and birth as an illness that needs to be treated and controlled by a bio-medical model assisted by technology (Davis-Floyd & Johnson, 2012; DeVries, 1992). This is true in New Zealand/Aotearoa as much as it is in other western style healthcare systems in spite of the introduction of a midwifery-led system of care. For many women accessing the service, the belief in childbirth as a normal physiological process has been replaced by paradigms related to choice, risk, safety and fear (MacKenzie, Bryers, & van Teijlingen, 2010; McAra-Couper, Jones & Smythe, 2010 Coxon, Sandall, & Fulop, 2014). These concepts contribute to the knowledge and understanding that women have about the childbirth continuum and the choices that they make during this time and play a part in constructing childbirth expectations and beliefs (Dixon et al., 2014). The concepts also align within consumerist systems of healthcare practice.

Consumerism, Choice and Autonomy

The term 'consumerism' reaches far beyond the sphere of economics as an ideological socio-political, transactional model that influences attitudes and practices located as the normative societal model (Gilbert, 2008). Consumerism is described by McGuigan (2014) as "the principle of civilisation that shapes the socio-cultural makeup of people through socialisation in the broadest sense"(p. 118). Social norms that focus on consumer/provider transaction have thus extended beyond the traditional areas of 'goods and services'[107], into the realm of public service such as education and health (Bauman, 1990). Rifkin (2000) remarks that neoliberalism has resulted in the commodification of everything, memories, experiences, the corporeal body, and identity, thus infiltrating every aspect of our lives and affecting the way that we view the world, form opinion, and make decisions.

The promotion of choice within the ideological framework of consumerism is fundamental to the consumerist economic model, as choice promotes competition which is the cornerstone of a capitalist economy. Increased competition is believed to promote economic growth by stimulating markets (Springer, Birch, & MacLeavy, 2016). In a world that is constructed on a foundation of neoliberal values, choice is considered to be central to the concept of personhood and the emphasis on and respect for individual choice is a defining feature of the era.

Through a neoliberal lens, the individual is portrayed as an agent of free choice with an internal locus of control that assumes that the individual is free to make choices. Further, those choices can be free of coercion and the individuals are free to act in ways that support

---

[107] In this context I am referring to businesses providing services such as electrical, hairdressing, plumbing etc.

their choices[108] (Payne, 2012). Autonomy thus is an inherent component in the model of an open market without which choices cannot legitimately be made.

Consumerism, for the purposes of this chapter will be viewed predominantly from the perspective of 'market consumerism', though some of the other categorizations of consumerism as defined by Stillerman (2015) will be called upon. These are bracketed into the following categories:-

- Consumerism based on the activities of 1960s counter culture which had a reputation for being anti-consumerist, but was really more focused on non-conformity which manifested as a rejection of standardised mass-consumption and promoting individual self expression. This sometimes referred to as democratic consumerism (Mold 2015)
- Consumerism based in alterations in class structure, based on the work of Bourdieu. This definition views the growth of consumption as being a result of the rise of the 'new middle classes' and an increase in the number of people working in jobs such as the media and fashion.
- Consumerism presented as an 'ethic of self-expression through consumption' – where people engage in practices of self care in order to self improve in order to improve social and economic capital
- Consumerism associated with the concept of individualism. Within this category consumerism is used as a means of constructing a life narrative that gives focus and meaning to individuals.

Market consumerism within health care can be seen as including a strict purchaser/provider divide modelled on that of buyer and seller in a broader market place context. This model holds that health care providers compete for business in the same way that commercial

---

[108] Clearly these choices have to be viewed in context and have to fall within legal, ethical and social mores of that context.

operators do and this competition aids in reducing costs and increasing quality. In order to monitor effectiveness of the system, stringent measures of performance have to be agreed, targets set and audit performed. The competition inherent within the system results in choices for users/patient/consumers. A cited justification for the introduction of the market culture in healthcare is that it shifts the locus of control from something defined by the predilections of the professionals in the field, to one influenced much more by the views and desires of the users of the service. Thus, health care is redefined as a 'commodity', those working in health care as 'service providers' and those receiving care as 'consumers' (Davis 2003).

Consumerism, Choice and Autonomy in Maternity Care

In the field of maternity in the 1980s and 1990s, pregnant women were remodeled from passive recipients of care into active consumers who could exercise choice and control during their maternity experience. In so doing, the newly consumerised pregnant woman was expected to directly engage with the experience and so control her own destiny (Edwards 2004). As discussed at length in Chapter 6, the midwifery protagonists of the time saw this as a welcome development that would enable the overturning of the patriarchy of medically dominated care (Guilliland and Pairman 2010). Care was now negotiated between the woman and her care giver who was usually a midwife and choice was embraced as an integral component of maternity care.

Informed choice is considered to be fundamental to every aspect of care received by women during their maternity experience[109]. This is signified by the inclusion of the concept of choice in the Code of Rights (Health and Disability Commission, 1996); Competencies for Entry to the Register(Midwifery Council of New Zealand, 2010b) Code of Conduct (Midwifery Council of New Zealand, 2010a) and Standards for Practice (New Zealand College of

---

[109] The principle of informed choice means that for a choice to be autonomous,

Midwives, 2015); and the Code of Ethics and the Referral Guidelines (Ministry of Health, 2012).[110] In order to make informed choices in maternity care the woman is required to understand the range of options open to her alongside the associated risks and potential outcomes for each alternative and her primary health care provider is expected to provide this information and discuss this with her. The term 'partnership' infers empowerment and informed choice facilitated by Lead Maternity Carer with mothers involved in all aspects of planning and care. In order to ensure autonomy, the decisions made must be intentional, made with understanding, without controlling influences and be made voluntarily, so that the woman is able to give informed consent (Beauchamp & Childress, 2013).

By promoting the concept of choice in maternity care and supporting women as they exercise decision making, midwives are said to be facilitating the empowerment of women and in so doing enhancing their autonomy, decision making, and galvanising their self-determination and self-governance. From the liberal feminist standpoint that midwives adopted to regain a position of autonomy in the maternity network, choice serves to ostensibly provide women with a greater degree of control over their childbirth experience. (Mander & Melender, 2009; Guilliland & Pairman, 2010;). However, Richardson (2005) describes the universal promotion of choice as the facilitation of the ideal neoliberal subject. Additionally, the concept of choice is often viewed in isolation from the socio-political structures and autonomy and the right to choose is seen as a civil, and even human, right of an individual without any context at a community or societal level (Sherwin, 1998). This

---

[110] Right 6(1) of the Code states that "every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive."

Code of Ethics- Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience.

Code of Health and Disability Services Consumers' Rights (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

Standards for Practice Two: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience

separation of choice from its connection with socio-political structures has resulted in a lack of understanding of what choice actually means and how it is defined (Beauchamp & Childress, 2013)

Autonomy

Autonomy in healthcare is broadly construed as a patient's right to make their own decisions about care offered, including treatment and tests. Autonomy is enshrined within the partnership model of midwifery in New Zealand/Aotearoa (Guilliland & Pairman, 1995a) and is also a central concept to the international definition of a midwife (ICM, 2011). It is therefore a key concept in the ethical framework of New Zealand midwifery.

Informed choice, and therefore informed consent, cannot be undertaken without the attendance of autonomy or self-determination (Kirkham, 2004). There are a number of factors that are said to contribute to the autonomy of women during the childbirth continuum. They are the need to feel respected and valued, and for self-knowledge to be honoured (Lothian, 2008). Autonomy enables the woman to access embodied knowledge, which includes knowledge of her own body, her values and beliefs, and the things in her life that are important to her. By achieving autonomy, it is believed that the woman will be confident and be able to make decisions that are appropriate for her and her baby (Edwards, 2005). The autonomy within the context of midwifery care has been classified as the applied form of autonomy referred to as relational or contextual autonomy (Noseworthy, Phibbs, & Benn, 2013). The theory of relational autonomy espouses that within a relationship that is based upon trust and reciprocity women's needs are heard and acted upon, which in turn reduces risk, increases safety, and becomes the foundation for decision making. Relational autonomy is described by as being dynamic in nature, changing with the meanings and structures of people's relationships and their world (Sherwin & Feminist Health Care Ethics Research Network, 1998; Mackenzie & Stoljar, 2000; Ells, Hunt, & Chambers-Evans, 2011).

The language of consumerism in maternity care

The women accessing the landscape of maternity care today have been raised in a consumerist world beyond the confines of healthcare and this will inevitably have shaped their values, beliefs, attitudes and behaviour to a greater or lesser extent (Springer, Birch, & MacLeavy, 2016). Similarly, midwives will have spent most of their adult lives at least, in a world where they have been influenced by the same values such as choice, individuality and empowerment. These concepts are distributed widely throughout the data from the conversation in the focus groups.

> Amber (1): *I see our role and our philosophy as a practice, as encompassing all of those things like choice and empowerment, that what we actually do is, we do the best that we can for the individual woman that's in front of us, and it's different for everybody because there's individualised care.*
> Sarah (3): *I feel that we treat each woman as an individual so it doesn't really matter what nationality or ethnicity or whatever, that each woman is an individual in the family and that's how you treat them.*
> Betty (2): *It's all about empowering the woman and you know you can't do that by doing it for her.*
> Amber (1): *Because it's individualised care …*
> Alice (1): *We just go with what the woman wants.*

In an opinion piece written for the NZCOM journal in 2004, Banks (2004) accuses midwives of using the rhetoric of professional "politspeak" and observes that "the longer you converse in it, the more familiar it becomes" (p. 6). The selection of quotes above brings that state of affairs to mind where words such as "empowerment" and terms like "individualised care" become empty magniloquence without any real meaning. One could ask for example, is it realistic to suggest the midwives can empower women when all a midwife can actually hope to achieve is to enable or facilitate empowerment. The client, to use the vernacular, can only ever empower herself.

Contemporary reflexivity is dominated by a consumerist approach to the construction of identity which includes areas such as self-care, goal-attainment and relationship maintenance (Featherstone, 2007). Consumerism has become so central to self-identity, even in the public service sector, that the consumer perspective takes precedence over most other considerations such as the environmental impact of the manufacturing of goods for consumer spending (Davies, Daellenbach, & Kensington, 2011). The identity of the consumer of health care has acquired a deep-rooted 'common sense' acceptance in the broad field of health care including maternity care (Dombroski, Mckinnon, & Healy, 2016).

Patient, Client, Consumer or Woman?

Within a market based framework of healthcare, nomenclature can prove to be problematic. One of the groups struggled to find an agreed word or a term that fits well within the relational context of midwife/woman.

Alice (1): *'Consumer' is like something you buy.*

Amber (1): *I call them clients.*

Patricia (1): *Clients is nice I think.*

Lorna: *Client is about a transaction isn't it, a contract and a transaction*

Amber (1): *I use clients.*

Alice (1): *I use clients.*

Amber (1): *Because they're signing a document when they sign the registration, and they don't actually hand over money, the government does that on a contractual basis with us. I don't like consumers or users.*

Alice (1): *No I don't like that either.*

Lorna: *Recipient of service?*

Amber (1): *No.*

Alice (1): *I often say woman. Woman or client, the woman for whom I'm caring.*

Jane (1): *Definitely, never patient.*

Amber (1): *No not patient.*

Jane (1): *They only become patients if they're seriously unwell and that's a completely different concept for us, because we're not looking after patients, we're looking after individuals. Patient is more a generic term isn't it.*

This discussion illustrates the dilemma that the midwives face when endeavouring to find the words to describe the 'role' of women in relation to midwifery care. They speak of the word 'client' as fitting in with the contractual nature of their work with women. The word client is usually associated with a business relationship and the self-employed status of New Zealand midwives are reported as working within a business model (Pelvin & Thompson 2015). The word 'client' could ostensibly therefore be considered to be a fitting description.

The introduction of a 'woman centred' approach, corresponded with the adoption of the term 'consumer' within midwifery care at a time when it began to replace the word 'patient', and so understandably this term has implicit value from a midwifery philosophical perspective. The term 'patient' still exists in many areas of healthcare. However, midwives consider themselves as working with a healthy and well population of women experiencing a physiological event, whereas patient is a word that is generally synonymous with pathophysiology (Mander, 2013). The midwives here contend that the word 'patient' is inappropriate for use with childbearing women but do accept resorting to the term if a woman happens to become unwell and a woman with additional medical or obstetric conditions may, within that criteria, already be a patient.

The midwives did not like the choice of the word consumer either which is interesting as it is a word that is ubiquitous in midwifery care in New Zealand/Aotearoa with 'consumer' representation on most bodies and committees pertaining to midwifery care. This to an extent refers back to the 'consumers' of the 1970s and 1980s who classified themselves as activists within a 'consumer movement' and would therefore fall into the category of

217

'democratic consumers'[111] (Mold, 2015). However, the increasing presence of neoliberal policy in public policy decision making means that the market is now the ultimate arbiter of citizen's rights, which means that the democratic definition of consumer could be argued as being defunct (Craven, 2007).

The question of how to describe users within the service is a relatively new challenge for health care, particularly in areas such as primary care, where the term 'patient'[112] was used for centuries without challenge. The field of social work has grappled with this problem of what to call those who use their service for a longer period of time and the rationale that McDonald (2006) uses for social work parallels with health care.

> The words we use to describe those who use our services are, at one level, metaphors that indicate how we conceive them. At another level such labels operate discursively, constructing both the relationship and attendant identities of people participating in the relationships, inducing very practical and material outcomes (McDonald 2006 , p. 115)

In a semiotic sense the labels that we ascribe to women interfacing with the maternity service, can change the meaning of the relationship by altering nuance and inadvertently introducing assumptions about the character of the relationship. The words that we use therefore, both for ourselves or women, can create or alter identity both for 'user' and 'provider'.

---

[111] Craven (2007) informs that the feminists in the USA women's health movement in the 1960s and 1970s who initiated the familiar slogan "a woman's right to choose" prompted the onset of women's rights activism throughout the world. These activists adopted the use of the term consumer as a liberatory alternative to paternalistic representations of the (female) patient and (male) doctor.

[112] Patient comes from the Latin "patiens", which translates as 'to suffer' or 'bear'. The patient, is viewed as truly passive—bearing whatever suffering is necessary and tolerating patiently the interventions of the outside expert. It could be queried whether it fits the description of any healthcare user in the 21st century.

Business or Service?

The same issue was evident in relation to what the midwives called themselves and this maybe significant in terms of a sustaining a strong sense of identity.

> Melanie (3): *I'm not a private midwife I'm a publicly funded midwife.*
>
> Jess (3): *I call myself an LMC midwife.*
>
> Sarah (3): *Last year we [sic] didn't we change it [the name] to publicly funded community midwives, fully integrated community midwives yeah? Yeah but see people won't know what that means.*

There were concerns that LMC midwives were viewed by the public as being isolated from the maternity services network. For many years the term 'independent'[113] midwife was used by midwives, the public, and other practitioners to differentiate between community based continuity of care and core hospital based midwives. The labelling of 'independent' was felt to fuel a perception that LMC midwives sat outside the mainstream provision of maternity care. In an endeavour to clarify that midwives are an integral component of the larger maternity system, NZCOM introduced the description "publicly funded, fully integrated, community and hospital based midwives" (NZCOM Fact Sheet3). However, the midwife's perception is that clear definition is still elusive, and that at least some of the public remain confused about the role of the LMC midwife.

> Wanda (2): *A lot of women still believe that their baby is going to be delivered by a doctor, particularly, those from overseas.*
>
> Sally (2): *There is a huge amount of confusion.*

---

[113] 'Independent midwife' is a term generally used by midwives in settings such as the UK or the USA where the midwives work privately and independently of the health care system. These midwives are paid directly by the women that they provide care for. As the midwives in New Zealand are funded by the MoH, the term was deemed to be confusing.

When the midwives are asked to clarify how they would describe the way in which they operate as LMC's, further uncertainty about their perceived identity is revealed. This time the debate relates to whether they work within a business model or not.

> Jane (1): *I don't think we use a business model as such. Well we do to a certain extent.*
> Lorna: *The way funding takes place?.*
> Jane (1): *Funding issue yes, like we're paid 'fee for service' essentially I guess, and I guess that's part of the business model.*
> Lorna: *Yeah*
> Alice (1): *But we don't have to worry about collecting fees. In that way it's good because your care isn't linked to them paying you which is good. I imagine if you'd been charging someone for their care, and then they hadn't paid you, like why would you get out of bed at three in the morning to go to their birth if they're not going to pay you. I think it is actually fantastic that it's not linked.*

Although they are broadly classified as self-employed, and are professed to work within a business model (Pelvin & Thompson, 2015), these midwives do not enthusiastically embrace the identity of 'business woman'. They express relief that they are not responsible for the collection of fees and are reticent to acknowledge that they work within a business mode. Kirkham (2017) warns that "a society based on commercial values neglects care at its peril" (para. 22). She postulates that a business-based approach creates conditions such as time poverty, that impacts on how well midwives are able to relate to women (Kirkham, 2010). Interestingly, the midwives make several references to the 'time and money' premise in the transcripts, such as "*But the point is that like my money, my time is valuable*". (Jane:1) and "*Only having twenty four hours in a day is a barrier, and not being able to time travel*" (Sarah:2).

The comments may simply reflect a time-impoverished world, where time is viewed as a precious commodity and anything that releases time is viewed as a valued commodity. However, in the case of New Zealand midwives, it may have an additional layer of complexity,

as a result of the inclusion of a temporality that is related to earnings. As discussed in Chapter 6, the emergence of the self-employed status of the LMC in the 1980s was purported to suit the needs of the profession (Guilliland & Pairman, 2010) and was viewed enthusiastically as "a totally midwifery run project and autonomy in action" (Guilliland, 1999, para. 9). The model was established to create the "same contracting structure available to them as doctors [GP's]" so that they were able to "retain their market position" and "compete equally" (Guilliland, 1999, para. 10).[114] Kirkham (2017) asserts that the holistic objectives of midwifery cannot be achieved in a business type model as there is an inherent conflict of interest. She argues that "tight control and penny pinching" along with "addressing only short term, easily measurable outcomes, is not a commitment to the next generation" and demands that a different ethic is required for public service than for business[115].

The rhetoric of choice

In spite of uncertainty about what terminology to use for women in the system, when they discuss 'choice', the midwives embrace the concept with almost zealous enthusiasm.

> Jess (3): *Because we believe that the women deserve to have a choice and I think that's the whole thing...*
>
> Sarah (3): *But it's not only the choice of midwife or LMC as such it's actually the choice that comes within that as well, like you know when we talk about screening tests for example like the gestational diabetes screening tests we tell them it's a screening test, we give them the information, we encourage them to go online and talk about it and*

---

[114] See Chapter 6 for further details

[115] Consideration of an appropriate ethic for midwifery discussed later in the chapter.

become informed. And then they make that decision as to whether they want to be screened for it given that the only risk factor that they have may be that they are pregnant, but they have to make a choice.

Treating women as a co-contributors to the knowledge-garnering that enables decision-making within the mother-midwife relationship, can be argued to be a positive ethical stance because the shared action acknowledges women as complex, social beings with the primary share in the process (Kirkham, 2004; Thompson, 2006). However, the informed choice framework operates on the premise that both recipient and provider of care have access to first rate information on which to base decisions around care (Noseworthy, Phibbs, & Benn, 2013). If we look to the area of antenatal screening for chromosomal and other abnormalities as an example, Seavilleklein (2009) contends that there is mounting evidence that women are unable to make genuinely informed choices about this antenatal screening because of an increase in the number of screening tests available and the convoluted nature of the tests. The complexity of the processes involved, such as methods, specificity and sensitivity, and choices following a screen positive result, make information sharing a thorny process. Yet there is an expectation that women will accept the responsibility of making informed choices about their childbirth experience by engaging in "reflexive modernity" (Davis & Craven, 2007). As such they will access appropriate information (evidence-based where possible); make sure that that the information is aligned with their values and beliefs; integrate information that meets their specific health needs; validate an understanding of the risks, benefits and alternatives that are available; and then work out how to minimise the risks (Lupton, 1999; McCourt, 2006). I acknowledge that the screening framework in New Zealand/Aotearoa emerged from the Cartwright Enquiry (Chapter 6) and that this area of practice has a strong emotive connotations and ethical ramifications as a result. However, the escalating complexity of the tests available and the issues at stake for women led to this area becoming a veritable quagmire in terms of informed choice and consent.

There are many other areas, in addition to this screening in maternity care, where considerable deliberation is required in order to provide the woman with enough

information for her to make a truly informed choice. The reality of comprehensive information sharing is certainly more achievable within the context of a continuity of carer model, where the midwife and the woman have an ongoing relationship (Noseworthy, Phibbs, & Benn, 2013). However, Douglas (2003) suggests that decisions are made and risk calculated according to cultural norms, values and beliefs and this means that decisions are predominantly made on a social rather than scientific basis. Choice is therefore rarely likely to be based on rationality, but on social consensus.

The seemingly almost sanctified status of informed choice, so integral to the partnership model leads the midwife in the extract above to insist that the woman 'has' to make a choice. The pressure of gaining informed consent could therefore compromise the relationship. The midwife's assertion would seem to contradict the notion of freedom of choice. If a woman has to make a choice, then it would surely follow that a choice to make no choice should be an option. However, this may be viewed as turning to the midwife as the expert, which is at variance with the partnership model and may be considered an act of paternalism. As a result the midwife is left in a perplexed state. The consequences of making decisions can be hard for women to comprehend, which may reflect the fact that individual decisions cannot be considered in isolation, but need to be placed in a much broader frame (Agledahl, Førde, & Wifstad, 2011). Mol (2008) condemns the notion of consumer choice in such a context stating that it serves to undermine the relational dynamic between midwife and woman by generating anxiety for both. As a result, a sense of detachment between the recipient of care and the health care provider may be triggered thus reducing levels of trust and reciprocity and potentially damaging the relationship. (Glynos, 2014). Although this sort of dilemma may be prevalent in other health professional-patient/client contexts, the professional friend status (see Chapter 6) that exists within the partnership model here in New Zealand/Aotearoa adds an additional layer of complexity. In spite of this status in the relationship, both the HDC and Midwifery Council of New Zealand highlight the issue of informed consent as a cause of many complaints (Godbolt, 2010).

Hewson (2004) has suggested that available screening policies that are purportedly offered to provide information on which they can base informed decisions, are less about choice and more about ever-increasing regulation. She argues that "a remorseless rise in social regulation" has led to the measures deployed by the rhetoric of choice and empowerment becoming "increasingly authoritarian in nature" (p. 5). This suggests that the notion of informed choice within a consumerist framework is actually decreasing self-determination in decision making.

No wrong choice

In the following exchange, the midwives were discussing the visit of an important overseas visitor where the issue of choice was raised in relation to the New Zealand midwifery model.

> Alice (1): *At the end of the day, she [the woman receiving care] could have said no I don't want that, I want to stay pregnant and not be induced. She could have at any point said no, and that would have been her prerogative.*
>
> Jane (1): *And that was one of the things ***** found really interesting and unique about New Zealand midwifery, was that people were given information and were able to make choices. She said, "but what if they make the wrong choice?", and it's like there isn't a wrong choice, it's a different choice. It may be a choice you don't agree with but it's not a wrong choice.*
>
> Amber (1): *Sometimes it is hard when people make decisions that you don't agree with.*
>
> Jane (1): *Absolutely, it doesn't mean that it's the wrong choice.*
>
> Amber (1): *No it doesn't.*
>
> Jane (1): *It's just that they have the ability in this country to make that choice.*

When the visitor asks about the woman making a 'wrong choice', the response of the midwife is that there is no such thing as a 'wrong choice'. This response resonates with 'multi-potentiality' a term that the self-help industry uses to market the belief that the act of making choices is in some ways more important than the outcome of the choice in terms of personal growth (McGuigan, 2014). Refrains are inscribed on websites where browsers are informed

224

that "there is no such thing as a wrong decision"(Northrup, 2016) or "There are no wrong choices, just different paths" (Carolina, 2017). In recent years self-help has been promoted by governments and policy makers to support the neoliberal objective of dismantling health and social welfare resources and to transfer responsibility for care to individual citizens (Branelly, Ward, & Ward, 2015). We are increasingly expected to take responsibility for our own health and well-being and the phenomenon of self-help is used to promote the values of autonomy, self-determinism and empowerment (Seavilleklein, 2009). These are values that also sit within the manifesto of health care and more specifically within the philosophy of midwifery care in New Zealand/Aotearoa.

McGuigan (2014) postulates that the phenomenon of individualism may:

> feel like freedom, especially for women liberated from patriarchal control. But when things go wrong, there is no excuse for anyone. The individual is penalized harshly not only for personal failure, but also for sheer bad luck in a highly competitive and relentlessly harsh social environment. (p. 234)

Autonomy therefore comes with a high personal risk potential. Mol (2008) suggests that the rhetoric of individual choice is illusory and only exists if the other actants in a network allow it. If the choice of an individual threatens the stability of the network, there are consequences. For example, a woman can step outside the boundaries of social norms by choosing to birth her breech baby at home, but if her choice creates the need for transfer to a hospital, the network may not provide the psychosocial support that she needs. Her choice may even be condemned as a selfish act that places her baby at risk. As Dombroski, Mckinnon, and Healy (2016) express:

> The idea that mothers can choose the 'best care' for themselves ignores the reality of a fierce political and ideological debate about how a woman should give birth and leads 'consumers' to assume that a 'best choice' is indeed possible. Regardless of the choices made, or what ended up happening in a given birth, mothers carry the moral weight and emotional depth of those decisions through life. (p. 237)

This is not to suggest that many policies and protocols are not valid and are there to ensure consistency in practice to ensure that therapy/treatment is as effective and safe as possible. The problem arises when they are treated as "tramlines, not guidelines" (Tingle, 2016, p. 344) which does not take into consideration the individual needs of the woman. [116]

Mauvaise foi

Paradoxically, in spite of their apparent clarion call of support for the neoliberal value of choice, the midwives were willing to express a view of the concept of choice from a markedly different perspective. When the midwives in Group 1 were asked if there was ever a power differential between themselves and women, they responded thus:

> Alice (1): *Well there is because they don't really know what they're doing half of the time, so they only know what you choose to tell them really, unless they are very pro-active at chasing their own…, you know finding out more for themselves, which a lot of women haven't got time for, or aren't interested in. So if you feed them a certain point of view that's what they take. So we have a lot of power in that I think. But you know I was just reading, I've got a new pamphlet from the maternity services council about it, third stage it's just out, and it's quite, I think it's a little bit skewed because it talks about how wonderful physiological third stage is, which I practice but it's quite derogatory*

---

[116] The terminology for protocols, policies and guidelines is often used interchangeably adding to misconstruing on the part of practitioners.

- Protocol- An agreed framework outlining the care that will be provided in a designated area of practice. They do not describe how a procedure is performed, but why, where, when and by whom the care is given
- Policy- A formal written statement detailing the particular action to be taken in a particular situation that is contractually binding
- Guideline- Systematically derived statements that help practitioners to make decisions about care in specific clinical circumstances. These should be research or evidence based.

about active management, in that sometimes active management is best, I'm not saying I do active management all the time, but if I always did active management and didn't give that woman any information about physiological, she wouldn't know any different.

Lorna: *Because that would be your decision making process rather than hers?*

Alice (1): *But she doesn't know what she doesn't know. I can keep that information back from her because I can be the gate keeper of knowledge in a sense, whereas you know if I give her that pamphlet and I do active, it looks like I've done something wrong. To me sometimes active management is actually the most appropriate way, you know for some situations. I haven't read it thoroughly I just glanced over it and I thought I don't know, it doesn't really sit well with me and I think sometimes there's a clinical judgement that you have to be able to make, and physiological doesn't always work.*

Jane (1): *That's why they've got a midwife after all.*

The above exchange brings to mind the French phrase 'mauvaise foi'[117]. This is an existential philosophical concept used to describe a phenomenon where, when under force of social pressure, people adopt false values and disavow intrinsic freedoms (Flynn, 2013). This led me to consider if the responses of the midwives to the rhetoric of choice in maternity care could be considered to be a modified form of mauvaise foi. Could it possibly be that the concept has become deeply embedded in practice and in the collective psyche of midwifery, but it cannot in reality deliver the promise of 'freedom of choice'? If that is the case, then practitioners may be adopting compensatory behaviours in order to enable them to manage the essentially unmanageable. In the exchange the midwives could be seen to be reinterpreting what might be described as 'idealised choice' to fit the realities of their practice. The comments of the midwife who describes her professional colleagues as 'gatekeepers of knowledge' could be viewed as either a cynical response to the expectation of the information sharing informed choice/consent process or as a legitimate reclaiming of authentic self-identity.

---

[117] Translates as 'bad faith'.

The midwife then goes on to ameliorate the statement made, by qualifying the importance of trust between midwife and mother in the process of decision making.

> Alice (1): *Exactly, but it does come down to trust though. I think in that situation when you say to a woman look this is the way we do, you know this is what can happen, this is one way, this is the other but if you're bleeding to death I'm going to do this, and you know is that OK on the day? and they say yes, yes, fine, and it comes down to their judgement and your judgement on the day doesn't it, and that relationship comes back into that trust.*

As mentioned earlier in the chapter, autonomy in New Zealand midwifery has been mooted as a feminist formulated "relational" or "contextualized" autonomy. The trust that the midwife refers to in the above quote could be said to reflect the ethos of relational autonomy where a midwife/woman pair have a tacit understanding that the woman is in control until such time that the midwife needs to step in and take control, in an emergency situation for example. The problem with relational autonomy as a theory, is that "women hold multiple knowledge positions" (Edwards, 2005, p. 88). What is perceived as a single action within the context of relational autonomy in fact invariably involves many actants as the relational aspect of the mother/midwife relationship is only one aspect of the complex landscapes that form the lives and inform the decision making of women (Agledahl, Førde, & Wifstad, 2011). Midwives also work within networks that create interconnections and interdependencies that can influence decision-making. Women are therefore vicariously enmeshed within these networks that contain cultural, institutional, social and political elements.

The rhetoric of Risk

Risk and safety

The neoliberal concept of individualism within a market based consumerist context is dependent on the decision making capabilities of the individual, and this leads to an

expectation that the individual will make choices based on a balance of risk (Lupton, 1999). The concept of 'choice' is therefore connected with that of 'risk' and as Symon (2006) observes "choice produces an array of threats that must be identified, evaluated, controlled and ultimately accepted within a mature decision making process" (p.13).

In the seminal text, Risk Society: Towards a New Modernity, Beck (1992) postulates that the current risk-based culture in western society emerged as a mainstream entity during the 20th century, with substantial acceleration in the latter half of the century as neoliberalism gained a stronger footing. As a result, externally located notions of fate and destiny have now been largely replaced with the belief that human actants can control hazards by implementing practices to avoid risk. Therefore, the concept of risk has changed from being a neutral term used to calculate probability, to something that we consider to being an unacceptable element that must be avoided or minimised (Skinner, 2008a). We have become a "risk-adverse society that values control over and security from potential threats." (Jordan & Murphy, 2009, p. 181). This belief has led to a large scale adoption of risk management in every sphere of contemporary western style society and particularly in the fields of science and technology (Sena, 2014). Lupton (1999) describes this risk averse world with a preoccupation with safety, as paradoxical and names it "neo-prudentialism" because it fortifies the neoliberal ideals of self-responsibility for risk aversion, whilst simultaneously abdicating the responsibility of the state for the welfare of its subjects.

The pursuit of safety

As the world has become ever more risk averse, societal concerns have moved to the pursuit of safety (Beck & Beck-Gernsheim, 2002). Hewson (2004) suggests that as a society, we are excessively preoccupied with 'playing it safe' which fuels the might of the risk discourse. Within the sphere of health care, an unpredictable outcome is not uncommonly perceived as a failure to adequately monitor and intervene on the part of health care providers (Jordan & Murphy, 2009). Consequently as risk consciousness has increased in maternity care, there has been a shift to greater levels of medicalisation and technology in an endeavour to mitigate the risk of such unpredictability (Symon, 2006; Jordan & Murphy 2009; Nolan,

229

2015). MacKenzie Bryers & van Teijlingen, (2010) suggest that this has "occurred in parallel with wider medical, economic and political reforms and that as state-organised health services developed over the past century the concept of risk and risk management became a central tenet of care"(p. 489). The authoritative biomedical knowledge embedded within a techno-rational model of care has the power to define the parameters of risk and what is 'safe' practice by controlling the information that women receive and the information that is available to them (Davis & Craven, 2011).

A range of studies have indicated that the primary consideration for women in birthplace decision-making is the safety of themselves and their baby (McAra-Couper, 2007; Regan & McElroy, 2013; Grigg et al., 2014; Murray-Davis et al., 2014) If safety is not achieved as a result of what is construed as poor decision-making, then there is a risk of retribution for the midwife in the form of litigation, castigation by the profession or public exposure by the media (Kirkham, 2004; Edwards et al., 2011). Contemporary midwifery practice is therefore significantly influenced by risk assessment and systems are driven by clinical governance where women are categorized by their risk profile in order to reduce the chances of poor outcomes (MacKenzie Bryers & van Teijlingen, 2010; Davis & Craven, 2011). At a rudimentary level this means high risk or low risk, but this can be further filtered into a placing along a spectrum of risk. Absurdly, the increasing emphasis on risk assessment, which it can be argued serves to limit choice by portraying birth as a risky business, has coincided with a greater emphasis on a woman's right to make choices (Symon, 2006). As McIntosh (2013) states "Risk is a concept as slippery and value-laden as choice and as easily open to interpretation" (p. 145).

The Responsibility of the Consumer

The powerful belief systems that operate to ensure that free choice is available also uphold a moral obligation on the part of the woman to minimise any risk to society and to make safe,

logical and morally appropriate choices. The narrative below serves to illustrate this status quo.

> Patricia (1): *My woman whose wound did dehisce*[118] *was going to get into the* [*birthing*] *pool. It was all run and she was about to get into the pool, she was desperate to, that's what she talked about the whole pregnancy, she really wanted to be able to get in a pool, and she'd had such negative birthing experiences before etc. Anyway we said to her if you have pain between contractions you must tell us, and so just before she got in the pool she said "oh the pain isn't going", I said "OK then" so we went to caesarean theatre about five minutes later. It wasn't a big deal, it was no problem. She didn't get in the pool but she wasn't going to put herself or her baby at risk, but what she did say was how wonderful her birthing experience was, because she felt she'd been listened to and that she was allowed to have a choice. The fact that she didn't get to do what she wanted to do was not relevant to her, and that's often all it needs, for people to feel positive about their birth experience.*

In this narrative the outcome appears positive, a healthy baby and a healthy mother. The woman is viewed as a self-determining individual who governs her own body and has made decisions with the expert support and guidance of health professionals. The discourse is built around her rights as an individual within the principles of the free market. She has ostensibly made her own free choices. The self-determination of the woman is locked into the neoliberal objective of forming life as a project that has to be planned and rationalized (Beck-Gernsheim, 1996). Neoliberalism bestows on women the privilege of 'consumption' within the sphere of maternity services, where they are encouraged to choose the services and commodities that will meet their needs for their preferred birthing experience. However, the right to free choice exists alongside an obligation to ensure that control is maintained by ensuring that the least risky options are chosen (Beck-Gernsheim, 1996). There is therefore an expectation that the

---

[118] Dehiscence *occurs when the scar from a previous caesarean section begins to separate during labour.*

woman will manage any elements of risk, both for herself and her baby by making the medically defined 'right choices'. This risk is structured in the binary terms of danger/safety with nuance of good/bad which has the potential to significant reduce the free choice of the woman (Lupton, 1999).

The Default Position and other strategies of mitigating risk

Within the context of continuity of care, this tacit contractual agreement around choice and risk has the potential to place midwives in an unenviable position. They must attempt to broker between the woman's wishes and the path of least resistance in terms of the safe, logical and morally appropriate choices available by negotiating their way within the network. There was evidence that the midwives were using a variety of means to circumvent the constraints of risk, to enable women to have their choices met.

What is the Default Position?

Jane (1): *I guess that essentially since I started working in ******, I've always had high risk, women who are perceived to have high risk medical conditions etc., so for me the big thing is to try and keep that as normal an experience as possible, and you know like just because somebody's high risk as far as I'm concerned it doesn't mean they can't have a water birth, it depends on why they're high risk, and the hospital protocols and procedures and stuff are often too confining, and I think that's an issue that the hospital needs to look at, they're too risk averse and they're too afraid of you know, negative outcomes, they're so afraid of negative outcomes they're creating negative outcomes I think.*

(Frolich, 2013) suggests that the only way to embrace the concept of choice beyond rhetoric is to re-evaluate our paternalistic acceptance of the current status quo within the maternity care framework and stop relying on the application of policies and guidelines. This experienced midwife was using what could be referred to as the 'default position' (Davies & Martis, personal communication, March 3rd 2011). This means that she was attempting to use an individual

232

assessment of the woman to negotiate ways to keep the pregnancy and birthing experience as normal as possible whilst staying within the accepted boundaries of the choice/risk contract.

Evidence Informed Practice

The use of research evidence was another strategy utilised to assuage the impact of risk management.

> Alice (3): *You can sort of dispel some of those myths with some of the studies out recently that's saying that it's actually safer to be in a primary unit have intervention, you're more likely to have a normal birth, even if you don't have your baby there if you end up transferring, you're still more likely to have a normal birth and less intervention if you start out and plan to birth at one of the primary units.*

This quote demonstrates that midwifery is developing and utilizing a body of research evidence that lies beyond that of medically led research. The sources that the midwife is referring to are good quality New Zealand midwifery studies that are validated by inclusion in systematic reviews. This is a gratifying observation that illustrates a maturing of the profession with the active utilisation of research in practice. However, the heterogeneous nature of networks in ANT, means that any piece of research evidence, which can either be an intermediary or a mediator, is acting alongside other elements that can work to either facilitate or obstruct the objectives of research informed practice. The interwoven assemblage of ANT means that the validity of research evidence is influenced by intra-professional relationships, support of the public, institutional endorsement and other tangible and intangible resources. Without the endorsement of enough of the other actants, research evidence will not be enough to change attitudes, behaviours, actions and outcomes.

Culture of Blame

Relationality within the partnership model was also advocated as a mitigating factor in curbing the encroachment of the risk agenda by several of the midwives.

Jess(3): *I just think you do a good job and have a good relationship with the woman, and even if it turns to custard if you've maintained that relationship with her, and she feels like she's informed and knows what's going on, I don't think there's this level of blame that you get if you haven't had that relationship.*

However there is also a suggestion that that the midwife/mother partnership may mitigate any blame that could be targeted at the midwife which could be construed as the midwife managing her own elements of risk within a culture of fear and blame. Blame is viewed as a derivative of a risk culture and it has been propositioned that the need to apportion blame is central to the selection of risk. Every culture draws its own ideas of what constitutes as normal and of natural. For example if death is held to be normal within that culture then no-one is blamed. If death however, is viewed as avoidable that someone has to be held responsible and to take the blame (Coxon, Sandall, & Fulop, 2014).

Ever growing menu of risk factors

It has been identified that an ever-growing list of risk factors is making the job of brokering the network of choice and risk increasingly challenging for midwives (McIlhone, 2016) and the midwife below expresses her frustrations relating to this.

Alice (1): *They're now saying that IVF women have to be induced at forty weeks, and forty year old women have to be induced at forty weeks and then there's increasing BMIs, I mean I've got women of all of these things recently who've had issues, and it does become hard to, you cannot keep it normal because everyone wants to interfere with that pregnancy, everyone wants to get that baby out early.*

Increasing complexity is a much cited phenomenon in maternity care, and it is used as a rationale for increasing intervention, such as the induction of labour referred to by the midwife

(McAra-Couper, Jones, & Smythe, 2010). There is no single definition of 'clinical complexity' but the increasing occurrence of chronic disease and co-morbid conditions are generally included in the term. The use of the term co-morbidity is generally used if the woman has an underlying medical condition such as gestational diabetes. However, co-morbidity means the existence of more than one condition or disease and if a woman only has one condition, then this would suggest that pregnancy is at times being referred to as a 'condition'. This is wholly at odds with the definition of childbirth as an altered state of health as opposed to a state of pathology and the risk agenda appears to have facilitated this

(Davies, 2012). Interestingly, risk factors which are not medical conditions per se, such as Body Mass Index (BMI) and maternal age are also ostensibly included in the list of 'conditions' (Ministry of Health, 2012). There is little argument that obesity can present challenges during the childbirth continuum and that these challenges can pose serious threats to the health and wellbeing of both mother and baby (McAra-Couper, Jones, & Smythe, 2010). However, critics argue that the root cause of endemic obesity within society is not being addressed at a sociopolitical level and that this leaves women in the maternity system vulnerable and labelled as 'risky' (Deery, 2011). Additionally, an obese woman may be clinically and nutritionally healthy whereas a woman of medically acceptable weight may be poorly nourished which may put her at risk (Keely, Gunning, & Denison, 2011). The same principles can be applied to older women who are classified as being at increased risk, and to other categories such as younger women and those who have conceived using assisted reproductive technology. Midwives today are said to be facing a level of complexity in care that is unprecedented (Pairman et al., 2015; NZCOM, 2016) leaving them to grapple with the interpretation and consequences with women in their care.

In their discussion of risk as a concept within their caseload, the midwives vacillate between trying to hold onto a sense of normality for the woman to resorting to a risk based approach to construct their own perspectives of women which fit within a risk managed mode of practice.

Patricia (1): *You know there are definite risks being a very big BMI, there's huge risks with that.*

235

www.manaraa.com

Amber (1): *Much more so than with age. I had a forty five year old who I just discharged this morning, who had the most beautiful pregnancy and straight forward labour and birth, and she's on such a high, she's a well woman, healthy baby, but I have someone who is twenty five with a BMI of too much to think about at 150kg, much worse off from a complexity point of view.*

Jane (1): *My women with huge BMIs pop their babies out.*

Alice (1): *Not all of them.*

Amber (1): *This one's got hypertension, she's got gestational diabetes, she's got problems with swelling already at sixteen weeks, so moving an issue, she's going to see the physio already, she's going through the hospital clinic because she's had wound infections, you know it's all those things on top of.*

Jane (1): *It takes so much longer when there's all these additional aches and pains etc.*

Amber (1): *But even though it's a complex issue, it still doesn't mean that I'm not going to look after her, this will be the third time that I've looked after her, so I'm guessing it's going to get easier every time. Well I know her better.*

Alice (1): *She puts more weight on every time though.*

This discussion serves to illustrate the internal conflict of the midwives where they are struggling with their philosophical standpoint as 'guardian of normal birth' and external conflict as they aim to negotiate a way past the 'condition' with obstetric colleagues, be it pre-existing medical, obstetric or socially constructed. However, they are also, albeit inadvertently, supporting the notion of risk categorization and therefore validating a hierarchy of risk.

Unique Normality Revisited

The discussion above leaves little doubt that in spite of endeavours to normalize the woman's experience as much as possible, or to capitalise on their relationship with women, the biomedical paradigm and the techno-rational mindset that resides within it has had a significant influence around the rhetoric of risk for the midwives. There is contradiction and

236

confusion within the group who are trying to hold onto what Downe (2010) describes as the "uniquely normal" aspect of each woman's birth. By this Downe is suggesting that the:

> dynamic biological systems and psychological orientation of mother and baby interact
> in unique and unpredictable ways with the context in which [pregnancy and] labour is
> happening including the attitudes, beliefs and care practices of her birth companion
> and attending staff and the setting in which she is giving birth (Downe, 2012, para 17).

By applying complexity theory to childbirth, there is an acceptance that a one-size fits-all approach cannot be employed because each woman has unique needs and crude risk categorization cannot address this. Complexity theory accepts that our reality is composed of a broad-based range of interrelated phenomena which may be orderly, complex and disorderly. This eclecticism allows for many different ways of being and doing and embraces a flexible and unbiased approach to epistemological viewpoints and philosophical approaches that eschews ascribing a greater status to one set of professional values over another (Byrne 1998). Risk management conversely is about order and predictability (Beck 1992; Lupton, McCarthy, & Chapman 1995) and this does not sit comfortably with complexity, uncertainty and unique normality. As a result, the midwives experience professional conflict, and misperception and frustration ensue. Skinner (2008) defends midwives and the position that they find themselves in. She contends that midwives are vulnerable within a system governed by risk. They can be challenged by the women using the service, managers of maternity care, as well as others at the interface of care such as doctors and even their own colleagues at times. "Despite having developed a strong, autonomous midwifery profession, which now provides most primary maternity care, we have not succeeded in making a significant dent in our risk framework" (p. 54).

Pushing the Boundaries (a little)

Consequently, midwives have been forced to find other ways of making it possible for women to circumvent the results of perceived risk. Sometimes this is by 'doing good by

stealth' which is described by Kirkham (1999) as, "the complexity required in order to achieve objectives which cannot be voiced clearly and directly" (p. 737). In her study, Kirkham found that this surreptitious behaviour was common in midwifery practice, often presenting at the interface of inter-professionalism. In the quotation below, I would suggest that the midwife uses the euphemism of 'pushing back the boundaries a little bit' in this way.

> Amber (1): *I say to the women, this is the protocol this is what they recommend, but it's not the law, you're not breaking the law if we push the boundaries a little bit. But I want to give you really good safe care. I'm not going to do anything that's going to put your baby at risk.*

Although short, the quotation above is loaded with meaning about the constructs of risk, choice and safety in contemporary midwifery care. The midwife appears to offer the woman choice and control by explaining that she is able to "push the boundaries" which suggests that the boundaries, defined by medical policies and protocols, can be pushed back, but there is a caveat that they can only be pushed "a little bit". If they are pushed too far, it might be detected.

It may be, of course, that the midwife considers that to push further *may* impact on the safety of the baby. However, the problem with the message delivered is the potential for misinterpretation. For example, the woman may receive this message as advising her that if the boundaries are pushed a lot rather than a little, she might be breaking the law as well as potentially putting the baby 'at risk'. This creates a degree of ambiguity laced with fear and now it seems that the midwife will govern the level of risk to the baby so that the baby is 'safe', with of course, the woman's informed consent. Risk has potentially added a layer of what could be described as chaotic interpretation. The cited scenario could be interpreted as the midwife redefining the notion of risk and setting herself up as a better judge of what constitutes risk than the institutional frameworks of risk.   Conversely, the midwife may be viewing her part in the process as shielding the woman from over-zealous protocols that, as she rightly states, are only protocols, not law (Tingle, 2016). Yet whatever the reality, the

238

message that the midwife carries could be construed as a fearful one that may result in the woman relinquishing control over her experience.

The discourses of risk and safety have a strong association with the discourse of fear, although it has been advocated that the deficit of theory on societal fear in the 21st century has been overshadowed by the expanding literature on risk (Furedi, 2007). Furedi (2007) suggests that risk has become a new moral consensus and that transgressing this societal covenant of risk is not dissimilar to that of the contravening of codes of religious belief in times past. Before the revision of the neoliberal concept of risk, risk-taking behaviour was viewed as having the potential for either positive or negative outcomes. However, in the current ideological climate, it is viewed as an external and free-standing concept that exists independently of the individual (Lupton, 1999). Furedi (2007) therefore theorises that in a climate where insecurity is used to maintain a sense of control the "autonomous individual disappears" (p. 26). The individual is thus remodelled as submissive, passive and reliant of expert advice and a culture of fear is achieved. "fear does not just happen; it is socially constructed and then manipulated by those who seek to benefit" (p. 26). In many ways the scenario serves to represent the Hobson's Choice that midwives are frequently faced with in current maternity care where the rhetoric of risk results in a climate of fear.

An Acceptable Risk?

There are a number of examples of the presence of both risk and fear in the disclosure of the midwives, where the degree of risk that the midwife is willing to take, encroaches on the choices that women can make.

> Alice (1): *I think all that we're doing is trying to advocate what the woman wants, I don't want to be a dangerous midwife that puts women's lives at risk and babies die, I don't want to ruin my reputation by doing that, so why would I do something that I think is unsafe?*

This quote offers an example of how the pressure of accountability can lead to fear and stress in practitioners. The midwife wants to be able to act as an advocate for women when they make their choices, but feels that she is not always able to do this because, as she stresses, she cannot put women and babies at what could be considered as being at risk. Although this sentiment is almost certainly made in good faith, it effectively nullifies this advocacy role and places the midwife in a position of authority. If a woman steps outside the parameters of what is considered to be an 'acceptable' risk, her choice becomes problematic and risk and safety become the driving forces for decision making. The identification of risk according to Skinner and Maude (2016), is tied up with control and as midwives attempt to predict the possibility of a specific outcome, they have a tendency to attempt to make the decisions for their clients. In a UK based study Hindley and Thomson (2005) explored the themes of informed choice and the power of the midwife. They found that although midwives supported the application of informed choice and shared a professional consensus for the concept, this was not translated in practice where midwives struggled with the competing agenda of medically driven protocols and a relationship with women. In this particular study, the midwives manipulated information during their interactions with women, which as the researchers concluded meant that women got the choice that midwives wanted them to have.

Additionally,(Stahl & Hundley, 2003) claim that health professionals and women use quite different approaches in the interpretation of risk and that this influences the information that is shared. Health professionals have a tendency to use epidemiological and evidence based approaches when examining risk and this reflects their specialist knowledge and understanding. Although the values and beliefs of midwives will also inevitably play a part in informing their perception of risk, when women assess their own pregnancy risk, it tends to be far more contextualized and influenced by many social constructs such as peer and media influence (Jordan & Murphy 2009). As a result, the self-assessment of risk for women can be very different from that of a health practitioner and this could lead to conflict within the relationship in a continuity of care model.

A Well Mother and a Well Baby

There are a number of studies that highlight how fear of litigation, public exposure and professional disciplining cause practitioners to focus on physical outcomes relating to clients and their babies rather than psychosocial elements of care. (MacKenzie Bryers & van Teijlingen, 2010; Copeland, Dahlen, & Homer, 2014; Healy, Humphreys, & Kennedy, 2016). This may explain the response of the midwife here below:

> Amber (1): *I'm happy to use the medicine, I'm happy to use the tried and tested because at the end of the day you want a well baby and a well mum.*

Here, the midwife indicates that she is willing to use whatever is on offer in terms of medical support in the endeavour of achieving the outcomes of well baby and well mother, once again inadvertently adhering to the parameters of a risk focused service. Whether the 'tried and tested' will enable achievement of such outcomes is not addressed and the matter of whether the woman will consent to the 'tried and tested' is not elucidated. The midwife is primarily focused on the parameters of safety within a techno-rational context.

The belief that we can prevent, manage and control risk is a potent, pervasive and persuasive one in birthing territory, an area of life that is in many ways fraught with uncertainty. Thus, safety has been turned into a commodity within the techno-rational health care setting, and health-care professionals are expected to provide 'safety' for patients/clients/consumers (Skinner & Maude, 2016), usually in the form of technological intervention from screening in pregnancy through to surgical childbirth. Fearful connotations of risk result in women being more reliant on technology in order to reduce any element of risk and to seek reassurance that the pregnancy or labour and birth are progressing normally (Scamell, 2014; Seavilleklein, 2009).

One of the midwives in the study contested the assumption that technology can provide assurances of risk reduction.

Betty (2): *Midwives need to support physiological birth and not buy into the fact that people all have to go to the hospital to have their baby. They all have to have the modern technology. Just because you've got something that goes there, doesn't mean we have to use it…. we are actually protecting a style of care which has never been wrong but still can be seen as not as modern and so as flash.*

This is a perspective that would almost certainly position midwifery in the literature "as an antagonistic agent, guarding women's interests by stubbornly maintaining a professional faith in women's ability to birth and nurture their offspring without recourse to technology" (Scamell, 2014, p. 925).

It would be incomprehensible to argue against the outcome of a healthy baby and mother as the primary outcome of birth. The Midwifery Scope of Practice included in Chapter 6 (p.142) provides boundaries of midwifery practice to ensure safe practice and this is further accentuated in the Competencies for Entry to the Register. However, the 'safety' of mothers and babies has been used as justification to coerce women into compliance (Reed, Sharman, & Inglis, 2017; Bohren et al., 2015). In a systematic review that included a range of international studies, Bohren et al. (2015) reported that although this sort of coercive communication occurs at the interface between provider and recipient of care, it actually results from systematic failures at institutional and healthcare system levels. Even within a continuity of care model, the need to conform to systematic requirements influences the choices that a midwife feels that she can offer. Risk aversion is a key element that influences the actions and care that a practitioner feels able to provide and the frameworks that guide practice, particularly within the confines of a hospital setting, are viewed as mandatory risk management tools. This may be an indication of why, in spite of the continuity of care model, the intervention rates here in New Zealand/Aotearoa are similar or only marginally better than countries such as the UK, Australia and the USA (Rowland, McLeod, & Froese-Burns, 2012).

Risk, Fear and Place of Birth

Primary Maternity Units

A sense of fear among midwives generated by perceived risk around place of birth emerged during discussions in the focus groups. One of the DHB midwives was speculating about why LMC midwives are reluctant to bring birthing women to the Primary Maternity Unit (PMU).

> Betty (2): *It's really hard from a primary unit midwife point of view when you were talking about the midwives that don't feel confident about birthing out here. How do you support them to do that? I mean, we've done tech skills, we've done everything. We've all proven to them we can cannulate and cope with the one or two emergencies we have a year, and yet they still will not come. They don't want to be out here because they're scared of something going wrong.*

As discussed in Chapter 6, the decision of assorted governments to centralize health services in order to rationalize resources and improve safety, led to a wide scale programme of closure of primary maternity units throughout the country. This was fuelled by a public who were persuaded that technology and increased medicalisation would provide a safer environment for birth. More recently, in spite of substantive evidence about the advantages of using these units to birth, including a greater likelihood of normal birth with less intervention and low levels of perinatal mortality and morbidity, many of the primary maternity units in New Zealand/Aotearoa are experiencing decreasing occupancy rates whilst the obstetric units in tertiary hospitals are over utilized (Dixon et al., 2012). In 2014, the percentage of births in a tertiary facility unit was 46.6%, secondary 41% and primary just 9.1% 2014 (MoH, 2015b). This can do little to engender the confidence of the midwives about the future of their primary unit.

> Helen (2): *It would be a huge shame to see this place go.*
> Lorna: *And are the local community using it?*
> Wanda (2): *Not always.*

Lorna: *For birthing or?*

Wanda (2): *I think most of those women that live in the townships would rather go in to town.*

Helen (2): *Cause it's just so convenient if you live in ******isn't it yeah?*

Wanda (2): *It's still that message out there that first time mothers do have to birth in a you know secondary you know tertiary unit yeah, which is a shame.*

The evidence that some women feel that the units are not as safe as birthing in a hospital unit is often cited as a reason for their under usage (Davis et al., 2011). Grigg et al. (2014) claim that the women in their large scale New Zealand based study perceived themselves as the main birthplace decision makers with midwives being the most influential health professional to assist in the decision making process. However, just because they are the main decision-makers, does not mean that the decisions are always activated and Grigg et al. (2014) acknowledge that women are sometimes prevented from accessing their preferred place by organisational constraints or conditions. These include not being offered options around birthplace and restrictive primary unit booking criteria which exclude many women at the first stage of the process.(Tracy, 2011) states that a loss of PMU's is a "clear example of the lack of attention being given to the relationship between healthcare, sustainable communities and overall quality of life"(p. 41). She stresses that this important consideration is overlooked by maternity policy and decision makers.

These are relatively new findings and it seems that Canterbury District Health Board (CDHB) are endeavouring to encourage 'low-risk' women to consider using PMU's in order to avoid unnecessary interventions and to deal with the logistical problems created by excessive bed occupancy in a tertiary facility. In early 2017, CDHB invited midwives to attend a series of forums to explore ways to actively promote the use of Primary Maternity Units. However, the forums were strongly opposed by the maternity advocates group Action to Improve Maternity (AIM) (Meier, 2017). The spokesperson for the group claimed that the initiative would restrict choice and increase risk for mothers and babies. She went on to add that CDHB's strategy ignored women's choices and that women were not choosing birthing units

because they want the security and safety of a medical space. The doctrine of the consumer organisation effectively used the rhetoric of choice to support the rhetoric of risk in spite of the strength of the research evidence. Any plans to further this initiative on the part of CDHB appear to have been placed on hold at the time of writing.

Homebirth

In relation to the place of birth, one of the midwives spoke of an occasion when an obstetrician had condemned homebirth during a discussion with a woman who was planning for this .

> Sarah (3): *They well, they went and spoke to one of the obstetricians up there who talked about how dangerous home births were and the fact that England had outlawed them. Well England hasn't outlawed them at all.*
> Melanie (3): *I had my children at home in England actually (laughs).*
> Sarah (3): *But they can undo months of hard work with one lie like this. They don't have to prove it, just to create doubt in the woman's mind. She's not planning a homebirth now.*

The safety record of home birth has been extensively researched and like PMU birth is associated with much lower rates of intervention, less pharmacological pain relief and postpartum haemmorrhage, whilst outcomes for the babies are similar or better than those in planned hospital births for low risk women, even for first time mothers (Davis et al., 2011; Sandall et al., 2013; Dixon et al,. 2014). Hospital based birth conversely is associated with a range of technological interventions such as augmentation of labour and emergency caesarean section even within a population of low risk women (Tracy et al., 2007; Davis et al., 2011; Tew, 2013). Although this cannot be fully explained in the literature, the field of risk management has led to a risk surveillance approach to pregnancy and intrapartum care which is believed to be a contributory factor. As Davis and Walker (2012) speculate, the power of observation in the obstetric domain cannot be understated and the "unpredictable

potential for consultation with obstetricians" disciplines midwives practice because "in every decision and action; they imagine a future obstetric confrontation, judgment and scrutiny" (p. 608) The cultural norm of risk aversion heightened by the perspective of the obstetrician, in this case led to an exaggerated assessment of risk which led the woman to change her mind about place of birth. As a result the midwife is left feeling powerless in the shadow of what she indicates is the woman's trust in the perceived superior knowledge of the doctor.

Risk and Safety Following a Natural Disaster

The original focus group meetings for this project took place in the aftermath of the Christchurch series of earthquakes in 2011-2012. It was therefore unsurprising that the event came up for discussion and that the midwives chose to share some of their stories. Whilst analysing the data, a unique feature in some of the earthquake related discussions became apparent; this centred around the change in the decisions that some women were making regarding their place of birth. As a result of the state of disorder in the city following the major events and the aftershocks, the conceptualisation of what was deemed to be a safe birthing place was altered for at least some of the women for a short time afterwards[119].

> Helen (2): *After the February earthquake we had a lot of women actually who didn't know that we existed and didn't know that that was an option for them to come anywhere near our doors.*
>
> Lorna: *But they came here and birthed did they?*
>
> Helen (2): *Some of them did.*
>
> Wanda (2): *Yeah and some felt that ***** was a safer place to birth than ****.*
>
> Others: *Yeah.*
>
> Wanda (2): *After February yeah, yeah.*
>
> Lorna: *But you say it was only a transient thing and now?*

---

[119] I acknowledge that a large number of pregnant women did not stay in Christchurch following the earthquake and made their way to other parts of the country to birth their babies. I also acknowledge that home did not exist for many families after the quakes and that many were too traumatized to remain in what had been their family home.

Terrie (2): *And now it's reverted back yeah.*

At a time when the city turned momentarily from risk management to survival mode, the parameters of safety changed for women who were due to labour and birth and their perception of risk appeared to change as a result. There does not seem to be any readily accessible research that has expressly looked at this phenomenon, but it emerged as a point of interest in more than one of the groups on more than one occasion. In a discussion with one of the LMC groups they spoke of the women who had planned a hospital birth but felt that they now wanted to be in their own homes to birth.

Lorna: *What about place of birth, has it changed?*

Alice (1): *Definitely, I've had many more home births.*

Lorna: *Really?*

Alice (1): *Yeah, I had quite a few women who were too scared, didn't want to go to the buildings, even though you know Christchurch Women's is supposed to be safe, which it obviously is but……*

Amber (1): *People are birthing and going straight home cause they didn't want to be away from their family.*

It seems that the place where these women had thought that they would feel safe had become a place of threat and that their own homes offered a reassurance that a medical environment was unable to provide. There is admittedly the matter of the conflicting risk of unsafe hospital buildings, but the women also viewed the value of staying with their families for safety rather than a stay in a hospital facility with hospital personnel who could not offer the emotional reassurance that they required at that time. This finding led me to reflect on the contingent nature of the societal constructs of choice and risk. Both are value-laden concepts that impact on our cultural understanding and have a powerful influence on how we view, speak about, and manage our way in the world (Lupton, 1999), and both are provisional and subject to the vagaries of change.

247

Conclusion

The data presented in this chapter indicates that midwives have a good understanding of the importance of birth in a broader societal context and are keen to promote their role as the defender of normal physiological birth. This might suggest that the New Zealand midwifery model is antithetical to a choice/risk dynamic during the childbirth experiences of women. However, the maternity care system which claims to facilitate a 'woman-centred ethic of care' and to promote personal autonomy by embracing liberal feminist values, does so within a framework of informed choice and consent (De Souza & Butt, 2016). The midwives place a considerable value on that framework of choice and, as discussed, within a 'consumer-based' approach to care choice is never far away from risk. Thus the presence of risk consciousness, risk management, and risk aversion are not hard to identify in the discussions of the midwives. Midwifery may have located itself as an anti-authoritarian feminist paradigm that positioned itself in opposition to obstetrically managed birth practices, but the choices on offer within this paradigm belong incontrovertibly within a neoliberal consumerist context of health care (Spoel, 2006).This predilection is by no means restricted to the delivery of maternity or even health care. A risk-averse health care system is symptomatic of the magnitude that we have grown to attribute to the constructs of choice and risk at a societal level (Beck, 1992). These constructs within the context of current Western style culture, have resulted in devastating outcomes far beyond the reach of healthcare. Consumption is occurring at an extraordinary rate and contributing to environmental and economic degradation on an unprecedented global scale (Gilbert, 2008).

What the choice/risk/safety agenda does, is introduce doubt and mistrust in the dynamic of physiological birth and foster an overinflated dependency upon expert knowledge and technology. Additionally, midwives experience professional anxiety and an exaggerated belief in the intrinsic value of risk (Scamell, 2014). This loss of faith in the reproductive process for midwives may have been transferred to women, or perhaps a loss of faith for women has been transferred to midwives. Notwithstanding, the upshot is that both women

and midwives have been potentially left with a sense of distrust that is attended by an ever growing reliance on the technologies of risk such as antenatal screening and birth interventions such as caesarean section. Midwives are thus caught in the cross fire of choice and risk. They are passionate about the nature of their work overall, and value greatly the relationships that they have with women, their families and with colleagues, but they cannot actualize their authentic sense of identity within the constraints of consumerist expectations. As Skinner (2003) rightly heeds, there is no easy remedy to the quandary that a risk based culture can propagate and the effect that it potentially has on outcomes.

From an ANT perspective, the network of maternity care in the context of a market-led ideological position is a complicated and contextually situated assemblage. The central metaphor of ANT is that of a province of competing social forces and strategies that are recurrently shifting, with alliances being formed and dissolved. By analysing the impact of consumerism and its components of choice, risk and safety, the dynamic and power laden perspectives of life within the current network of maternity care have been presented; power and contestation have been observed and multiple perspectives explored. Whilst the discourse of choice and rational decision making appears to facilitate empowerment for women in the system, the complex delivery of care, where material and semiotic as well as human and intra-human interactions operate, means that the rhetoric of choice can never engage with all of the players in the tableau. As a result it is not possible therefore to guarantee a risk free experience in the world of maternity.

Chapter 9. Nostalgia

By telling stories and tracing histories, ANT demonstrates that it is "a pragmatic, recursive sociology of process with an interest in the uncertain processes" (Law & Hassard, 1999, p. 39). By analysing the narrative the researcher is able to gain insight into how actants work together or lose their place of influence within a network. The analysis of stories offers a clearer understanding of the formation and progress of relationships within the network. Stanforth (2007) claims that ANT flourishes on the 'pixels' of evidence, that contribute to the narrative. These fragments may not offer a complete picture but may uncover something unexpected or unanticipated .

As I returned once more to the network via the data, I encountered such unexpected findings in the stories of the midwives. It was revealed in the form of the concept of nostalgia. The midwives appeared to be grappling with a rapidly changing world in terms of their practice and identity and I wondered if this was manifested in nostalgia. Change is a constant in life, most often representing a steady, routine and everyday quality. Human actants within a network have a tendency to focus on continuity rather than the changes that occur constantly and this may evoke what Back (2009) refers to as a sense of 'ontological insecurity'. The past and the present cannot be viewed individually because each one informs and influences the other (Bennett, 2015). The data analysis of the consumerism theme in Chapter 8 had led me to deliberate about how people manage both change and continuity simultaneously. I became aware that the concept of nostalgia offered a vehicle to explore this phenomenon. In this chapter therefore, I will present the midwives connection to the past in order to explore further the question of midwifery identity in the contemporary field of maternity care.

Defining Nostalgia

From an etymological perspective the word nostalgia results from the merging of the Greek words, nostas (return home) and algos (pain) and the term was introduced in the 17th

www.manaraa.com

century to describe the severe homesickness of Swiss soldiers that resulted in pathology. It lost its pathological connotations in the 20th century however, becoming instead more typically described as an emotion "the bittersweet recall of emotional past events… a type of autobiographical memory" (Mills & Coleman, 1994, p. 205). Wilson (1999) suggests that this bittersweet character of nostalgia renders it a 'difficult emotion' because although nostalgia may evoke pleasant memories it may also elicit sorrow and a sense of loss.

Nostalgia is also said to provide defence against anxiety (Brown & Humphreys, 2002), act as a strategy for resisting change (McDonald, Waring, & Harrison, 2006), reiterate professional identity (Tsouroufli, Özbilgin, & Smith, 2011), and provide group identity for those with a shared past (Milligan, 2003). It may also serve to reduce feelings of fear and anxiety during major transitions in life (Kessous & Roux, 2013).

Davis (1977) describes nostalgia as "an individual's view of their present situation as contrasted with their memories of the past" that can sometimes present as a "painful yearning to return 'home'" (Davis, 1977 p.73). Bietti (2014) terms nostalgic memories as "situated reconstructions of [past] experiences in the present" (p. 29). As these definitions imply, nostalgia is an abstract concept which can make it hard to determine. The word 'home' used in Davis's definition for example, is contentious in terms of what meaning it carries for the individual. Aden (1995) views nostalgia as a way of "symbolically escaping cultural conditions that people find depressing and/or disorienting". He suggests that the use of nostalgia allows individuals to "situate themselves in a sanctuary of meaning, a place where they feel safe from oppressive cultural conditions" (p. 35 These recollections Aden suggests, can lift us momentarily from the grind of everyday life to revisit a kinder, gentler world with pleasant memories. In the same vein, Davis (1977) writes that in the face of modernisation programmes such as those in institutional and organisational settings, not everyone is able to throw the past to one side and accept a new regimen. For some this may mean the loss of long held and cherished identities; nostalgia therefore becomes a coping mechanism. Davis goes on to say that our relationship with the past contributes to our sense of who we are and what we stand for. It is argued that nostalgic thoughts actually inform us more about the present than the past because they are actually more about

making meaning from current events than about the past (Ybema, 2010). In this way, nostalgia is more about "the discontents of today" than the "contents of yesteryear" (Gabriel, 1993, p. 137)

IN ANT terms, nostalgia can be seen as an actant that is semiotic in nature. It is an emotion that primarily evolves from the absence of something and so exemplifies the semiotic process which is the ontological result of "something staying for something else" (p. 1) and nostalgia is the resulting emotional manifestation (Leone, 2015). As Davis (1979) observes, any established culture contains powerful symbols of the past that influence the construction of current identity by drawing upon the past. The past therefore becomes "one of the means....at our disposal for the never ending work of constructing, maintaining and reconstructing our identities" (Davis, 1979, p. 419). The sentiment of nostalgia is ascribed meaning by symbols that represent something from our past. The symbols remind us that time is linear, signifying the impermanence of times, places, things, and people that cannot be evoked in the present, a reminder of the contingent nature of any network. Additionally and interestingly, I found that the nostalgic narratives were often focused around interactions with others and that the self was the major actant in the story. This would render nostalgia a network within itself.

Nostalgia in Practice

This emotion of nostalgia has a significant presence in the words of the midwives. It appears in many different contexts and guises throughout the data. As identified in Chapter 3, the midwives ranged in age between their early forties into the sixties, which means that many had been in practice for a long period of time. Some had trained as nurses before becoming midwives, others had come from a variety of different backgrounds. The midwives had experienced many changes in practice during that time and although they may not have shared the direct experiences, they had a shared understanding about how things once were. According to Davis (1979) nostalgia creates generations by implanting a sense of identity

between individuals that is founded on a shared past. However psychologists have argued that memory is a totally private phenomenon of the individual that extends at most to their families (Batcho, 1995; Werman, 1977). Sociologists have argue that it is impossible to view memory or nostalgia as a totally separate phenomenon as it is constructed from a world view that is formed by societal interaction. Wilson (2005) argues that nostalgia calls upon a reconstruction of the past that may reflect selective memory as well as oversight and can occur at both an individual and at a collective level.

 The midwives frequently reminisced about how things were better/easier/less complicated in the past. However, it should be stated that the emotion conveyed by nostalgia is more than reminiscence, which is simply related to recollection and recall. Nostalgia involves emotion, which has cognitive and affective connotations and also, it could be said, an element of behavioural response. In other words, the distinction of nostalgia from just remembering is the emotional component. "One can remember without being nostalgic, but one cannot be nostalgic without remembering" (Batcho, 2007, p. 363).

A Hands off Approach

Werman (1977) refers to nostalgia as "a wistful pleasure, a joy tinged with sadness" (p. 393) and there was a sense of both wistfulness and loss at times on the part of the midwives for times, places and events from the memories of their working lives. One speaks of a time when midwives used to be able to offer greater 'hands on' support to women and their babies in practice. Although there is pragmatism in the words spoken, there is equally a 'tinge of sadness' for times gone by:

> Helen (2): *I was thinking you know in the old days when we did quite a lot of handling of babies and..., if I'm doing any clinical shifts now I'm almost completely hands off and I think we, I think midwives are now, you're hands off. I don't bath the babies any more. I know why but...*
> General: *No, that's right*

Helen (2): *I don't do nappy, well I do nappy changes sometimes in the night time just cause it's a nice thing to do and if mum doesn't have to get out of the bed I just think. But it's just, cause we've got so little time you have to really encourage the family unit to do everything for the baby so that they get used to, certainly the first time mums, so that they get used to handling the baby and being with their baby which is quite different from quite a few, from a few years ago. Or even when I started here you know I think we did quite a lot of handling of babies...*

The 'hands off ' approach in this context, refers to the practice of minimising any handling of the baby (or the woman) on the part of the midwife, unless there is a good reason to do so and that explicit consent is obtained from the woman. It is particularly pertinent in terms of breastfeeding support and has been described as a way of ensuring that routine practices or interventions which are applied on a population basis without consideration of the needs of the woman are not adopted (Wickham, 2009). It is also about engendering confidence in the parents by quietly supporting them without controlling and in a world where many parents have never even held a baby, this seems a valid and responsible thing to do. Yet the midwives, at an emotional level, indicate some sense of loss as though it feels counter intuitive to stand back and talk parents through rather than offer support in the form of active participation.

This change could also be attributed to an ANT process of translation, where the heterogeneous entities in the network have come together, reconnected and changed form as a result. Translation takes place as a result of the action of one or more actants reinterpreting or relocating the interests or even the identity of those in the assemblage in order to align the interests of these other actants with their own (Garrety, 2013). I would suggest that the expectation on the part of the midwives to 'step back' and watch could also be linked to the 'grand narrative' of neoliberalism which emphasizes individuality, self-management and resilience, which is here extended into the realm of new parenting (Beck & Beck-Gernsheim, 2002; Shirani, Henwood, & Coltart, 2012). In a sociopolitical milieu where citizens are encouraged to be self-reliant and to foster resilience, this essentially innocuous

shifting of the emphasis of responsibility from practitioner to parent creates a subtle change in the configuration of the network which becomes an opportunity to foster the ideological concept of individualism.

Crafts and Music

The midwives nostalgia for the past was shaped by both human and non-human relationships. ANT decrees that relationships between subjects and objects should be considered as a way in which actants transform each other within a network that is redefined by reciprocal interaction (Latour, 1999b). ANT allows us to observe the co-dependency between human meanings and everyday technologies and raises questions and theory. The two examples from two different discussions below, serve to illustrate the symmetrical analysis of ANT, involving the inclusion of both human and material actants. In the first example, the non-human actant was the craft of knitting and in the second, a piano.

> Betty (2): *It's a shame they've gone, knitting and crochet groups, we used to have them*.
>
> Lorna: *Yeah, yeah, yeah. Midwives always used to knit and sew in labours and things as well didn't they? You know it was always something that was sort of associated with birth and labour.*
>
> Wanda (2): *I still do (laughs) when I get time because these days in a hospital situation there's often jobs to be doing just the entire time…*

Wanda appears to make light of the discussion by laughing about the amount of work to be done that prevents them from engaging in traditional midwifery activity such as knitting. Yet there is a bittersweet note when Betty acknowledges a degree of regret in her comment about the loss of such an endeavour. In recent years, some midwives who have been knitting or working on other forms of crafting during a woman's labour have been reproached for engaging in unprofessional behaviour (Wickham, MacNeille, & Read, 2013). This could be seen to be the response of the reason and logic of a market-led health care

255

system where 'time is money' and the notion of quietly 'watchfully waiting' for events to unfold, like knitting, are viewed as anachronistic and valueless. Wickham speculates that the repetitive sense of rhythm created by knitting or other crafts can produce a quasi-meditative state in the midwife that may be vicariously transferred to the labouring woman (Wickham, 2013). Leap and Hunter (2016) speak of it as a "metaphor for presence" in the birthing room and inform that it can increase neuro-hormonal activity that facilitates uterine contractions. In the past, the midwives would not have known the science behind the crafting but appeared to have a tacit understanding that this passive activity could contribute to a positive birthing experience and outcome (Leap & Hunter 2016). Knitting in the birthing room could therefore be seen to represent an intuitive ontological understanding of what women need in order to labour effectively (Davis-Floyd & Arvidson 2016; Cruz & Smedt, 2007) and yet it is viewed as unconventional with questionable value in the technocratic, medicalised environment of a 21st century maternity facility (Wickham, MacNeille, & Read, 2013).

Building Community

The role of social connector within the network introduced in Chapter 7, re-emerged in the nostalgic discourse as the midwives talked about the desire to encourage greater community amongst the women in their care. As I established in Chapter 8, they did explore ideas around how to make this happen, but there was a pensive acknowledgement that women did not develop a stronger sense of camaraderie by sharing experiences and information during their stay in hospital as they had done in the past:

> Sally (2) : *I thought of Michel Odent and his antenatal classes around a piano. That's what's missing. And it's not just about a piano. Women don't have that opportunity to meet and just chill together any more.*

Michel Odent is a French obstetrician who introduced antenatal singing sessions for pregnant women at his birth centre in Pithiviers in the 1970s as an alternative to more conventional childbirth education. All who worked at the centre at the time including midwives,

administrative staff, and cleaners were invited to join the pregnant women and their support people around the piano. The communal singing was believed to create an endorphin response to make those singing feel good and to engender a sense of community through the shared experience (Odent, 2007). Singing in pregnancy offers many benefits over and above creating a sense of community, including increasing oxygenation for the baby (Pitman-Will, 2013), but it does not conform to current professional expectations in either midwifery or childbirth education. The current mainstream structure of antenatal education in New Zealand/Aotearoa is reliant on funding from the Ministry of Health. This requires those delivering the content to conform to stringent specifications that could be seen to limit a creative approach and encourage the delivery of sessions that tend to offer a reductionist and medically biased approach (Dwyer, 2009). As discussed in the previous chapter, the emphasis on choice is of paramount importance within a market based healthcare system, in order to facilitate informed decision making on the part of consumers. The issue of choice is clearly important but the rhetoric of choice has a tendency to supersede other elements such as the emotional and cultural impact of becoming a parent (Dwyer, 2009).

The Voluntary Sector in the Maternity Network

This desire to create community extended to the involvement of the local population and the more active role that they used to play in the service :

Sally (2): *20 years ago or something was that the Friends of ***** used to provide meals for some of the needier mums and I think that was from when they had a sort of meals on wheels service running here and so they could do that. It sort of gave me a real surprise in a nice way I thought that's like home birth groups where they look after those who are in need so it's not only that the hospital benefits but the community benefits, the community supports the hospital which in turn supports those in need which is a lovely gesture, it would be fantastic to go back to that.*

Here, Sally expresses a desire to go back to a time when she perceives that relationships between support groups, communities and health services were stronger. This echoes back

to the comments in the last chapter about 'no going back'. This led me to consider further the role of the voluntary sector in the context of maternity care in contemporary New Zealand/Aotearoa. The State of the World's Volunteerism Report 2015 (UNDP, 2015) indicates that the voluntary sector is suffering from a dearth of volunteers in many countries and Volunteering New Zealand (2017) confirm this trend more locally. There are a number of suggested reasons why this might be the case such as: a lack of investment in resources; the capacity to effectively engage volunteers; people are working harder and consequently have less time on their hands; and a shifting trend away from community involvement, due to a number of factors including perhaps the emergence of online communities and a more mobile population (NCVO, 2017; VolunteerMatch.org, 2016).

Volunteering New Zealand (2017) describes itself as being an organisation that "promotes values and supports effective volunteering for the benefit of individuals and communities". It has a vision, a mission statement and it lists its core values and outcomes in an annual report that would not look out of place in the corporate business world. The last decade of the 20th century has observed the introduction of competition by funders of the voluntary sector which is being transformed by the increasing influence of new managerial tools. This is referred to as the ''bureaucratic restructuring of the sector" (Fyfe, 2005, p. 553), suggesting that increasingly controlling mechanisms are accompanying an increasing professionalisation in the voluntary sector and that this is driven by the unprecedented advancement of neoliberal practices. A primary goal of neoliberalism's policy agenda for both economic expansion and social governance is privatisation, in particular the 'rolling back' of the state and the transfer of 'public' services and functions to private (for profit) interests. This professionalisation of voluntary work has brought its own form of risk management which decrees that health and safety legislation must be met and robust screening in terms of police and security checks. This is not to decry safe practice in any sector, but the shifting in the network means that the days of the local community popping into hospital in an ad hoc way to offer a helping hand are gone.

Health Care Conferences

An area of strong growth in the era of the corporatisation of healthcare is that of the conference and events industry, and sponsorship and commercially related funding feature frequently. The midwives discuss the organising of midwifery professional conferences and events.

> Sally (2): *If people want to have a nice venue and they want to have flash catering and we're no longer doing the sort of church hall arrangement and uncomfortable chairs and bring a plate, it's sort of a different age that we've reached where they want something different. Something flashier.*

The midwife speaks about the 'uncomfortable chairs' and 'bring a plate' and both items are loaded with symbolism in terms of a past where comfort was not a priority but sharing food was. This sentiment is augmented with the use of the term 'flashier', a word associated with something that is ostentatiously attractive. It may be that the midwife is nostalgic about a time, which although less grandiose, felt more authentic in some way.

There has been some critique regarding the influence of neoliberal practices on conferences and events in both academia and health profession associations. (Jacobson, 2005; Poduval & Poduval, 2008; Nicolson, 2017). Healthcare related conferences are not a new phenomenon; however, the burgeoning in the number and variety of conferences, expositions, and events in the past half century has been prodigious. Conferences are said to play a significant part in the construction of professional identity (Jacobson, 2005b) . They serve to enable practitioners to update in terms of research and to keep in contact and network with their professional colleagues. Van Teijlingen (cited in Nicolson, 2017) states that applied health conferences are viewed as a platform for making a difference in a way that other conferences cannot achieve. They find it easy to attract politicians and subsequently often manage to get their issues on the political agenda.

Health Professional Conferences also attract a lot of interest from the health related industries that are happy to support the funding of such events in return for being able to

259

www.manaraa.com

promote their services and products. Conferences are traditionally places where buyers can view the products before purchase, which legitimises the presence of companies selling or promoting goods or services associated with maternity care at midwifery conferences. The problem is that the sponsorship that keeps most health professional conferences afloat financially is subtly, or sometimes not so subtly, using it as a platform for marketing purposes (Nicolson, 2017). Both the public and the members of the profession may perceive the professional identity of the host organisation as advocating the sponsorship products. Health Professional Associations are generally considered to be objective and there to serve the public interest. However the trusted professions that represent health professionals are also viewed by the corporate world as a means to "influence public opinion and public policy more effectively by working through seemingly independent organisations in addition to under their own names" (Jacobson, 2005a; 2005b). A midwifery organisation that agrees for a disposable nappy company to sponsor a conference in order to increase funding and provide the event with a greater sense of 'professional' quality, are allowing industry to use their reputation to promote a product which in the case of disposable nappies has serious environmental ramifications, has questionable values. Professional organisations therefore need to be fully cognisant of all of the potential areas of conflict of interest and of the conceivable influence of a company on their independence if they agree to monetary contribution from such a company.

The introduction of commercialism has set a precedent that would make it difficult to return to the time identified by the midwife, Sally (2), because the demand for corporate conference style events has fundamentally altered expectations. The same midwife goes on to talk about her experience of being involved in a group who did manage to organise a conference without sponsorship and the outcome of this led into a more general discussion about this.

> Sally (2): *I've just done the ***** conference and we did that without sponsorship and we made a wonderful loss. And that is the only way to do it unfortunately. Lose money.*

Betty (2): *And that's the shame of it because they have to promote it. There's none of this, "Here's a donation, we expect nothing back" any more.*

General: *Yeah. That's dreadful.*

Sally (2): *So, certainly the discussion, you stimulate discussion as to what we take for granted or what we're so used to having around us. I mean, even all our cot cards are done by ******

The sponsored cot card introduced in Chapter 3 is yet another semiotic object that demonstrates how industry is able to influence the network of maternity care by adding the caveat that their company name is included on the card. In this situation the midwives become a conduit for the target market of new parents. Companies rely on brand loyalty, and the 'free' gift culture in maternity care has traditionally been used to attract what is essentially a captive audience. In the discussion below the midwives speak at a later focus group meeting about why this project did not come to fruition and again an element of nostalgia is tangible.

Lorna: *So I wonder what's happened that more and more people have been leaving them and don't seem to have that level of interest [in keeping cot cards] anymore?*

Wanda (2): *People seem to be in to electronic things now so.*

Sally (2): *They do.*

Wanda (2): *They like emailing, texting and…*

Sally (2): *I just think that it used to be an important thing to people and it occurs to me as something that they are not interested in anymore.*

Wanda (2): *For some reason, the cot cards just don't seem all that important.*

What was particularly significant about the recurring theme of nostalgia from an analytical perspective, was the underlying presence of neoliberalism. Each time that nostalgia was encountered, there was a socio-political layer of investigation relating to the impact of the ideology.

Generational diversity and nostalgia

Another aspect of the 'rapidly changing world' theme, strongly linked with nostalgia, is that of intergenerational differences between the midwives and women. As previously stated the midwives in the study are by standard generational definitions, almost exclusively a baby boomer cohort, whereas the women that they are providing care for are likely to be part of a predominantly Generation Y or Millennial cohort. [120]

Davis (1979) suggests that nostalgia works toward "engendering collective identities among people generally, but most especially among members of 'the same generation'" (p. 101). People have a tendency to gravitate towards their own generation or cohort in order to reinforce their memory store with shared experiences (Milligan, 2003). However, they may not perceive themselves as such until after the fact, when nostalgia allows them to realize and better define what they have shared. In this way nostalgia helps to 'mould' a generation by enabling a group of people to assemble components from the past into a scaffolding that provides security and restores a sense of continuity to its members lives through the creation of a collective past. The differences in attributes, attitude and behaviour between generations

---

[120] There are several definitions of the age span of different generational groups within the literature, for the purposes of this paper I have used the work of Grasso (2016) who adopted Manheims 1928 classic definition of generational span being based on the socio-historic formative years of mid-adolescence which Manheim defined as 15-25. This means that a cohort would include a group of people who had spent at least six of their formative years in a specific time period which then takes on the mantle of being a generational span. Thus Generation Y or Millennials would be those born between 1981 to 2000; Generation X: 1965 to 1980; Baby Boomers: 1946 to 1964; Traditionalists or Silent Generation: 1945 and before. Mc Queen (2007) stresses that although it can be tempting to dismiss what may appear to be simply boxing people into groups, the notion of analysing values, beliefs, and behaviours in terms of years of birth does constitute the branch of sociology known as Generational Theory.

is not a new field of interest but is a developing one, particularly in the field of workforce planning (Twenge & Campbell, 2008) .

According to White (1992) the origin of generational difference pivots around a historical event and this event impacts on the self-identity of the generation defined by that time. For example, the baby boomer generation is synonymous with the post war era where society was upbeat and optimistic as the world around them was rebuilt following the Second World War, whereas Generation Y are considered to be 'digital natives' who are very much part of the technical revolution of the last few decades (McQueen, 2007). If we applied the principal of a historical generational focus to the context of the midwives in the study, that historical point for them is likely be the reforming of maternity services in the 1990s. There were several comments from the midwives indicating that the childbearing women of today do not have a full appreciation of the service they receive because they do not understand the hard fought battles that were undertaken in order them to be able to access the midwifery led maternity service of today.

> Sarah (3): *Women today forget the process that we and women had to go through to get to this point.*

The comment above alludes to the feminist rhetoric that framed the re-establishment of the midwifery profession in the 1980s and 1990s. The   comment below is not so specific but it suggests that the midwives are constructing the identity of a younger age cohort of childbearing women based on an inter-generational premise of not appreciating what they have within the maternity system here.

> Amber (1): *Well because the generation of women having babies now, they haven't had to fight for anything, they haven't had to struggle, they've just been used to having everything done and handed quite easily, and so they don't appreciate what they've got.*
> Patricia (1): *And society's very much…. the society that they've grown up in…*
> Alice (1): *Consumer driven.*

Amber (1): *And you don't have to work to earn something, you just get it.*

Consumerism is a defining feature of the Generation Y era and it has been described as "the central feature of this generation's life" (Benckendorff, Moscardo, & Pendergast, 2010.p.29). Consumerism has been considered in greater depth in Chapter 8 but as Orbach (2008) points out "they [Gen Y] are subject to extraordinary pressures from the market and consumer society that creates and then exploit vulnerabilities in ways that are more intense than we had to experience at their age" (p. 126).

The following comment is another where the constructing of a stereotype is used to describe women who do not want to travel further than they need to for their chosen birth place.

Helen (2): *That is the message that we're hearing over and over again though that people want an option that's close to town, that's why ******used to be very popular because it was, it was within a short distance. People have a huge perception that the drive to the unit where they're going to birth is going to be awful and it needs to be as short as possible. And new is important to a lot of people…*

This links back to the earlier discussion around using church halls for conferences which suggested that the midwives are sold the idea of what constitutes normalcy in the context of a consumerist society, as much as are younger childbearing women. Consumerism is certainly not generation specific. This does create a sense of irony when there are comments about the young women of today having unrealistic expectations, where terms such as 'demand' and 'expect' are frequently used.

Sarah (3): *We don't get paid extra for going to see women antenatally and I think they tend to forget, because we're sort of on to the next generation basically cause it's been over 20 years….They kind of forget why the system has changed to the way it is now and you know they just expect and demand and you know they won't come in to the [clinic] rooms. They expect us to go and see them a lot.*

Patricia (1): *And once you start with one, and you do home visits she'll tell her friend oh that midwife does home visits, and then is that what the women will expect like you say, expecting more and more.*

This discussion raises the question of how much women as 'consumers' really understand what services have been purchased on their behalf. This may be linked to earlier discussion of co-dependency, but it may be that women, in spite of information that is expected to be relayed during the early stages of the contractual agreement, are not fully cognisant of their consumer rights in terms of what it is acceptable to expect.

Characteristics of Generation Y and Reciprocity

In the Generation Theory literature, the Generation Y cohort are described as being, flexible, adaptable and having a good sense of work life balance (Hendricks & Cope, 2013). They are also said to be loyal, able to form strong relationships and have high levels of self-esteem and self-belief (McQueen, 2007). Conversely, the term 'entitlement' is frequently attributed to the Generation Y cohort (Alexander & Sysko, 2012). They are also described as selfish, impatient, narcissistic and hedonistic (Kindrick Patterson, 2007; Twenge & Campbell, 2008). The label of selfish may be mistaken for what has been termed a non-reciprocal tendency on the part of this cohort. This is an interesting theory as much of the literature around continuity of care in midwifery includes the word reciprocity as a significant value in the relationship between mother and midwife (Stevens & McCourt, 2002;Hunter,2006; Kirkham, 2010; McAra-Couper et al., 2014; M. Hunter et al., 2016;). Heath (2013) suggests that reciprocity is not always the virtue that we may accredit it to be and that overreliance on reciprocity can result in co-dependency. Furthermore, Heath states that the belief about this non-reciprocal tendency in Generation Y has arisen from a narrowly defined assumption of what reciprocity actually means. He points out that there are indirect systems of reciprocity that engender cooperation where there is no expectation of any mutual benefit. This can be seen, for example, in altruistic behaviour. Additionally, reciprocity in inter-generational relationships has some very specific features.

Past, present, and future generations do not seem to cooperate in any significant sense of the term. First of all, the benefits seem to flow only one way—following time's arrow, from the present to the future. While we (those alive today) have received enormous benefits from our ancestors, we are unable to return the favour, since we are (according to the usual understanding) unable to benefit the dead. Furthermore, we are generally thought to be under an obligation to pass along some of these benefits to future generations, even though it is unclear what we stand to gain from doing so. Thus the relationship does not seem to be cooperative in any sense of the term (Heath, 2013, p. 39).

Identity Confusion as a result of intergenerational expectations.

It may be that the age differential in terms of average age of a New Zealand registered midwife (47) and median age of a birthing woman here (30)[121] results in generational divergence that leads to different expectations with regard to the relationship that Pairman (1998) refers to as "professional friendship" (p. 163). Furthermore, the exposure to a life time of consumerism by this cohort, may mean that some Generation Y women view maternity care more as a commodity than a service and that this may affect the way that they view the relationship at times. This potential for different expectations may have an effect the self-identity of the older baby boomer midwives, who may expect reciprocity and to provide a service rather than a product. This perspective contrasts with the focus on relationships in the previous chapter but may explain some of the paradoxical comments and attitudes that the midwives express in the data that bestows an air of ambiguity at times.

---

[121] These are the most recent figures from Statistics New Zealand who release their data every five years. Although the average age is increasing (although more slowly now than in recent decades) the median age of 30 means that most childbearing women would fall into the cohort of Generation Y.

> Terrie (2):*They don't have time for anything because they're all working.*
>
> Sally (2): *They're all working, yeah, that's right. And they swoop into antenatal classes and then they're off home again.*

This last comment is an unusual criticism from a women from a generation that are equally likely to have worked through pregnancy. The one income family is more relevant to the 'Builders' generation of their parents. However, the comments tend to be more generalized about the women rather than targeted at specific women. More 'railing against the world' than against their client base.

Food and nutrition highlight another division between the midwives and childbearing women.

> Betty (2): *It's not rocket science but again a disposable convenient generation that will slip into McDonalds to get a quick burger on the way home. The number of women who want KFC brought into them…*
>
> Sarah (3): *It's the health ramifications [of poor diet] in the long term that they [current generation of birthing women] don't care about because all they do is live in the now and not in the future.*

Daellenbach (2014) states that "Food choices signal identity and belonging to a particular peer group within the social milieu" (p. 68) and the two quotes above are representative of this belief. The comments from the midwives reflect the reality that the current childbearing generation of women in many cases have 'learned how to eat' from a food industry that is interested in profit over health and nutrition. Yet nutrition in relation to pregnancy is only just beginning to creep into the curricula of midwifery education. This could therefore lead to frustration on the part of the midwives who feel ill-equipped to provide the support that this generation of women need in order to grow healthy well-nourished babies.

267

By leading me to explore the space between generations in the context of the mother/midwife relationship, the midwives have offered me insight into the fluid dynamic that exists. Women accessing the maternity service now are a very different group to those who fought alongside the midwives in the 1980s and 1990s for the reinstatement of midwifery. Additionally, the formative years of many of the midwives were lived out in a world that was essentially situated in an ideological landscape of social welfare provision. The current landscape has evolved into a paradigm of free market economics and politics, thus forming generationally defined values and beliefs. This is not to say that young women are not appreciative of the continuity of care model and the broader maternity service, but they did grow up in a different sociopolitical climate and consequently have different expectations and needs. This, as demonstrated, can create barriers which, although not insurmountable with good communication and interpersonal skills, need to be understood. Although nursing have addressed the intergenerational issues in their profession, this does not appear to be the case in midwifery practice (Earle & Letherby, 2008; Lavoie-Tremblay et al., 2010; Jamieson et al., 2015). This situation appears to create a degree of tension in the midwife/mother relationship and impacts on the professional identity of the midwives.

Nostalgia a Multi-faceted Concept

First time and Long Standing Nostalgia

The issues relating to neoliberalism and its pervasive impact on midwifery practice, was not the only thought-provoking factor to arise from the concept of nostalgia. It became apparent during the analysis that the majority of the more disconsolate nostalgia related comments had surfaced from the discussions between the DHB midwives working in a primary maternity unit. Tsouroufli, Özbilgin, and Smith (2011) speak of nostalgia as being "a resource for reliving a real or imagined past" (p. 499) and the nostalgic domain of the hospital based midwives was essentially experiential and practice based.

However, when the LMC midwives spoke about the past, it had a mediated quality that generated a sense of detachment. Kessous and Roux (2013) identify two distinct forms of nostalgia: first-time nostalgia, which is a first-hand experience and long-standing nostalgia, which relates to the recalled memories of childhood and adolescence.

When the LMC midwives reminisce, there are typically references to childhood experiences.

> Patricia (1): *Growing up…in a village and not having much sort of medical care around we knew we could always call on a lady called Sister English, she was a nurse and a midwife and if you were sick during the night someone just went a couple of streets around and knocked on her door, no telephone, no nothing. And she'd come out and take a look at you and say you're alright yeah don't worry or yes need to get an ambulance. And nobody took liberties with her it was the case that you knew she was there and it was for the emergency, just the way sort of you lived.*

It has been proposed that childhood memories are in fact memories of memories whereas adult memories are more reliable as first-time nostalgic experiences (Boren, 2016). There is distance that is less apparent when adult memories are evoked. The reminiscence of one of the other LMC midwives is of a vicarious nature, based on the inherited memories of a family member who had been a midwife.

> Amber (1): *My grandmother was one of those women.*
> Alice (1): *Was she?*
> Amber (1): *Yeah, she'd lay out the dead and she brought the babies in to the world.*
> Patricia (1): *Really?*
> Amber (1): *Yeah.*
> Amber (1): *She was, she was very revered, they lived in what we would probably call poverty now but it was just the way it was in terraced houses and close to the rocks. And everybody just looked after them, you know cause my granddad died when my uncle, before my uncle was born so there was just her and six kids. And my dad stepped*

269

up and took over that role and he left school and went to be the breadwinner and stuff and then she kept hand delivering babies and going to the church and laying out the dead and all that sort of stuff. But there was always food, like they were never hungry, there was always someone to go and sit with the kids while she went off to work and. And they lived in a real tight community.

Alice (1): *So they'd bring around food and that rather than pay her?*

Amber (1): *Yeah.*

Lorna: *For her services?*

Amber (1): *Yeah.*

Alice (1): *Okay.*

Another of the midwives continues to add to the discussion bringing in a more contemporary but still assumed perspective.

Jane (1): *In Holland they sort of have like a village midwife, they have only sort of one midwife in an area and that midwife is so overworked that everybody feeds her.*

The Unlived or Imagined Past

The midwives spoke fondly as they formed a narrative, built around the reminiscence of a childhood based memory, a mediated intergenerational memory, and a circuitous shared recollection with an element based in reality. All three of these observations are idealised to some extent, using the romantic notion of the 'village' midwife who holds a valued and respected position within the community. As the history in Chapter 5 would indicate, this idealised figure, in real terms, is unlikely to have existed at any point in history. McDonald, Waring, and Harrison (2006) discuss this preference for the unlived or imagined past as a broader conceptualization of nostalgia. To return to a conversation introduced in the last chapter, when the midwives discussed the possibility of living in their own communities in order to build social capacity, there was a markedly different response.

Patricia (1): *So it does sound nice but I can see why logistically it's not possible*

Jane (1): *I think it doesn't work, it wouldn't work for us because of the way we work. In like some areas in the UK they could actually say these three midwives work here because they don't provide an LMC type service generally. So the expectation is not to know the, generally is not to know the midwife who is going to be at your birth and not to have the same midwife for every birth. Now I'm not saying that doesn't happen or that people wouldn't like that to happen it's just not the expectation and that's a difference I think yeah.*

In terms of sustainability, the midwives can see the benefits of working within their own community based geographical area, However, they concur that the fantasy of the 'village midwife' would not fit into the LMC business model in New Zealand/Aotearoa in the 21st century. Yet the desire for stronger community connection was very evident even when nostalgia is exemplified on screen in the form of the television series "Call the Midwife".

Gemma (3): *It's what happened on 'Call the Midwife'.*

Gemma (3): *Yeah.*

Melanie (3): *No one's going to miss having their blood pressure taken ever again.*

Lorna: *Yeah but we talk about complexity but gosh their job was complex you know.*

Gemma (3): *Yeah.*

Lorna: *The women were complex.*

Sarah (3): *Yeah. And yet they just seemed to have an acceptance of birth and it brings.*

Melanie (3): *But the episode where the woman lost her baby because she didn't have her blood pressure taken, everyone saw that one.*

Gemma (3): *Yeah, but they didn't get wrapped up in the politics like we do did they?*

Melanie (3): *No.*

Gemma (3): *They, this is how it was and they expected losses and......*

Melanie (3): *Yeah.*

Gemma (3): *Yeah.*

Lorna: *Different worlds.*

Melanie (3):Yeah.

Gemma (3): *Yeah that's right. No risk management, no litigation. Yeah.*

Anne (3): *And wonderful, just about everybody had home births, it was like assumed.*

Gemma (3): *Yes.*

This is a significantly nostalgic discourse where the midwives grasp at a fantasy about a world of maternity care where risk management and litigation are non-existent and the politics are left to someone else, leaving the practitioners to get on with providing care. Whether this world ever existed is debatable but the escape of the midwives into this world is telling about the factors that prevents them from doing what they want to do.

Nostalgia is both a public and a private phenomenon and the collective nostalgia generated by something like a television programme, a book or a film can be viewed as a cultural event as opposed to a personal subjective experience (Aden, 1995). The collectivization of nostalgic experience has increased significantly in recent years largely as a result of the realization that nostalgia can be used as a powerful marketing tool (Leone, 2015). The shared experience of watching a television programme about midwifery in the 1950s UK contrasts with the private personally experienced nostalgia of the DHB midwives where the symbolic images and frames of reference of the past are resources in the unique history of the individual midwife. I was perplexed by this marked difference in the identity that nostalgia created between the two groups of midwives. The use of the unlived or imagined past was only evident in the LMC focus groups, whereas in the DHB midwives group, the reminiscence was all based on personal experience.

Physical Space

I considered whether the difference between the physical space occupied by the LMC and the DHB midwives could make a difference to how nostalgia is framed within their discussions and whether that could impact on their sense of professional identity. The LMC's are community based and, although they may utilise clinic space, they do not have the same constancy of location as the DHB midwives, who are sited in a permanent working

272

environment within a primary birthing unit. Many of the midwives have worked there or have had association with the unit for many years. As humans in the network, we form connections with physical landmarks such as buildings just as we do with people. This connectivity anchors us to the spaces within the built environment and establishes a sense of territorial ownership and belonging (Ross, 2015). "Place attachment is ultimately linked to continuity of experience and, consequently, continuity of identity" (Milligan, 2003, p. 398). The midwives were very protective of their environment, viewing it as a place to safeguard normality in birth, which has already been identified as a key identity in the form of guardian of normal birth.

> Betty (2): *And from a social aspect, the support of physiological birth and not buying into the fact that people all have to go to the hospital to have their baby, that they all have to have the modern technology. Just because you've got something, doesn't mean you have to use it. And so here, we're actually protecting a style of care which has never been wrong but still can be seen as not as modern and so as flash and that means protecting units like this.*

The phrase "not as modern and flash" is telling in terms of the concerns of the midwives about the number of women opting to birth at the primary unit and what it meant to the future of the facility. This reflects on the discussion on risk in Chapter 8. This fondness that the employed DHB midwives expressed for their place of work possible contribute to the stronger presence of nostalgia in the discourse of the DHB midwives than the self-employed LMC's who move between spaces—from women's homes, to clinic rooms, to hospital, and to other locations.

Autonomy and Nostalgia

Another possibility is that differences in the self-employed status of LMC's in contrast with the employed status of DHB midwives influences the way in which the two groups of midwives 'use' nostalgia in terms of their construction of identity. Baldwin (2011) reports that nostalgia has been associated with how the individual considers their own sense of

personal control and autonomy. In his doctoral study Baldwin found that speaking of and writing about nostalgia "bolstered perceptions of personal control and decreased concern with extrinsically defined standards of value" (p. 20). LMC Midwives in New Zealand/ Aotearoa are self-employed continuity midwives and recent research suggests that they do have a strong sense of autonomy in practice (McAra-Couper et al., 2014; Dixon et al., 2017) Research relating to these schemes has revealed midwives who also speak of high levels of satisfaction in their work (Stevens & McCourt, 2002; Collins et al., 2010; Homer, 2016). A recently published study by Dixon et al. (2017) concludes that, unless they are working alone in an unsupported situation, continuity of care midwives in New Zealand/Aotearoa have better emotional health and less burnout than employed midwives in spite of working longer and less predictable hours. "Employed midwives reported lower levels of autonomy, empowerment and professional recognition, with less access to resources" (p. 13).

In a discussion around how the DHB midwives could engage effectively with the local community, one of the midwives spoke of her employment as being a safeguard. She did not feel that this was possible in the less predictable practice domain of the LMC midwives.

> Helen (2): *In LMC groups how they build their practice and how they manage their time, those are their burning focuses. We don't have that, we've never had that because we've got the shift work and so on, so the social, our position in the community we haven't even been looking at that much because of being really babied by the DHB in that they put the funds in and they keep us going.*

The reference to being 'babied' by the DHB could suggest a submissive resignation to patriarchal control and a relinquishing of autonomy which could suggest a very different sense of self-worth and professional self-governance.

Changing Worlds

I deliberated on the possibility of a link with the findings in the study by Dixon et al. (2017) conveyed above and the recurrence of the concept of nostalgia that figured so significantly

274

in the data from my study. I was unable to locate any studies that specifically explore the concept of nostalgia in relation to midwifery so I extended my search to include the broader health care field. In their study on the nostalgic tendencies of surgeons in the UK, McDonald, Waring, & Harrison (2006) report that the doctors "draw on nostalgic memories to present an alternative, competing version of the world in order to challenge the discourse of modernization which permeates government and hence hospital policy" (p. 1108). This research advocates that extensive changes in health care systems in the neoliberal era have challenged not only the ways in which those in the medical profession work, but has also impacted on their professional identity.

The Dixon study had identified that inadequate resourcing and poor support from midwifery management led to less than optimal emotional health and burnout for employed midwives. Like the doctors in the McDonald et al. study (McDonald, Waring, & Harrison, 2006), might the midwives have attempted to "develop an alternative, competing version" (p.1097) of their working lives in order to nullify the agenda of change that modernization and neoliberalism (see Chapter 6) has brought to maternity care.

The midwives did express concern that changes to maternity care were being considered by the DHB. They were anxious that their unit was in danger of being closed once a new city based facility was built.

> Helen (2): *I do have some concerns that we will stay open as a maternity unit once the new Health hub is built, I really do*
>
> Anne: *That's a different kettle of fish.*
>
> Helen (2): *I've not heard anything but I actually can't see that it would be a viable prospect to keep us going.*
>
> Claire: *Do you worry about the numbers of women coming here if they open one in town?*
>
> Helen (2): *I don't know.*

Another midwife expressed her sense of frustration about a consultation process that she viewed as having a degree of bias. There is a sense of loss of faith and trust in an organisation that does not seem to have the best interests of the midwives at heart.

Wanda (2): *I don't know if I told anyone, they've surveyed women and they overwhelmingly want new units but you know you can word any questionnaire to make it sound attractive but if they knew they were going to lose the services they already have would they still have that same opinion?*

A Kinder, Gentler World

The discussion below illustrates this well by showing how one of the midwives is affected by the decision to modernize the layout of the unit and to provide women with single rooms during their hospital stay instead of the two bedded wards that have been in place for many years.

Betty (2): *I came from a rural background and had my kids and we made friendships in the hospital, in the kind of rooming we've had setup is very good for that, but they don't want it today, shared rooms. We made friends in the hospital and then we set up a playgroup or a mother's group and then we invited other people we knew and these people are still in touch with me.*

Helen (2): *But 20 years on that's changed cause it's how long, how old is…*

Betty (2): *26*

Helen (2): *26, yeah. Look at how the stay in hospital has changed.*

Terrie (2): *They are only in for 48 hours*

Rather than use her current clinical knowledge of the situation, the midwife who made the comment uses her own nostalgic reminiscence from 26 years ago to legitimize the misgivings that she has about the contemporary decisions of both women and health care management. Nostalgia has been described as a "component of self" by Gabriel (1993) who suggests that a nostalgic glorification of the past can be used to demonize the here and now

especially in the context of change at an organisational level. Ritivoi (2002) suggests that the concept of nostalgia is strongly interlocked with the concept of identity and so is capable of harm because of the risk of self-estrangement and an inability to adapt to change under any circumstances.

The length of time spent in DHB facilities for postnatal care has decreased in the last thirty years or so from ten days to 48 hours maximum stay, with many women opting to return home within hours of their baby being born. There is an argument in New Zealand maternity care, that women do not need a long period of time postnatally because they have the benefit of an LMC midwife who will provide care at home. However, it could be advocated that there is also an economic benefit if women are not 'in-patients'. Although care at home will incur considerably less cost for the DHB, women lose the benefit of support on demand for baby care and breastfeeding from facility based core midwives. The midwives went on to joke that the current generation of women want 'hotel services' with single rooms with en suite facilities and modern facilities.

> Wanda (2): *It's still that message out there that first time mothers do have to birth in a you know secondary you know tertiary unit yeah, which is a shame*
>
> Helen (2): *And I think that also there is some of that consumer driven wanting all the bells and whistles.*
>
> Wanda (2): *Yes, yeah, yeah.*
>
> Helen (2): *Wanting a hotel, hotel experience.*
>
> Lorna: *Do they get a hotel experience?*
>
> Helen (2): *They get the television and the telephone (laughs) but are completely isolated*

This could be analysed as midwives demonstrating a lack of empathy. However, the cynicism could reflect frustrations relating to the creation of an individualistic culture that leads women to detach themselves from others. This detachment results in a reliance on the help

of the 'expert' health personnel rather than mingling with other mothers from whom they could learn and share experiences.

Nostalgia as a Weapon

Nostalgia can be used as a weapon against those who are resistant to change by for example accusing them of being entrenched in the past or of being luddites. This impacts on their sense of identity by leaving them feeling like laggards or being surplus to requirement .

> Jess (3): *We are a couple of old birds that have been together for 15 years or something so it is hard to change*

> Helen (2): *I sometimes think that ***** is a little outpost and we do try and make do with what we've got.*

These type of comments gave the midwives an air of vulnerability that added to the 'profession under siege' impression identified earlier in the thesis. The disparaging of a group or individuals can be used to drive through a new agenda and this is achieved by destabilizing loyalties and destroying existing identities (Baldwin, 2011). Thus nostalgic discourse can be used to enforce change within a network as a mediator. This is in fact the ANT concept of translation in action where an actant is displaced from one status to another by the shifting of loyalties and the formation of new affiliations.

The 'Good Old Days'

The work carried out by McDonald, Waring, and Harrison (2006) with UK doctors demonstrates the sense of loss that they have experienced as a result of neoteric health care structures that led them to turn to nostalgia in a similar way to the midwives in my study. Most of the surgeons interviewed in their study had fond memories of how things were in times past and they compared both contemporary and future ways of practising adversely with these memories. They painted the old days as a time, "when resources were more plentiful, staff turnover was lower and work was more enjoyable" (p. 1102).

278

This is not dissimilar sentiment to that expressed by the DHB midwives in my study and less so, but occasionally by the LMC midwives. The main difference in terms of the participants is that doctors as discussed in Chapter 6 have a far longer history in relation to a sense of professional identity. Theorists suggest that the neoliberal infiltration of health systems and services had a significant effect on the professional autonomy of the medical profession (Light & Levine, 1988; Gauld, 2008; Timmermans & Oh, 2010). Yet midwifery in New Zealand/Aotearoa, as discussed in Chapter 6, was re-invented with the assistance of the proponents of the ideology. It might therefore be assumed that midwives might have received benefits from the market-led model established in healthcare. However, as De Souza and Butt (2016) point out "although midwifery has positioned itself outside dominant norms as an anti-authoritarian discourse, the choices (in midwifery) are made within a neoliberal consumerist context of health care" (para 1.).

Nostalgia and Displacement

Nostalgia has a tendency to arise following displacement as those involved try to recoup a sense of continuity of identity by identifying a shared past (Davis, 1979). Therefore, the theme of nostalgia that emerges in the data could be viewed as a response to a slow erosion of the professional identity that was initially designed around the premise of liberal feminism but was ultimately shaped by neoliberalism. As De Souza and Butt (2016) state "the emancipatory promise of liberal feminism has disturbingly converged with the economic 'freedoms' of neoliberalism" (para. 1). The feminist agenda had served to bring together groups of consumers and midwives who forged a formidable sorority, but midwives were probably in reality invited into the network because it suited the meta-agenda of the time. Nostalgia had been ostensibly used to reconfigure the delivery of maternity care by restoring the role of the midwife within a new context with a new professional identity. The identity of being 'with woman' became a powerful metaphor to re-establish midwifery at the time. A powerful group in the network had effectively reconstructed the past in order to quell another actant group and had thus reconceptualised the identity of midwives of another age.

Conclusion

In this chapter I have analysed the concept of nostalgia, which emerged as a strong and recurring theme in the data from the focus groups and as a powerful actant in the network. Nostalgia served as a vehicle to introduce some of the barriers that may have contributed to the 'profession under siege' position that the midwives insentiently reveal in the data. These barriers were a perceived loss of autonomy on the part of the hospital based midwives, a reduced level of DHB support for maternity care, and inter-generational differences between midwives and women.

In using ANT as an analytical tool, understanding has been gained and meaning made about what the midwives in the study experience as a rapidly changing world. Gaining insight into a set of relationships at an abstract level within an actor network enables the researcher to enter territory that may not have been accessed before (Law, 1992). In this case using ANT has granted a greater understanding of why, in spite of having what they consider to be strong and functional relationships with women in their care, the midwives feel a sense of disquiet. This disquiet is compounded by a series of multifarious influences in the form of a range of actants within the network. In using nostalgia it would seem that the midwives are able to return to the past that perhaps rescues them from the confusion of the present in terms of their true professional identity.

Chapter 10. Discussion and Conclusion

Section 1 – Where are we now?

By supporting a sustainable approach to practice philosophy, resource management and personal and professional sustainability, midwifery could ultimately lead the field in health care as a truly ecological and socially responsible profession.

<div align="right">Davies, Daellenbach and Kensington 2011</div>

Midwifery is inherently sustainable. As arguably the oldest health care profession the philosophical essence of midwifery aligns with that of sustainability. Midwives are in a position to adopt low resource and low impact sustainable health care practices. Midwives are also instrumental in supporting the development of the most profound of relationships within the eco-niche of the mother/baby dyad. Yet to date there have been negligible attempts to nurture this association.

The original purpose of this PhD study was to determine how midwives in New Zealand/Aotearoa viewed the broad concept of sustainability in relation to midwifery practice and to ascertain whether active involvement in a sustainability change agency could lead to a change in practical and philosophical aspects of practice. However, although the midwives in the study were interested in the concept both at a personal level and from the perspective of their own profession, they were not really able to fully engage with the tenets of sustainability. This impacted on the initial decision to use PAR as a methodology. The use of reflexivity helped to facilitate a change in approach from a position of pragmatism, and the ensuing reflection led to the introduction of ANT as a theoretical framework and analytical tool. ANT enabled access to the networks via historical sources and from the data generated from this study. As a result, I was able to examine the networks where midwives have dwelled for many centuries as well as within the contemporaneous practice setting, through a different lens. ANT allowed a move beyond feminist and power theories, both of which have been used extensively within analysis of historical and contemporary midwifery practice

in recent years. The relationships within networks became the focus of my enquiry and I was able to view the actants that were operating, either to stabilise or destabilise the existing status quo, at various times throughout history via their relationships with others. Thematic analysis and the use of ANT provided the means to elicit a range of themes and sub-themes from the data and these were: the role of the midwife, consumerism, rapidly changing world, and sustainability.

In the preceding three chapters, ANT was employed as a means of exploring the contemporary network of maternity care in New Zealand/Aotearoa in order to establish why the midwives in the study were unwilling or unable to engage fully in ways of becoming more sustainable in their practice. Chapter 7 explored the midwives' understanding of and connection with environmental sustainability within midwifery practice and led to the discovery of number of hurdles that deterred them from engaging with the concept at a practice level. However, their social bonds with the women with whom they work and their families, placed them in the role of social connector. In Chapter 8 the concept of consumerism was analysed in relation to the professional lives of the midwives. The analysis identified the effects that consumerism and its subsidiaries of choice and risk had on the identities of the midwives. The midwifery role as carer was contrasted with that of the role of the midwife as business woman. This discussion revealed some conflict within the relationships that they valued with women as a result of the consumerist ethic prevalent within maternity care, resulting from the hegemonic status of neoliberalism in contemporary western style societies. The concept of neoliberalism was given further divulgence in Chapter 9 when other elements such as sponsorship and the place of the voluntary sector in healthcare were introduced within the data. These issues manifested in the form of nostalgia where the midwives questioned both the nature and the worth of their professional persona within a contemporary maternity setting.

As established at various points throughout the thesis, midwifery practice is continuously adapting and transforming in order to meet the changing needs of the profession and society. In the first section of this concluding chapter the focus will return to the

contemporary setting again to consider further the findings of the study in relation to a political milieu that has materialized recently in the field of maternity in New Zealand/Aotearoa. The ramifications of events still unfolding could mean that the recommendations emerging from the thesis might have greater practical application than was originally anticipated. Section Two continues by exploring some of the strategies that may help to formalize an alliance between midwifery and sustainability.

What about the Politics?

The completion of the analysis of the data calls upon Quinlan's fourth and final question 'what about the politics?' (Quinlan 2014). The themes that emerged from the data generated from the focus group meetings had felt eclectic. However, by continuing to trace the relational elements it became possible to identify the ideological influence of neoliberalism within the network. The principles of neoliberalism are embedded in so many aspects of the working lives of the midwives, affecting their working conditions, decision making, and relationships with the colleagues and clients that they interface with. These hegemonic principles manifest as, and within, the actants in the network of maternity care. Neoliberalism makes its presence felt in multiple ways within the network, for instance in the concept of consumerism, in the materiality status of technology, in the semiotic nature of the nostalgia expressed by the midwives, and in the professional issues identified. These elements demonstrate that the barriers that impact on the professional identity of the midwives generate a 'siege' mentality, and it can be concluded that they prevent the midwives from engaging with the concept of sustainability in practice.

Sustainability and Neoliberalism – Opposing Ideologies

Sustainability and neoliberalism are diametrically opposed ideologies that emerged as paradigmatic standpoints in the latter half of the twentieth century (Cervantes, 2013; Kumi, Arhin, & Yeboah, 2013; Monbiot, 2017). As discussed in Chapter 2, sustainability surfaced in the 1960s as a concept that reflected growing concerns around the undesirable effects of economic and industrial development upon ecosystems and the detrimental impact that

such events could have on human survival. As discussed in Chapter 6, neoliberalism, which emerged a decade later, was based on an insistence that human well-being can most effectively be achieved by encouraging individual entrepreneurialism within an institutional framework characterized by strong private property rights, free markets and free trade (Harvey, 2005).

It is argued that these two philosophically opposing world views will never be able to exist harmoniously within either an economic or political context (Cervantes, 2013; Klein, 2014). The consumption of natural resources is perceived as an unavoidable consequence of economic growth and industrial development which derides the assurances of sustainable development discussed in Chapter 2. The hegemonic strength of neoliberalism has increased in the 21st century to unanticipated levels. Its acceptance as a universal political discourse has ensured an accession that has made it "difficult to think about…when it has become so commonplace…that conventional wisdom can seem ubiquitous, inevitable natural and all encompassing" (Peck, 2010, p. xi).

It has further been proposed that not only has neoliberalism overshadowed the rhetoric of sustainability, it has engulfed it. Van den Berg (2016) suggests that the practice of 'greenwashing' discussed in Chapter 2, presents the unsustainable discourse of consumerism as a 'solution' to make consumers feel as though they are doing something at an individual level to help to 'save the planet'. In so doing, argues van den Berg, the root causes of environmental degradation, such as profiteering, injustice, inequality, and overconsumption are left untouched while people's gaze is diverted by the chimera of sustainable development and green consumerism.

Maternity Care and the Agenda of Neoliberalism

This thesis has shown that maternity care, like other areas of health-care has been significantly influenced by neoliberalism and the values of the free market. Midwifery employed a corporate mechanism in order to promote the establishment of a quasi-market funding model that constructed LMC midwives as self-employed business women and the

women who utilised their services as consumers. It is unlikely that the midwifery leaders who brokered the deal with the incumbent government for the reinstatement of midwifery could have foreseen the future trajectory of the ideology of neoliberalism. As Harvey (2005) states even the most uncompromising proponents of neoliberalism could not have seen that neoliberalism would "become hegemonic as a mode of discourse …to the point where it has become incorporated into the common-sense way we…understand the world" (p. 23). The midwives viewed their rationale as being gender related, and drew arguments to support their cause from feminist theory. The identity of being 'with woman' therefore became a powerful metaphor in the re-establishment of midwifery. This thesis argues that neoliberalism may have allowed the 'Trojan Horse' of midwifery access into the network, but it also assisted in incarcerating the midwives within the grand narrative of neoliberalism.

A Stronger Profession

The midwifery profession in New Zealand/Aotearoa has worked assiduously in the last few decades to establish itself as strong and sustainable in a professional sense. As noted in Chapter 6, frameworks were put in place to ensure the durability of the profession and these were galvanised by the instituting of a regulatory body. Quality assurance mechanisms to improve maternity outcomes for women and their families were operationalised. These included the Midwifery Standards Review process and a Midwifery First Year in Practice Programme which increased levels of support in transitioning graduate midwives from undergraduate to registered midwife status (Pairman et al., 2016). New Zealand midwifery has an influential voice on the international midwifery stage with representation on the Board of the International Confederation of Midwives (ICM), both at a regional and an international level. Additionally there is now a New Zealand midwife at the helm of the International Confederation of Midwives (ICM) in her role as CEO. Midwifery education in New Zealand/Aotearoa is viewed as a strong model (Rowland, McLeod, & Froese-Burns, 2012) and increasing numbers of midwives are graduating at masters and doctorate level (NZCOM, 2014). This has assisted the profession in working towards becoming more research active and evidence informed, and NZCOM has facilitated the development of a national midwifery research strategy. Midwifery is represented on the vast majority of

committees and boards relating to maternity services and collegial relationships with the medical and other health related organisations that interface with the profession have improved over the years. Midwifery leaders provide expert advice to government and other relevant agencies such as the coroners court and ACC, which serves to strengthen the credibility and kudos of midwifery. There are strategic plans in place to increase the number of Māori and Pasifika midwives in order to specifically meet the needs of their own communities, and the issues of rural midwifery discussed in Chapter 6 have been at least partly addressed[122]. The findings of a maternity consumer survey conducted in 2014 reported that 77% of women were very satisfied or satisfied with the overall care they received during their childbirth experience and 90% of women were satisfied with the services they obtained from their LMC (MoH, 2015).

A Crisis Point

However, in spite of what could be viewed as considerable gains and strengthening measures, the midwifery model and workforce in New Zealand/Aotearoa has been faced with counter-pressure from a variety of actants within the network. These include the changing expectations on the part of women, a lack of investment in the service, a poorly informed media and the stance of current maternity activist groups. These challenges faced by the profession are generating uncertainty in the minds of the midwives, leading many to adopt a cautious and self-protective stance as documented in Chapters 8-10. These factors have doubtless contributed to the view advanced by NZCOM that midwifery is reaching a "crisis point" (Ryan, 2017a). In an interview on RNZ on March 22, 2017, the Chief Executive (CE) of NZCOM, Karen Guilliland, explained that the working conditions of midwives were causing sickness and burnout in the workforce and that the "service needs help". She continued by stating that she feels that there needs to be an urgent review of funding and allocation of funds by the MoH. She expressed concern that funding was being diverted into other areas of healthcare and that the MoH were aware of this but unwilling to act upon it. She finished the

---

[122] A Rural Midwifery Service is supported with MoH funding that has contributed to improving the rural recruitment and retention issues that were plaguing the service in many parts of the country.

interview by stating that "midwives were being held responsible for a context that they have no control over". This interview was a marked departure from the previous stance of NZCOM that appeared to be to keep any signs of perceived 'weakness' as a professionally private matter. Guilliland did go on to comment in the radio interview that this concealment was designed to maintain public trust and faith in the service. However, what equates to organisational silence, which is defined as collective behaviour of saying or doing little in response to significant problems within an organisation (Morrison & Milliken, 2000), has proved to be counter-productive, leading to "diffusion of responsibility, and microclimates of distrust" (Henriksen & Dayton, 2006).

The Contingent Nature of the Network

The clarion call of support for the midwifery workforce, is part of a significant change that is currently in progress. In August 2016, the New Zealand College of Midwives filed a Statement of Claim against the Ministry of Health on behalf of its members (Jones, 2016), alleging discrimination on the basis of gender in breach of the New Zealand Bill of Rights Act 1990[123](New Zealand Government, 2017). According to NZCOM the alleged gender discrimination was underlined by the fact that remuneration experts have estimated that comparable male dominated areas of work can expect to earn 60% more than LMC midwives (Small, 2016).

---

[123] The College's case was that the Ministry of Health (MOH) had breached its obligation to comply with Section 19 (1) and s5 of the NZ Bill of Rights Act 1990 in deciding to issue the 2007 Primary Maternity services Notice and the 2012 and 2016 Amendment Notices under S88 of the NZ Public Health and Disability Act 2000, and in omitting or refusing to issue further notice under S88. These actions and/or omissions by the Ministry of Health directly and/or indirectly discriminated against midwives providing lead maternity care under the Notices on the basis of gender. The College's legal advice was that the Bill of Rights was the fastest and most feasible option for a legal challenge as LMC midwives are 'self-employed' and therefore do not fall under the Employment Act or the Pay Equity Act. The High Court was asked to undertake a judicial review to decide if the lack of equitable funding was the result of discrimination because midwives were women, and that these actions included systemic/ historical factors (Guilliland & Pittam, 2017).

The College of Midwives have argued that there has only been one increase of 2.5% to the fees that can be claimed under Maternity Services Notice (Section 88) (MoH 2007) since 2007. DHB employed midwives fall under the Multi-Employer Collective Agreement (MECA) which has been negotiated at regular intervals and has received percentage increases as a result. However, the self-employed status of LMC midwives has created a somewhat anomalous situation. Unlike other self-employed individuals, LMC midwives cannot charge women directly for any of their services and therefore are unable to recover any increases in costs. They rely on the MoH to set fair fees, and negotiating rights are not agreed within the Section 88 Notice (2007). It would seem that no other primary health care publicly funded service has been subjected to such insufficient adjustment in funding. Because midwives in New Zealand/Aotearoa are self-employed, the case cannot be treated as an employment pay equity case as there is no mechanism to support this and so a decision was made to take the case forward as discrimination on the grounds of gender under the Bill of Rights (NZCOM, 2016). In the days leading up to the Court Case, the Ministry of Health requested that the case be arbitrated and after this was agreed with by NZCOM, the case went to mediation in August 2016.

A risk of losing the system

The result of one of the actants redefining or repositioning the interests or identity of others in the network in order to realign them with their own, initiates the process of translation in ANT. In defining their problem as a gender related issue and seeking means of employing the 'co-operation' of the MoH to resolve it, the midwifery profession set the wheels for such a translation in motion. The support of other important actants is crucial in such reconfiguration and in this case, in addition to the MOH, the other actants that were pulled into the frame by the New Zealand College of Midwives were the community of women that midwives serve.

Exponents of ANT have been criticised for taking an objective and even constructivist stance that does not embrace subjectivity and emotion. However, Müller (2015b) points out that

the thinking and rearranging that takes place within networks is not infrequently governed by affect and emotions. Employing feminist theory in conjunction with ANT helps us to make meaning from the changes occurring. In a media release in 2015, NZCOM CE, Karen Guilliland, reported that " there is a real risk of losing this system that works so well for women and their babies, if a financially unsustainable payment system means we can't recruit and retain our LMC workforce" (Guilliland as cited in Keast, 2015). This was a candid appeal to women and their families, the actants that midwives consistently identify as providing their greatest support and strength, as well as to the Ministry of Health and the government. Until this point, the College of Midwives had resolutely committed to a position of unity and strength. Reports constantly referred to the strength and stability of the midwifery workforce and the continuity of care model. The presentation of a strong sense of group identity through the value of loyalty is a formidable defence, one that the classical profession such as medicine and the law have relied on for many centuries (Freidson, 1988) . Therefore acknowledging to a measure of frailty may have been a calculated risk.

Firkin (2004) describes the shared values and resources of the relationship between women and midwives as "cultural capital" and states that "midwifery is a collective comprising both practitioners and consumers who shared, and continue to share, a sense of belonging arising from their commitments to a specific culture" (p. 7). Thus the declaration of vulnerability by NZCOM was equally levelled at midwives themselves. When a profession is under threat, it is not uncommon for it to turn on itself (Curtis, Ball, & Kirkham, 2006; Behruzi et al., 2017). By acknowledging that problems may exist, anxiety and stress can begin to be addressed and defused (Gawande, 2010). The Deputy CEO of NZCOM recently stated publicly that there are some areas of conflict within the profession itself, but that these areas of conflict have resulted from breakdown at a systematic level (Ryan, 2017b). This acknowledgement opened the way for the College to advocate measures to unite the factions that had become evident within midwifery.

The Outcome of the Mediation Process

In April 2017 the Ministry of Health agreed to a pay increase for LMC midwives around the principle that equal pay has no element of gender-based differential and the midwifery profession was invited to assist in what was referred to as a co-design of the midwifery model alongside representatives from the Ministry of Health. The meditation public statement indicated that the co-design process would not "remove or renegotiate the Primary Maternity Services Notice 2007, or change the primary midwifery service model of lead maternity carers." (April 5th 2017). The statement also claimed that it would support the sustainability of community LMC midwives and include the right to negotiate terms and conditions. The "female professional project" (Witz, 1990, p. 679) had been yet again used to effect another Obligatory Passage Point (OPP) (Callon, 1986a) and in so doing strengthened the position of midwifery within the network, for the time being at least. The pay increase and the redesigning of the fee payment schedule within Section 88 of the Primary Health Maternity Act has the potential to alter the relational space within the network and even, in ANT phraseology, to 'black box' the new configuration.

The change in the dynamic of the network that the negotiations between the profession and the Ministry has effected, has the potential to trigger a series of further actions. These could prove to be as significant as those that established the autonomy of midwifery in the 1980s prompting the legislative changes. Although the proposed changes in the structure of the assemblage apply directly only to the primary care based service that LMC midwives deliver, the corollary effects could exert a powerful influence on the structure and functioning of the network that will benefit both community and facility based midwives. A more confident and less fatigued LMC workforce could result in enhanced collegiality at both intra-relational and inter-relational levels. The move could also serve to improve retention rates within the profession, and to increase the number of graduates entering the workforce by improving recruitment and retention rates within midwifery undergraduate programmes. At the very least, if the LMC midwives experience greater job satisfaction by being able to provide the level of care that they feel is commensurate with their role, then further attention could be given by the profession to the situation for those employed midwives working within

hospitals and other facilities to improve their sense of professional wellbeing [124]. The NZCOM mediation team is currently (August 2017) in the process of carrying out a consultation exercise to elicit from members what shape a new funding model should take. The midwives who have responded to the consultation to date are sending the message that midwifery should not be beholden to Public Health Organisation's or District Health Board's for any administration of funding; that it must remain independent and that any management should be undertaken at national level.

Conveying the advantages of a new model to a midwifery workforce at a low ebb is likely to create some challenges. When morale in a profession is low, there is a tendency for resistance to change (Conroy, 2009). The consultation process appears to have established that although midwives feel that the current model is not necessarily working particularly well for their interests, they may be struggling to envisage a feasible alternative. This co-design and consultation process could be a critical window of opportunity for midwives to embrace a model that addresses not only funding but a more sustainable way of being and doing within practice. It offers an opportunity to challenge the hegemonic status quo, albeit on a micro-scale, and to make a difference within the framework of healthcare.

Section 2 – A way forward

A central role

A significant outcome of the negotiated process, is an implicit acknowledgement of the worth of the profession and the recognition that midwifery forms the nucleus of maternity services in New Zealand/Aotearoa. The Minister of Health, Jonathan Coleman made a speech at the NZCOM Conference in 2016 where he stated that "the sustainability of Lead Maternity Care midwifery is central to the national primary maternity service and requires national support" (Coleman 2016). This is a strong statement of commitment to the establishment of

---

[124] a body that provides primary health services either directly or through its provider members.

a sustainable professional model. In this context this is related to issues pertaining to sustainability of practice focussing on issues such as caseload size, adequate remuneration and reduced levels of burnout. [125]

However, as has been shown sustainability involves more than just practice related issues. Reflecting on the major determinants identified in my data, this section of the thesis will present three models for practice, philosophy and education, that demonstrate how the definition of sustainability in a midwifery context may be broadened to include the tenets of sociocultural, environmental and economic sustainability. The models will demonstrate how sustainability could potentially be formally integrated into midwifery practice.

A practice model - Social Enterprise

As discussed in Chapter 6, the LMC model was conceived in a ferment of neoliberal activity that reinstated community-based midwives as self-employed business-women who were encouraged to adopt commercial practices in a rapidly changing field of health care provision and to take advantage of the ideology of competition and choice (Tully, Daellenbach, and Guilliland, 1998.) In the spirit of deregulation, there were no conditions around the way that midwives practised in terms of the configuration and location of their practice. The only caveat was that there had to be a named LMC for every woman, but there were no constraints on either the minimum or maximum number of women that a midwife could take on within a caseload.   The variances in practice adopted by midwives in New Zealand/Aotearoa practice, the shape that they take and the impact on care that they have

---

[125] There is an aim within the group to create a situation where midwives will be remunerated sufficiently by taking on a caseload of 50 or more women per year, meaning that midwives will not have to take on the very high caseloads that some do now.

has never been accurately determined or evaluated[126]. This neoliberal approach to the structure of LMC practice may have contributed to the alleged current crisis by creating a market based approach to practice that is more likely to lead to competition than collaboration between practitioners. The prospect of a redesign that encourages deliberation of long held assumptions about the way that funding is allocated, has major significance for the ways in which midwives practise. As discussed in Chapter 2, midwifery is well placed to assume a broad based sustainable approach to practice. LMC midwifery practice is situated within a social model within a primary healthcare capacity providing care that promotes physical, emotional, psychological, social, and cultural well-being. Such care should reduce healthcare costs and resource requirements and foster strong social support and networking.

Criticisms of the Social Enterprise model

A social enterprise model is just one example of an alternative approach that may have the capacity to create this potential. There are valid criticisms of social enterprise, not least that the term is lacking a clear definition which means that anything from a small organic fruit and vegetable delivery service to the housebound to the Bill and Melinda Gates Foundation could ostensibly be viewed as social enterprise (Martin & Osberg, 2007). It has been posited

---

[126] It is commonly observed that LMC's work in a number of ways from solo practitioner, to pairs, to larger group practices of any number of midwives but often between 4-8 in number. Although most midwives appear to work within the original framework of one on one, continuity of carer practices have also been established using alternative formats where the partnership model is adapted to make the system work for the specific needs of the practice members. A number of models have been implemented, such as midwives working in pairs covering a caseload on a week on, week off basis. In this format, although one midwife is nominally the LMC, the woman will receive care from both midwives throughout pregnancy and may be attended by either during labour and birth. Others have used a team based approach, where three or four midwives share responsibility for the care of a woman within a group case loading system. Some midwives pool their combined income and share the earnings equitably between the practice members and others have a shared resource funding stream within their practice. The variants discussed above are based on observation and discussions that I have had with midwives around the country and are therefore anecdotal. I have been unable to locate any research or even formal recording of the fact that midwives do practice in a variety of ways and would therefore suggest that this is an area that would benefit from research.

that the term social enterprise maintains the status quo by presenting as a radical alternative what is essentially still part of a free market economy (Ridley-Duff & Bull, 2015). It has also been argued that social enterprises are viewed by market focussed governments as being yet another means of achieving the goals of competition and choice in the provision of public services such as health care (Teasdale, Lyon, & Baldock, 2013)

The benefits of social enterprise

Although they are essentially commercially driven ventures, it can be countered that social enterprises at their heart have objectives that are primarily socially validated, with any surpluses that they generate reinvested in the business or in the community where the organisation is sited, rather than being driven by the need to maximise profit. In so doing they can combine a commitment to the public good, such as regeneration, training or tackling inequalities, with the drive and discipline traditionally associated with private sector organisations. Unlike private businesses however, social enterprises are designed to promote an ethos of social responsibility and delivery of service that is seen within the movement as being more important than simply being profitable. Social Enterprises therefore have the potential to shift the emphasis of practice away from a profit-oriented business model towards an approach that is more philanthropic and focussed on social good (Martin & Osberg, 2007; O' Sullivan, 2008; Defourny, 2014; Sustainable Enterprise, 2014; Teasdale, Lyon, & Baldock, 2013; Ridley-Duff & Bull, 2015). As demonstrated below in Figure 9, this model has more in common with the philosophical stance of midwifery in New Zealand/Aotearoa than the current business model utilised.
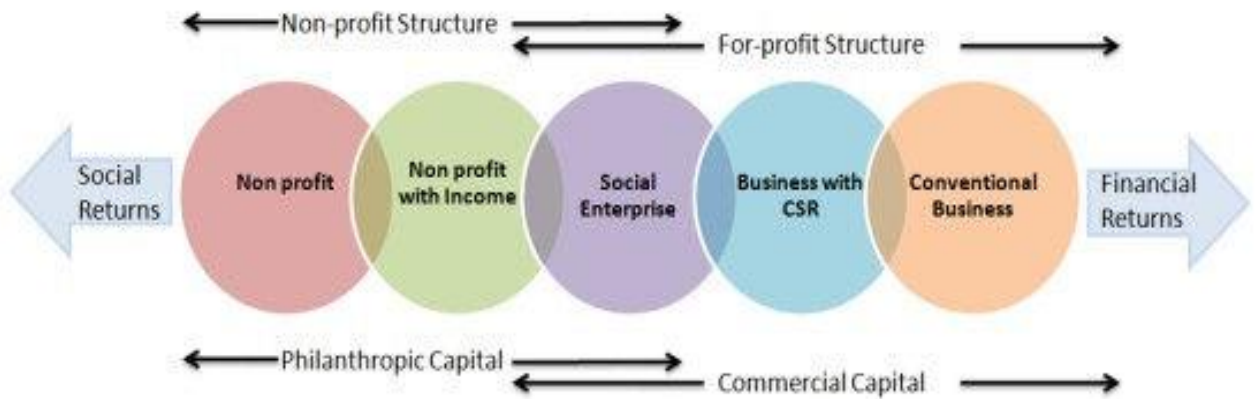
Source: Community Development Investment Review 5.2 (2009)

Fig 9 Social Enterprise Model

From a sustainability perspective, social enterprise models appear to be favoured by businesses with environmental concerns because they are considered to accommodate the core principles of sustainability (Defourny. 2014; Brechin et al., 2003).

Figure 10.

A model developed by an initiative called Sustainable Enterprise (2014) (see Figure 10) illustrates the four quadrants that represent the triple bottom line (3BL) dynamic processes of sustainability, namely environmental, social, and economic. The authors have added

295

ethical to these. The model depicts synthesis between economy and ethics (eco-effectiveness) and equity with environment. In so doing, eco-effectiveness becomes the fusion of environmental and economic dynamics whilst social responsibility is a blend of economics and equity. Human rights are achieved through equity and ethics and environmental ethics through an understanding of the association between ethics and the environment.

The benefits of Social Enterprise for midwifery in New Zealand

There have been attempts to introduce social enterprise models in the UK by NHS Trust based midwives. These endeavours have had some small scale degrees of success, but have encountered stumbling blocks in the establishment of the schemes. This is largely because the shift from a traditional NHS organisational set-up to a social enterprise framework is fraught with metaphorical administrative and bureaucratic tripwires (O'Sullivan, 2008). However, there are a number of factors present in New Zealand/Aotearoa that would almost certainly pave the way for a smoother transition, not least because the change would be from the existing business model to one of social enterprise. The concern that midwifery values could be compromised by increased attention to efficiency, costs and resources, holds little weight when the workforce have self-employed experience with skills in business administration and self-governance. They also have all the resources that they would require within the other model, such as practice equipment and administration tools. As far as payroll and financial management are concerned, it may be possible for the existing organisations who manage this here, such as the practice management system organisation, MMPO (see page 162), to continue to provide this service under the mantle of social enterprise.

Midwives also generally practice in a group setting as discussed previously and there are few solo practitioners, with the exception perhaps of rural practitioners. This means that the infrastructure for a move to social enterprise is already largely in place and this might mean re-configuration rather than comprehensive groundwork is required. The continuity of carer system gives itself well to an approach that values engagement with local groups and

communities. Social enterprises are said to be particularly well suited to working in partnership with those accessing services, which again fits with the partnership model of midwifery employed here.

Social enterprise in practice

In practical terms, if a group of midwives established a social enterprise, they would each have an equal say in any decision making processes within the practice. There is no reason why the named lead maternity carer should not continue, with one midwife taking the lead and holding her own caseload but it would be required that there were good levels of support from the practice to allow the midwife to have adequate breaks from being on call and to take leave. In terms of funding arrangements, instead of individual midwives being paid capitation for each woman, the group might be funded for a combined caseload by the MoH. Providing the remuneration was commensurate with the true worth of the work involved with each woman, a maximum of 50 women in a full time caseload could be considered as a maximum number. From this funding, the practice members would be paid a salary that was commensurate with their caseload to allow for full or part time employment. The midwives would be paid annual leave and sick leave and be part of a superannuation contribution scheme. Any surplus funding would be reinvested into the practice to fund the resources or services that the group agree to be necessary for either their own practice or for the community. This may constitute new equipment, the employment of an administrator, the purchase of a clinic accommodation, the establishment of parent education groups, or any number of other possibilities.

Social enterprise could work to ameliorate some of the issues that emerge from self-employment. It could also ostensibly lead to a more sustainable practice model with less focus on individualism, consumerism, and choice and a greater focus on equity and social justice. However, this is primarily a model for a practice framework that would allow a more socially responsible approach. There additionally needs to be consideration of a more inclusive methodology that reflects the specific philosophy of care for midwifery.

297

A Cultural Ecosystem Model

Mauri Model

To return to the models of sustainability introduced in Chapter 2, The Mauri[127] model of sustainability developed by Morgan (2004) (see Figure 4 p. 22) could legitimately be used to connect the two domains of sustainability and midwifery practice. The unique bicultural heritage of New Zealand/Aotearoa grounded in the relationship between the indigenous Māori people and other New Zealanders is strongly supported within the midwifery frameworks such as the partnership model, cultural competence and Tauranga Kaupapa as discussed in Chapter 6. The Māori concept of kaitiakitanga embodies a number of beliefs that connect the physical, environmental, spiritual, economic, and political aspects of Māori society which a midwifery philosophy aligns with. It defines the relationships that humans have with each other, the environment and the spiritual world. In so doing, kaitiakitanga offers a framework for responsible management of natural resources (Marsden et al., 1992). The model provides a set of assessment criteria that correspond to the three triple bottom line facets of sustainability—environment, society, and economy, plus a cultural perspective. These are represented as four levels or spheres: the environment, hapū[128], community, and whānau. Although the model was designed for the deliberation of sustainability within a Māori context, the author of the model suggests that Pākehā communities, groups and organisations could adapt the model for use by defining what sustainability means to them within their own context, based on their own values and beliefs (Morgan, 2004). In

---

[127] Mauri is the life force that exists in all living beings. The world is composed of spiritual and physical aspects that are intertwined and cannot be separated. Since resources emanate from the atua, they also have spiritual and physical aspects. Kaitiakitanga is a reciprocal arrangement that Tangata Whenua have with resources.

[128] Hapū - A named division of Māori iwi (tribes), hapū have membership determined by genealogical descent; a hapū comprises a number of whānau groups.

consideration of the findings of this thesis, the Mauri model has been modified to create a sustainability midwifery model. This is presented below.
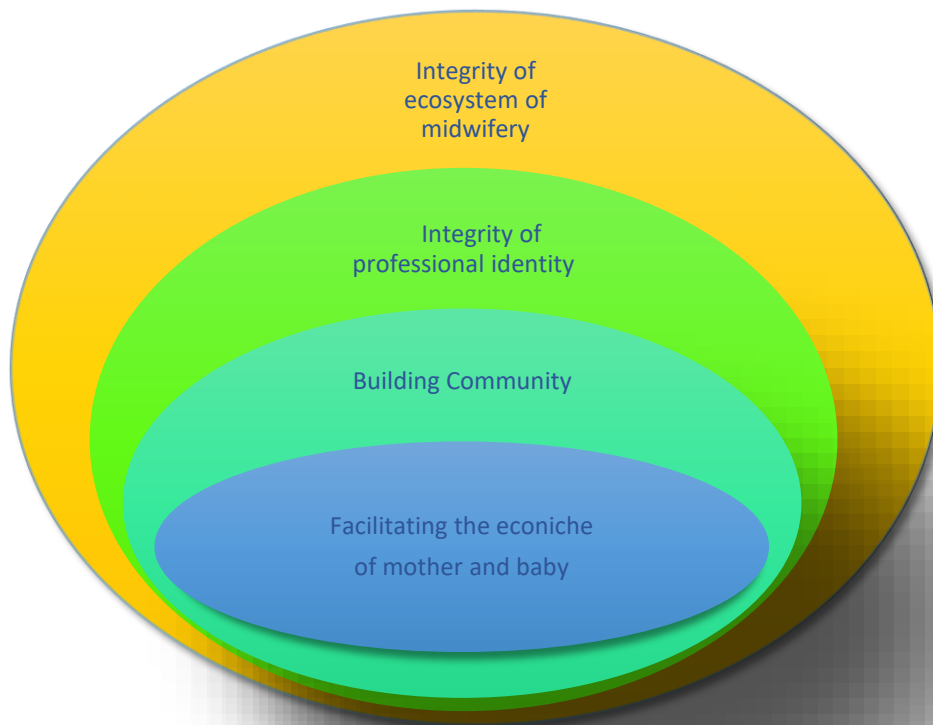
Figure 11: A Cultural Ecosystem Model

Features of the model

The figure represents what could essentially be termed as a cultural ecosystem model. A cultural ecosystem has been described as the "the non-material benefits people obtain from ecosystems through spiritual enrichment, cognitive development, reflection, recreation, and aesthetic experiences" (Sarukhán & Whyte, 2005). An analysis utilising a cultural ecosystem approach offers an opportunity for exploring the physical, emotional and psychological well-being of those within a specific cultural setting and the relationship between the components. Cultural ecosystem frameworks are said to be under-utilised and under-valued in comparison with other ecosystems such as those in the physical environment (Milcu et al., 2013). It is suggested that this is possibly because they lack tangibility (Daw, Sergio, & Pomeroy, 2011), but it may also be that they have little value in areas such as industry and service provision because they fall under a non-consumptive category which, within a hegemony based around economic consumption, leaves cultural ecosystems with little value.

299

However, from a human capacity perspective they have considerable value (Sarukhan & Whyte, 2005), not least because they can "serve as stepping stones in today's sea of ideas by, for example, creating congruencies between social and ecological systems theory" (Milcu et al., 2013, p. 44). Like all ecosystems, cultural ecosystems are also networks in an ANT capacity. Thus, any change in equilibrium caused by an alteration in relationships within the system is likely to modify the structure and the relational status within it. This may be to the benefit or to the detriment of those within the system.

The model in action

Although there appears to be a hierarchical structure which could be envisioned from the outermost circle inwards or the inner most circle outwards, the concentricity of the model actually creates an integrated structure where the layers are intersecting and interdependent. Thus, the integrity of the ecosystem of midwifery practice will only be sustained if the other components are realised, and conversely the mother/baby dyad will only flourish if midwives have a strong sense of their own identity and respectful collegial relationships within the larger network of maternity care.

Integrity of ecosystem

The Social Enterprise Model described on page 282 could realistically provide the framework for an ecosystem of practice, the outer circle of the model. This is where the key tenets of environmental, sociocultural, and economic would coalesce. A workforce with a well-defined sense of identity is said to be more likely to experience job satisfaction (Caza & Creary, 2016). The reinforcing of professional identity could also improve the quality of midwifery care (Ferlie et al., 2005), lead to a reduction in interventions (Hunter & Segrott, 2014), and increase the confidence of women using the maternity service (Lothian, 2008; Tracy et al,. 2013). These improvements would recompense by leading to fewer referrals and transfers, relieving some of the pressure on the secondary and tertiary hospital services, and creating space and time for hospital based midwives and other associated groups such as obstetricians and neonatology teams. This should improve both intra-professional and inter-

professional relationships, helping to build communities of practice. Decreased intervention would mean a less resource-intensive environment (Martis, 2011) and this would confer economic benefits (Bartlett et al., 2014; Tracy, 2011). This may feel like an idealistic, hypothetical speculation but the evidence suggests that these changes could manifest in a more sustainable midwifery ecosystem as well as in the broader maternity services network.

In summary the cultural ecosystem of midwifery model works on the premise that the underlying, philosophy of the midwifery profession supports a community based primary health service that strengthens family relationships and promotes normal birth (NZCOM, 2011). The need for a strong professional identity is key in this endeavour. Self-sustainability is another factor in maintaining the stability of the ecosystem and the midwife needs to be aware of the need for self-care in practice and to develop strategies to ameliorate the potential for stress related consequence and burnout (McCourt & Stevens, 2008; Wakelin & Skinner, 2007; Donald, 2014). Within the culture of the model, a midwife would be expected to protect, preserve and promote the 'econiche' created by the mother-baby dyad at each professional encounter with the women during the childbearing continuum, within the boundaries of cultural safety for that particular woman and her whānau/family (Davies, Daellenbach, & Kensington, 2011).

A Model of Sustainability for Education

Education forms the third cornerstone in the establishment of a midwifery workforce that understands and embraces the significance of a sustainable approach to practice. Apart from my own small study detailed below, I have been unable to locate any published research on the inclusion of sustainability within midwifery education or relating to any outcome at either undergraduate or post graduate level in either New Zealand or overseas. Likewise, there is little evidence of the delivery of education for sustainability that is tailored specifically for midwives. As discussed in Chapter 1, CPIT and Otago Polytechnic did incorporate a sustainability thread in the newly developed Bachelor of Midwifery back in 2009 and a post-graduate course is currently being offered through Otago Polytechnic as part of the Post-

Graduate Diploma in Midwifery. Ara Institute of Canterbury (formally CPIT) is currently exploring the possibility of introducing a Masters level trans-disciplinary Sustainability Studies that would enable midwives to enrol for a post-graduate, certificate/diploma or Master's degree in applied sustainability.

Education for sustainability requires an approach that includes fostering an understanding of the precautionary principle with an ability to apply the principles to one's own specific workplace or sphere of professional practice (Goodman, 2013). This is particularly important at undergraduate level in courses with a focus on professional practice, such as midwifery. In this instance, an epistemological and ontological approach to sustainability that is focused on the needs of a specific profession may help to build a stronger sense of professional identity. There is however, an argument for introducing a cross disciplinary approach at post graduate level, once professional identity is established, in order to allow a range of perspectives to consider ways to decipher, resolve and integrate different traditions, discourses and methodologies (Warburton, 2003). Such a multi-disciplinary approach would be an effective way of ensuring that different health groups have a similar philosophical and pragmatic understanding of the issues and can work towards shared solutions to the problems faced.

Sustainability literacy

The term sustainability literacy has been beleaguered by accusations of being a cosmetic exercise that serves little more purpose than marketing sustainability, but fails to provide any guidance for educational practice (Vare & Blewitt, 2009). Vare and Scott (2007) argue that any form of education for sustainability needs to achieve a balance between information with prescribed positive behaviour change and a more emancipatory approach that involves building the capacity of students to think critically about and beyond sustainability messages. Vare (Vare & Blewitt 2009) contends that literacy or numeracy and even computer literacy all have consistent rules. Within the context of sustainability however, such application is likely to lead to inflexibility and an inability to critique the

302

complexity that sustainability presents. Street (1984) argues that literacy is a contextual ideological concept that merely reflects the values associated with that context. This means that any application of sustainability literacy needs to be very carefully considered within a specific context.

Blewitt in Vare and Blewitt (2009) counters the arguments against sustainability literacy by stating that the concept has been defined too narrowly, taught without imagination and applied unconvincingly. He cites the work of Freire (1972) who claimed that literacy resulted in conscientisation, social transformation, empowerment, and liberation, and argues that it could therefore be seen as an emancipatory process. Blewitt continues by suggesting that it may not be literacy that is the problem but "sustainability and its correspondent , sustainable development" and that both sustainability and sustainable development are "often conflated, incessantly debated, sometimes dismissed and frequently misunderstood and misused" (p. 4).

A change in perspective

In 2013, as part of my journey of inquiry relating to the thesis, I carried out a small qualitative study that set out to explore the awareness of sustainability in midwifery practice as a result of having been introduced to the contextualized concept of sustainability within the undergraduate midwifery curriculum developed between the two institutions (Davies, 2016). The data was gathered from two focus groups of midwives who had graduated from the BM programme at CPIT/Ara, one year previously. There were six students in each group. I used a data-driven iterative thematic qualitative analysis of focus group interview transcripts, and identified major themes and pertinent concepts. The findings from this small qualitative study were encouraging, indicating that the inclusion of a component of sustainability literacy within an undergraduate midwifery programme may encourage graduate midwives to give greater consideration to all of the key tenets of sustainability during their first year as practitioners, at least. This is certainly an area that would benefit from further exploration. However, there was a note of caution that emerged from the data. This hinged on the recognition that approaching the subject of sustainability from an

'Apocalyptic' position with a focus on climate change and global population expansion, was likely to alienate rather than encourage constructive engagement. I had assumed that these subjects would be a legitimate point of access to the subject. However for all of the reasons outlined in Chapter 2, with regard to creating feelings of futility and helplessness, it proved to be less than a useful entry point for the subject (Grothmann & Patt, 2005; Oreske, 2004).

Alarmism or Core Values?

In 2014, I altered my approach to the delivery of sustainability education within the Bachelor of Midwifery programme as a result of being introduced to the work of Harre (2011). Harre uses evidence from the positive psychology movement in an endeavour to encourage people to recognise the importance of core values in adopting a greater sustainability awareness. She emphasises the value of positivity, which incorporates creative problem solving and self-affirming rather than negativity which fosters fear and reluctance to change, in order to approach the subject of sustainability. Harre advocates that a values-based approach to learning about sustainability, that begins with an evaluation of our own core values and beliefs, is a more useful starting point than a 'reduce, reuse, and recycle' approach which she claims may seem innocuous and responsible, but can be interpreted as a coveted form of alarmism (Harre, 2011).

In order to convey this message, Harre has designed an activity, "The Infinite Game", which is based on the work of Carse (2011). The game, that Harre describes as offering a metaphor to help understand the complexity of the time in which we live, encourages the players to explore what are referred to as finite and infinite values. Finite values are classified as ego or material based, such as wealth, status and physical attraction and tend to be associated with individualism (Beck & Beck-Gernsheim, 2002; Bockman, 2013; Eagleton-Pierce, 2016). Infinite values are affective or ethical values such as love, respect, and trust that are relational and communitarian (Bollier & Helfrich, 2014). In the finite game the objective is to win at any cost, whereas the infinite game requires that the game is kept in play. Finite games have boundaries and invite players by selection and have rules that cannot be altered. Infinite games have no selection and everyone is welcome and the rules must change or the

game will cease. The aim of the 'game' is to get students to understand current social structures that limit progress towards human and ecological flourishing and the vital role that institutions, organisations and professional groups can play (Harre, 2017). This type of learning triggers students to reflect on their learning and this is what can lead to changes in values, behaviours and attitudes (See Chapter 3 p. 58). By facilitating learning that enables a deep understanding of the underlying concepts, the students are more likely to develop a sense of personal responsibility, seek solutions, and act upon them (Mezirow, 1990: Moon, 2004).

A transformative process

Corcoran and Wals (2007) pose the questions, 'what we are educating for when it comes to sustainability?' and 'what is the goal'? They continue by surmising that if we ask these questions then the pedagogy has the potential to becomes a transformative rather than a transmissive process and that a deconstruction of values and beliefs and a challenging of assumptions can take place. This requires the use of critical reflection and an ability to synthesize information in order to change perspectives and paradigms. This deep learning (Warburton, 2003) is described by Sterling (2001) as a "creative shift in consciousness that involves a 'deep awareness of alternative world views'" (p. 15).

The model below illustrates how the content from a typical midwifery undergraduate curriculum can be effectively located within a framework that maps the content with the tenets of sustainability. The content is not restricted to any one tenet and most will navigate across all three circles. As stated above, what is central to any learning related to sustainability is the exploration of attitudes, values, and behaviours, hence the inclusion of core values as a central feature. The model is bordered by the midwifery frameworks for practice as described in Chapter 6. This integrated configuration would mean that sustainability would be considered in all content and aspects of learning and teaching within the curriculum.

Practice management

Economic

Nutrition   Breastfeeding

Pharmacology

Core Values

Bioscience   History of midwifery

Practice Skills

Environmental   **Sociocultural**

Communication

Law and ethics   Self-care

Resource management   Cultural Safety
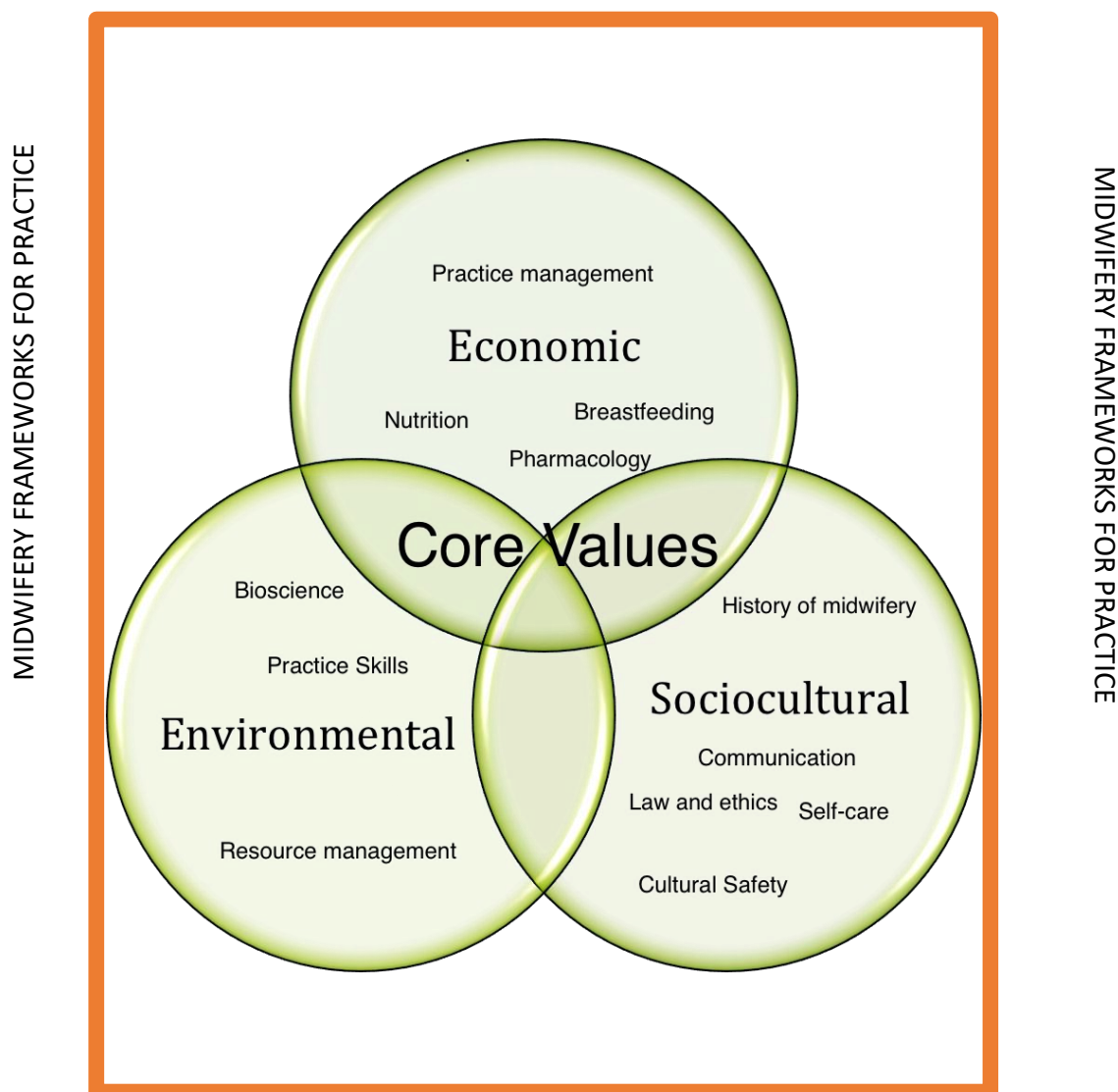
Figure 12. A model for sustainable midwifery education

The ideological standpoint of the tertiary education sector

There is one final cautionary principle that needs to be included in this discussion of education and sustainability. It has been said that Universities, Polytechnics and other organisations in this public sector have metamorphosed from institutions of knowledge into production line style 'industry' in the last few decades (Rolfe, 2013). Educational institutions have become corporate style bodies and in so doing have become the purveyors of neoliberal attitudes and behaviours in students who subsequently transfer these into the

workforce, perpetuating the hegemonic status of neoliberalism. This is antithetically opposed to the sustainability agenda which serves to challenge the existing status quo and seek the establishment of an alternative world view. As discussed in Chapter 2, the concept of sustainable development can be used to highjack the discourse of sustainability and use it to meet the agenda of the dominant discourse of neoliberalism (Tulloch & Neilson, 2014). This applies to education as much as it does to any other 'industry' (Goodman, 2013). It is therefore imperative that sustainability education is not used in a perfunctory manner that renders the commitment to sustainability little more than a superficial exercise in greenwash. This would suggest that well considered professional development of all staff involved in curriculum development and teaching is necessary and important.

The three cornerstones of practice, philosophy, and education model discussed in relation to social enterprise, cultural ecosystems, and holistic education support the sustainable values that are assembled synergistically in the form of a 'Möbius Strip' framework. This represents the overarching model of sustainability for midwifery practice.   The Möbius Strip, which is named after the astronomer and mathematician, August Möbius (1790-1868) is a complex and paradoxical object of perception. It is simultaneously, a 2D and 3D mathematical object but with mono-dimensional properties. It has properties, but equally has abstraction. It has flow, yet is non-orientable and has only one edge, yet still appears multi-faceted. Its fluidity encourages evolution and development yet it retains form and structure. I find that many of these esoteric features resonate with those within the spheres of both sustainability and midwifery. Sustainability is a multifaceted complex concept that is abstract and concrete simultaneously. Midwifery too is multidimensional entity with a fluidity that has enabled it to slip from view only to reappear in another form in another temporal plane. Both have an existential quality and have evolved, into their current shape in the 21st century as a result of their contribution to the human experience.

An Overarching Model for Sustainability in Midwifery
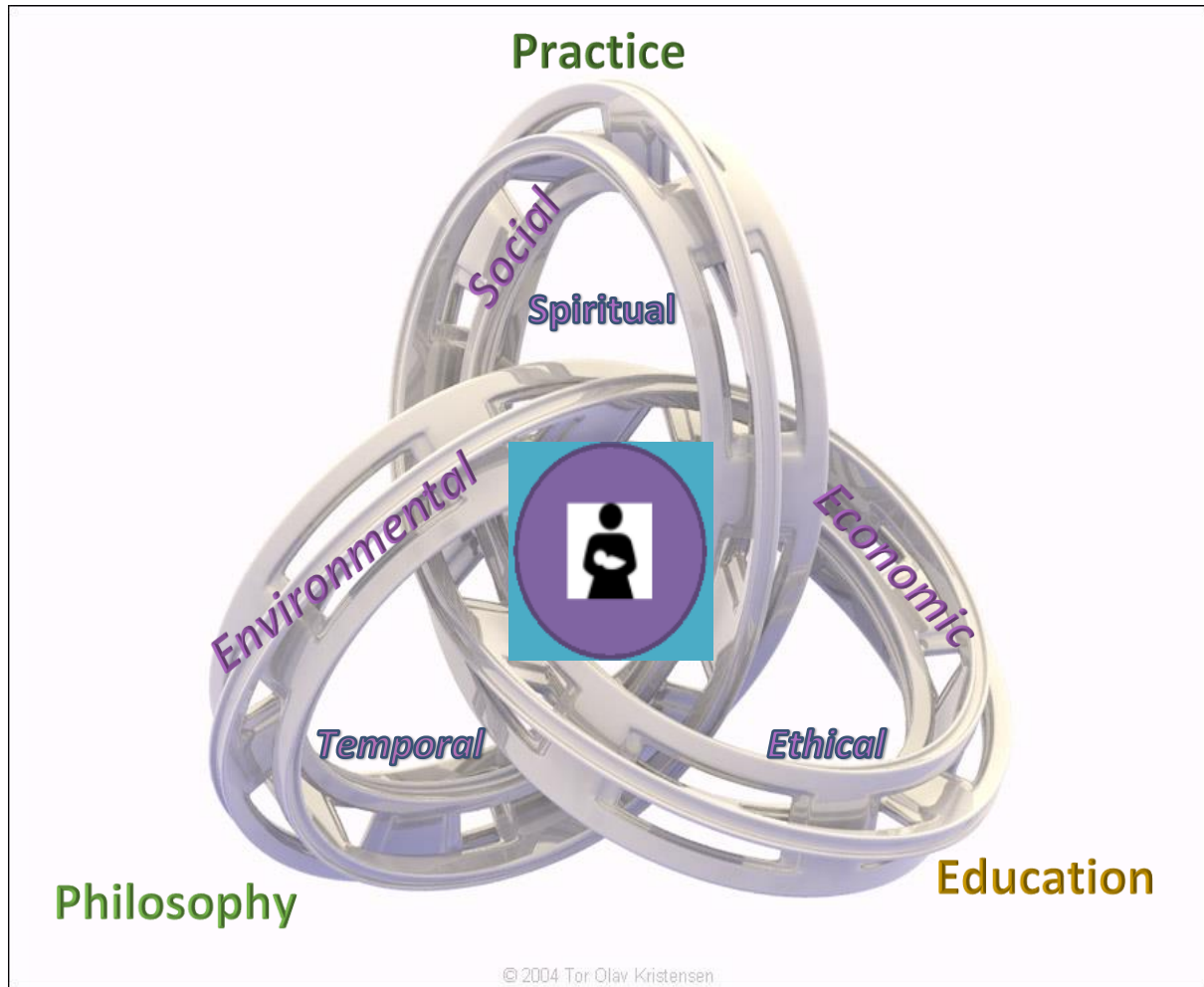
Figure 13. A Möbius Model for Sustainable Midwifery (Kristensen 2004)

White (2016) describes the Mobius Strip in a way that encompasses the relationship between sustainability and midwifery. It is expressed as being "a deeply symbolic representation of so many recurring ideas that I see in the mind and in nature – representative of constant change, both discrete and continuous and how both can reside together in one coherent whole reality..." (para. 10).

The tenets in the model

The triple bottom line tenets are represented in the model, but they sit alongside a number of other tenets including ethical, spiritual and temporal dimensions because these have a specific relevance in relation to the spheres of midwifery and childbirth. The tenet of spirituality evokes a sense of deep understanding that combines, inspiration, purpose and meaning. Crowther and Hall (2015) write that the importance of the spiritual dimension of childbirth is in danger of becoming lost "in the policy rhetoric" of contemporary midwifery practice and "may be at odds in contemporary standardised technocratic approaches to childbirth" (p. 176). The inclusion of spirituality therefore is an essential consideration for any model of sustainability and midwifery in order to ensure this important perspective is not lost.

The consideration of an ethical tenet that affiliates philosophically with the model, leads once again to indigenous world views such as the fundamental Māori notions of whakapapa (interconnection) and mauri (life supporting capacity) (Morgan, 2004). Or of Ubunto, an African philosophical view of becoming human that incorporates a holistic and inclusive view of humanity as sharing spaces and resources (Shumba, 2011). These alternative world views stand in contrast to many of the Western ethical frameworks that place emphasis on individualism, although the work of Bioethicist James Dwyer (Dwyer, 2008) has some useful application in a broader social context.

> [We] need to develop norms and institutions that will help us to share fairly the biosphere's capacity to….The virtues that we need are social justice, international justice, a concern for the most vulnerable, modesty of demands, and the creativity to fashion healthy and good lives with limited natural resources. The vices that we need to avoid are ignorance of our situation, the corruption of vested interests, the injustice of taking more than our share, and indifference to the plight of others. (p. 285)

Finally, a temporal dimension, which considers the intergenerational interconnectedness across time and space is included. This is an important consideration during this time in the

life of a woman, her partner and her family. It provides links to both the past and the future engendering "rootedness, connection and remembering" (Murphy-Lawless, 2006, p. 439). The model notionally provides a haven in which to safeguard the core philosophical values of midwifery. It represents a move away from consumerist values and individualism that have "created disengagement, disconnection, forgetting & discarding" (p. 439).

The transcendent form and fluidity of the Möbius Strip means that the tenets can be positioned anywhere on the model. Sometimes they will be clearly visible and at other times undetectable. However, the non-orientable quality of the single, yet multiple faceted, shape means that the individual tenets are always present and may be brought to greater prominence at any time by either midwife or mother. This is a dynamic model that can accommodate any number of tenets and so this is far from being a definitive item. In keeping with this, the supporting midwifery structures are not fixed either and can be placed anywhere around the model to frame it. The only constant in the model is the mother/baby dyad who maintain a central position.

Final Thoughts

The concept of 'network' means ever changing configurations that relocate and reshape according to whose connections are significant within it. It is the connection and entanglement of elements that create meaning, not the individual elements. This involves an awareness of movement and connection within the network, within the phenomenon itself, and in the relationship of the researcher to this movement. As a reflexive researcher, my aim was to capture the perception of moving in, with and through the data, rather than taking an external perspective. As result of this 'embodiment' I feel that I was able to move through more freely through the network enabling me to analyse elements that generated a greater sense of direction, extra layers of meaning, and more data. It also enabled me to witness some unexpected and exciting phenomena unfold.

My analysis using ANT suggests that neoliberalism and its component actants of capitalism, consumerism and individualism have had a significant impact on midwifery practice in the context of New Zealand/ Aotearoa. However, I am aware that ANT is not without its limitations. I have already addressed the rejection of the grand narrative on the part of Latour (1999), which renders it difficult to address meta-concepts such as governmentality without breaking the macro into the micro in order to acknowledge the full extent of the actants involved in any given network or series of networks.

ANT has been described as 'the narrative of organization', and it has been stated that the story of the 'actors' emerging from the narrative is more important than that of the analyst. In light of the reticence of the midwives to participate in the analysis, it was therefore important that I was able to present their stories in a way that honoured their lived experience as the theory was woven into the practice and the practice was woven into the theory.

The analysis of the data using ANT has revealed that neoliberalism and its component actants of capitalism, consumerism and individualism have had a significant impact on both the structuring of maternity services and midwifery practice in the context of New Zealand/ Aotearoa in the last few decades. The use of ANT reveals that although the starting point of the thesis was generated by the macro-social, it focussed on the micro-social interactions of the midwives and other actants within the network (Law 2002 p.2) in the assemblages that have shaped maternity care across spatial and temporal planes. By using ANT I was able to observe how the interactions in the settings had been used to overcome resistance and generate power or conversely to lead to loss of power and even obliteration at times of various actants. This micro context approach enabled me to draw conclusions about the macro context, in this case the political environment where the practices were situated

Recommendations for Research

This study has revealed that there is a dearth of research relating to sustainability within the context of midwifery practice. This is particularly so in relation to the area of education where it would be valuable :

- to gain insight into what would be the most effective way to include sustainability within both undergraduate and postgraduate midwifery programmes.
- to elicit the views of students and graduate midwives about the benefits, if any, of the inclusion of sustainability within midwifery programmes.
- to explore what preparation midwifery lecturers feel that they need in order to be equipped to teach sustainability.
- to determine the value in a multi-disciplinary approach to sustainability in healthcare at post-graduate level.

Limitations of the Study

There are some limitations in any form of research that are inherent to that method. The specific issues relating to both PAR and ANT have been addressed at length in the critical reflection of the methodologies throughout the thesis, but specifically in Chapters 4 & 5.

Qualitative studies cannot be judged by quantitative criteria, but by criteria that is developed for the qualitative paradigm, (Northcote, 2012). Although qualitative research is valued for its own unique features some researchers continue to raise epistemological issues about the validity of qualitative research suggesting that it does meet the required standards for validity. For example, the findings of this study cannot be generalised and are not replicable. However the transferability which is used to consider the extent to which the findings could be applied to other contexts is valid.

Furthermore, although the findings cannot be generalised, they are able to offer a good degree of insight and explication that provides midwifery, and perhaps other health

professions, a platform from which to observe the concept of sustainability and its application to those professions.

The other limitations are related to the scope of the study. The midwives who participated were from a geographical area in the South Island of New Zealand/Aotearoa and were purposefully selected; this could potentially have created bias. In fairness, the original plan was to use the database of the local branch of the New Zealand College of Midwives to recruit practices. However, the February 22nd 2011 earthquake in Christchurch changed the landscape both literally and metaphorically. Many of the Christchurch midwives were profoundly affected by the effects of the earthquake, losing homes and clients and it seemed inappropriate to recruit in the way that was originally planned. At that time I made a decision to approach midwifery group practices personally and invited them to participate.

With hindsight I realise that at least some who were participants in the project were in survival mode in the early days of the project. It could therefore be argued that this was not the best of times to expose people to what may have been new ideas and concepts. However, full ethics approval was granted from two research ethics committees at the time. Additionally, a post natural disaster setting may have been an appropriate time because of the recognition in our world that nothing stays the same and that many of the things that seem important in our lives take on different meanings in emergency situations.

In Conclusion

Midwifery in New Zealand/Aotearoa is currently standing on the threshold of change at a time when events could precipitate a paradigm shift within maternity services.   This is a time of opportunity and a time for midwifery to take a radical stance in order to locate the profession within a social and ecological context that could provide a strong sense of professional identity for midwives and a leadership role in the development of a sustainable healthcare system.

Capra (1986) describes paradigms as "A constellation of concepts, values, perceptions and practices shared by a community, which forms a particular vision of reality and a collective mood that is the basis of the way the community organises itself"(p. 14). Dominant social paradigms, as reinforced by Actor Network Theory, are only ever contingent. As a result, from time to time, because of circumstances within a network, they can give way to new paradigms and a paradigm shift is enacted.

However, for many reasons, pragmatic as well as practical, the emergent design of the new funding model is unlikely to make any allusion to sustainability in a broad environmental or societal sense. Although there has been discussion of a sustainable professional model in the discussions to date, this focus has been exclusively on how to sustain midwifery practice rather than sustainable ways of being and doing in a broader sense within midwifery practice. This may mean that an opportunity to create a workforce committed to facing the inevitable environmental, economic, social, and political challenges that the future will bring is likely to be lost on this occasion. Additionally, the task of attempting to persuade people to engage or identify with alternatives to neoliberalism is a sizeable undertaking. As Byrne et al. (1998) observe:

> To re-read a landscape we have always read as capitalist, to read it as a landscape of difference, populated by various capitalist and non-capitalist economic practices and institutions—that is a difficult task. It requires us to contend not only with our colonized imaginations, but with our beliefs about politics, understandings of power, conceptions of economy, and structures of desire. (p. 103)

Notwithstanding, I am optimistic that a new funding model will generate a level of remuneration for the important work that community based midwives do that is fair and just. As a result of a successful negotiation process, LMC midwives will hopefully feel that their voices have been heard and that they have been listened to. Such an outcome should provide the profession with time and space to metaphorically look over the parapet and observe the factors in the broader landscape that impact on their practice. A rejuvenated community midwifery service with a stronger sense of professional identity, enhanced autonomy and new alliances within the network will be much better placed to offer another

314

'window of opportunity' to advance the agenda of sustainability by more fully recognizing what it can offer midwives. As Derrick Jensen rightly states:

We cannot hope to create a sustainable culture with any but sustainable souls.

(Jensen, 2006, p. 190)

References

Abbott, Andrew. 1988. *The System of Professions*. Chicago: University of Chicago Press.
http://www.press.uchicago.edu/ucp/books/book/chicago/S/bo5965590.html.

Abel, Sally. 1997. "Midwifery and Maternity Services in Transition: An Examination of Change Following The Nurses Amendment Act 1990." Thesis, ResearchSpace@Auckland.
https://researchspace.auckland.ac.nz/handle/2292/1968.

Abel-Smith, Brian. 1960. *A History of the Nursing Profession*. Portsmouth: Heinemann.

ACNM, MANA & NACPM. 2012. "Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by the American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives." *Journal of Midwifery & Women's Health* 57 (5): 529–32. doi:10.1111/j.1542-2011.2012.00218.x.

Adams, Tracey L., and Ivy Bourgeault. 2004. "Feminism and Women's Health Professions in Ontario." *Women & Health* 38 (4): 73–90. doi:10.1300/J013v38n04_05.

Aden, Roger C. 1995. "Nostalgic Communication as Temporal Escape: When It Was a Game's Re-construction of a Baseball/Work Community." *Western Journal of Communication* 59 (1): 20–38. doi:10.1080/10570319509374505.

Agledahl, Kari Milch, Reidun Førde, and Åge Wifstad. 2011. "Choice Is Not the Issue. The Misrepresentation of Healthcare in Bioethical Discourse." *Journal of Medical Ethics* 37 (4): 212–15. doi:10.1136/jme.2010.039172.

Aldridge, Meryl, and Julia Evetts. 2003. "Rethinking the Concept of Professionalism: The Case of Journalism." *The British Journal of Sociology* 54 (4): 547–64. doi:10.1111/j.1468-4446.2003.00547.x.

Alexander, Christopher S., and James M. Sysko. 2012. "A Study of the Cognitive Determinants of Generation Y's Entitlement Mentality." *Academy of Educational Leadership Journal* 16 (2): 63–68.

Alexander, Clarence, Nora Bynum, Elizabeth Johnson, Ursula King, Tero Mustonen, Peter Neofotis, Noel Oettlé, et al. 2011. "Linking Indigenous and Scientific Knowledge of Climate Change." *BioScience* 61 (June): 477–84. doi:10.1525/bio.2011.61.6.10.

Allen, Isobel, Shirley Bourke Dowling, Sandra Williams, and Policy Studies Institute. 1996. *A Leading Role for Midwives?: Evaluation of Midwifery Group Practice Development Projects*. Policy Studies Institute.

Allotey, Janette C. 2011. "Writing Midwives' History: Problems and Pitfalls." *Midwifery* 27 (2): 131–37. doi:10.1016/j.midw.2009.03.003.

Amalberti, René, Yves Auroy, Don Berwick, and Paul Barach. 2005. "Five System Barriers to Achieving
   Ultrasafe Health Care." *Annals of Internal Medicine* 142 (9): 756. doi:10.7326/0003-4819-142-9-
   200505030-00012.

Amey, Julian. 2014. "Ensuring Best Practice and High Standards Are Maintained in Healthcare." *British
   Journal of Healthcare Management* 20 (11): 512–512.

Andersen, Lars Bo, Peter Danholt, Kim Halskov, Nicolai Brodersen Hansen, and Peter Lauritsen. 2015.
   "Participation as a Matter of Concern in Participatory Design." *CoDesign* 11 (3–4): 250–61.
   doi:10.1080/15710882.2015.1081246.

Anderson, Ben, and Colin McFarlane. 2011. "Assemblage and Geography." *Area* 43 (2): 124–27.
   doi:10.1111/j.1475-4762.2011.01004.x.

Anderson, Claire. 2010. "Presenting and Evaluating Qualitative Research." *American Journal of
   Pharmaceutical Education* 74 (8). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2987281/.

Anderson, G. 2003. "A Concept Analysis of 'Normal Birth.'" Evidence Based Midwifery. London: RCM.
   https://www.rcm.org.uk/learning-and-career/learning-and-research/ebm-articles/a-concept-
   analysis-of-%E2%80%98normal-birth%E2%80%99.

Ang, Frederic, and Steven Van Passel. 2012. "Beyond the Environmentalist's Paradox and the Debate on
   Weak versus Strong Sustainability." *BioScience* 62 (3): 251. doi:10.1525/bio.2012.62.3.6.

Argaw, Daniel, Mesganaw Fanthahun, and Yemane Berhane. 2007. "Sustainability and Factors Affecting
   the Success of Community-Based Reproductive Health Programs in Rural Northwest Ethiopia."
   African Journal of Reproductive Health; Benin City 11 (2): 70–88.

Association of Teachers and Lecturers. 2009. "Sustainable Education:Review, Rethink and Reform."
   London: Association of Teachers and Lecturers.
   https://www.atl.org.uk/Images/ATL%20sustainable%20education%20position%20statement.pdf.

Avison, David, Richard Baskerville, and Michael Myers. 2001. "Controlling Action Research Projects."
   Information Technology & People 14 (1): 28–45. doi:10.1108/09593840110384762.

Baer, Hans A., and Merrill Singer. 2009. *Global Warming and the Political Ecology of Health: Emerging
   Crises and Systemic Solutions*. Vol. 1. Advances in Critical Medical Anthropology. Walnut Creek,
   CA: Left Coast Press.

Baldwin, Matthew. 2011. "Who I Am Is Who I Was: Exploring the Identity - Maintenance Function of
   Nostalgia." MA, Kansas: University of Kansas.
   https://kuscholarworks.ku.edu/bitstream/handle/1808/8048/Baldwin_ku_0099M_11573_DATA
   _1.pdf;sequence=1.

Ballantyne, Tony, and Brian Moloughney. 2006. *Disputed Histories: Imagining New Zealand's Pasts*.
   Dunedin: Otago University Press.

317

Banerjee, Subhabrata Bobby. 2003. "Who Sustains Whose Development? Sustainable Development and the Reinvention of Nature." *Organization Studies* 24 (1): 143–80. doi:10.1177/0170840603024001341.

Banks, Amanda Carson. 1999. *Birth Chairs, Midwives, and Medicine*. Jackson: Univ. Press of Mississippi.

Banks, David. 2016. "#Review Actor-Network Theory's Approach to Agency - Cyborgology." Accessed January 25. http://thesocietypages.org/cyborgology/2014/01/31/review-actor-network-theorys-approach-to-agency/.

Banks, Maggie. 2004. "Hey Mind You Language." *NZCOM Journal* 31: 6.

———. 2007. "Out on a Limb: The Personal Mandate to Practise Midwifery by Midwives of the Domicillary Midwives Society of New Zealand Incorporated. 1974-1986." Wellington, NZ: Victoria University of Wellington. http://birthspirit.co.nz/wp-content/uploads/OutOnALimb-MaggieBanks-PhDThesis2007.pdf.

Barbera, Rosemary A. 2008. "Relationships and the Research Process: Participatory Action Research and Social Work." *Journal of Progressive Human Services* 19 (2): 140–59. doi:10.1080/10428230802475448.

Barbour, Rosaline. 2008. *Doing Focus Groups*. London: Sage.

Barclay, Lesley. 2008. "A Feminist History of Australian Midwifery from Colonisation until the 1980s." *Women and Birth* 21 (1): 3–8. doi:10.1016/j.wombi.2007.12.001.

Barker, Sue. 2011. *Midwives' Emotional Care of Women Becoming Mothers*. Newcastle-on-Tyne: Cambridge Scholars Publishing.

Barnett, J R, and R A Kearns. 1996. "Shopping around? Consumerism and the Use of Private Accident and Medical Clinics in Auckland, New Zealand." *Environment and Planning A* 28 (6): 1053–75. doi:10.1068/a281053.

Barnett, Pauline, Tim Tenbensel, Jacqueline Cumming, Clare Clayden, Toni Ashton, Megan Pledger, and Mili Burnette. 2009. "Implementing New Modes of Governance in the New Zealand Health System: An Empirical Study." *Health Policy* 93 (2–3): 118–27. doi:10.1016/j.healthpol.2009.06.004.

Barron, Leanne, and Eric Gauntlett. 2002. "'Housing and Sustainable Communities Indicators Project',." In , 4. Adelaide. http://www.adelaide.sa.gov.au/soc/pdf/barron_gauntlett.pdf.

Barry, Andrew. 2013. "The Translation Zone: Between Actor-Network Theory and International Relations." *Millennium: Journal of International Studies* 41 (3): 413–29. doi:10.1177/0305829813481007.

Bartlett, Linda, Eva Weissman, Rehana Gubin, Rachel Patton-Molitors, and Ingrid K. Friberg. 2014. "The Impact and Cost of Scaling up Midwifery and Obstetrics in 58 Low- and Middle-Income Countries." Edited by Ajay Mahal. *PLoS ONE* 9 (6): e98550. doi:10.1371/journal.pone.0098550.

318

Barzun, J. 1979. "The Professions under Siege: Private Practice versus Public Need." *Journal of the American Dental Association (1939)* 98 (4): 672.

Bashford, Alison, and Philippa Levine, eds. 2010. *The Oxford Handbook of the History of Eugenics*. 1st ed. Oxford: Oxford University Press. http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780195373141.001.0001/oxfordhb -9780195373141.

Bassett, Michael. 1998. *The State in New Zealand, 1840-1984 : Socialism without Doctrines?* Auckland: Auckland University Press.

Batcho, Krystine Irene. 1995. "Nostalgia: A Psychological Perspective." *Perceptual and Motor Skills* 80: 131–43.

———. 2007. "Nostalgia and the Emotional Tone and Content of Song Lyrics." *American Journal of Psychology* 120: 361–81.

Battilana, Julie, and Tiziana Casciaro. 2013. "The Network Secrets of Great Change Agents." *Harvard Business Review* 91 (7–8): 62–68, 132.

Baum, Fran, Colin MacDougall, and Danielle Smith. 2006. "Participatory Action Research." *Journal of Epidemiology and Community Health* 60 (10): 854–57. doi:10.1136/jech.2004.028662.

Bauman, Zygmunt. 1990. "Modernity and Ambivalence." *Theory, Culture and Society* 7: 143–69.

———. 2013. *Liquid Modernity*. Chichester: John Wiley & Sons.

Bayer, Kurt. 2015. "Midwives File Fair-Pay Claim." *New Zealand Herald*, September 1, sec. National. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11505891.

Beatrice, C. 1998. "Is Midwifery a Branch of Nursing?" *Midwifery Matters*, no. 76 (March): 5–8.

Beauchamp, Tom L., and James F. Childress. 2013. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press.

Beausang, Elisabeth. 2000. "Childbirth in Prehistory: An Introduction." *European Journal of Archaeology* 3 (1): 69–87. doi:10.1179/eja.2000.3.1.69.

Beck, Ulrich. 1992. *Risk Society: Towards a New Modernity*. Thousand Oaks CA: SAGE Publications.

Beck, Ulrich, and Elisabeth Beck-Gernsheim. 2002. *Individualization: Institutionalized Individualism and Its Social and Political Consequences*. Theory, Culture & Society. London ; Thousand Oaks, Calif: SAGE.

Beckerman, Wilfred. 1992. "Economic Growth and the Environment: Whose Growth? Whose Environment?" *World Development* 20 (4): 481–96. doi:10.1016/0305-750X(92)90038-W.

Beck-Gernsheim, Elisabeth. 1996. "Life as a Planning Project." In *Risk, Environment and Modernity; Towards a New Modernity.* London: SAGE Publications.

Behnke, Marylou, Vincent C. Smith, Committee on Substance Abuse, and Committee on Fetus And Newborn. 2013. "Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus." *Pediatrics* 131 (3): e1009–24. doi:10.1542/peds.2012-3931.

Behruzi, Roxana, Stephanie Klam, Marleen Dehertog, Vania Jimenez, and Marie Hatem. 2017. "Understanding Factors Affecting Collaboration between Midwives and Other Health Care Professionals in a Birth Center and Its Affiliated Quebec Hospital: A Case Study." *BMC Pregnancy and Childbirth* 17 (June): 200. doi:10.1186/s12884-017-1381-x.

Belar, Cynthia. 2013. "A New Professionalism." *Http://Www.Apa.Org*. http://www.apa.org/monitor/2013/07-08/soe.aspx.

Bell, J. D., and M. T. Fay. 1991. "The Medical Profession and Changing Attitudes towards Advertising and Competition." *The New Zealand Medical Journal* 104 (906): 69.

Bell, and Stephen Morse. 2008. *Sustainability Indicators: Measuring the Immeasurable?* London: Earthscan.

Bellah, Robert N. 1997. "Professions under Siege: Can Ethical Autonomy Survive?" *Logos: A Journal of Catholic Thought and Culture* 1 (3): 31–50. doi:10.1353/log.1997.0007.

Benckendorff, Pierre, Gianna Moscardo, and Donna Pendergast. 2010. *Tourism and Generation Y*. Wallingford: CABI.

Benn, Cheryl. 1999. "Midwifery Partnership; Individualism, Contractualism or Feminist Praxis." *NZCOM Journal* 21: 18–20.

Bennett, Jane. 2009. *Vibrant Matter: A Political Ecology of Things*. Durham NC: Duke University Press.

Bennett, Julia. 2015. "Narrating Family Histories: Negotiating Identity and Belonging through Tropes of Nostalgia and Authenticity." *Current Sociology*, April, 0011392115578984. doi:10.1177/0011392115578984.

Benoit, Cecilia, Sirpa Wrede, Ivy Bourgeault, Jane Sandall, Raymond De Vries, and Edwin R. van Teijlingen. 2005. "Understanding the Social Organisation of Maternity Care Systems: Midwifery as a Touchstone." *Sociology of Health & Illness* 27 (6): 722–37. doi:10.1111/j.1467-9566.2005.00471.x.

Berg, Karijn van den. 2016. "Neoliberal Sustainability? The Biopolitical Dynamics of 'Green' Capitalism." In , 15. The Hague. https://www.tni.org/files/publication-downloads/31-icas_cp_van_der_berg.pdf.

Berger, R. 2015. "Now I See It, Now I Don't: Researcher's Position and Reflexivity in Qualitative Research." *Qualitative Research* 15 (2): 219–34. doi:10.1177/1468794112468475.

Berghs, M. 2006. "Nursing, Obedience, and Complicity with Eugenics: A Contextual Interpretation of Nursing Morality at the Turn of the Twentieth Century." *Journal of Medical Ethics* 32 (2): 117–22. doi:10.1136/jme.2004.011171.

Bergman, Nils J. 2014. "The Neuroscience of Birth – and the Case for Zero Separation." *Curationis* 37 (2): 4 pages. doi:10.4102/curationis.v37i2.1440.

Bergold, Jarg, and Stefan Thomas. 2012. "Participatory Research Methods: A Methodological Approach in Motion." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 13 (1). http://www.qualitative-research.net/index.php/fqs/article/view/1801.

Berkes, Fikret. 2009. "Indigenous Ways of Knowing and the Study of Environmental Change." *Journal of the Royal Society of New Zealand* 39 (4): 151–56. doi:10.1080/03014220909510568.

Best. 1906. "The Lore of the Whare-Kohanga." *The Journal of the Polynesian Society* 15 (1 (57)): 1–26.

Bietti, Lucas M. 2014. *Discursive Remembering: Individual and Collective Remembering as a Discursive, Cognitive and Historical Process*. Berlin: Walter de Gruyter GmbH & Co KG.

Biggs, Cecilia. 2004. "Rethinking the History of Midwifery in Canada." In *Reconceiving Midwifery*. Montreal and Kingston: McGill-Queen's Press - MQUP.

Birch, Kean, and Vlad Mykhnenko. 2010. *Rise and Fall of Neoliberalism : The Collapse of an Economic Order?* 1st ed. London: Zed Books.

Birch, Tony. 2016. "Climate Change, Mining and Traditional Indigenous Knowledge in Australia." *Social Inclusion* 4 (1): 92. doi:10.17645/si.v4i1.442.

Blaser, Mario, Harvey A. Feit, and Glenn McRae. 2004. *In the Way of Development: Indigenous Peoples, Life Projects and Globalization*. Ottawa: IDRC.

Blaxter, Mildred. 2010. *Health*. Cambridge: Polity.

Blewitt, John. 2014. *Understanding Sustainable Development*. 2nd ed. Milton Park, Didcot: Taylor and Francis.

Bloor, David. 1983. *Wittgenstein: A Social Theory of Knowledge*. Basingstoke: Macmillan.

Boas, Taylor C., and Jordan Gans-Morse. 2009. "Neoliberalism: From New Liberal Philosophy to Anti-Liberal Slogan." *Studies in Comparative International Development* 44 (2): 137–61. doi:10.1007/s12116-009-9040-5.

Bobel, Chris. 2010. *Paradox Of Natural Mothering*. Philadelphia: Temple University Press.

Bockman, Johanna. 2013a. "Neoliberalism." *Contexts* 12 (3): 14–15. doi:10.1177/1536504213499873.

———. 2013b. "Neoliberalism." *Contexts* 12 (3): 14–15. doi:10.1177/1536504213499873.

Bøgh Andersen, Lotte, and Lene Holm Pedersen. 2012. "Public Service Motivation and Professionalism." *International Journal of Public Administration* 35 (1): 46–57. doi:10.1080/01900692.2011.635278.

Bohren, Meghan A., Joshua P. Vogel, Erin C. Hunter, Olha Lutsiv, Suprita K. Makh, João Paulo Souza, Carolina Aguiar, et al. 2015. "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review." *PLoS Medicine* 12 (6). doi:10.1371/journal.pmed.1001847.

Boillat, Sébastien, and Fikret Berkes. 2013. "Perception and Interpretation of Climate Change among Quechua Farmers of Bolivia: Indigenous Knowledge as a Resource for Adaptive Capacity." *Ecology and Society* 18 (4). doi:10.5751/ES-05894-180421.

Bollier, David, and Silke Helfrich. 2014. *The Wealth of the Commons: A World Beyond Market and State*. Amherst, MA: Levellers Press.

Bolten, Margarete I., Harald Wurmser, Angelika Buske-Kirschbaum, Mechthild Papoušek, Karl-Martin Pirke, and Dirk Hellhammer. 2011. "Cortisol Levels in Pregnancy as a Psychobiological Predictor for Birth Weight." *Archives of Women's Mental Health* 14 (1): 33–41. doi:10.1007/s00737-010-0183-1.

Bonner, Bill, Mike Chiasson, and Abhijit Gopal. 2009. "Restoring Balance: How History Tilts the Scales against Privacy. An Actor-Network Theory Investigation." *Information and Organization* 19 (2): 84–102. doi:10.1016/j.infoandorg.2008.12.001.

Bookchin, Murray. 1987. "Social Ecology versus Deep Ecology: A Challenge for the Ecology Movement." *Green Perspectives: Newsletter of the Green Program Project.* Sumer (4–5). http://environment-ecology.com/deep-ecology/64-social-ecology-versus-deep-ecology.html.

Bordo, Susan. 1986. "The Cartesian Masculinization of Thought." *Signs* 11 (3): 439–56.

Boren, Zachary. 2016. "The Nature of Nostalgia." *Contemporary Psychology*. http://www.contemporarypsychotherapy.org/volume-5-no-1-spring-2013/the-nature-of-nostalgia/.

Borg, Marit, Bengt Karlsson, Susie Kim Hesook, and McCormack. 2012. "Opening up for Many Voices in Knowledge Construction." *Forum: Qualitative Social Research* 13 (1): 17.

Borsay, Anne, and Billie Hunter. 2012. *Nursing and Midwifery in Britain Since 1700*. Basingstoke: Palgrave Macmillan.

Bos, Abraham P. 2002. "'Aristotelian' and 'Platonic' Dualism in Hellenistic and Early Christian Philosophy and in Gnosticism." *Vigiliae Christianae* 56 (3): 273–91.

Boyatzis, Richard E. 1998. *Transforming Qualitative Information: Thematic Analysis and Code Development*. SAGE.

Branelly, Tula, Lizzie Ward, and Nicki Ward. 2015. *Caring for Ourselves? Self-Care and Neoliberalism - Policy Press Scholarship*. Bristol: Policy Press Scholarship. http://policypress.universitypressscholarship.com/view/10.1332/policypress/9781447316510.001.0001/upso-9781447316510-chapter-004.

Brannick, Teresa, and David Coghlan. 2007. "In Defense of Being 'Native': The Case for Insider Academic Research." *Organizational Research Methods* 10 (1): 59–74. doi:10.1177/1094428106289253.

Braun, Virginia, and Victoria Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3 (2): 77–101. doi:10.1191/1478088706qp063oa.

———. 2014. "What Can Thematic Analysis Offer Health and Wellbeing Researchers?" *International Journal of Qualitative Studies on Health and Well-Being* 9. http://eprints.uwe.ac.uk/26537.

Brechin, Steven R., Crystal L. Fortwangler, Peter R. Wilshusen, and Patrick C. West. 2003. *Contested Nature: Promoting International Biodiversity with Social Justice in the Twenty-First Century*. SUNY Press.

Briggs, Robin. 1998. *Witches & Neighbors: The Social and Cultural Context of European Witchcraft*. London: Penguin Books.

Brodie, Pat. 2002. "Addressing the Barriers to Midwifery." *Journal of the Australian College of Midwives* 15 (3): 5–14.

Broedel, Hans Peter. 2003. *The Malleus Maleficarum and the Construction of Witchcraft*. Manchester: Manchester University Press.

Bromley, Daniel W. 1998. "Searching for Sustainability: The Poverty of Spontaneous Order1." *Ecological Economics* 24 (2–3): 231–40. doi:10.1016/S0921-8009(97)00145-6.

Brown, A. D., and M. Humphreys. 2002. "Nostalgia and the Narrativization of Identity: A Turkish Case Study." *British Journal of Management* 13 (2): 141.

Brown, Anna. 2002. "Foucauldian Perspectives on Midwifery Practices and Education." *The Internet Journal of Advanced Nursing Practice* 6 (1): 1–9.

Bryce, Trevor. 2002. *Life and Society in the Hittite World*. Oxford: Oxford University Press.

Bryder, Linda. 2013. *A History of the "Unfortunate Experiment" at National Women's Hospital*. Auckland University Press.

———. 2014. *The Rise and Fall of National Women's Hospital: A History*. Auckland: Auckland University Press.

Bryson, Valerie, and Ruth Deery. 2010. "Public Policy, 'Men's Time' and Power: The Work of Community Midwives in the British National Health Service." *Women's Studies International Forum* 33 (2): 91–98. doi:10.1016/j.wsif.2009.11.004.

Buckingham, Susan. 2010. "Call in the Women." *Nature; London* 468 (7323): 502.

Buckley, Sarah. 2013. *Gentle Birth, Gentle Mothering: A Doctor's Guide to Natural Childbirth and Gentle Early Parenting Choices*. Tokyo: Potter/TenSpeed/Harmony.

———. 2015. "Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care." Washington D.C.: NChildbirth Connection Programs: National Partnership for Women and families. http://childbirthconnection.org/pdfs/CC.NPWF.HPoC.Report.2015.pdf.

Buckley, Thomas, and Alma Gottlieb, eds. 1988. *Blood Magic: The Anthropology of Menstruation*. Berkeley: University of California Press.

Burgess, Judy. 2006. "Participatory Action Research First-Person Perspectives of a Graduate Student." *Action Research* 4 (4): 419–37. doi:10.1177/1476750306070104.

Burke, Peter J., and Donald C. Reitzes. 1981. "The Link Between Identity and Role Performance." *Social Psychology Quarterly* 44 (2): 83. doi:10.2307/3033704.

Burke, T. 2012. "Climate Change: What Needs to Be Done." *BMJ* 344 (mar19 1): e1358–e1358. doi:10.1136/bmj.e1358.

Burrows, Pamela. 2004. "Midwifery:Profession with a Future." In *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, edited by Edwin van Teijlingen, George W. Lowis, Peter McCaffery, and Maureen Porter, 373–74. New York: Nova Science Publishers.

Butler, and Thomas Hinch. 2007. *Tourism and Indigenous Peoples: Issues and Implications*. London: Routledge.

Butler, Michelle M., Diane M. Fraser, and Roger J.L. Murphy. 2008. "What Are the Essential Competencies Required of a Midwife at the Point of Registration?" *Midwifery* 24 (3): 260–69. doi:10.1016/j.midw.2006.10.010.

Byrne. 1998. *Complexity Theory and the Social Sciences: An Introduction*. London: Routledge.

Byrne, K, JK Gibson-Graham, R Forest, S Healy, and Horvath G. 1998. "Imagining and Enacting Non-Capitalist Futures, Rethinking." *Socialist Review*, No. 1, 28 (3 & 4): 93–135.

Cabeza Gutés, Maite. 1996. "The Concept of Weak Sustainability." *Ecological Economics* 17 (3): 147–56. doi:10.1016/S0921-8009(96)80003-6.

Callon, Michel. 1986a. "Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St Brieuc Bay." *The Sociological Revew* 36: 169–208.

———. 1986b. "The Sociology of an Actor-Network." In *Mapping the Dynamics of Science and Technology*. London: McMillan.

———. 1987. "Society in the Making: The Study OfTechnology as a Tool for SociologicalAnalysis." In *The SocialConstruction of Technological Systems*. Cambridge, Mass: MIT Press.

———. 1999. "Actor - Network Theory: The Market Te St." In *Actor Network and After*, 181–95. Oxford: Oxford and Keele.

Callon, Michel, Arie Rip, and John Law. 1986. *Mapping the Dynamics of Science and Technology: Sociology of Science in the Real World*. New York: Springer.

Calvert, Susan. 2015. "Working towards Being Ready A Theory of How Practising Midwives Maintain Their Ongoing Competence to Practise Their Profession." DHSc, Auckland: AUT. https://aut.researchgateway.ac.nz/bitstream/handle/10292/9639/CalvertS.pdf?sequence=3&isAllowed=y.

Capra, Fritjof. 1986. "The Concept of Paradigm and Paradigm Shift." *ReVision* 9 (1): 14.

Caradonna, Jeremy L. 2014. *Sustainability : A History*. Oxford: Oxford University Press.

Cargo, Margaret, and Shawna L. Mercer. 2008. "The Value and Challenges of Participatory Research: Strengthening Its Practice * ‡." *Annual Review of Public Health* 29 (1): 325–50. doi:10.1146/annurev.publhealth.29.091307.083824.

Carolina. 2017. "There Are No Wrong Choices, Just Different Paths." *Yogaleena Yoga Studio*. April 3. http://yogaleenastudio.com/2017/04/03/no-wrong-choices-just-different-paths/.

Carse, James. 2011. *Finite and Infinite Games*. New York: Simon and Schuster.

Carson, Rachel. 1962. *Silent Spring*. First. Boston: Houghton Mifflin. https://archive.org/details/fp_Silent_Spring-Rachel_Carson-1962.

Cassidy, Jude, and Phillip R. Shaver. 2008. *Handbook of Attachment, Second Edition: Theory, Research, and Clinical Applications*. London: Guilford Press.

Caza, Brianna, and Stephanie J Creary. 2016. "The Construction of Professional Identity." In *Perspectives on Contemporary Professional Work: Challenges and Experiences*, 259–85. Cheltenham: Edward Edgar Publishing. http://scholarship.sha.cornell.edu/articles/878.

Celine Capel. 2014. "Mindfulness, Indigenous Knowledge, Indigenous Innovations and Entrepreneurship." *Journal of Research in Marketing and Entrepreneurship* 16 (1): 63–83. doi:10.1108/JRME-10-2013-0031.

Cervantes, Juan. 2013. "Ideology, Neoliberalism and Sustainable Development." *Journal of Studies and Research in Human Geogra Phy* 7 (2): 25–34.

Chomsky, Noam. 1999. *Profit Over People*. New York: Seven Stories Press. https://books.google.co.nz/books/about/Profit_Over_People.html?id=NrLv4surz7UC.

Clark, Helen. 1990. "Opening Address; New Zealand College of Midwives." presented at the New Zealand College of Midwives Conference, Dunedin.

Clausen, Jette A. 2010. "'How Does Materiality Shape Childbirth? An Explorative Journey into Evidence, Childbirth Practices & Science and Technology Studies.'" PhD, Aarhus, Denmark: Aarhus University. http://pure.au.dk/portal/en/publications/how-does-materiality-shape-childbirth-an-explorative-journey-into-evidence-childbirth-practices--science-and-technology-studies(801a56c3-c062-4773-ae55-10ad994ba64b).html.

Coburn, David. 2006. "Medical Dominance Then and Now: Critical Reflections." *Health Sociology Review* 15 (5): 432–43. doi:10.5172/hesr.2006.15.5.432.

Cody, Lisa Forman. 1999. "The Politics of Reproduction: From Midwives' Alternative Public Sphere to the Public Spectacle of Man-Midwifery." *Eighteenth-Century Studies* 32 (4): 477–95. doi:10.1353/ecs.1999.0033.

Cohen, LeoNora M., Karen M. Higgins, and Don Ambrose. 2008. "Educators under Seige: The Killing of the Teaching Profession." *The Educational Forum*, January. doi:10.1080/00131729908984403.

Colantonio, Andrea. 2007. "Social Sustainability: An Exploratory Analysis of Its Definition, Assessment Methods Metrics and Tools." Monograph. July. http://www.brookes.ac.uk/schools/be/oisd/sustainable_communities/.

———. 2008. "Traditional and Emerging Prospects in Social Sustainability." 2008/02. EIBURS Working Paper Series. Oxford. http://eprints.lse.ac.uk/35909/.

Coleman. 2016. "New Zealand College of Midwives Conference, Auckland." In . Auckland. https://www.beehive.govt.nz/speech/new-zealand-college-midwives-conference-auckland.

Collins, Carmel T., Jennifer Fereday, Jan Pincombe, Candice Oster, and Deborah Turnbull. 2010. "An Evaluation of the Satisfaction of Midwives' Working in Midwifery Group Practice." *Midwifery* 26 (4): 435–41. doi:10.1016/j.midw.2008.09.004.

Conesa Ferrer, Ma Belén, Manuel Canteras Jordana, Carmen Ballesteros Meseguer, César Carrillo García, and M Emilia Martínez Roche. 2016. "Comparative Study Analysing Women's Childbirth Satisfaction and Obstetric Outcomes across Two Different Models of Maternity Care." *BMJ Open* 6 (8): e011362. doi:10.1136/bmjopen-2016-011362.

Coney, Sandra. 1988. *The Unfortunate Experiment*. Penguin Group New Zealand, Limited.

———. 2004. "Effective Consumer Voice and Participation for New Zealand." New Zealand Guidleines Group. https://www.health.govt.nz/system/files/documents/publications/050511_consumer_report.pdf.

Confino, Jo. 2012. "Moments of Revelation Trigger the Biggest Transformations." *The Guardian*, November 9, sec. Guardian Sustainable Business. http://www.theguardian.com/sustainable-business/epiphany-transform-corporate-sustainability.

Conroy, M. 2009. *An Ethical Approach to Leading Change: An Alternative and Sustainable Application*. New York: Springer.

Cook, Katie, and Colleen Loomis. 2012. "The Impact of Choice and Control on Women's Childbirth Experiences." *The Journal of Perinatal Education* 21 (3): 158–68. doi:10.1891/1058-1243.21.3.158.

Cook, Megan. 2012. "'Women's Health - Māori Women's Health, Pre-Colonial Times to 1940s',." *Te Ara - the Encyclopedia of New Zealand,*. http://www.TeAra.govt.nz/en/womens-health/page-2.

Copeland, Felicity, Hannah G. Dahlen, and Caroline S. E. Homer. 2014. "Conflicting Contexts: Midwives' Interpretation of Childbirth through Photo Elicitation." *Women and Birth* 27 (2): 126–31. doi:10.1016/j.wombi.2013.11.004.

Corbett, Andrea M, Karen Francis, and Ysanne Chapman. 2007. "Feminist-Informed Participatory Action Research: A Methodology of Choice for Examining Critical Nursing Issues." *International Journal of Nursing Practice* 13 (2): 81–88. doi:10.1111/j.1440-172X.2007.00612.x.

Corbin Dwyer, Sonya, and Jennifer L Buckle. 2009. "The Space Between: On Being an Insider-Outsid Er in Qualitative Research." *International Journal of Qualitative Methods* 8 (1): 54–63.

Corcoran, Peter Blaze, and Arjen E. J. Wals. 2007. *Higher Education and the Challenge of Sustainability: Problematics, Promise, and Practice*. Berlin: Springer Science & Business Media.

Cordella, Antonia, and Maha Shaikh. 2006. "" From Epistemology to Ontology: Challenging the Constructed 'Truth' of ANT "." 43. London: London School of Economics and Political Science. http://www.lse.ac.uk/management/documents/research/is-working-papers/ISIG-WP-143.PDF.

Coser, Lewis A., Otto N. Larsen, and American Sociological Association. 1976. *The Uses of Controversy in Sociology*. London: Free Press.

Costello, Anthony M. de L., and David Osrin. 2003. "Micronutrient Status during Pregnancy and Outcomes for Newborn Infants in Developing Countries." *The Journal of Nutrition* 133 (5): 1757S–1764S.

Cowen, Tyler. 2008. "Public Goods: The Concise Encyclopedia of Economics | Library of Economics and Liberty." *The Concise Encyclopedia of Economics*. http://www.econlib.org/library/Enc/PublicGoods.html.

Coxon, Kirstie, Jane Sandall, and Naomi J. Fulop. 2014. "To What Extent Are Women Free to Choose Where to Give Birth? How Discourses of Risk, Blame and Responsibility Influence Birth Place Decisions." *Health, Risk & Society* 16 (1): 51–67. doi:10.1080/13698575.2013.859231.

Craig, David Alan, and Doug Porter. 2006. *Development Beyond Neoliberalism?: Governance, Poverty Reduction and Political Economy*. London: Routledge.

Crampton, Peter, and Barbara Starfield. 2004. "A Case for Government Ownership of Primary Care Services in New Zealand: Weighing the Arguments." *International Journal of Health Services* 34 (4): 709–27. doi:10.2190/FMJW-R4R9-C4R1-W8RJ.

Crano, William D., Michael Burgoon, and Stuart Oskamp. 2001. *Mass Media and Drug Prevention: Classic and Contemporary Theories and Research*. Milton Park, Didcot: Psychology Press.

Craven, Christa. 2007. "A 'Consumer's Right' to Choose a Midwife: Shifting Meanings for Reproductive Rights under Neoliberalism." *American Anthropologist* 109 (4): 701–12. doi:10.1525/aa.2007.109.4.701.

———. 2010. *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*. Philadelphia: Temple University Press.

Cressman, Darryl. 2009. "A Brief Overview of Actor - Network Theory: Punctualization, Heterogeneous Engineering & Translation." Simon Fraser University. http://blogs.sfu.ca/departments/cprost/wp-content/uploads/2012/08/0901.pdf.

Cresswell, Kathrin M., Allison Worth, and Aziz Sheikh. 2010. "Actor-Network Theory and Its Role in Understanding the Implementation of Information Technology Developments in Healthcare." *BMC Medical Informatics and Decision Making* 10: 67. doi:10.1186/1472-6947-10-67.

327

Cressy, David. 1993. "Purification, Thanksgiving and the Churching of Women in Post-Reformation England." *Past & Present*, no. 141: 106–46.

Crittenden, Victoria L., William F. Crittenden, Linda K. Ferrell, O. C. Ferrell, and Christopher C. Pinney. 2011. "Market-Oriented Sustainability: A Conceptual Framework and Propositions." *Journal of the Academy of Marketing Science* 39 (1): 71–85. doi:10.1007/s11747-010-0217-2.

Crocker, Jennifer, and Riia K. Luhtanen. 2003. "Level of Self-Esteem and Contingencies of Self-Worth: Unique Effects on Academic, Social, and Financial Problems in College Students." *Personality and Social Psychology Bulletin* 29 (6): 701–12. doi:10.1177/0146167203029006003.

Crowther, Susan, and Jennifer Hall. 2015. "Spirituality and Spiritual Care in and around Childbirth." *Women and Birth* 28 (2): 173–78. doi:10.1016/j.wombi.2015.01.001.

Crowther, Susan, Billie Hunter, Judith McAra-Couper, Lucie Warren, Andrea Gilkison, Marion Hunter, Anna Fielder, and Mavis Kirkham. 2016. "Sustainability and Resilience in Midwifery: A Discussion Paper." *Midwifery* 40 (September): 40–48. doi:10.1016/j.midw.2016.06.005.

Crutzen, Paul J. 2002. "Geology of Mankind." *Nature* 415 (6867): 23–23. doi:10.1038/415023a.

Cruz, Helen De, and Johan De Smedt. 2007. "The Role of Intuitive Ontologies in Scientific Understanding – the Case of Human Evolution." *Biology & Philosophy* 22 (3): 351–68. doi:10.1007/s10539-006-9036-8.

Cumberledge, Julia. 2016. "Better Births: Improving Outtcomes of Maternity Services." London: NHS.

Curtis, Penny, Linda Ball, and Mavis Kirkham. 2006. "Bullying and Horizontal Violence: Cultural or Individual Phenomena?" *British Journal of Midwifery* 14 (4): 218–21. doi:10.12968/bjom.2006.14.4.20790.

Cuthill, Michael. 2010. "Strengthening the 'Social' in Sustainable Development: Developing a Conceptual Framework for Social Sustainability in a Rapid Urban Growth Region in Australia." *Sustainable Development* 18 (6): 362–73. doi:10.1002/sd.397.

Dadax. 2017. "World Population Clock: 7.5 Billion People (2017) - Worldometers." Accessed June 12. http://www.worldometers.info/world-population/.

Daellenbach, Rea. 1999a. "Midwifery Partnership: A Consumers Persepctive." *NZCOM Journal* 21: 22–23.

———. 1999b. "The Paradox of Success and the Challenge of Change : Home Birth Associations of Aotearoa/New Zealand." Christchurch, NZ: University of Canterbury. http://ir.canterbury.ac.nz/handle/10092/6525.

———. 2014. "Nourishment:Food, Culture and Identity." In *Nutrition in Pregnancy and Childbirth: Food for Thought*, edited by Lorna Davies and Ruth Deery. London: Routledge.

Dahlberg, Unn, and Ingvild Aune. 2013. "The Woman's Birth Experience—The Effect of Interpersonal Relationships and Continuity of Care." *Midwifery* 29 (4): 407–15. doi:10.1016/j.midw.2012.09.006.

Daly, Herman E. 1990. "Toward Some Operational Principles of Sustainable Development." *Ecological Economics* 2 (1): 1–6. doi:10.1016/0921-8009(90)90010-R.

———. 2007. *Ecological Economics and Sustainable Development*. Cheltenham: Edward Elgar Publishing.

Dankert, Ritske. 2011. "Using Actor-Network Theory (ANT) Doing Research." *Ritske Dankert Ruimte En Wonen*. October 30. http://ritskedankert.nl/publicaties/2010/item/using-actor-network-theory-ant-doing-research.

Davies. 1996. "The Sociology of Professions and the Profession of Gender." *Sociology* 30 (4): 661–78.

Davies, Lorna. 1994. "Ecological Midwifery." Edited by June. *Midwifery Matters* 61: 8–10.

———. 1995. "Babies Co-Sleeping with Parents." *Midwives: Official Journal of the Royal College of Midwives* 108 (1295): 384–86.

———. 2012. "Clinical Complexity: The Emperor's New Clothes?" *MIDIRS* 3 (6): 17–22.

———. 2014. "Research Journal Entry." Research Journal.

———. 2017. "Biobehavioural Aspects of Parenting." In *Physiology in Childbearing*, 4th ed., 597–603. Edinburgh, GB: Elsevier.

Davies, Lorna, Rea Daellenbach, and Mary Kensington. 2011. *Sustainability, Midwifery and Birth*. First. London: Routledge.

Davies, Lorna. 2011. Parents as Consumers in Davies, Lorna, Rea Daellenbach, and Mary Kensington. 2011. *Sustainability, Midwifery and Birth.* First. London: Routledge.

Davies, Lorna, and Ruth Martis. 2011. "Normal Birth." *BMSP500*.

Davis D. 2003. "Professional Issues. Spoilt for Choice: Consuming Maternity Care." *British Journal of Midwifery* 11 (9): 574–78.

Davis, Dána-Ain, and Christa Craven. 2011. "Revisiting Feminist Ethnography: Methods and Activism at the Intersection of Neoliberal Policy." *Feminist Formations* 23 (2): 190–208. doi:10.1353/ff.2011.0018.

Davis, Deborah, Sally Baddock, Sally Pairman, Marion Hunter, Cheryl Benn, Don Wilson, Lesley Dixon, and Peter Herbison. n.d. "Planned Place of Birth in New Zealand: Does It Affect Mode of Birth and Intervention Rates Among Low-Risk Women?" *Birth* 38: 111–19.

Davis, Deborah L., and Kim Walker. 2010. "Re-Discovering the Material Body in Midwifery through an Exploration of Theories of Embodiment." *Midwifery* 26 (4): 457–62. doi:10.1016/j.midw.2008.10.004.

Davis, Deborah, and Kim Walker. 2012. "Towards an 'Optics of Power': Technologies of Surveillance and Discipline and Case-Loading Midwifery Practice in New Zealand." *Gender, Place & Culture* 20 (5): 597–612. doi:10.1080/0966369X.2012.701199.

———. 2013. "Towards an 'Optics of Power': Technologies of Surveillance and Discipline and Case-Loading Midwifery Practice in New Zealand." *Gender, Place & Culture* 20 (5): 597–612. doi:10.1080/0966369X.2012.701199.

Davis, Elizabeth. 2004. *Heart & Hands: A Midwife's Guide to Pregnancy & Birth*. Celestial Arts.

Davis, Fred. 1979. *Yearning for Yesterday: A Sociology of Nostalgia*. London: Free Press.

Davis, Frederick. 1977. "Nostalgia, Identity and the Current Nostalgia Wave." *Journal of Popular Culture* 11 (2): 414–24. doi:10.1111/j.0022-3840.1977.00414.x.

Davis-Floyd, Robbie. 1997. *Childbirth and Authoritative Knowledge : Cross-Cultural Perspectives*. Berkeley: University of California Press.

———. 2014. "» Daughter of Time: The Postmodern Midwife." http://davis-floyd.com/uncategorized/daughter-of-time-the-postmodern-midwife/.

Davis-Floyd, Robbie, and P. Sven Arvidson. 2016. *Intuition: The Inside Story: Interdisciplinary Perspectives*. Routledge.

Davis-Floyd, Robbie, and Christine Barbara Johnson. 2012. *Mainstreaming Midwives: The Politics of Change*. London: Routledge.

Daw, Tim, Rosendo Sergio, and Robert Pomeroy. 2011. "Applying the Ecosystem Services Concept to Poverty Alleviation: The Need to Disaggregate Human Well-Being - ProQuest." *Environmental Conservation*, 3rd IASME/WSEAS Int. Conf. on Energy, Environment, Ecosystems and Sustainable Development, 38 (4): 370–79. doi:doi:http://dx.doi.org.ezproxy.canterbury.ac.nz/10.1017/S0376892911000506.

D'Cruz, Heather, Struan Jacobs, and Adrian M. M. Schoo. 2009. *Knowledge-in-Practice in the Caring Professions: Multidisciplinary Perspectives*. Ashgate Publishing, Ltd.

De Lee, Joseph B. 1934. "Obstetrics versus Midwifery:Chairmans Address." *The Journal of the American Medical Association* 103 (5): 307–11. doi:doi:10.1001/jama.1934.

De Souza, Ruth, and D Butt. 2016. "'I Had to Keep My Options Open': White Mothers and Neoliberal Maternity." *Dr Ruth De Souza*. http://www.ruthdesouza.com/2016/06/11/i-had-to-keep-my-options-open-white-mothers-and-neoliberal-maternity/.

Deave, Toity, and Debbie Johnson. 2008. "The Transition to Parenthood: What Does It Mean for Fathers?" *Journal of Advanced Nursing* 63 (6): 626–33.

Deery, Ruth. 2003a. "Engaging with Clinical Supervison in a Community Midwifery Setting." PhD, Sheffield: University of Sheffield. http://etheses.whiterose.ac.uk/3544/1/397489_vol_2.pdf.

———. 2003b. "Engaging with Clinical Supervision in a Community Midwifery Setting: An Action Research Study." Doctoral, University of Sheffield. http://eprints.hud.ac.uk/id/eprint/6913/.

———. 2011. "'Obesing' Pregnant Women: By Whom, and for What Reasons?" *AIMS Journal* 23 (4): 12–13.

Defourny, Jacques. 2014. *Social Enterprise and the Third Sector: Changing European Landscapes in a Comparative Perspective*. London: Routledge.

Deleuze, Gilles, and Felix Guattari. 1987. *A Thousand Plateaus: Capitalism and Schizophrenia*. Minneapolis: University of Minnesota Press.

Dept of Health, Dept of. 1993. "The Report of the Expert Maternity Group (Changing Childbirth)." London: Stationery Office Books.

DeVries, Rg. 1992. "Barriers to Midwifery: An International Perspective." *Journal of Perinatal Education* 1 (1): 1–10.

Dewey, John. 1922. *Human Nature and Conduct: An Introduction to Social Psychology*. New York, NY: Henry Holt and Company.

Diamond, Irene. 1990. *Reweaving the World: The Emergence of Ecofeminism*. Edited by Gloria Orenstein. 2nd edition. San Francisco: Sierra Club Books.

Dillabough, Jo-Anne. 1999. "Gender Politics and Conceptions of the Modern Teacher: Women, Identity and Professionalism." *British Journal of Sociology of Education* 20 (3): 373–94. doi:10.1080/01425699995326.

Dixon, Lesley, Judith T. Fullerton, Cecily Begley, Holly Powell Kennedy, and Karen Guilliland. 2011. "Systematic Review: The Clinical Effectiveness of Physiological (Expectant) Management of the Third Stage of Labor Following a Physiological Labor and Birth." *International Journal of Childbirth* 1 (3): 179–95. doi:10.1891/2156-5287.1.3.179.

Dixon, Lesley, Karen Guilliland, Julie F Pallant, Mary Sidebotham, Jennifer Fenwick, Judith McAra-Couper, and Andrea Gilkinson. 2017. "The Emotional Wellbeing of New Zealand Midwives: Comparing Responses for Midwives in Caseloading and Shift Work Settings." *New Zealand College of Midwives Journal* 53: 5–14.

Dixon, Lesley, Gail Prileszky, Karen Guilliland, Chris Hendry, Suzanne Miller, and Jacqui Anderson. 2012. "What Evidence Supports the Use of Free-Standing Midwifery Led Units (Primary Units) in New Zealand/ Aotearoa?" *New Zealand College of Midwives Journal*, no. 46 (June): 13–20.

Dixon, Lesley, Gail Prileszky, Karen Guilliland, Suzanne Millar, and Jacqui Anderson. 2014. "Place of Birth and Outcomes for a Cohort of Low Risk Women in New Zealand: A Comparison with Birthplace England." *NZCOM Journal* 50: 11–18.

Dockry, Michael J., Katherine Hall, William Van Lopik, and Christopher M. Caldwell. 2015. "Sustainable Development Education, Practice, and Research: An Indigenous Model of Sustainable Development at the College of Menominee Nation, Keshena, WI, USA." *Sustainability Science*, April, 1–12. doi:10.1007/s11625-015-0304-x.

Dolan, Frances E. 2013. *True Relations: Reading, Literature, and Evidence in Seventeenth-Century England*. Philadelphia: University of Pennsylvania Press.

331

Dolwick, Jim S. 2009. "'The Social' and Beyond: Introducing Actor-Network Theory." *Journal of Maritime Archaeology* 4 (1): 21–49. doi:10.1007/s11457-009-9044-3.

Dombroski, Kelly, Katharine Mckinnon, and Stephen Healy. 2016. "Beyond the Birth Wars: Diverse Assemblages of Care." *New Zealand Geographer* 72 (3): 230–39. doi:10.1111/nzg.12142.

Donald, Heather. 2014. "The Work Life Balance of the Case-Loading Midwife: A Cooperative Inquiry." Auckland: AUT.

http://aut.researchgateway.ac.nz/bitstream/handle/10292/4663/DonaldH.pdf?sequence=3.

Donley, Joan. 1986. *Save the Midwife*. Wellington: New Women's Press.

———. 1988. "Midwives or Moas?" In . Auckland. http://wwat.nz/wp-content/uploads/1988Midwives-or-moas-citation.pdf.

Donnison. 1988. *Midwives and Medical Men : : A History of the Struggle for the Control of Childbirth.* 2nd ed.. London: : Historical Publications.

Doucet, Andrea. 2006. *Do Men Mother?: Fathering, Care, and Domestic Responsibility*. University of Toronto Press.

Douglas, Mary. 2003. *Risk and Blame*. London: Psychology Press.

Dowling, Maura. 2006. "Approaches to Reflexivity in Qualitative Research." *Nurse Researcher* 13 (3): 7–21. doi:10.7748/nr2006.04.13.3.7.c5975.

Downe, Soo. 1997. "The Less We Do the More We Give." *British Journal of Midwifery* 5 (1): 43–43.

———. 2010. "Towards Salutogenic Birth in the 21st Century." In *Essential Midwifery Practice: Intrapartum Care*. Oxford: Wiley Blackwell.

———. 2012. "Skilled Help from the Heart: The Story of a Midwifery Research Programme | RCM." *The Royal College of Midwives*. https://www.rcm.org.uk/learning-and-career/learning-and-research/ebm-articles/skilled-help-from-the-heart-the-story-of-a.

———. 2017. "Query," August 9.

Drife, J. 2002. "The Start of Life: A History of Obstetrics." *Postgraduate Medical Journal* 78 (919): 311–15. doi:10.1136/pmj.78.919.311.

Duim, René van der, Carina Ren, and Gunnar Thór Jóhannesson. 2012. *Actor-Network Theory and Tourism: Ordering, Materiality and Multiplicity*. London: Routledge.

Dunn, P. M. 1995. "Dr William Smellie (1697-1763), the Master of British Midwifery." *Archives of Disease in Childhood. Fetal and Neonatal Edition* 72 (1): F77–78.

Dutta, Mohan J. 2011. *Communicating Social Change: Structure, Culture, and Agency*. Taylor & Francis.

Dwyer, James. 2008. "The Century of Biology: Three Views." *Sustainability Science* 3 (2): 283–85. doi:10.1007/s11625-008-0057-x.

Dwyer, Sarah. 2009. "Childbirth Education: Antenatal Education and Transitions of Maternity Care in New Zealand." 1/09. Wellington: Families Commission.

Eagleton-Pierce, Matthew. 2016. "On Individualism in the Neoliberal Period." In . Brighton.

Earle, Sarah, and Gayle Letherby. 2008. *The Sociology of Healthcare: A Reader for Health Professionals*. Basingstoke: Palgrave Macmillan.

Easton, Brian. 2002. "The New Zealand Health Reforms in Context | Brian Easton." *Brian Easton*. http://www.eastonbh.ac.nz/2002/06/the_new_zealand_health_reforms_in_context/.

Easton, Brian. H. 2001. *The Nationbuilders*. Auckland: Auckland University Press.

Eccles, Audrey. 1982. *Obstetrics and Gynaecology in Tudor and Stuart England*. London: Croom Helm.

Eckersley, Richard. 2006. "Progress, Sustainability and Human Wellbeing: Is a New Worldview Emerging?" *International Journal of Innovation and Sustainable Development,* 1 (4): 306–17.

Edelstein, Dan. 2010. *The Enlightenment : A Genealogy*. Chicago: University of Chicago Press.

Edwards, Nadine Pilley. 2004. "Informed Choice in Maternity Care." In *Informed Choice in Maternity Care*, 1–30. Basingstoke: Palgrave Macmillan.

———. 2005. *Birthing Autonomy: Women's Experiences of Planning Home Births*. London: Psychology Press.

Edwards, Nadine Pilley, Jo Murphy-Lawless, Mavis Kirkham, and Sarah Davies. 2011. "Attacks on Midwives, Attacks on Women's Choices." *AIMS Journal* 23 (11).

Egan, R. Danielle, and Gail Hawkes. 2007. "Producing the Prurient through the Pedagogy of Purity: Childhood Sexuality and the Social Purity Movement." *Journal of Historical Sociology* 20 (4): 443–61. doi:10.1111/j.1467-6443.2007.00319.x.

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

Elkington, John. 1998. *Cannibals with Forks: The Triple Bottom Line of 21st Century Business*. New Society Publishers.

Eller, Cynthia. 2011. *Gentlemen and Amazons*. Berkeley, US: University of California Press. http://site.ebrary.com/lib/alltitles/docDetail.action?docID=10504623.

Ells, Carolyn, Matthew R. Hunt, and Jane Chambers-Evans. 2011. "Relational Autonomy as an Essential Component of Patient-Centered Care." *International Journal of Feminist Approaches to Bioethics* 4 (2): 79–101. doi:10.2979/intjfemappbio.4.2.79.

Englund, T. 1996. "Are Professional Teachers a Good Thing?" In *Teachers' Profesional Lives*. London: Farmer.

Evans, David B, Riku Elovainio, and Gary Humphreys. 2010. "Health Systems Financing The Path to Universal Coverage." Executive Summary. Geneva: World Health Organisation. http://www.who.int/whr/2010/10_summary_en.pdf.

Evenden, Doreen. 2000. *The Midwives of Seventeenth-Century London*. Cambridge University Press.

333

Evetts, J. 2011. "A New Professionalism? Challenges and Opportunities." *Current Sociology* 59 (4): 406–22. doi:10.1177/0011392111402585.

Evetts, Julia. 2012. "Similarities in Contexts and Theorizing: Professionalism and Inequality." *Professions and Professionalism* 2 (2). doi:10.7577/pp.322.

———. 2013. "Professionalism: Value and Ideology." *Current Sociology* 61 (5–6): 778–96. doi:10.1177/0011392113479316.

Exton, Lynda. 2008. *The Baby Business: What's Happened to Maternity Care in New Zealand?* Nelson: Craig Potton Publishing Limited.

Fahy, Kathleen. 2002. "Reflecting on Practice to Theorise Empowerment for Women: Using Foucault's Concepts." *The Australian Journal of Midwifery* 15 (1): 5–13. doi:10.1016/S1445-4386(02)80017-9.

Fahy, Kathleen, Maralyn Foureur, and Carolyn Hastie. 2008. *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. London: Elsevier Health Sciences.

Featherstone, Mike. 2007. *Consumer Culture and Postmodernism Consumer Culture and Postmodernism*. London: SAGE Publications Ltd. doi:10.4135/9781446212424.

Fee, Elizabeth, Theodore M. Brown, and Roxanne L. Beatty. 2003. "Early Modern Childbirth." *American Journal of Public Health* 93 (3): 432.

Femia, F, and C Werrell. 2015. "Tag Archives: Rear Admiral Neil Morisetti «." *Exploring the Security Risks of Climate Change*. Accessed March 24. http://climateandsecurity.org/tag/rear-admiral-neil-morisetti/.

Fenwick, Tara J., and Richard Edwards. 2010. *Actor-Network Theory in Education*. New York: Routledge. http://www.canterbury.eblib.com.au/EBLWeb/patron?target=patron&extendedid=P_544021_0.

Fereday, Jennifer, and Eimear Muir-Cochrane. 2006. "Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development." *International Journal of Qualitative Methods* 5 (1): 80–92. doi:10.1177/160940690600500107.

Ferlie, E., L. Fitzgerald, M. Wood, and C. Hawkins. 2005. "The Nonspread of Innovations: The Mediating Role of Professionals." *Academy of Management Journal* 48 (1): 117–34. doi:10.5465/AMJ.2005.15993150.

Fern, Edward F. 2001. *Advanced Focus Group Research*. Thousand Oaks CA: SAGE Publications.

Firkin, Patrick. 2004. "The Cultural Capital of Midwifery: Unique Foundations for Self-Employment." *NZCOM Journal* 30: 6–11.

Fitzsimons, Patrick. 2000. "Neoliberalism and 'Social Capital': Revinventing Community." In *Proceedings AREA Conference, New Orleans*, 1–21. New Orleans. http://www.amat.org.nz/Neoliberalism.pdf.

Fleming, P. J. 1994. "Understanding and Preventing Sudden Infant Death Syndrome." *Current Opinion in Pediatrics* 6 (2): 158.

334

Fleming, Valerie. 1994. "Partenership. Power and Politics: Feminist Perceptions of Midwifery Practice." Wellington, NZ: Massey University. http://mro.massey.ac.nz/bitstream/handle/10179/4602/02_whole.pdf?sequence=1.

Fleming, Valerie E. M. 1996. "Midwifery in New Zealand: Responding to Changing Times." *Health Care for Women International* 17 (4): 343–59. doi:10.1080/07399339609516250.

Fleming, Valerie EM. 1998. "Autonomous or Automatons? An Exploration through History of the Concept of Autonomy in Midwifery in Scotland and New Zealand." *Nursing Ethics* 5 (1): 43–51. doi:10.1177/096973309800500106.

Flynn, Thomas. 2013. "Jean-Paul Sartre." In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Fall 2013. Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/fall2013/entries/sartre/.

Ford, James D., Laura Cameron, Jennifer Rubis, Michelle Maillet, Douglas Nakashima, Ashlee Cunsolo Willox, and Tristan Pearce. 2016. "Including Indigenous Knowledge and Experience in IPCC Assessment Reports." *Nature Climate Change* 6 (4): 349–53. doi:10.1038/nclimate2954.

Forman, Fonna. 2013. *The Adam Smith Review*. London: Routledge.

Forster, Della A., Helen L. McLachlan, Mary-Ann Davey, Mary Anne Biro, Tanya Farrell, Lisa Gold, Maggie Flood, Touran Shafiei, and Ulla Waldenström. 2016. "Continuity of Care by a Primary Midwife (Caseload Midwifery) Increases Women's Satisfaction with Antenatal, Intrapartum and Postpartum Care: Results from the COSMOS Randomised Controlled Trial." *BMC Pregnancy and Childbirth* 16. doi:10.1186/s12884-016-0798-y.

Foster, Illysa R., and Jon Lasser. 2010. *Professional Ethics in Midwifery Practice*. Burlington: Jones & Bartlett Publishers.

Foucault, Michel. 1978. *The History of Sexuality.* 1st ed. New York: Pantheon Books.

———. 1980. *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. Pantheon Books.

———. 2008. *The Birth of Biopolitics*. Michel Foucault:Lecutres at the College de France. London: Palgrave McMillan.

Fournier, Valérie. 1999. "The Appeal to 'Professionalism' as a Disciplinary Mechanism." *Sociological Review* 47 (2): 280–307.

Fox, CJ. 1992. "What Do We Mean When We Say Professionalism? A Language Usage Analysis for Public Administration." *The American Review of Public Administration* 22 (1): 1–17.

Frank Thompson, and Chad Perry. 2004. "Generalising Results of an Action Research Project in One Work Place to Other Situations: Principles and Practice." *European Journal of Marketing* 38 (3/4): 401–17. doi:10.1108/03090560410518611.

Fraser, Nancy. 2009. "Feminism, Capitalism and the Cunning of History." *New Left Review*, II, , no. 56 (April): 97–117.

335

Freeman, Lesa M. 2006. "Continuity of Carer and Partnership: A Review of the Literature." *Women and Birth* 19 (2): 39–44. doi:10.1016/j.wombi.2006.05.002.

Freidson, Eliot. 1988. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press.

———. 1994. *Professionalism Reborn: Theory, Prophecy, and Policy*. Chicago: University of Chicago Press.

———. 2001. *Professionalism, the Third Logic: On the Practice of Knowledge*. Chicago: University of Chicago Press.

Freire, Paulo. 1972. *Pedagogy of the Oppressed*. Freiburg im Breisgau: Herder and Herder.

Frolich, Julie. 2013. "The Misleading Myth of Choice: A Decade on Are We Any Further Forward?" *MIDIRS Midwifery Digest* 23 (3): 279–87.

Fuentes-Nieva, Ricardo, and Nicholas Galasso. 2014. "Working for the Few: Political Capture and Economic Inequality." *Policy & Practice*, January. http://policy-practice.oxfam.org.uk/publications/working-for-the-few-political-capture-and-economic-inequality-311312.

Furedi, Frank. 2007. *Politics of Fear*. New York: Continuum.

Fyfe, Nicholas R. 2005. "Making Space for 'Neo-Communitarianism'? The Third Sector, State and Civil Society in the UK." *Antipode* 37 (3): 536–57. doi:10.1111/j.0066-4812.2005.00510.x.

Gabriel, Yiannis. 1993. "Organizational Nostalgia - Reflections on 'TheGolden Age." In *Emotion in Organsiations*, 118–41. London: Sage.

Gad, Christopher, and Casper Bruun Jensen. 2010. "On the Consequences of Post-ANT." *Science, Technology, & Human Values* 35 (1): 55–80.

Galton, Francis. 1883. *Inquiries Into Human Faculty and Its Development*. Basingstoke: Macmillan.

Game, Ann. 1997. "Sociology's Emotions*." *Canadian Review of Sociology/Revue Canadienne de Sociologie* 34 (4): 385–99. doi:10.1111/j.1755-618X.1997.tb00215.x.

Gardosi, Jason, Francesc Figueras, Britt Clausson, and Andre Francis. 2011. "The Customised Growth Potential: An International Research Tool to Study the Epidemiology of Fetal Growth: Customised Growth Potential." *Paediatric and Perinatal Epidemiology* 25 (1): 2–10. doi:10.1111/j.1365-3016.2010.01166.x.

Garratt, Rosemary Ann. 2001. "The Midwife as Healer." *Complementary Therapies in Nursing and Midwifery* 7 (4): 197–201. doi:10.1054/ctnm.2001.0573.

Garrety, Karin. 2013. "Actor-Network Theory." THEORI research Group, Univeristy of Wollongong.

Gaskin, Ina May. 1978. *Spiritual Midwifery*. 1st ed. Summertown TN: The Book Publishing Company.

Gastaldo, Denise, and Dave Holmes. 1999. "Foucault and Nursing: A History of the Present." *Nursing Inquiry* 6 (4): 231–40. doi:10.1046/j.1440-1800.1999.00042.x.

Gauld, Robin. 2008. "The Unintended Consequences of New Zealand's Primary Health Care Reforms." *Journal of Health Politics, Policy & Law* 33 (1): 93–115.

———. 2009. *Revolving Doors: New Zealand's Health Reforms – The Continuing Saga*. 2nd ed. Wellington: nstitute of Policy Studies and Health Services Research Centre.

Gawande, Atul. 2010. *The Checklist Manifesto: How to Get Things Right*. London: Profile.

Gewirtz, Jacob L., William M. Kurtines, and Jacob L. Lamb. 2013. *Intersections With Attachment*. London: Psychology Press.

Gibbs, Graham. 1988. *Learning by Doing: A Guide to Teaching and Learning Methods*. Manila: FEU.

Gibson-Graham, J.k. 2008. "Diverse Economies: Performative Practices for 'Other Worlds.'" *Progress in Human Geography* 32 (5): 613–32. doi:10.1177/0309132508090821.

Giddings, Bob, Bill Hopwood, and Geoff O'Brien. 2002. "Environment, Economy and Society: Fitting Them Together into Sustainable Development." *Sustainable Development* 10 (4): 187–96. doi:10.1002/sd.199.

Gilbert, Jeremy. 2008. "Against the Commodification of Everything." *Cultural Studies* 22 (5): 551–66. doi:10.1080/09502380802245811.

Gilkinson, Andrea. 2013. "The Shaping of Midwifery Education." *NZCOM Journal* 47: 18–23.

Gilkison, Andrea, Lynne S. Giddings, and Liz Smythe. 2013. "The Shaping of Midwifery Education in Aotearoa, New Zealand." *New Zealand College of Midwives Journal*, no. 47 (June): 18–23. doi:10.12784/nzcomjnl47.2013.4.18-23.

Gladwell, Malcolm. 2006. *The Tipping Point: How Little Things Can Make a Big Difference*. New York: Little, Brown and Company.

Glasson, Janet B, Esther ML Chang, and John W Bidewell. 2008. "The Value of Participatory Action Research in Clinical Nursing Practice." *International Journal of Nursing Practice* 14 (1): 34–39. doi:10.1111/j.1440-172X.2007.00665.x.

Glazer, Judith S. 1990. "Feminism and Professionalism: The Case of Education and Business. ASHE Annual Meeting Paper." In *ASHE*. Portland: ASHE. http://eric.ed.gov/?id=ED326120.

Glynos, Jason. 2014. "Neoliberalism, Markets, Fantasy: The Case of Health and Social Care." *Psychoanalysis, Culture & Society* 19 (1): 5–12. doi:10.1057/pcs.2013.23.

Godbolt, Rosemary. 2010. "Informed Consent and Midwifery Practice in New Zealand: Lessons from the Health and Disability Commissioner." *NZCOM Journal* 42 (January): 12–16.

Goduscheit, René Chester, Carsten Bergenholtz, Jacob Høj Jørgensen, and Erik S. Rasmussen. 2008. "Action Research in Inter-Organisational Networks: Impartial Studies or the Trojan Horse?" *Systemic Practice and Action Research* 21 (4): 267–81. doi:10.1007/s11213-008-9096-6.

Goeke, Stephanie, and Dagmar Kubanski. 2012. "People with Disabilities as Border Crossers in the Academic Sector—Chances for Participatory Research." *Forum Qualitative Sozialforschung /*

337

Forum: Qualitative Social Research 13 (1). http://www.qualitative-research.net/index.php/fqs/article/view/1782.

Goguen, Joseph. 1998. "Actor-Network Theory." *Social Aspects of Technology and Science*. http://cseweb.ucsd.edu/~goguen/courses/268D/5.html.

Gold, Rachel, Ichiro Kawachi, Bruce P. Kennedy, John W. Lynch, and Frederick A. Connell. 2001. "Ecological Analysis of Teen Birth Rates: Association with Community Income and Income Inequality." *Maternal and Child Health Journal* 5 (3): 161–67. doi:10.1023/A:1011343817153.

Goldsmith, Judith. 1984. *Childbirth Wisdom: From the World's Oldest Societies*. New York: Congdon & Weed.

Goodman, Benny. 2013. "Education for Sustainability - Principles for Nursing Curricula." Education Briefing. Plymouth: Plymouth University. https://www.academia.edu/3109351/Education_for_Sustainability_-_Principles_for_nursing_curricula.

Grasso, Maria T. 2016. *Generations, Political Participation and Social Change in Western Europe*. London: Routledge.

Gray, A. M. 1982. "Inequalities in Health. The Black Report: A Summary and Comment." *International Journal of Health Services: Planning, Administration, Evaluation* 12 (3): 349–80.

Green, D., and G. Raygorodetsky. 2010. "Indigenous Knowledge of a Changing Climate." *Climatic Change* 100 (2): 239–42. doi:10.1007/s10584-010-9804-y.

Greenhalgh, Trisha, and Rob Stones. 2010. "Theorising Big IT Programmes in Healthcare: Strong Structuration Theory Meets Actor-Network Theory." *Social Science & Medicine* 70 (9): 1285–94. doi:10.1016/j.socscimed.2009.12.034.

Greer, Germaine. 1991. *The Change: Women, Ageing and the Menopause.* London: Hamish Hamilton.

Griffin, Susan. 1978. *Woman and Nature: The Roaring inside Her*. New York: Harper & Row.

Grigg, Celia, Sally K Tracy, Rea Daellenbach, Mary Kensington, and Virginia Schmied. 2014. "An Exploration of Influences on Women's Birthplace Decision-Making in New Zealand: A Mixed Methods Prospective Cohort within the Evaluating Maternity Units Study." *BMC Pregnancy and Childbirth* 14 (1). doi:10.1186/1471-2393-14-210.

Gringeri, Christina E., Stéphanie Wahab, and Ben Anderson-Nathe. 2010. "What Makes It Feminist?: Mapping the Landscape of Feminist Social Work Research." *Affilia* 25 (4): 390–405. doi:10.1177/0886109910384072.

Grober, Ulrich, and Ray Cunningham. 2012. *Sustainability:A Cultural History*. Cambridge: UIT Cambridge Ltd.

Grossmann, Klaus E., Karin Grossmann, and Everett Waters. 2006. *Attachment from Infancy to Adulthood: The Major Longitudinal Studies*. Guildford: Guilford Press.

338

Grothmann, Torsten, and Anthony Patt. 2005. "Adaptive Capacity and Human Cognition: The Process of Individual Adaptation to Climate Change." *Global Environmental Change* 15 (3): 199–213. doi:10.1016/j.gloenvcha.2005.01.002.

Guenther, Robin, and Gail Vittori. 2013. *Sustainable Healthcare Architecture*. Chiches: John Wiley & Sons.

Guilliland, Karen. 1999. "Midwifery in New Zealand – Birth International." *Birth International*. https://www.birthinternational.com/article/midwifery/midwifery-in-new-zealand/.

———. 2010. *Women's Business : The Story of the New Zealand College of Midwives 1986-2010*. Christchurch, NZ: New Zealand College of Midwives.

Guilliland, Karen, and Sally Pairman. 1995a. *The Midwifery Partnership: A Model for Practice*. Department of Nursing and Midwifery, Victoria University of Wellington.

Guilliland, Karen, and Deb Pittam. 2017. "Mediation Report to College Members," May 25.

Guilliland, and Pairman. 1995b. *The Midwifery Partnership : A Model for Practice*. Wellington, NZ: Deptof Nursing and Midwifery, Victoria University of Wellington.

———. 2010. *Women's Business : The Story of the New Zealand College of Midwives 1986-2010*. Christchurch, NZ: New Zealand College of Midwives.

Gulson, Kalervo N., Matthew Clarke, and Eva Bendix Petersen. 2015. *Education Policy and Contemporary Theory: Implications for Research*. London: Routledge.

Haenn, Nora, and Richard R. Wilk. 2006. *The Environment in Anthropology: A Reader in Ecology, Culture, and Sustainable Living*. New York: NYU Press.

Hafferty, Frederic W. 2006. "Definitions of Professionalism: A Search For Meaning and Identity:" *Clinical Orthopaedics and Related Research* PAP (June). doi:10.1097/01.blo.0000229273.20829.d0.

Hall, B. 1981. "The Democratization of Research in Adult and Non-Formal Education." In *Human Inquiry: A Source of New Paradigm Research*, 447–56. New York: John Wily and Sons.

Hanlon, Phil, Sandra Carlisle, Margaret Hannah, Andrew Lyon, and David Reilly. 2012. "A Perspective on the Future Public Health: An Integrative and Ecological Framework." *Perspectives in Public Health* 132 (6): 313–19. doi:10.1177/1757913912440781.

Hansen, Craig, Adrian Barnett, and Gary Pritchard. 2008. "The Effect of Ambient Air Pollution during Early Pregnancy on Fetal Ultrasonic Measurements during Mid-Pregnancy." *Environmental Health Perspectives,* 116 (March).

Haraway, Donna Jeanne. 1991. *Simians, Cyborgs, and Women: The Reinvention of Nature*. London: Free Association Books.

Harding, Sandra. 2008. *Sciences from Below: Feminisms, Postcolonialities, and Modernities*. Durham NC: Duke University Press.

Harding, Sandra G. 1987. *Feminism and Methodology: Social Science Issues*. Indiana University Press.

Hargreaves, Andrew, and I Goodson. 1996. *Teachers' Professional Lives.* London: Falmer.

Hargreaves, David H. 1994. "The New Professionalism: The Synthesis of Professional and Institutional Development." *Teaching and Teacher Education* 10 (4): 423–38. doi:10.1016/0742-051X(94)90023-X.

Harley, David. 1990. "Historians as Demonologists: The Myth of the Midwife-Witch." *Social History of Medicine* 3 (1): 1–26. doi:10.1093/shm/3.1.1.

Harre, Niki. 2011. *Psychology for a Better World*. Morrisville: Lulu.com.

———. 2017. "The Infinite Game." *The Infinite Game*. http://www.infinite-game.net/.

Harvey, David. 2005. *A Brief History of Neoliberalism*. Oxford: Oxford University Press, UK.

Hawken, Paul. 2007. *Blessed Unrest : How the Largest Movement in the World Came into Being, and Why No One Saw It Coming*. New York: Viking.

Hawkins, Sue. 2010. *Nursing and Women s Labour in the Nineteenth Century: The Quest for Independence*. London: Taylor & Francis.

Hay, Colin. 1998. "Globalisation, Welfare Retrenchment and 'the Logic of No Alternative': Why Second-Best Won't Do." *Journal of Social Policy*. October. /core/journals/journal-of-social-policy/article/globalisation-welfare-retrenchment-and-the-logic-of-no-alternative-why-secondbest-wont-do/BBEAF0FDF58F28B212E8F7E470F3CD23.

Hay, Iain. 2015. *Qualitative Research Methods in Human Geography*. Oxford University Press.

Heagarty, Bronwyn. 1996. "'Re-Assessing the Guilty: The Midwives Act and the Control of English Midwives in the Early Twentieth Century." In *Supervision of Midwives.*, edited by Mavis Kirkham. London: Balliere Tindall.

Health and Disability Commission. 1996. "The Code of Rights." *Health and Disability Commisoner*. http://www.hdc.org.nz/the-act--code/the-code-of-rights.

Healy, Sandra, Eileen Humphreys, and Catriona Kennedy. 2016. "Midwives' and Obstetricians' Perceptions of Risk and Its Impact on Clinical Practice and Decision-Making in Labour: An Integrative Review." *Women and Birth: Journal of the Australian College of Midwives* 29 (2): 107–16. doi:10.1016/j.wombi.2015.08.010.

Heath, Joseph. 2013. "The Structure of Intergenerational Cooperation." *Philosophy & Public Affairs* 41 (1): 31–66. doi:10.1111/papa.12009.

Heeks, Richard, and Carolyn Stanforth. 2013. "Actor-Network Theory for Dvelopement." Working Paper No. 5. Manchester: Centre for Development Informatics, Manchester University. http://www.seed.manchester.ac.uk/medialibrary/IDPM/working_papers/cdi_ant4d/ANT4DWorkingPaper5HeeksStanforth.pdf.

Heidegger, Martin. 1998. *Basic Concepts*. Indiana University Press.

Helmstadter, Carol, and Judith Godden. 2011. *Nursing Before Nightingale, 1815-1899*. Farnham: Ashgate Publishing, Ltd.

340

Henaghan, Mark. 2012. *Health Professionals and Trust: The Cure for Healthcare Law and Policy*. London: Routledge.

Hendricks, Joyce M., and Vicki C. Cope. 2013. "Generational Diversity: What Nurse Managers Need to Know." *Journal of Advanced Nursing* 69 (3): 717–25. doi:10.1111/j.1365-2648.2012.06079.x.

Hendry, Christine. 2003. "Midwifery in New Zealand 1990-2003: The Complexities of Service Provision." Doctor of Midwifery, Sydney: University of Technology Sydney. https://opus.lib.uts.edu.au/bitstream/2100/256/4707/01Front.pdf.

Henriksen, Kerm, and Elizabeth Dayton. 2006. "Organizational Silence and Hidden Threats to Patient Safety." *Health Services Research* 41 (4 Pt 2): 1539–54. doi:10.1111/j.1475-6773.2006.00564.x.

Hesse-Biber, Sharlene Nagy. 2011. "Feminist Research: Exploring, Interrogating, and Transforming the Interconnections." In *Handbook of Feminist Research: Theory and Praxis*, 2nd ed., 1–27. Thousand Oaks CA: SAGE Publications.

Hewson B. 2004. "Risk Aversion and the Culture of Fear." *British Journal of Midwifery* 12 (1): 5–5.

Hibbeln, Joseph R. 2002. "Seafood Consumption, the DHA Content of Mothers' Milk and Prevalence Rates of Postpartum Depression: A Cross-National, Ecological Analysis." *Journal of Affective Disorders* 69 (1–3): 15–29. doi:10.1016/S0165-0327(01)00374-3.

Hibbert, Paul, and Anne Cunliffe. 2013. "Responsible Management: Engaging Moral Reflexive Practice through Threshold Concepts." *Journal of Business Ethics* 127 (1). doi:10.1007/s10551 - 013 - 1993 - 7.

Hillier, Dawn. 2013. *Childbirth in the Global Village: Implications for Midwifery Education and Practice*. Routledge.

Hindley, Carol, and Ann M. Thomson. 2005. "The Rhetoric of Informed Choice: Perspectives from Midwives on Intrapartum Fetal Heart Rate Monitoring." *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy* 8 (4): 306–14. doi:10.1111/j.1369-7625.2005.00355.x.

Holzer, Boris. 2006. "Political Consumerism between Individual Choice and Collective Action: Social Movements, Role Mobilization and Signalling." *International Journal of Consumer Studies* 30 (5): 405–15. doi:10.1111/j.1470-6431.2006.00538.x.

Homer, Caroline, and Pat Brodie. 2008. *Midwifery Continuity of Care: A Practical Guide*. Elsevier Health Sciences.

Homer, Caroline SE. 2016. "Models of Maternity Care: Evidence for Midwifery Continuity of Care." *The Medical Journal of Australia* 205 (8): 370–74. doi:10.5694/mja16.00844.

Hood, Christopher, Henry Rothstein, and Robert Baldwin. 2001. *The Government of Risk: Understanding Risk Regulation Regimes*. Oxford University Press.

341

Horowitz, Leah S. 2012. "Translation Alignment: Actor-Network Theory, Resistance, and the Power Dynamics of Alliance in New Caledonia." *Antipode* 44 (3): 806–27. doi:10.1111/j.1467-8330.2011.00926.x.

Horton, Eleanor.S. 2007. "Neoliberalism and the Australian Healthcare System (Factory)." In *Proceedings 2007 Conference of the Philosophy of Education Society of Australasia ,*. Wellington, NZ: QUT Digital Repository. http://eprints.qut.edu.au/14444/1/14444.pdf.

Hubbard, Ryan. 2014. "Wicked Problems." *Wicked Problems; Problems Worth Solving*. https://www.wickedproblems.com/table_of_contents.php.

Huber, Ulli S., and Jane Sandall. 2009. "A Qualitative Exploration of the Creation of Calm in a Continuity of Carer Model of Maternity Care in London." *Midwifery* 25 (6): 613–21. doi:10.1016/j.midw.2007.10.011.

Huckle, J. 2008. "Sustainable Development." In *The Sage Handbook of Education for Citizenship and Democracy*. London: SAGE Publications, Inc.

Hudson, Christopher G., and Yvonne M. Vissing. 2013. "Sustainability at the Edge of Chaos: Its Limits and Possibilities in Public Health." *BioMed Research International* 2013 (August): e801614. doi:10.1155/2013/801614.

Hughes, Everett C. 1963. "Professions." *Daedalus* 92 (4): 655–68.

Humpage, Louise. 2014. *Policy Change, Public Attitudes and Social Citizenship: Does Neoliberalism Matter?* Bristol: Policy Press.

Hunter, Billie. 2006. "The Importance of Reciprocity in Relationships between Community-Based Midwives and Mothers." *Midwifery* 22 (4): 308–22. doi:10.1016/j.midw.2005.11.002.

Hunter, Billie, Marie Berg, Ingela Lundgren, Ólöf Ásta Ólafsdóttir, and Mavis Kirkham. 2008. "Relationships: The Hidden Threads in the Tapestry of Maternity Care." *Midwifery* 24 (2): 132–37. doi:10.1016/j.midw.2008.02.003.

Hunter, Billie, and Jeremy Segrott. 2014. "Renegotiating Inter-Professional Boundaries in Maternity Care: Implementing a Clinical Pathway for Normal Labour." *Sociology of Health & Illness* 36 (5): 719–37. doi:10.1111/1467-9566.12096.

Hunter, Billie, and Lucie Warren. 2014. "Midwives' Experiences of Workplace Resilience." *Midwifery*, Special Focus on Mental Health and Special Focus on Education, 30 (8): 926–34. doi:10.1016/j.midw.2014.03.010.

Hunter, Marion, Susan Crowther, Judith McAra-Couper, Andrea Gilkison, Debbie MacGregor, and Jackie Gunn. 2016. "Generosity of Spirit Sustains Case Loading Lead Maternity Carer Midwives in New Zealand." *New Zealand College of Midwives Journal* 52 (December): 50–55. doi:10.12784/nzcomjnl52.2016.8.50-55.

342

Ibarra, Herminia. 1999a. "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation." *Administrative Science Quarterly* 44 (4): 764–91. doi:10.2307/2667055.

———. 1999b. "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation." *Administrative Science Quarterly* 44 (4): 764–91. doi:10.2307/2667055.

Ibbotson, Suphunnika, Tina Dettmer, Sami Kara, and Christoph Herrmann. 2013. "Eco-Efficiency of Disposable and Reusable Surgical Instruments—a Scissors Case." *The International Journal of Life Cycle Assessment* 18 (5): 1137–48. doi:10.1007/s11367-013-0547-7.

ICM. 2011a. "ICM - ICM International Definition of the Midwife." http://internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/.

———. 2011b. "ICM International Definition of the Midwife." http://internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/.

Ingram, Jenny, Debbie Johnson, and Nishat Hamid. 2003. "South Asian Grandmothers' Influence on Breast Feeding in Bristol." *Midwifery* 19 (4): 318–27.

Irwin, Alan, and Brian Wynne. 2003. *Misunderstanding Science?: The Public Reconstruction of Science and Technology*. Cambridge University Press.

Jackson, Tim. 2009. *Prosperity without Growth: Economics for a Finite Planet*. London ; Sterling, VA: Earthscan.

Jacobson, Michael F. 2005a. "Lifting the Veil of Secrecy from Industry Funding of Nonprofit Health Organizations." *International Journal of Occupational and Environmental Health* 11 (4): 349–55. doi:10.1179/oeh.2005.11.4.349.

———. 2005b. "Lifting the Veil of Secrecy from Industry Funding of Nonprofit Health Organizations." *International Journal of Occupational and Environmental Health* 11 (4): 349–55. doi:10.1179/oeh.2005.11.4.349.

Jahan, Sarwat, Ahmed Mahmud, and Chris Papageorgiou. 2014. "What Is Keynesian Economics? - Back to Basics - Finance & Development, September 2014." http://www.imf.org/external/pubs/ft/fandd/2014/09/basics.htm.

Jamieson, Isabel, Ray Kirk, Sarah Wright, and Cathy Andrew. 2015. "Generation Y New Zealand Registered Nurses' Views about Nursing Work: A Survey of Motivation and Maintenance Factors." *Nursing Open* 2 (2): 49–61. doi:10.1002/nop2.16.

Janin, Hunt. 2008. *The University in Medieval Life, 1179-1499*. Jefferson: McFarland.

Jasper, Melanie. 2003. *Beginning Reflective Practice*. Nelson Thornes.

Javadi, M., and K. Zarea. 2016. "Understanding Thematic Analysis and Its Pitfall." *Journal of Client Care* 1 (1). doi:10.15412/J.JCC.02010107.

Jeannerod, Marc, and Elisabeth Pacherie. 2004. "Agency, Simulation and Self-Identification." *Mind & Language* 19 (2): 113–46. doi:10.1111/j.1468-0017.2004.00251.x.

343

Jensen, Derrick. 2006. *Endgame*. New York: Seven Stories Press.

Johnson. n.d. *William Smellie, the Master of British Midwifery.* London: Livingstone.

Jollands, Nigel, and Garth Harmsworth. 2007. "Participation of Indigenous Groups in Sustainable Development Monitoring: Rationale and Examples from New Zealand." *Ecological Economics* 62 (3–4): 716–26. doi:10.1016/j.ecolecon.2006.09.010.

Jones, Ali. 2016. "Historic Bill of Rights Case to Be Filed in the High Court Tomorrow." *New Zealand College of Midwives*. August 30. https://www.midwife.org.nz/latest-news/midwives-take-legal-action/.

Jones, Paula, Dr David Selby, and Stephen R. Sterling. 2010. *Sustainability Education: Perspectives and Practice Across Higher Education*. London: Earthscan.

Jordan, Robin G., and Patricia Aikins Murphy. 2009. "Risk Assessment and Risk Distortion: Finding the Balance." *The Journal of Midwifery & Women΄s Health* 54 (3): 191–200. doi:10.1016/j.jmwh.2009.02.001.

Kahle, Lynn R., and Eda Gurel-Atay. 2015. *Communicating Sustainability for the Green Economy*. London: Routledge.

Kamal, Baher. 2017. "Support IPS Inter Press Service on Razoo." *Razoo*. https://www.razoo.com/story/Ipsnews.

Karen. Guilliland, and Sally Pairman. 2010. *Women's Business : The Story of the New Zealand College of Midwives 1986-2010*. Christchurch, NZ: New Zealand College of Midwives.

Kates, Robert W, Thomas M. Parris, and Anthony A. Leiserowitz. 2005. "What Is Sustainable Development? Goals, Indicators, Values, and Practice." *Environment, Science and Policy for Sustainable Development* 47 (3): 8–21.

Katz, Eric, Andrew Light, and David Rothenberg. 2000. *Beneath the Surface: Critical Essays in the Philosophy of Deep Ecology*. MIT Press.

Kay, Joseph. 2014. "The Vivisection of Oikeios: Beyond the Binary of Nature and Society." *Libcom.Org*. http://libcom.org/blog/vivisection-oikeios-beyond-binary-nature-society-25092014.

Keast, Karen. 2015. "New Zealand Midwives Take Pay Parity Fight to Court." *Health Times*. August 31. https://healthtimes.com.au/hub/midwifery/38/news/kk1/new-zealand-midwives-take-pay-parity-fight-to-court/1093/.

Keely, Alice, Melanie Gunning, and Fiona Denison. 2011. "Maternal Obesity in Pregnancy: Women's Understanding of Risks." *British Journal of Midwifery* 19 (6): 364–69. doi:10.12968/bjom.2011.19.6.364.

Kemmis, Stephen, Robin McTaggart, and Rhonda Nixon. 2013. *The Action Research Planner: Doing Critical Participatory Action Research*. Springer Science & Business Media.

Kendall-Tackett, Kathleen A. 2007. "Violence Against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy, Postpartum, and Breastfeeding." *Trauma, Violence, & Abuse* 8 (3): 344–53. doi:10.1177/1524838007304406.

Kenney, Christine M. 2009. "Me Aro Ki Te Ha o Hineahuone : Women, Miscarriage Stories, and Midwifery : Towards a Contextually Relevant Research Methodology." PhD, Palmerston North: Massey University. Me aro ki te ha o hineahuone : women, miscarriage stories, and midwifery : towards a contextually relevant research methodology - See more at: http://muir.massey.ac.nz/handle/10179/1191#sthash.sRj2UAfN.dpuf.

Kessous, Aurélie, and Elyette Roux. 2013. "A Semiotic Analysis of Nostalgia as a Connection to the Past." *Qualitative Market Research: An International Journal*, April. doi:10.1108/13522750810864440.

Khashan AS, Abel KM, McNamee R, and et al. 2008. "HIgher Risk of Offspring Schizophrenia Following Antenatal Maternal Exposure to Severe Adverse Life Events." *Archives of General Psychiatry* 65 (2): 146–52. doi:10.1001/archgenpsychiatry.2007.20.

Kindon, Sara, Rachel Pain, and Mike Kesby. 2007. *Participatory Action Research Approaches and Methods: Connecting People, Participation and Place*. Routledge.

Kipnis, Andrew. 2015. "Agency between Humanism and Posthumanism: Latour and His Opponents." *HAU: Journal of Ethnographic Theory* 5 (2): 43–58. doi:10.14318/hau5.2.004.

Kirkham, Mavis. 1999. "The Culture of Midwifery in the National Health Service in England." *Journal of Advanced Nursing* 30 (3): 732–39. doi:10.1046/j.1365-2648.1999.01139.x.

———. 2004. *Informed Choice in Maternity Care*. Basingstoke: Palgrave Macmillan.

———. 2010. *The Mother-Midwife Relationship*. London: Palgrave Macmillan.

———. 2017. "A Fundamental Contradiction: The Business Model Does Not Fit Midwifery Values." *Sarawickham*. March 13. https://www.sarawickham.com/articles-2/a-fundamental-contradiction-the-business-model-does-not-fit-midwifery-values/.

Kitzinger, Jenny, and Rosaline Barbour. 1999. *Developing Focus Group Research: Politics, Theory and Practice*. SAGE.

Klein, Naomi. 2014. *This Changes Everything : Capitalism vs. the Climate*. London, England: Allen Lane an imprint of Penguin Books.

Kluge, Eike-Henner W. 2007. "Resource Allocation in Healthcare: Implications of Models of Medicine as a Profession." *Medscape General Medicine* 9 (1): 57.

Knights, Mark. 2010. "The Enlightenment." http://www.oxfordbibliographies.com.ezproxy.canterbury.ac.nz/view/document/obo-9780199730414/obo-9780199730414-0074.xml.

Knodel, Natalie. 1997. "Reconsidering an Obsolete Rite: The Churching of Women and Feminist Liturgical Theology." *Feminist Theology* 5 (14): 106–25. doi:10.1177/096673509700001406.

Koch, Tina, and Debbie Kralik. 2009. *Participatory Action Research in Health Care*. Chichester: John Wiley & Sons.

Kotz, David M. 2015. *The Rise and Fall of Neoliberal Capitalism*. Harvard University Press.

Krieger, David J., and Andréa Belliger. 2014. *Interpreting Networks: Hermeneutics, Actor-Network Theory & New Media*. New York: transcript Verlag.

Krueger, Richard A., and Mary Anne Casey. 2009. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks CA: SAGE.

Kuhn, Thomas S. 1970. *The Structure of Scientific Revolutions*. Chicago: University Press.

Kumi, Emmanuel, Albert A. Arhin, and Thomas Yeboah. 2013. "Can Post-2015 Sustainable Development Goals Survive Neoliberalism? A Critical Examination of the Sustainable Development–neoliberalism Nexus in Developing Countries." *Environment, Development and Sustainability* 16 (3): 539–54. doi:10.1007/s10668-013-9492-7.

Kutinova, Andrea. 2008. "Midwifery in New Zealand: Government Policies, Provider Choice and Health Outcomes." University of Canterbury. http://nzae.org.nz/wp-content/uploads/2011/08/nr1215138029.pdf.

Lacroix, Richard N, and Eleni Stamatiou. 2007. "France's Remote Sensing Strategy for Sustainable Development." Conference Proceedings. 3rd IASME/WSEAS Int. Conf. on Energy, Environment, Ecosystems and Sustainable Development. Athens.

Landaur, Jeff, and Joseph Rowlands. 2001. "Philosophy Dictionary." *Importance of Philosophy*. http://www.importanceofphilosophy.com/Dictionary.html.

Lane, K. 2006. "The Plasticity of Professional Boundaries: A Case Study of Collaborative Care in Maternity Services." *Health Sociology Review: The Journal of the Health Section of the Australian Sociological Association* 15 (4): 341.

Lane, Karen. 2002. "Midwifery: A Profession in Transition." *The Australian Journal of Midwifery* 15 (2): 26–31. doi:10.1016/S1445-4386(02)70013-X.

———. 2012. "When Is Collaboration Not Collaboration? When It's Militarized." *Women and Birth* 25 (1): 29–38. doi:10.1016/j.wombi.2011.03.003.

Larner, W. 2000. "Post-Welfare State Governance: Towards a Code of Social and Family Responsibility." *Social Politics: International Studies in Gender, State & Society* 7 (2): 244–65. doi:10.1093/sp/7.2.244.

Larson, Magali S., and Magali Sarfatti Larson. 1979. *The Rise of Professionalism: A Sociological Analysis*. University of California Press.

Larson, Magali Sarfatti. 1977. *The Rise of Professionalism: A Sociological Analysis*. Berkeley CA: University of California Press.

Larsson, Margareta. 2009. "Professional Role and Identity in a Changing Society: Three Paradoxes in Swedish Midwives' Experiences." *Midwifery* 25: 373 – 381.

Larsson, Margareta, Ulrike Aldegarmann, and Clara Aarts. 2009. "Professional Role and Identity in a Changing Society: Three Paradoxes in Swedish Midwives' Experiences." *Midwifery* 25 (4): 373–81. doi:10.1016/j.midw.2007.07.009.

Latour, Bruno. 1986. "The Powers of Association." In *Power, Action and Belief: A New Sociology of Knowledge*, 264–80. London: Routeldge and Kegan Paul.

———. 1987a. *Science in Action: How to Follow Scientists and Engineers Through Society*. Harvard University Press.

———. 1987b. *Science in Action: How to Follow Scientists and Engineers Through Society*. Harvard: Harvard University Press.

———. 1992. "Technology Is Society Made Durable." In *Sociology of Monsters: Essays on Power, Technology and Domination*, 103–30. Routledge.

———. 1993. *We Have Never Been Modern*. Cambridge, Mass: Harvard University Press.

———. 1996. "On Actor-Network Theory. A Few Clarifications plus More than a Few Complications." *Soziale Welt* 47: 369–81.

———. 1999a. *Pandora's Hope: Essays on the Reality of Science Studies*. Harvard: Harvard University Press.

———. 1999b. "On Recalling ANT." *The Sociological Review* 47 (S1): 15–25. doi:10.1111/j.1467-954X.1999.tb03480.x.

———. 2005a. *Reassembling the Social: An Introduction to Actor-Network-Theory*. Oxford: Oxford University Press.

———. 2005b. *Reassembling the Social: An Introduction to Actor-Network-Theory*. Oxford: Oxford University Press.

———. 2010. "Networks, Societies, Spheres: Reflections of an Actor--network Theorist." In , 1–18. Los Angeles: Annenberg School for Communication and Journalism. http://www.bruno-latour.fr/sites/default/files/121-CASTELLS-GB.pdf.

Latour, Bruno, and Michel Callon. 1981. "Unscrewing the Big Leviathan; or How Actors Macrostructure Reality, and How Sociologists Help Them To Do So?" In *Advances in Social Theory and Methodology,* 277–303. London: Routledge and Kegan Paul. http://www.bruno-latour.fr/sites/default/files/09-LEVIATHAN-GB.pdf.

Lavoie-Tremblay, Melanie, Maxime Paquet, Marie-Anick Duchesne, Anelise Santo, Ana Gavrancic, François Courcy, and Serge Gagnon. 2010. "Retaining Nurses and Other Hospital Workers: An Intergenerational Perspective of the Work Climate: Intergenerational Perspective and Work Climate." *Journal of Nursing Scholarship* 42 (4): 414–22. doi:10.1111/j.1547-5069.2010.01370.x.

Law, John. 1992. "Notes on the Theory of the Actor-Network: Ordering, Strategy, and Heterogeneity." *Systems Practice* 5 (4): 379–93.

———. 1994. "Organization, Narrative and Strategy'." In *Towards a New Theory of Organizations*, 248–68. London: Routledge.

———. 2002. *Complexities: Social Studies of Knowledge Practices*. Duke University Press.

———. 2004. *After Method: Mess in Social Science Research*. London: Psychology Press.

———. 2007. "Actor Network Theory and Material Semiotics." Centre for Science Studies and Dept of Sociology: Lancaster University. http://www.heterogeneities.net/publications/Law2007ANTandMaterialSemiotics.pdf.

———. n.d. "Actor Network Theory and Material Semiotics." In .

Law, John, and John Hassard. 1999. "After ANT:Complexity, Naming and Topology." In *Actor Network Theory and After*. Oxford: Blackwell Publishers.

Law, John, and Annemarie Mol. 2002. *Complexities: Social Studies of Knowledge Practices*. Durham NC: Duke University Press.

Lay, Mary M. 2000. *The Rhetoric of Midwifery: Gender, Knowledge, and Power*. New Brunswick: Rutgers University Press.

Layard, Richard. 2011. *Happiness: Lessons from a New Science (Second Edition)*. London: Penguin UK.

Leap, Nicky, Hannah Grace Dahlen, Pat Brodie, and Juliet Thorpe. 2011. "Relationships- the Glue That Holds It All Together: Midwifery Continuity of Care and Sustainability." In *Sustainability, Midwifery and Birth.* London: Routledge.

Leap, Nicky, and Billie Hunter. 2016. *Supporting Women for Labour and Birth: A Thoughtful Guide*. London: Routledge.

Leap, Nicky, Jane Sandall, Sara Buckland, and Ulli Huber. 2010. "Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care." *The Journal of Midwifery & Women ́s Health* 55 (3): 234–42. doi:10.1016/j.jmwh.2010.02.001.

Leclère, Chloë, Sylvie Viaux, Marie Avril, Catherine Achard, Mohamed Chetouani, Sylvain Missonnier, and David Cohen. 2014. "Why Synchrony Matters during Mother-Child Interactions: A Systematic Review." Edited by Sharon Dekel. *PLoS ONE* 9 (12): e113571. doi:10.1371/journal.pone.0113571.

Lee, Nick, and Steve Brown. 1994. "Otherness and the Actor-Network: The Undiscovered Continent." *American Behavioural Scientist* 37: 772–79. doi:10.1177/0002764294037006005.

Lehtonen, Markku. 2004. "The Environmental–social Interface of Sustainable Development: Capabilities, Social Capital, Institutions." *Ecological Economics*, Papers of the Eight Meeting of the International Society for Ecological Economics; Montreal, Ont. Canada; July 11-14, 2004, 49 (2): 199–214. doi:10.1016/j.ecolecon.2004.03.019.

Leining, Catherine, and Scott White. 2015. "From Fact to Act: New Zealanders' Beliefs and Actions on Climate Change." Motu Economic and Public Policy Research.

Leone, Massimo. 2015. "Longing for the Past: A Semiotic Reading of the Role of Nostalgia in Present-Day Consumption Trends." *Social Semiotics* 25 (1): 1–15. doi:10.1080/10350330.2014.950008.

Levine, Hal B. 2009. "Embracing Neoliberalism? A Reconsideration Fo the Restructuring of the New Zealand Non-Governmental Organsation." *Ethnology* 48 (2): 161–74.

Lewis, E. 2015. "Why There's No Point Telling Me to Lose Weight." *BMJ* 350 (jan20 31): g6845–g6845. doi:10.1136/bmj.g6845.

Lewis, N, and W Moran. 1998. "Restructuring, Democracy, and Geography in New Zealand." *Environment and Planning C: Government and Policy* 16 (2): 127–53. doi:10.1068/c160127.

Liamputtong, Pranee. 2011. *Focus Group Methodology: Principle and Practice*. SAGE.

Liedloff, Jean. 2004. *The Continuum Concept*. London: Penguin UK.

Light, Donald. 2010. "Health-Care Professions, Markets, and Countervailing Powers."." In *Handbook of Medical Sociology*, edited by P Bird, AM Conrad, and Stefan Timmermans. Fremont: Prentice-Hall.

Light, Donald, and Sol Levine. 1988. "The Changing Character of the Medical Profession: A Theoretical Overview." *The Milbank Quarterly* 66: 10–32. doi:10.2307/3349912.

Lincoln, Yvonna. 2011. "Emerging Criteria for Quality in Qualitative and Interpretive Research." In *SAGE Qualitative Research Methods*, by Paul Atkinson and Sara Delamont. Vol. IV. SAGE.

Litosseliti, Lia. 2003. *Using Focus Groups in Research*. New York: A&C Black.

Littig, B, and Grießler E. 2005a. "Social Sustainability: A Catch Word between Political Pragmatism and Social Theory." *Int. J. Sustainable Development* 8 (1/2). http://www.forschungsnetzwerk.at/downloadpub/2005_littig_61193241.pdf.

———. 2005b. "Social Sustainability: A Catchword between Political Pragmatism and Social Theory." *Int. J. Sustainable Development* 8 (1/2): 65–79.

Liu, James H., and Denis J. Hilton. 2005a. "How the Past Weighs on the Present: Social Representations of History and Their Role in Identity Politics." *The British Journal of Social Psychology* 44 (December): 537–56.

———. 2005b. "How the Past Weighs on the Present: Social Representations of History and Their Role in Identity Politics." *British Journal of Social Psychology* 44 (4): 537–56. doi:10.1348/014466605X27162.

Lorenzoni, Irene, Sophie Nicholson-Cole, and Lorraine Whitmarsh. 2007. "Barriers Perceived to Engaging with Climate Change among the UK Public and Their Policy Implications." *Global Environmental Change* 17 (3–4): 445–59. doi:10.1016/j.gloenvcha.2007.01.004.

Lothian, Judith A. 2008. "Choice, Autonomy, and Childbirth Education." *The Journal of Perinatal Education* 17 (1): 35–38. doi:10.1624/105812408X266278.

Lovell, Sarah A. 2009. "Social Capital: The Panacea for Community?" *Geography Compass* 3 (2): 781–96. doi:10.1111/j.1749-8198.2008.00208.x.

Lovelock, James. 2007. *The Revenge of Gaia: Earth's Climate Crisis & The Fate of Humanity*. Basic Books.

Lupton, Deborah. 1999. *Risk*. London: Psychology Press.

Lupton, Deborah, Sophie McCarthy, and Simon Chapman. 1995. "'Panic Bodies': Discourses on Risk and HIV Antibody Testing." *Sociology of Health & Illness* 17 (1): 89–108. doi:10.1111/1467-9566.ep10934489.

MacDonald, Anne. 2000. "The Story of Grace Neill." *Paediatric Nursing* 12 (7): 28.

Macdonald, Charlotte. n.d. "Grace Neil." In *The Book of New Zealand Women / Ko Kui Ma Te Kaupapa*, 467–71. Wellington: Bridget Williams Books.

MacKenzie Bryers, Helen, and Edwin van Teijlingen. 2010. "Risk, Theory, Social and Medical Models: A Critical Analysis of the Concept of Risk in Maternity Care." *Midwifery*, Safety in Maternity Care, 26 (5): 488–96. doi:10.1016/j.midw.2010.07.003.

Mackenzie, Catriona, and Natalie Stoljar. 2000. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford University Press.

MacOg, Oengus. 2013. *The Burning Times (Complete Documentary)*. https://www.youtube.com/watch?v=YizdSL2_pMo.

Maggs, Christopher J. 1983. *The Origins of General Nursing*. London: Croom Helm.

Malthus, Thomas. 1826. *An Essay on the Principle of Population*. 6th ed. London, England: John Murray. http://www.econlib.org/library/Malthus/malPlong1.html.

Mander, Rosemary. 2013. *The Politics of Maternity*. First edition. Abingdon, Oxon: Routledge.

Mander, Rosemary, and Valerie Fleming. 2002. *Failure to Progress: The Contraction of the Midwifery Profession*. London: Psychology Press.

Mander, Rosemary, and Hanna-Leena Melender. 2009. "Choice in Maternity: Rhetoric, Reality and Resistance." *Midwifery* 25 (6): 637–48. doi:10.1016/j.midw.2007.10.009.

Mander, Rosemary, and Jo Murphy-Lawless. 2013. *The Politics of Maternity*. London: Routledge.

Marland, Hilary. 2005. *The Art of Midwifery : Early Modern Midwives in Europe*. Hoboken: Taylor and Francis.

Marland, Hilary, and Anne Marie Rafferty. 2002. *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*. London: Routledge.

Marsden, Māori, T. A Henare, New Zealand, and Ministry for the Environment. 1992. *Kaitiakitanga: A Definitive Introduction to the Holistic World View of the Māori*. Wellington, N.Z.: Ministry for the Environment.

Marshall, Julian D., and Michael W. Toffel. 2005. "Framing the Elusive Concept of Sustainability: A
    Sustainability Hierarchy." *Environmental Science & Technology* 39 (3): 673–82.
    doi:10.1021/es040394k.

Martin, Roger L, and Sally Osberg. 2007. "Social Entrepreneurship: The Case for Definition (SSIR)."
    Stanford Socail Innovation Review.
    https://ssir.org/articles/entry/social_entrepreneurship_the_case_for_definition.

Martis, Ruth. 2011. "Good Housekeeping in Midwifery Practice." In *Sustainability, Midwifery and Birth*,
    edited by Lorna Davies, Rea Daellenbach, and Mary Kensington, 141–55. London: Routledge.

Marx, Karl, and Friedrich Engels. 1970. *The German Ideology*. New York: International Publishers Co.

Maslow, Abraham H. 2013. *Toward a Psychology of Being*. 4th ed. New York: Simon and Schuster.

Matheson, Linda Kay, and Kathleen Bobay. 2007. "Validation of Oppressed Group Behaviors in Nursing."
    Journal of Professional Nursing 23 (4): 226–34. doi:10.1016/j.profnurs.2007.01.007.

McAra-Couper J, Jones M, and Smythe E. 2010. "Rising Rates of Intervention in Childbirth." *British Journal
    of Midwifery* 18 (3): 160–69.

McAra-Couper, J., M. Jones, and L. Smythe. 2012. "Caesarean-Section, My Body, My Choice: The
    Construction of 'Informed Choice' in Relation to Intervention in Childbirth." *Feminism &
    Psychology* 22 (1): 81–97. doi:10.1177/0959353511424369.

McAra-Couper, Judith. 2007. "What Is Shaping the Practice of Health Professionals and the
    Understanding of the Public in Relation to Increasing Intervention in Childbirth?" Thesis,
    Auckland: Auckland University of Technology.
    http://aut.researchgateway.ac.nz/bitstream/handle/10292/323/McAraCouperJ.pdf?sequence=2.

McAra-Couper, Judith, Andrea Gilkison, Susan Crowther, Marion Hunter, Claire Hotchin, and Jackie Gunn.
    2014. "Partnership and Reciprocity with Women Sustain Lead Maternity Carer Midwives in
    Practice." *New Zealand College of Midwives Journal* 49 (June): 29–33.
    doi:10.12784/nzcomjnl49.2014.5.29-33.

McCartney, G., and P. Hanlon. 2009. "What Can Health Professionals Contribute to the Challenge of
    Sustainability?" *Public Health* 123 (12): 761–64. doi:10.1016/j.puhe.2009.09.008.

McChesney, Robert W. 2008. *The Political Economy of Media: Enduring Issues, Emerging Dilemmas*. New
    York: NYU Press.

Mccool, Stephen F., and George H. Stankey. 2004. "Indicators of Sustainability: Challenges and
    Opportunities at the Interface of Science and Policy." *Environmental Management* 33 (3): 294–
    305. doi:10.1007/s00267-003-0084-4.

McCourt, Chris, and Trudy Stevens. 2008. "Relationship and Reciprocity in Caseload Midwifery." In
    Emotions in Midwifery and Reproduction. Basingstoke: Palgrave Macmillan.

Mccredie, Margaret R.E., Charlotte Paul, Katrina J. Sharples, Judith Baranyai, Gabriele Medley, David C.G. Skegg, and Ronald W. Jones. 2010. "Consequences in Women of Participating in a Study of the Natural History of Cervical Intraepithelial Neoplasia 3: Consequences of Participating in Study of CIN3." *Australian and New Zealand Journal of Obstetrics and Gynaecology* 50 (4): 363–70. doi:10.1111/j.1479-828X.2010.01170.x.

McDonagh-Philp, D. 2012. "Undergraduate Design Project Utilising Users as a Design Resource:A Case Study." In *Collaborative Design:Proceedings of CoDesigning 2000*, 493–500. London: Springer Verlag.

McDonald, Catherine. 2006. *Challenging Social Work: The Institutional Context of Practice*. Basingstoke: Palgrave Macmillan.

McDonald, Cathy. 2012. "Understanding Participatory Action Research: A Qualitative Research Methodology Option." *Canadian Journal of Action Research* 13 (2): 35–50.

McDonald, Ruth, Justin Waring, and Stephen Harrison. 2006. "At the Cutting Edge? Modernization and Nostalgia in a Hospital Operating Theatre Department." *Sociology* 40 (6): 1097–1115. doi:10.1177/0038038506069851.

McGuigan, Jim. 2014. "The Neoliberal Self." *Culture Unbound: Journal of Current Cultural Research* 6 (1): 223–40. doi:10.3384/cu.2000.1525.146223.

McIlhone, Bernard. 2016. "MERAS:MECA Settled and Ratified." *Midwifery News*, March.

McIntosh, Tania. 2013. *A Social History of Maternity and Childbirth: Key Themes in Maternity Care*. London: Routledge.

McIntyre, Alice. 2008. *Participatory Action Research*. 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc. http://srmo.sagepub.com/view/participatory-action-research-qrm/SAGE.xml.

McIntyre, Meredith, Karen Francis, and Ysanne Chapman. 2012. "Critical Discourse Analysis: Understanding Change in Maternity Services." *International Journal of Nursing Practice* 18 (1): 36–43. doi:10.1111/j.1440-172X.2011.01991.x.

McKenna, James, Sarah Mosko, Christopher Richard, and Sean Drummond. 1994. "Experimental Studies of Infant-Parent Co-Sleeping: Mutual Physiological and Behavioral Influences and Their Relevance to SIDS (Sudden Infant Death Syndrome)." *Early Human Development* 38 (3): 187–201. doi:10.1016/0378-3782(94)90211-9.

McKenzie, Stephen. 2004. "Social Sustainability: Twoards Some Definitions." Working Paper. No. 27. Magill: Hawkes research Institute, University of South Australia.

McMichael, T., H. Montgomery, and A. Costello. 2012a. "Health Risks, Present and Future, from Global Climate Change." *BMJ* 344 (mar19 1): e1359–e1359. doi:10.1136/bmj.e1359.

———. 2012b. "Health Risks, Present and Future, from Global Climate Change." *BMJ* 344 (mar19 1): e1359–e1359. doi:10.1136/bmj.e1359.

MCNZ. 2008. "Ensuring Midwives Are Competent | Midwifery Council of New Zealand." *Midwifery Council of New Zealand*. https://www.midwiferycouncil.health.nz/professional-standards/ensuring-midwives-are-competent.

McQueen, Michael. 2007. *The New Rules of Engagement: A Guide to Understanding and Connecting with Generation Y*. BookBaby.

McTaggart, Robin. 1991. "Principles for Participatory Action Research." *Adult Education Quarterly* 41 (3): 168–87. doi:10.1177/0001848191041003003.

———. 1999. "Reflection on the Purposes of Research, Action, and Scholarship: A Case of Cross-Cultural Participatory Action Research." *Systemic Practice and Action Research* 12 (5): 493–511. doi:10.1023/A:1022417623393.

Meakin, Stephanie. 1992. "The Rio Earth Summit. Summary of the UN Conference of Environment and Development." BP-317E. United Nations. http://publications.gc.ca/Collection-R/LoPBdP/BP/bp317-e.htm.

Meier, Cecile. 2017. "Plan to Push Women to Birth Away from Christchurch Women's Hospital 'Adds Risk' | Stuff.Co.Nz." News. *Stuff*. March 25. http://www.stuff.co.nz/national/health/90661827/plan-to-push-women-to-birth-away-from-christchurch-womens-hospital-adds-risk.

Merchant, Carolyn. 1990. *The Death of Nature: Women, Ecology, and the Scientific Revolution*. New York: HarperCollins.

———. 2006. "The Scientific Revolution and the Death of Nature." *Isis* 97 (3): 513–33. doi:10.1086/isis.2006.97.issue-3.

Mezirow, Jack. 1990. *Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning*. San Francisco: Jossey-Bass Publishers.

Michael, Mike. 2012. *Reconnecting Culture, Technology and Nature: From Society to Heterogeneity*. London: Routledge.

Midwifery Council of New Zealand. 2010a. "Code of Conduct." MCNZ. https://www.google.co.uk/search?q=how+are+personal+and+professional+identity+separated&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&ei=Dr7IWIG3D9ST8QeS64PgAw#q=do+codes+of+conduct+and+ethics+help+to+separate++personal+and+professional+identity+in+NZ+midwifery&*.

———. 2010b. "The Midwifery Scope of Practice." *Midwifery Council of New Zealand*. https://www.midwiferycouncil.health.nz/midwives/midwifery-scope-practice.

———. 2012. "Statement on Cultural Competence for Midwives." Wellington: Midwifery Council of New Zealand.

353

https://www.midwiferycouncil.health.nz/sites/default/files/documents/PDF%20cultural%20com
petence.pdf.

Mies, María, and Vandana Shiva. 1993. *Ecofeminism*. Fernwood Publications.

Mikaere, Annie. 1994. "Maori Women: Caught in the Contradictions of a Colonised Reality - Annie
Mikaere - Te Piringa - Faculty of Law : University of Waikato."
http://www.waikato.ac.nz/law/research/waikato_law_review/volume_2_1994/7.

Milcu, Andra, Jan Hanspach, David Abson, and Joern Fischer. 2013. "Cultural Ecosystem Services: A
Literature Review and Prospects for Future Research." *Ecology and Society* 18 (3).
doi:10.5751/ES-05790-180344.

Miller, Suzanne, and Liz Wilkes. 2015. "Working in Partnership." In *Preparation for Practice*, edited by
Sally Pairman, Sally K Tracy, Jan Pincombe, and Carol Thorogood, 3rd ed., 412–26. Morrinsville:
Elsevier Health Sciences.

Milligan, Melinda J. 2003. "Displacement and Identity Discontinuity: The Role of Nostalgia in Establishing
New Identity Categories." *Symbolic Interaction* 26 (3): 381–403. doi:10.1525/si.2003.26.3.381.

Mills, MA, and PG Coleman. 1994. "Nostalgic Memories in Dementia--a Case Study. - PubMed - NCBI."
International Journal of Aging and Human Development 38: 203–19.

Milne, Markus J., and Rob Gray. 2012. "W(h)Ither Ecology? The Triple Bottom Line, the Global Reporting
Initiative, and Corporate Sustainability Reporting." *Journal of Business Ethics* 118 (1): 13–29.
doi:10.1007/s10551-012-1543-8.

Ministry of Health. 2007. "Section 88 Primary Maternity Services Notice 2007." *Ministry of Health NZ*.
http://www.health.govt.nz/publication/section-88-primary-maternity-services-notice-2007.

———. 2012. "Guidelines for Consultation with Obstetric and Related Medical Services (Referral
Guidelines)." Wellington, NZ: MoH.

———. 2015. "Health Practitioners Competence Assurance Act." *Ministry of Health NZ*.
http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-
practitioners-competence-assurance-act.

———. 2017. "Nurses Act 1977 (1977 No 53)." Accessed August 15.
http://www.nzlii.org/nz/legis/hist_act/na19771977n53138/.

Minkowski, W L. 1992. "Women Healers of the Middle Ages: Selected Aspects of Their History." *American
Journal of Public Health* 82 (2): 288–95.

MoH. 1990. "Nurses Amendment Act 1990." *Ministry of Health NZ*.
http://www.moh.govt.nz/notebook/nbbooks.nsf/0/7E9811383ED959B34C2565D7000DE831.

———. 2015a. "Maternity Consumer Survey 2014." *Ministry of Health NZ*.
http://www.health.govt.nz/publication/maternity-consumer-survey-2014.

———. 2015b. "Report on Maternity, 2014." *Ministry of Health NZ*.

http://www.health.govt.nz/publication/report-maternity-2014.

———. 2017. "The Cartwright Inquiry 1988." *Ministry of Health NZ*. Accessed August 15.

http://www.health.govt.nz/publication/cartwright-inquiry-1988.

Mol, A. 2010. "Actor-Network Theory: Sensitive Terms and Enduring Tensions." *Kölner Zeitschrift Für Soziologie Und Sozialpsychologie. Sonderheft* 50. http://dare.uva.nl/search?identifier=75bbc661-0a89-475a-9eef-8c8c5a2e9904.

Mol, Annemarie. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. Routledge.

Mold, Alex. 2015. *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain*. Oxford University Press.

Moon, Jennifer A. 2004. *A Handbook of Reflective and Experiential Learning: Theory and Practice*. London: Psychology Press.

Moon, Tracey. 2008. "Psychology & Society, 2008, Vol. 1 (1), 77 - 83 77 Reflexivity and Its Usefulness When Conducting a Secondary Analysis of Existing Data." *Psychology and Society* 1 (1): 77–83.

Moore-Lappe, Frances. 2011. EcoMind: Changing the way that we think. Nashville. HatchetteBook Group

Morgan, Brian. 2004. "A Tangata Whenua Perspective on Sustainability Using the Mauri Model." In , 14. Auckland.

Morgan, and Alice U. Scannell. 1998. *Planning Focus Groups*. Thousand Oaks CA: SAGE.

Morrison, Elizabeth Wolfe, and Frances J. Milliken. 2000. "Organizational Silence: A Barrier to Change and Development in a Pluralistic World." *The Academy of Management Review* 25 (4): 706

doi:10.2307/259200.

Moser, Susanne C., and Maxwell T. Boykoff. 2013. *Successful Adaptation to Climate Change: Linking Science and Policy in a Rapidly Changing World*. Routledge.

Moss, Richard H., Jae A. Edmonds, Kathy A. Hibbard, Martin R. Manning, Steven K. Rose, Detlef P. van Vuuren, Timothy R. Carter, et al. 2010. "The next Generation of Scenarios for Climate Change Research and Assessment." *Nature* 463 (7282): 747–56.

Moss, Walter G. 2008. *An Age of Progress?: Clashing Twentieth-Century Global Forces*. London, New York, Delhi: Anthem Press.

Müller, Martin. 2015a. "Assemblages and Actor-Networks: Rethinking Socio-Material Power, Politics and Space." *Geography Compass* 9 (1): 27–41. doi:10.1111/gec3.12192.

———. 2015b. "A Half-Hearted Romance? A Diagnosis and Agenda for the Relationship between Economic Geography and Actor-Network Theory (ANT)." *Progress in Human Geography; London* 39 (1): 65–86. doi:http://dx.doi.org.ezproxy.canterbury.ac.nz/10.1177/0309132513518833. Munday, Jennie. 2006. "Identity in Focus: The Use of Focus Groups to Study the Construction of

355

www.manaraa.com

Murdoch, Jonathan, and Marsden. 1995. "The Spatialization of Politics: Local and National Actor-Spaces in Environmental Conflict." *Transactions of the Institute of British Geographers* 20 (3): 368–80. doi:10.2307/622657.

Murphy-Lawless, Jo. 2006. "Birth and Mothering in Today's Social Order: The Challenge of New Knowledge's." *MIDIRS Midwifery Digest* 16 (4): 439–44.

———. 2011. "Globalisation, Midwifery and Maternity Services." In *Sustainability, Midwifery and Birth.*, edited by Lorna Davies, Rea Daellenbach, and Mary Kensington, 11–21. London: Routledge.

Murray-Davis, Beth, Helen McDonald, Angela Rietsma, Melissa Coubrough, and Eileen Hutton. 2014. "Deciding on Home or Hospital Birth: Results of the Ontario Choice of Birthplace Survey." *Midwifery* 30 (7): 869–76. doi:10.1016/j.midw.2014.01.008.

Mützel, Sophie. 2009. "Networks as Culturally Constituted Processes: A Comparison of Relational Sociology and Actor-Network Theory." *Current Sociology* 57 (6): 871–87. doi:10.1177/0011392109342223.

Muzio, Daniel, and Ian Kirkpatrick. 2011. "Introduction: Professions and Organizations - a Conceptual Framework." Edited by Daniel Muzio and Ian Kirkpatrick. *Current Sociology* 59 (4): 389–405. doi:10.1177/0011392111402584.

NCVO. 2017. "UK Civil Society Almanac 2012 / Has the Number of People Volunteering Changed over Time?" https://data.ncvo.org.uk/a/almanac12/has-the-number-of-people-volunteering-changed-over-time/.

"Neoliberalism and Global Sweatshops." 2015. Accessed July 28. http://courses.umass.edu/econ797a-rpollin/Pollin--Neoliberalism%20and%20Global%20Sweatshops--2007.pdf.

Neumayer, E. 2013. *Weak versus Strong Sustainability : Exploring the Limits of Two Opposing Paradigms*. Cheltenham: Edward Elgar Publishing.

New Zealand College of Midwives. 2015. *Midwives Handbook for Practice.* 3rd ed. Christchurch, NZ: NZCOM.

New Zealand Govenment. 2017. *New Zealand Bill of Rights Act 1990*. Vol. 109. Accessed June 23. http://www.legislation.govt.nz/act/public/1990/0109/latest/whole.html#DLM224792.

New Zealand Government. 1986. "Commerce Act 1986 No 5 (as at 30 May 2017), Public Act Contents – New Zealand Legislation." http://www.legislation.govt.nz/act/public/1986/0005/73.0/DLM87623.html.

———. 2017. "Social Security Act 1964 No 136 (as at 14 July 2017), Public Act Contents – New Zealand Legislation." Accessed August 15. http://www.legislation.govt.nz/act/public/1964/0136/latest/DLM359107.html.

Newton, Tim J. 2002. "Creating the New Ecological Order? Elias and Actor-Network Theory." *The Academy of Management Review* 27 (4): 523–40. doi:10.2307/4134401.

Nicolson, Donald J. 2017. *Academic Conferences as Neoliberal Commodities*. New York: Springer.

Niebrzydowski, Sue. 2011. "Asperges Me, Domine, Hyssopo: Male Voices, Female Interpretation and the Medieval English Purification of Women after Childbirth Ceremony." *Early Music* 39 (3): 327–34. doi:10.1093/em/car053.

Niven, Catherine A. 2013. *Psychological Care for Families: Before, During and After Birth*. Oxford: Butterworth-Heinemann.

Nolan, Mary. 2015. "Perceptions of Risk: How They Influence Women's and Health Professionals' Choices." *British Journal of Midwifery* 23 (8): 547–51.

Norman, Wayne, and Chris MacDonald. 2004. "Getting to the Bottom of 'Triple Bottom Line.'" *Business Ethics Quarterly* 14 (2): 243–62.

Northcote, Maria T. 2012. "Selecting Criteria to Evaluate Qualitative Research." Education Briefing 38. Avondale: Avondale College of HIgher Education. http://research.avondale.edu.au/cgi/viewcontent.cgi?article=1038&context=edu_papers.

Norton, Bryan G. 2005. *Sustainability : A Philosophy of Adaptive Ecosystem Management*. Chicago: University of Chicago Press.

Noseworthy, D. Ann, Suzanne R. Phibbs, and Cheryl A. Benn. 2013. "Towards a Relational Model of Decision-Making in Midwifery Care." *Midwifery* 29 (7): e42–48. doi:10.1016/j.midw.2012.06.022.

NZ Government. 2017. "Health and Disability Services Act 1993 (1993 No 22)." Accessed August 15. http://www.nzlii.org/nz//legis/hist_act/hadsa19931993n22304/.

NZCOM. 2014. "New Zealand College of Midwives Research Strategy." Christchurch, NZ: NZCOM. https://www.google.co.nz/#q=midwives+increasing+involvement+in+research+in+New+Zealand.

———. 2016. "Pay Equity for Midwives." NZCOM.

———. 2017. "New Zealand College of Midwives." *New Zealand College of Midwives*. https://www.midwife.org.nz/.

NZLII. 1983. "Area Health Boards Act 1983 (1983 No 134)." http://www.nzlii.org/nz/legis/hist_act/ahba19831983n134170/.

O' Sullivan, Sean. 2008. "Social Enterprise: Do Midwives Gain? | RCM." *The Royal College of Midwives*. https://www.rcm.org.uk/news-views-and-analysis/analysis/social-enterprise-do-midwives-gain.

Obasi, Chidi, Allison Agwu, Wale Akinpelu, Roger Hammons, Clyde Clark, Ralph Etienne-cummings, Peter Hill, et al. 2009. "Contamination of Equipment in Emergency Settings: An Exploratory Study with a Targeted Automated Intervention." *Annals of Surgical Innovation and Research* 3 (1): 8. doi:10.1186/1750-1164-3-8.

Odent, Michel. 1999. *The Scientification of Love*. London: Free Association Books.

———. 2007. *Primal Health: Understanding the Critical Period Between Conception and the First Birthday*. West Hoathley: CLAIRVIEW BOOKS.

357

Ogilvie, Sheilagh. 2011. *Institutions and European Trade: Merchant Guilds, 1000–1800*. Cambridge: Cambridge University Press.

Olsen Murray, Mary Jo. 2001. "A Profession under Siege: Opportunities for Re-Imaging What It Means to Be a School Psychologist." Ed.D., United States -- Minnesota: University of St. Thomas (Minnesota). http://search.proquest.com.ezproxy.canterbury.ac.nz/docview/251799516/abstract.

Olsen, Ole, and Jette A Clausen. 2012. "Planned Hospital Birth versus Planned Home Birth." In *Cochrane Database of Systematic Reviews*, edited by The Cochrane Collaboration. Chichester, UK: John Wiley & Sons, Ltd. doi:10.1002/14651858.CD000352.pub2.

Oppenheim, Robert. 2007a. "Actor-Network Theory and Anthropology after Science, Technology, and Society." *Anthropological Theory* 7 (4): 471–93. doi:10.1177/1463499607083430.

———. 2007b. "Actor-Network Theory and Anthropology after Science, Technology, and Society." *Anthropological Theory* 7 (4): 471–93. doi:10.1177/1463499607083430.

Orbach, Susie. 1986. *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age*. New York: Avon.

———. 2008. "Chinks in the Merged Attachment: Generational Bequests to Contemporary Teenage Girls." *Studies in Gender and Sexuality* 9 (3): 215–32. doi:10.1080/15240650802118018.

Oreskes, N. 2004. "BEYOND THE IVORY TOWER: The Scientific Consensus on Climate Change." *Science* 306 (5702): 1686–1686. doi:10.1126/science.1103618.

Orr, Suzeanne. 2004. "Social Support and Pregnancy Outcome: A Review of the Litera... : Clinical Obstetrics and Gynecology." *Clinical Obstetrics & Gynecology* 47 (4): 842–55.

Ott, Konrad. 2014. "Institutionalizing Strong Sustainability: A Rawlsian Perspective." *Sustainability* 6 (2): 894–912. doi:10.3390/su6020894.

Pachauri, R.K, and L. Meyer. 2014. "IPCC, 2014: Climate Change 2014: Synthesis Report. Contribution of Working Groups I, II and III to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change." Geneva, Switzerland: IPCC.

Pairman. 2005. *Workforce to Profession : An Exploration of New Zealand Midwifery's Professionalising Strategies from 1986 to 2005 : A Professional Doctorate Submitted in Partial Fulfilment of the Requirements for the Degree of Doctor of Midwifery*. Thesis DMid--University of Technology, Sydney.

Pairman, S. 2005. "Workforce to Profession : An Exploration of New Zealand Midwifery's Professionalising Strategies from 1986 to 2005." Thesis. https://opus.lib.uts.edu.au/handle/10453/37529.

Pairman, Sally. 1998. "The Midwifery Partnership: An Exploration of the Midwife/Woman Relationship." Wellington, NZ: Victoria University of Wellington.

———. 2005. "From Autonomy and Back Again: Educating Midwives across a Century." *New Zealand College of Midwives Journal* 33 (October): 4–9.

358

———. 2010. "Sustainable Midwifery Education: A Case Study from New Zealand." In *Sustainability, Midwifery and Birth*, 1st ed. London: Routledge.

Pairman, Sally, Lesley Dixon, Emma Tumilty, Elaine Gray, Norma Campbell, Susan Calvert, Sue Lennox, and Mary Kensington. 2016. "The Midwifery First Year of Practice Programme: Supporting New Zealand Midwifery Graduates in Their Transition to Practice." *NZCOM Journal*, no. 52 (December): 12–19.

Pairman, Sally, and R Donellen-Fernandez. 2015. "Professional Frameworks for Practice in Australia and New Zealand." In *Midwifery: Preparation for Practice*, edited by Sally Pairman, Sally K Tracy, Jan Pincombe, and Carol Thorogood, 3rd ed. Morrinsville: Elsevier Health Sciences.

Pairman, Sally, Jan Pincombe, Carol Thorogood, and Sally K. Tracy. 2015. *Midwifery: Preparation for Practice*. Elsevier Health Sciences.

Palmer, Gabrielle. 2009. *The Politics of Breastfeeding: When Breasts Are Bad for Business*. London: Pinter & Martin.

Papps, Elaine, and Mark Olssen. 1997. *Doctoring Childbirth and Regulating Midwifery in New Zealand: A Foucauldian Perspective*. Palmerston North: Dunmore Press.

Patterson, Ron. 2010. "Regulating Doctors: Finding the Optimal Balance between Professionalism and Self-Regulation." In *Publication of Proceedings. International Revalidation Symposium: Contributing to the Evidence Base, 3-7.* London. http://www.gmc-uk.org/International_Revalidation_Symposium_Publication_of_proceedings.pdf_44014486.pdf.

Payne, Christopher. 2012. *The Consumer, Credit and Neoliberalism: Governing the Modern Economy*. London: Routledge.

Peck, Jamie. 2010. *Constructions of Neoliberal Reason*. OUP Oxford.

Peck, Jamie, and Adam Tickell. 2002. "Neoliberalizing Space." *Antipode* 34 (3): 380–404. doi:10.1111/1467-8330.00247.

Pelvin, Bronwen, and Tricia Thompson. 2015. "Sustaining MIdwifery Practice." In *Midwifery - E-Book: Preparation for Practice*, edited by Sally Pairman, Sally K Tracy, Jan Pincombe, and Carol Thorogood, 3rd ed. Marricksville NSW: Elsevier Health Sciences.

Penley, Constance, Andrew Ross, and Donna Haraway. 1990. "Cyborgs at Large: Interview with Donna Haraway." *Social Text*, no. 25/26: 8. doi:10.2307/466237.

Pere, Rose. 1994. *Ako : Concepts and Learning in the Māori Tradition*. Wellington, NZ: Te Kohanga Reo National Trust Board.

———. 1997. *Te Wheke: A Celebration of Infinite Wisdom.* Dunedin: Ao Ako Global Learning.

Peters, Michael, and James Marshall. 2002. *Individualism And Community: Education And Social Policy In The Postmodern Condition*. Routledge.

Phillips, Mary. 2007. "Midwives versus Medics: A 17th-Century Professional Turf War." *Management & Organizational History* 2 (1): 27–44. doi:10.1177/1744935907076349.

Piaget, Jean. 1998. *The Language and Thought of the Child*. Third. Vol. 5. Hove, UK: Psychology Press.

Pitman-Will, Andrea. 2013. "Pregnancy and Postpartum: A Guide for Singers." Doctor of Musical Arts, Tucson: University of Arizona. https://repository.asu.edu/attachments/110302/content/Will_asu_0010E_12695.pdf.

Plumwood, Val. 2002. *Environmental Culture : The Ecological Crisis of Reason*. New York: Routledge.

Poduval, Murali, and Jayita Poduval. 2008. "Medicine as a Corporate Enterprise: A Welcome Step?" *Mens Sana Monographs* 6 (1): 157–74. doi:10.4103/0973-1229.34714.

Polomeno, Viola. 1999. "Perinatal Education and Grandparents: Creating an Interdependent Family Environment—Part II: The Pilot Study." *Journal of Perinatal Education* 8 (3): 1–11. doi:10.1624/105812499X87187.

Ponti, Marisa. 2011. "Uncovering Causality in Narratives of Collaboration: Actor-Network Theory and Event Structure Analysis." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 13 (1). http://www.qualitative-research.net/index.php/fqs/article/view/1659.

Porter, Doug, and David Craig. 2004. "The Third Way and the Third World: Poverty Reduction and Social Inclusion in the Rise of 'Inclusive' Liberalism." *Review of International Political Economy* 11 (2): 387–423.

Pringle, Rosemary. 1989. *Secretaries Talk: Sexuality, Power and Work*. London: Verso.

Purkiss, Diane. 1996. *The Witch in History : Early Modern and Twentieth-Century Representations.* London: Routledge.

Pyyhtinen, O., and S. Tamminen. 2011. "We Have Never Been Only Human: Foucault and Latour on the Question of the Anthropos." *Anthropological Theory* 11 (2): 135–52. doi:10.1177/1463499611407398.

Quinlan, Andrea. 2014. "Envisioning New Intersections between Feminist Metholdogies and Actor-Network Theory." In *Technological Advancements and the Impact of Actor-Network Theory*, edited by Arthur Tatnell. IGI Global.

Radcliffe, Walter. 1947. *Milestones in Midwifery ; And, The Secret Instrument (The Birth of the Midwifery Forceps)*. Novoto CA: Norman Publishing.

Radford, Andrew. 1991. "The Ecology of Breastfeeding and Dangers of Artificial Feeding." *INFACT Canada*. http://www.infactcanada.ca/ren_res.htm.

Raneri, Leslie G., and Constance M. Wiemann. 2007. "Social Ecological Predictors of Repeat Adolescent Pregnancy." *Perspectives on Sexual and Reproductive Health* 39 (1): 39–47.

Ratner, Blake D. 2004. "'Sustainability' as a Dialogue of Values: Challenges to the Sociology of Development." *Sociological Inquiry* 74 (1): 50–69. doi:10.1111/j.1475-682X.2004.00079.x.

360

Raynor, Maureen D., Jayne E. Marshall, and Amanda Sullivan. 2005. *Decision Making in Midwifery Practice*. London: Elsevier Health Sciences.

Read, Jen'Nan Ghazal, and John P. Bartkowski. 2000. "To Veil or Not to Veil? A Case Study of Identity Negotiation among Muslim Women in Austin, Texas." *Gender and Society* 14 (3): 395–417.

Read, Rupert. 2015. "Green Economics versus Growth Economics." *Radical Philosophy*. https://www.radicalphilosophy.com/commentary/green-economics-versus-growth-economics.

Reason, Peter, and Hilary Bradbury. 2006. *Handbook of Action Research: Concise Paperback Edition*. London: SAGE.

Redclift, Michael. 2005a. "Sustainable Development (1987–2005): An Oxymoron Comes of Age." *Sustainable Development* 13 (4): 212–27. doi:10.1002/sd.281.

———. 2005b. "Sustainable Development (1987–2005): An Oxymoron Comes of Age." *Sustainable Development* 13 (4): 212–27. doi:10.1002/sd.281.

Reed, Rachel, Rachael Sharman, and Christian Inglis. 2017. "Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions." *BMC Pregnancy and Childbirth* 17: 21. doi:10.1186/s12884-016-1197-0.

Regan, Mary, and Katie McElroy. 2013. "Women's Perceptions of Childbirth Risk and Place of Birth." *The Journal of Clinical Ethics* 24 (3): 239.

Rei Millar, David. 2004. "Western and Mäori Values for Sustainable Development." G. http://www.firstfound.org/david%20miller.htm.

Reid, Alice. 2012. "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire." *Social History of Medicine* 25 (2): 380–99. doi:10.1093/shm/hkr138.

Reid, Sian. 2006. *Between the Worlds: Readings in Contemporary Neopaganism*. Canadian Scholars' Press.

Remley, Theodore P. Remley, and Barbara P. Herlihy. 2013. *Ethical, Legal, and Professional Issues in Counseling*. London: Pearson Education.

Rhodes, Jo. 2009. "A Strategic Framework for Rural Micro-Enterprise Development: The Integration of Information Communication Technology (ICT), E-Commerce, Marketing, and Actor-Network Theory." *Perspectives on Global Development and Technology* 8 (1): 48–69. doi:10.1163/156914909X403180.

Richardson, Diane. 2005. "Desiring Sameness? The Rise of a Neoliberal Politics of Normalisation." *Antipode* 37 (3): 515–35. doi:10.1111/j.0066-4812.2005.00509.x.

Ridgway, S. 2002. "The Birth of the Midwifery Profession." *British Journal of Midwifery* 10 (12): 756–60.

Ridley-Duff, Rory, and Mike Bull. 2015. *Understanding Social Enterprise: Theory and Practice*. SAGE.

Riecken, Ted, Teresa Strong-Wilson, Frank Conibear, Corrine Michel, and Janet Riecken. 2005. "Connecting, Speaking, Listening: Toward an Ethics of Voice with/in Participatory Action

Research." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 6 (1). http://www.qualitative-research.net/index.php/fqs/article/view/533.

Rifkin, Jeremy. 2000. *The Age of Access: The New Culture of Hypercapitalism, Where All of Life Is a Paid-for Experience*. Katmandu: Tarcher/Putnam.

Rini, Christine, Christine Dunkel Schetter, Calvin J. Hobel, Laura M. Glynn, and Curt A. Sandman. 2006. "Effective Social Support: Antecedents and Consequences of Partner Support during Pregnancy." *Personal Relationships* 13 (2): 207–29. doi:10.1111/j.1475-6811.2006.00114.x.

Ritivoi, Andreea Deciu. 2002. *Yesterday's Self: Nostalgia and the Immigrant Identity*. Lanham ML: Rowman & Littlefield Publishers.

Ritzer, George, and J. Michael Ryan. 2011. *The Concise Encyclopedia of Sociology*. Chichester, West Sussex, UK: Wiley-Blackwell. http://www.canterbury.eblib.com.au/patron/FullRecord.aspx?p=624726.

Robinson, John. 2004. "Squaring the Circle? Some Thoughts on the Idea of Sustainable Development." *Ecological Economics* 48 (4): 369–84. doi:10.1016/j.ecolecon.2003.10.017.

Rolfe, Gary. 2013. *The University in Dissent: Scholarship in the Corporate University*. Routledge.

Roosvall, Anna, and Matthew Tegelberg. 2013. "Framing Climate Change and Indigenous Peoples: Intermediaries of Urgency, Spirituality and de-Nationalization." *International Communication Gazette* 75 (4): 392–409. doi:10.1177/1748048513482265.

Ross, Peter. 2015. "Memories Are Made of This: How Nostalgia for Hong Kong's Trams, Neon Signs and Other Physical Landmarks Creates a Sense of Identity." *South China Morning Post*. September 21. http://www.scmp.com/comment/insight-opinion/article/1860144/memories-are-made-how-nostalgia-hong-kongs-trams-neon-signs.

Rothman, Robert. 1979. "Occupational Roles: Power and Negotiation in the Division of Labor." *Sociological Quarterly* 20 (4): 495–515.

Rowland, Tim, Deborah McLeod, and Natalie Froese-Burns. 2012. "Comparative Study of Maternity Systems." Wellington, NZ: Ministry of Health. http://www.health.govt.nz/publication/comparative-study-maternity-systems.

Rubin, Allen, and Jennifer Bellamy. 2012. *Practitioner's Guide to Using Research for Evidence-Based Practice*. Chichester, West Sussex,: John Wiley & Sons.

Russill, Chris, and Zoe Nyssa. 2009. "The Tipping Point Trend in Climate Change Communication." *Global Environmental Change* 19 (3): 336–44. doi:10.1016/j.gloenvcha.2009.04.001.

Russo, Jasna. 2012. "Survivor-Controlled Research: A New Foundation for Thinking About Psychiatry and Mental Health." *Forum: Qualitative Social Research* 13 (1): 1–29.

362

Ryan, Kathryn. 2017a. "Midwife Shortage 'Heading for Crisis Level.'" *Radio New Zealand*. March 22. http://www.radionz.co.nz/national/programmes/ninetonoon/audio/201837520/midwife-shortage-'heading-for-crisis-level'.

———. 2017b. "Midwives Negotiate Overhaul of Funding." *Nine to Noon*. Wellington: RNZ.

———. 2016. "Nine To Noon, Wednesday 11 November 2015 | Radio New Zealand National." *Radio New Zealand*. Accessed February 13. http://www.radionz.co.nz/national/programmes/ninetonoon/20151111.

Saks, Mike. 2015. *The Professions, State and the Market: Medicine in Britain, the United States and Russia*. London: Routledge.

Saldanha, Arun. 2003. "Actor-Network Theory and Critical Sociology." *Critical Sociology (Brill Academic Publishers)* 29 (3): 419–32.

Sandall, Jane. 1997. "Midwives' Burnout and Continuity of Care." *British Journal of Midwifery* 5 (2): 106–11.

Sandall, Jane, Cecilia Benoit, Sirpa Wrede, Susan F. Murray, Edwin R. van Teijlingen, and Rachel Westfall. 2009. "Social Service Professional or Market Expert? Maternity Care Relations under Neoliberal Healthcare Reform." *Current Sociology* 57 (4): 529–53. doi:10.1177/0011392109104353.

Sandall, Jane, Hora Soltani, Simon Gates, Andrew Shennan, and Declan Devane. 2013. "Midwife-Led Continuity Models versus Other Models of Care for Childbearing Women." In *Cochrane Database of Systematic Reviews*, edited by The Cochrane Collaboration. Chichester, UK: John Wiley & Sons, Ltd. http://doi.wiley.com/10.1002/14651858.CD004667.pub3.

———. 2016. "Midwife-Led Continuity Models versus Other Models of Care for Childbearing Women." In *Cochrane Database of Systematic Reviews*. John Wiley & Sons, Ltd. doi:10.1002/14651858.CD004667.pub5.

Sarukhan, Jose, and Anne Whyte. 2005. *Ecosystems and Human Well-Being. A Synthesis*. GF50.E26 2005. Washington DC: Island Press.

Scamell, Mandie. 2014. "Childbirth Within the Risk Society." *Sociology Compass* 8 (7): 917–28. doi:10.1111/soc4.12077.

Schaab, Gloria L. 2007. *The Creative Suffering of the Triune God: An Evolutionary Theology*. Oxford: Oxford University Press.

Scheunemann, Leslie P., and Douglas B. White. 2011. "The Ethics and Reality of Rationing in Medicine." *Chest* 140 (6): 1625–32. doi:10.1378/chest.11-0622.

Schneider, Barbara. 2010. *Hearing (Our) Voices: Participatory Research in Mental Health*. Toronto: University of Toronto Press.

Schnorrenberg, B. B. 1981. "Is Childbirth Any Place for a Woman? The Decline of Midwifery in Eighteenth-Century England." *Studies in Eighteenth-Century Culture* 10 (January): 393.

Schon, Donald A. 1987. *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions*. Wiley.

Schorrenberg, barbara Brandon. 1981. "The Decline of Midwifery in Eighteenth Century England." *Studies in Eighteenth-Century Culture* 10: 393–408.

Schroeder, Knut, Trevor Thompson, Kathleen Frith, and David Pencheon. 2012. *Sustainable Healthcare*. Chichester: John Wiley & Sons.

Schumacher, E.F. 1973. *Small Is Beautiful: A Study of Economics As If People Mattered*. First. London: Blond and Briggs. http://www.ditext.com/schumacher/small/small.html.

Seabrook, Jeremy. 1987. "Agenda: Bringing up Baby to Enjoy the Wealth of the Nation- Uses and Abuses of Children." *Guardian*, August 24.

Seavilleklein, Victoria. 2009. "Challenging the Rhetoric of Choice in Prenatal Screening." *Bioethics* 23 (1): 68–77. doi:10.1111/j.1467-8519.2008.00674.x.

Seghezzo, Lucas. 2009. "The Five Dimensions of Sustainability." *Environmental Politics* 18 (4): 539–56. doi:10.1080/09644010903063669.

Selin, Helaine. 1997. *Encyclopaedia of the History of Science, Technology, and Medicine in Non-Westen Cultures*. Springer Science & Business Media.

Sena, Barbara. 2014. "The Sociological Link between Risk and Responsibility: A Critical Review and a Theoretical Proposal." *International Social Science Journal* 65 (215–216): 79–91. doi:10.1111/issj.12066.

Sense, Andrew. 2006. "Driving the Bus from the Rear Passenger Seat: Control Dilemmas of Participative Action Research." *International Journal of Social Research Methodology*, January, 1–13.

Serpe, Richard T., and Sheldon Stryker. 2011. "The Symbolic Interactionist Perspective and Identity Theory." In *Handbook of Identity Theory and Research*, edited by Seth J. Schwartz, Koen Luyckx, and Vivian L. Vignoles, 225–48. New York, NY: Springer New York. doi:10.1007/978-1-4419-7988-9_10.

Sharma, Sanjay, and Starik. 2004. *Stakeholders, the Environment and Society*. Cheltenham: Edward Edgar Publishing. https://books.google.co.nz/books/about/Stakeholders_the_Environment_and_Society.html?id=3VzGJEYiI5QC.

Shaw, James W., William C. Horrace, and Ronald J. Vogel. 2005. "The Determinants of Life Expectancy: An Analysis of the OECD Health Data." *Southern Economic Journal* 71 (4): 768–83. doi:10.2307/20062079.

Sheehan, Rebecca. 2011. "Actor-Network Theory as a Reflexive Tool: (Inter)Personal Relations and Relationships in the Research Process." *Area* 43 (3): 336–42. doi:10.1111/j.1475-4762.2011.01000.x.

364

Shelton, D. C. 2012. "Man-Midwifery History: 1730-1930." *Journal of Obstetrics & Gynaecology* 32 (8): 718–23. doi:10.3109/01443615.2012.721031.

Sherwin, Susan, and Feminist Health Care Ethics Research Network. 1998. *The Politics of Women's Health: Exploring Agency and Autonomy*. Philadelphia: Temple University Press.

Shiga, John. 2007. "Translations: Artifacts from an Actor-Network Perspective." *Artifact* 1 (1): 40–55. doi:10.1080/17493460600658318.

Shirani, Fiona, Karen Henwood, and Carrie Coltart. 2012. "Meeting the Challenges of Intensive Parenting Culture: Gender, Risk Management and the Moral Parent." *Sociology* 46 (1): 25–40.

Shumba, Overson. 2011. "Commons Thinking, Ecological Intelligence and the Ethical and Moral Framework of Ubuntu : An Imperative for Sustainable Development." *Journal of Media and Communication Studies* 3 (3): 84–96.

Simmonds, Naomi. 2011. "Mana Wahine: Decolonising Politics." *Women's Studies Journal* 25 (2): 11–25.

Skinner, Joan. 1999a. "Midwifery Partnership: Individualism, Contractualism or Feminist Praxis?" *NZCOM Journal*, no. 21: 14–18.

———. 1999b. "Midwifery Partnership; Individualism, Contractualism or Feminist Praxis." *NZCOM Journal* 21: 14–17.

———. 2003. "The Midwife in the Risk Society." *New Zealand College of Midwives Journal* 28: 4–7.

———. 2008a. "Risk: Let's Look at the Bigger Picture." *Women and Birth* 21 (2): 53–54. doi:10.1016/j.wombi.2008.03.007.

———. 2008b. "Risk: Let's Look at the Bigger Picture." *Women and Birth* 21 (2): 53–54. doi:10.1016/j.wombi.2008.03.007.

———. 2011. "Being with Women with Risk: The Referral and Consultation Practices and Attitudes of New Zealand Midwives.." *The Free Library* 45. /Being+with+women+with+risk%3a+the+referral+and+consultation+practices...-a0271323631.

Skinner, Joan, and Robyn Maude. 2016. "The Tensions of Uncertainty: Midwives Managing Risk in and of Their Practice." *Midwifery*, Reconceptualising Risk in Childbirth, 38 (July): 35–41. doi:10.1016/j.midw.2016.03.006.

Slay, Holly S., and Delmonize A. Smith. 2011. "Professional Identity Construction: Using Narrative to Understand the Negotiation of Professional and Stigmatized Cultural Identities." *Human Relations* 64 (1): 85–107. doi:10.1177/0018726710384290.

Small, David. 2016, June 26.

Small, Jamie. 2016. "Government in Mediation with Midwives over Gender Pay Discrimination." *Sunday Star Times*, August 10.

Snook, Ivan. 2003. "The Ethics and Politics of Social Research." In *Social Science Research in New Zealand*, 2nd ed., 69–87. Auckland: Pearson Higher Education AU.

365

Solar, O, and A Irwin. 2010. "A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2 (Policy and Practice)." Discussion Paper Series on Social Determinants of Health. Geveva: World Health Organisation (WHO).

Souza, A. C. Terra de, E. Cufino, K. E. Peterson, J. Gardner, M. I. Vasconcelos do Amaral, and A. Ascherio. 1999. "Variations in Infant Mortality Rates among Municipalities in the State of Ceará, Northeast Brazil: An Ecological Analysis." *International Journal of Epidemiology* 28 (2): 267–75. doi:10.1093/ije/28.2.267.

Spangenberg, Joachim H., Ines Omann, and Friedrich Hinterberger. 2002. "Sustainable Growth Criteria: Minimum Benchmarks and Scenarios for Employment and the Environment." *Ecological Economics* 42 (3): 429–43. doi:10.1016/S0921-8009(02)00125-8.

Spoel, Vera. 2006. "Midwifery, Consumerism and the Ethics of Informed Choice." In *Bordering Biomedicine*, 197–214. Amsterdam: Rodopi.

Spretnak, Charlene. 1996. "Beyond the Backlash: An Appreciation of the Work of Marija Gimbutas." *Journal of Feminist Studies in Religion* 12 (2): 91–98.

Springer, Simon, Kean Birch, and Julie MacLeavy. 2016. *Handbook of Neoliberalism*. Routledge.

Stahl, Katja, and Vanora Hundley. 2003. "Risk and Risk Assessment in Pregnancy – Do We Scare Because We Care?" *Midwifery* 19 (4): 298–309. doi:10.1016/S0266-6138(03)00041-X.

Stanforth, Carolyne. 2007. "Using Actor-Network Theory to Analyze E-Government Implementation in Developing Countries." *Information Technologies & International Development* 3 (3): 35–60.

Stanley, Heather. 2012. "Sairey Gamps, Feminine Nurses and Greedy Monopolists: Discourses of Gender and Professional Identity in the Lancet and the British Medical Journal, 1886-1902." *Canadian Bulletin of Medical History / Bulletin Canadien d'histoire de La Médecine* 29 (1): 49–68.

Star, Susan Leigh. 1990. "Power, Technology and the Phenomenology of Conventions: On Being Allergic to Onions." *The Sociological Review* 38 (S1): 26–56. doi:10.1111/j.1467-954X.1990.tb03347.x.

Steffen, Will, Wendy Broadgate, Lisa Deutsch, Owen Gaffney, and Cornelia Ludwig. 2015. "The Trajectory of the Anthropocene: The Great Acceleration." *The Anthropocene Review*, January, 2053019614564785. doi:10.1177/2053019614564785.

Steger, Manfred B., and Ravi K. Roy. 2010. *Neoliberalism : A Very Short Introduction*. Oxford: Oxford University Press.

Steiner, Gerald, and Alfred Posch. 2006. "Higher Education for Sustainability by Means of Transdisciplinary Case Studies: An Innovative Approach for Solving Complex, Real-World Problems." *Journal of Cleaner Production* 14 (9–11): 877–90. doi:10.1016/j.jclepro.2005.11.054.

Sterling, Stephen R. 2001. *Sustainable Education: Re-Visioning Learning and Change*. Cambridge: Green Books for the Schumacher Society.

Stern, Nicholas Herbert, and Great Britain Treasury. 2007. *The Economics of Climate Change: The Stern Review*. Cambridge University Press.

Stevens, Trudy, and Christine McCourt. 2002. "One-to-One Midwifery Practice Part 3: Meaning for Midwives." *British Journal of Midwifery* 10 (2): 111–15. doi:10.12968/bjom.2002.10.2.10185.

Stillerman, Joel. 2015. *The Sociology of Consumption: A Global Approach*. John Wiley & Sons.

Stojanovic, Jane. 2008a. "Midwifery in New Zealand 1904-1971." *Contemporary Nurse : A Journal for the Australian Nursing Profession* 30 (2): 156–67.

———. 2008b. "Midwifery in New Zealand 1904-1971." *Contemporary Nurse : A Journal for the Australian Nursing Profession* 30 (2): 156–67.

Street, B. 1984. *Literacy in Theory and Practice*. Cambridge: Cambridge University Press.

Surtees, Ruth. 2003. *Midwifery as Feminist Praxis in Aotearoa/New Zealand : A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Philosophy in Education*. Thesis PhD-- University of Canterbury.

Surtees, Ruth Joy. 2003a. "Midwifery as Feminist Praxis in Aotearoa/New Zealand." http://ir.canterbury.ac.nz/handle/10092/1662.

———. 2003b. "Midwifery as Feminist Praxis in Aotearoa/New Zealand." Ph.D., New Zealand: University of Canterbury (New Zealand). http://search.proquest.com.ezproxy.canterbury.ac.nz/docview/305345212/abstract?accountid= 14499.

"Sustainable Development Unit." 2015. Accessed May 4. http://www.sduhealth.org.uk/.

Sustainable Enterprise. 2014. "Sustainable Enterprise Models." *Sustainable Enterprise*. http://sustainableenterprise.org/model.aspx.

Swift, John M. 2011. "Persistence: The Key to Promoting and Implementing Sustainability." *Healthcare Design* 11 (4): 24-26,28,30-31.

Swim, Janet K., Paul C. Stern, Thomas J. Doherty, Susan Clayton, Joseph P. Reser, Elke U. Weber, Robert Gifford, and George S. Howard. 2011. "Psychology's Contributions to Understanding and Addressing Global Climate Change." *American Psychologist* 66 (4): 241–50. doi:10.1037/a0023220.

Symon, Andrew. 2000. "Litigation and Changes in Professional Behaviour: A Qualitative Appraisal." *Midwifery* 16 (1): 15–21. doi:10.1054/midw.1999.0193.

———. 2006. *E-Book Risk and Choice in Maternity Care: An International Perspective*. Edinburgh: Elsevier Health Sciences.

Tainter, Joseph A. 2006. "Social Complexity and Sustainability." *Ecological Complexity* 3 (2): 91–103. doi:10.1016/j.ecocom.2005.07.004.

Tainter, Joseph A., and Temis G. Taylor. 2013. "Complexity, Problem-Solving, Sustainability and Resilience." *Building Research & Information* 42 (2): 168–81. doi:10.1080/09613218.2014.850599.

Tajfel, H, and J Turner. 1986. "An Integrative Theory of Intergroup Conflict"." In *The Social Psychology of Intergroup Relations.*, edited by S Worshel and WG Austin, 33–47. Monteray: Brookes Cole.

Taonga, New Zealand Ministry for Culture and Heritage Te Manatu. 2015a. "5. – Te Ao Mārama – the Natural World – Te Ara Encyclopedia of New Zealand." Web page. Accessed July 14. http://www.teara.govt.nz/en/te-ao-marama-the-natural-world/page-5.

———. 2014b. "Birth Rates." Web page. Accessed October 15. http://www.teara.govt.nz/en/pregnancy-birth-and-baby-care/page-5.

Tatnall, Arthur, and Anthony Gilding. 1999. "'Actor-Network Theory in Information Systems Research.' (2005): 42-46." In *10th Australasian Conference on Information Systems*. Melbourne.

Teasdale, S., F. Lyon, and R. Baldock. 2013. "Playing with Numbers: A Methodological Critique of the Social Enterprise Growth Myth." *Journal of Social Entrepreneurship* 4 (2): 113–31. doi:10.1080/19420676.2012.762800.

Teijlingen, Edwin R. Van, George W. Lowis, Peter McCaffery, and Maureen Porter. 2004. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*. Nova Publishers.

Tew, Marjorie. 1995. *Safer Childbirth?: A Critical History of Maternity Care*. London: Chapman & Hall.

Thai, Khi V., Dianne Rahm, and Jerrell D. Coggburn. 2007. *Handbook of Globalization and the Environment*. Boca Raton, FL: CRC Press.

"The Big Push for Midwives." 2017. *The Big Push for Midwives*. Accessed May 21. http://pushformidwives.nationbuilder.com/.

"There's No Such Thing as the Wrong Decision." 2016. *Kate Northrup*. February 24. http://katenorthrup.com/theres-no-such-thing-as-the-wrong-decision/.

Thomas, Samuel S. 2009. "Early Modern Midwifery: Splitting the Profession, Connecting the History." *Journal of Social History* 43 (1): 115–38. doi:10.1353/jsh.0.0215.

Thompson, Joyce Beebe. 2004. "A Human Rights Framework for Midwifery Care." *The Journal of Midwifery & Women ́s Health* 49 (3): 175–81. doi:10.1016/S1526-9523(03)00561-0.

Thorsen, Dag Einar. 2011. "The Neoliberal Challenge." *Contemporary Readings in Law & Social Justice* 2 (2): 188–214.

Timmermans, Stefan, and Hyeyoung Oh. 2010. "The Continued Social Transformation of the Medical Profession." *Journal of Health and Social Behavior* 51: S94–106.

Timmons, S. 2011. "Professionalization and Its Discontents." *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 15 (4): 337–52. doi:10.1177/1363459310383594.

Tingle, John. 2016. "Guidelines Not Tramlines: The WHO Safe Childbirth Checklist." *British Journal of Nursing* 25 (6): 344–45.

Tobin, Robert Deam. 2001. *Doctor's Orders: Goethe and Enlightenment Thought*. Bucknell University Press.

Tolerton, Jane. 2017. "Eugenics." Web page. *Te Ara*. Accessed August 4. /en/document/26996/eugenics.

Towler, Jean, and Joan Bramall. 1986. *Midwives in History and Society.* London: Croom Helm.

Tracy, Sally. 2011. "Costing Birth as Commondity or Sustainable Public Good." In *Sustainability, Midwifery and Birth.*, edited by Lorna Davies, Rea Daellenbach, and Mary Kensington, 32–44.

Tracy, Sally K. 2011. "Costing Birth as Commodity or Sustainable Public Good." In *Sustainability, Midwifery and Birth*, 32–44. London: Routledge.

Tracy, Sally K, Donna L Hartz, Mark B Tracy, Jyai Allen, Amanda Forti, Bev Hall, Jan White, et al. 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@NGO, a Randomised Controlled Trial." *The Lancet* 382 (9906): 1723–32. doi:10.1016/S0140-6736(13)61406-3.

Tracy, Sally K., Elizabeth Sullivan, Yueping Alex Wang, Deborah Black, and Mark Tracy. 2007. "Birth Outcomes Associated with Interventions in Labour amongst Low Risk Women: A Population-Based Study." *Women and Birth* 20 (2): 41–48. doi:10.1016/j.wombi.2007.03.005.

Tsouroufli, Maria, Mustafa Özbilgin, and Merryn Smith. 2011. "Gendered Forms of Othering in UK Hospital Medicine: Nostalgia as Resistance against the Modern Doctor." *Equality, Diversity and Inclusion: An International Journal* 30 (6): 498–509. doi:10.1108/02610151111157710.

Tullberg, Jan. 2012. "Triple Bottom Line – a Vaulting Ambition?" *Business Ethics: A European Review* 21 (3): 310–24. doi:10.1111/j.1467-8608.2012.01656.x.

Tulloch, Lynley, and David Neilson. 2014. "The Neoliberalisation of Sustainability." *Citizenship, Social and Economics Education* 13 (1): 26–38. doi:10.2304/csee.2014.13.1.26.

Tullus, Kjell, and LarsG. Burman. 1989. "ECOLOGICAL IMPACT OF AMPICILLIN AND CEFUROXIME IN NEONATAL UNITS." *The Lancet* 333 (8652): 1405–7. doi:10.1016/S0140-6736(89)90122-0.

Tully, Elizabeth. 1999. "Doing Professionalism 'Differently' : Negotiating Midwifery Autonomy in Aotearoa/New Zealand." http://ir.canterbury.ac.nz:80/handle/10092/6531.

Tully, Elizabeth, Rea Daellenbach, and Karen Guilliland. n.d. "Feminism, Partnership, and Midwifery." In *Feminist Thought in Aotearoa/New Zealand*, 245–53. Auckland: Oxford University Press.

Twenge, Jean, and Stacie E. Campbell. 2008. "Generational Differences in Psychological Traits and Their Impact on the Workplace." *Journal of Managerial Psychology* 23 (8): 862–77. doi:10.1108/02683940810904367.

UN Dept of Economic and Social Affairs. 2007. "Indicators of Sustainable Development: Guidelines and Methodologies." 3. New York: United Nations. http://www.un.org/esa/sustdev/natlinfo/indicators/guidelines.pdf.

United Nations. 2017. "The Convention on Biological Diversity." *Convention on Biological Diversity*. https://www.cbd.int/convention/default.shtml.

United Nations Dvelopment Programme. 2015. "2015 State of the World's Volunteerism Report: Transforming Governance." Denmark: UNDP. https://www.unv.org/sites/default/files/2015%20State%20of%20the%20World%27s%20Volunteerism%20Report%20-%20Transforming%20Governance.pdf.

Upton, Simon. 1991. "Your Health and the Public Health: A Statement of Government Health Policy." Wellington: Minstry of Health.

Vallance, Suzanne, Harvey C. Perkins, and Jennifer E. Dixon. 2011. "What Is Social Sustainability? A Clarification of Concepts." *Geoforum*, Themed Issue: Subaltern Geopolitics, 42 (3): 342–48. doi:10.1016/j.geoforum.2011.01.002.

Vare, Paul, and John Blewitt. 2009. "Sustainability Literacy: Two Perspectives." In *The Handbook of Sustainability Literacy: Skills for a Changing World*. Brighton: Green Books.

Venturini, T. 2010. "Diving in Magma: How to Explore Controversies with Actor-Network Theory." *Public Understanding of Science* 19 (3): 258–73. doi:10.1177/0963662509102694.

Voet, Maria Christine Bernadetta Voet Rian, and Rian Voet. 1998. *Feminism and Citizenship*. Thousand Oaks CA: SAGE.

Volunteering New Zealand. 2017. "Statistics on Volunteering." *Volunteering New Zealand*. http://www.volunteeringnz.org.nz/policy/statistics/.

VolunteerMatch.org. 2016. "The U.S. Volunteer Rate Is Still Dropping. Why?" *Engaging Volunteers*. http://blogs.volunteermatch.org/engagingvolunteers/2016/03/25/the-u-s-volunteer-rate-is-still-dropping-why/.

Vos, Robert O. 2007. "Defining Sustainability: A Conceptual Orientation." *Journal of Chemical Technology & Biotechnology* 82 (4): 334–39. doi:10.1002/jctb.1675.

Waal, Hugo De, Amit Malik, and Dinesh Bhugra. 2010. "The Psychiatric Profession: An Expertise Under Siege?" *International Journal of Social Psychiatry* 56 (6): 647–56. doi:10.1177/0020764009106259.

Wajcman, Judy. 2000. "Reflections on Gender and Technology Studies: In What State Is the Art?" *Social Studies of Science* 30 (3): 447–64.

Wakelin, Karen, and Joan Skinner. 2007. "Staying or Leaving: A Telephone Survey of Midwives, Exploring the Sustainability of Practice as Lead Maternity Carers in One Urban Region of New Zealand." *New Zealand College of Midwives Journal*, no. 37 (October): 10–14.

Walker, Peter. 1994. "What Happens When You Scrap the Welfare State?'." *The Independent*, March 13. http://www.independent.co.uk/news/uk/what-happens-when-you-scrap-the-welfare-state-new-zealand-has-and-its-economy-is-stronger-but-there-is-a-dark-side--one-in-seven-below-poverty-line--record-numbers-of-people-in-jail--armed-police-on-the-streets--queues-at-charity-food-banks-1428688.html.

Walsh. 1999. "An Ethnographic Study of Women's Experience of Partnership Caseload Midwifery Practice: The Professional as a Friend." *Midwifery* 15 (3): 165–76. doi:10.1016/S0266-6138(99)90061-X.

Walsh, Aileen, and 2010. 2010. "Reawaken Your Sense of Vocation by Remembering Nursing's History." *Nursing Times* 106 (18): 11–17.

Walsh, Denis, Monica Christianson, and Mary Stewart. 2015. "Why Midwives Should Be Feminists." *MIDIRS* 25 (2): 154–60.

Walter, Maggie. 2010a. "Participatory Action Research." https://www.academia.edu/3563840/Participatory_Action_Research.

———. 2010b. *Social Research Methods*. Oxford University Press.

Warburton, Kevin. 2003. "Deep Learning and Education for Sustainability." *International Journal of Sustainability in Higher Education* 4 (1): 44–56. doi:10.1108/14676370310455332.

Ward, Louise. 2013. "Ready, Aim Fire! Mental Health Nurses Under Siege in Acute Inpatient Facilities." *Issues in Mental Health Nursing* 34 (4): 281–287 7p. doi:10.3109/01612840.2012.742603.

Warren, Karen. 1997. *Ecofeminism: Women, Culture, Nature*. Bloomington: Indiana University Press.

Watts, Duncan. 2014. *Dictionary of American Government and Politics*. Edinburgh, GB: Edinburgh University Press. http://site.ebrary.com/lib/alltitles/docDetail.action?docID=10391724.

Watts, Vanessa. 2013. "Indigenous Place-Thought and Agency Amongst Humans and Non Humans (First Woman and Sky Woman Go On a European World Tour!)." *Decolonization: Indigeneity, Education & Society* 2 (1). http://decolonization.org/index.php/des/article/download/19145.

Werman, David S. 1977. "Normal and Pathological Nostalgia." *Journal of the American Psychoanalytic Association* 25 (2): 387–98. doi:10.1177/000306517702500205.

Wheelan, Susan A. 2005. *The Handbook of Group Research and Practice*. Thousand Oaks CA: SAGE.

White, Thomas. 2016. "The Deep Symbolism of the Mobius Strip." *Tao Math*. March 1. http://taomath.org/2016/03/the-deep-symbolism-of-the-mobius-strip/.

Whitmarsh, Lorraine, Irene Lorenzoni, and Saffron O'Neill. 2012. *Engaging the Public with Climate Change : Behaviour Change and Communication*. Hoboken: Taylor and Francis.

Wickham, Sara. 2006. *Appraising Research Into Childbirth: An Interactive Workbook*. London: Elsevier Butterworth Heinemann.

———. 2009. "Hands-off Midwifery and the Art of Balance." *Birth Spirit*, no. 1: 22–24.

———. 2013. "The Value of the Knitting Midwife." *Sarawickham*. July 19.

    http://www.sarawickham.com/craft-reflections/the-value-of-the-knitting-midwife/.

Wickham, Sara, Cecile MacNeille, and Kristan Lee Read. 2013. "Passing Yarns Forward: Unravelling the

    Dimensions of Knitting and Birth." *Essentially MIDIRS* 4 (9): 42–49.

Wilkinson, Richard, and Kate Pickett. 2010. *The Spirit Level: Why Greater Equality Makes Societies*

    Stronger. London: Bloomsbury Publishing.

Willetts, David. 1992. *Modern Conservatism*. London: Penguin Books.

Williams, Christopher John Fards. 1989. *What Is Identity?* Oxford: Clarendon Press.

Williams, Jan. 1997. "The Controlling Power of Childbirth in Britain." In *Midwives Society and Childbirth*.

    London: Routledge.

Wilson, Janelle L. 1999. "`Remember When...' A Consideration of the Concept of Nostalgia." *ETC: A*

    Review of General Semantics 56 (3): 296.

———. 2005. *Nostalgia: Sanctuary of Meaning*. Lewisburg: Bucknell University Press.

Wilson, Virginia. 2012. "Research Methods: Focus Groups." *Evidence Based Library and Information*

    Practice 7 (1): 129–31. doi:10.18438/B8K32T.

Wiseman, John, Lara Williamson, and Jess Fritze. 2010. "Community Engagement and Climate Change:

    Learning from Recent Australian Experience." *International Journal of Climate Change Strategies*

    and Management 2 (2): 134–47. doi:10.1108/17568691011040399.

Wittenbaum, Gwen M., and Richard L. Moreland. 2008. "Small-Group Research in Social Psychology:

    Topics and Trends over Time." *Social and Personality Psychology Compass* 2 (1): 187–203.

    doi:10.1111/j.1751-9004.2007.00065.x.

Witz, Anne. 1990. "Patriarchy and Professions: The Gendered Politics of Occupational Closure." *Sociology*

    24 (4): 675–90. doi:10.1177/0038038590024004007.

Wood, Joanne V., Abraham Tesser, and John G. Holmes. 2013. *The Self and Social Relationships*.

    Psychology Press.

World Commission on Environment and Development. 1987. *Our Common Future*. Oxford: Oxford

    University Press.

Writes, Emily. 2017. "Midwives in Their Own Words: 'We Are Only Human.'" *The Spinoff*. April 3.

    https://thespinoff.co.nz/parenting/03-04-2017/midwives-in-their-own-words-we-are-only-

    human/.

Ybema, Sierk. 2010. "Talk of Change: Temporal Contrasts and Collective Identities." *Organization Studies*

    31 (4): 481–503. doi:10.1177/0170840610372205.

Young, Carolyn Mae. 2011. "The Experience of Burnout in Case Loading Midwives." Thesis, Auckland

    University of Technology. http://aut.researchgateway.ac.nz/handle/10292/2447.

Youngson, Robin. 2014a. "Re-Inspiring Compassionate Caring: The Reawakening Purpose Workshop."
Journal of Compassionate Health Care 1 (1): 1. doi:10.1186/s40639-014-0001-0.

———. 2014b. "Re-Inspiring Compassionate Caring: The Reawakening Purpose Workshop." *Journal of
Compassionate Health Care* 1 (1): 1. doi:10.1186/s40639-014-0001-0.

Yuill, Onje. 2012. "Feminism as a Theoretical Perspective for Research in Midwifery." *British Journal of
Midwifery* 20 (1): 36–40.

Zola, Irving Kenneth. 1983. *Socio-Medical Inquiries: Recollections, Reflections, and Reconsiderations*.
Philadelphia: Temple University Press.

Appendix A

University of Canterbury
Department of Sociology

Sustainability and Midwifery Practice

Information Sheet for Participants

Introduction

My name is Lorna Davies, I am a lecturer in Midwifery from Christchurch, and I am currently undertaking a PhD thesis exploring the concept of sustainability in relation to midwifery practice

Sustainability is a broad based concept which attracted the attention of many disciplines for discussion including economics, sociology, the natural sciences, ethics, politics and others. It is a concept that is defined in many different ways in different contexts. One commonly used definition of sustainability is that it meets the needs of the present without compromising the ability of future generations for meet their own needs. (Brundtland 1988)

An increasing awareness of the need for greater consideration of sustainability in many areas of our lives is leading us to look more closely at the concept. Many health care professions along with other disciplines are currently looking at the impact of their own area of practice and are in many cases developing strategies to increase their level of sustainability and to reduce their carbon footprint. However, to date the profession of midwifery has not received a great deal of focus as a sustainable healthcare practice.

Midwifery provides a service which is sited primarily in a community based, primary care setting. It makes few demands in terms of resources and has a strong public health role.

My study sets out to explore how midwives view the concept of sustainability and whether they consider that midwifery has the potential to develop as a sustainable healthcare profession.

Research Project

You are invited to participate in a research project, which aims to explore how midwives view the concept of sustainability, how they feel that it relates to their sphere of practice and whether they consider that midwifery has the potential to develop as a sustainable healthcare profession.

Who will be invited to take part? If you are a midwife registered and working in New Zealand you will fit the criteria to participate. You will need to sign a consent form before participating.

What I am asking participants to do? You may be invited to participate in what is known as the PAR (participatory action research) project or alternatively to contribute to the study by agreeing to a one-to-one telephone or face-to-face interview.

Participatory Action Research

As a member of the PAR arm of the study, you will be invited to attend an initial focus group meeting to discuss issues relating to sustainability and midwifery practice. We will use a group activity to launch this discussion. You will then be asked to consider an action relating to sustainability that you would be able to introduce within your practice. Over the course of an agreed timeframe, you will be requested to monitor the impact of your proposed action by recording your stories identifying observations and outcomes. You may do this in the form of a handwritten journal, an audio recording, video-diary or online blog format. This will be done as often as you feel it to be necessary.

These stories will be shared during 2-3 focus group meetings throughout the year which will be held over a mutually agreed time frame and the resulting data will be used to inform the development of the study.

The areas that I am hoping to address within the focus groups are:-

- What does sustainability mean to you personally?

- Do you think that the issues around sustainability relate to midwifery practice ?
- What are the characteristics of midwifery practice that you feel may contribute to the concept of sustainability?

How much time will it take? The focus group meetings will take place in a comfortable local meeting space and will take no more than two and a half hours of your time. This will include time for snacks, answering your questions and signing the consent forms. An activity may be initially used to introduce the concept of sustainability. Then, an interactive discussion will gently draw out your ideas about this concept. The meetings will be audio recorded. The number of focus groups will be agreed with the group members. It is anticipated that no more than 4-5 sessions will be held over an 18month-2 year period.

One-to-One Interviews

If you agree to be interviewed as part of the study data collection process, then this will take the form of a telephone or face to face individual interview, whichever is more convenient in terms of time and travel. This will be carried out by myself as the co-ordinator for the project.

The areas that I am hoping to address during the interviews are similar to those listed above in the PAR section of the information sheet.

It is anticipated that the interviews will take no more that 45 minutes.

What will I do with my results? The results will serve to inform the development of my PhD thesis. As part of the PAR team, you will be encouraged to review the data analysis throughout the data collection period during the focus group meetings. I will be presenting the findings on an ongoing basis at conferences and hui. I will also be publishing articles which emerge from the research in both national and international journals.

Confidentiality: Because of the participative nature of PAR, the midwives forming the research teams will be asked to negotiate the level of confidentiality that they feel to be appropriate. This may mean

total anonymity, open acknowledgement of individuals, or partial disclosure on the part of the participants.

In relation to the individual interviews, identifying personal information, names or identifying features of any workplaces will not be used in the transcripts or in the thesis or subsequent publications resulting from the study. A research assistant may be employed to transcribe the tapes, and they will be asked to sign a confidentiality agreement. Only pseudonyms will be used in the transcripts. The tapes consent forms and transcripts of the interviews will be kept securely for five years after publication of the completion of the thesis and then destroyed.

Right to withdraw: If you wish to withdraw from the project at any time, you are welcome to do so and should just inform me of your decision. If you do choose to withdraw then you may also consider whether you want to retract any information that you have already provided. If you decide to withdraw, you will not be disadvantaged in any way.

As previously stated I am carrying out the project as part of PhD research, under the supervision of Dr Anne Scott from the Dept. of Sociology at the University of Canterbury and Dr Lee Thompson, Dept of Public Health, University of Otago Medical School. If there are any questions or concerns that you may have about your rights as a participant in this study, please do not hesitate to contact me or one of my supervisors (please see contact details below)

Contact details:
Lorna Davies (researcher)
57a Major Hornbrook Road
Mt Pleasant
lornamidwife@hotmail.com
Christchurch 8081

Phone home (03) 384 4390
Phone work (03) 940 8713
Cell phone 027 600 7778
Email lornamidwife@hotmail.com

University of Canterbury
Department of Sociology

Consent Form

Lorna Davies (researcher)   *Phone home (03) 384 4390*

57a Major Hornbrook Road   *Phone work (03) 940 8713*

Mt Pleasant   *Cell phone 027 600 7778*

Christchurch 8081   lornamidwife@hotmail.com

Research Project: Midwifery: A model of sustainable healthcare practice?

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

This information will be used only for the research and publications arising from the research project.
I agree to the focus group interview being audiotaped. I also undersnd that I have the right to withdraw from the project at any time and to ask for the withdrawal of any information that I have provided. I understand that I have the right to ask further questions at any time.

Name (please print)

_____

Signature:

_____

Date:

_____

APPENDIX C

Application for expedited review by Upper South A Regional Ethic Committee

27 September 2011

Ms Lorna Davies
57a Major Hornbrook Road
Mt Pleasant,
Christchurch

Dear Lorna Davies

Ethics ref: **URA/11/EXP/053**   **(please quote in all correspondence)**
Study title: **Midwifery: A model of sustainable healthcare practice? A participatory action research study exploring midwives perceptions of sustainability and midwifery practice**
Investigators: **L Davies, Dr A Scott, Dr L Thompson**

Thank you for the above application for expedited review which has been considered by one member and the Chairperson of the Upper South A Regional Ethics Committee.

According to the *Ethical Guidelines for Observational Studies: Observational Research, Audits and Related Activities, NEAC, December 2006*, ethics committee review is not required for this study.

Please note, however, that the organisation in which you wish to carry out the study may specify their own processes regarding notification or approval.

We wish you all the best with your study.

Yours sincerely

Alieke Dierckx

Administrator
Upper South A Regional Ethics Committee
Uppersoutha_ethicscommittee@moh.govt.nz

APPENDIX D

Locality Assessment by Locality Organisation

Refer to pages 13–15 of Guidelines for Completion of the National Application Form for Ethical Approval of a Research Project (NAFG-2009-v1)

Locality organisation sign off

Ethics committees review whether investigators have ensured their studies would meet established ethical standards if conducted at appropriate localities. Each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality

Please note that the locality organisation may have additional requirements to be met before a study may commence at that locality

Part One: General

To be completed by the principal investigator for this locality

Full project title:	Midwifery: A model of sustainable healthcare practice? A participatory action research study exploring midwives perceptions of sustainability and midwifery practice.
Short project title:	Midwifery: A model of sustainable healthcare practice?
Locality to be assessed:	Lincoln Maternity Hospital
Brief outline of study:	Participatory Action research study exploring how midwives view the concept of sustainability and whether they consider that midwifery has the potential to develop as a sustainable healthcare profession
Principal investigator (for this locality):	Lorna Davies
Contact details:	Home: 03 384 4390 Work: 03 940 8713 Cell: 027 600 7778 57a Major Hornbrook Rd Mt Pleasant Christchurch 8081 lornamidwife@hotmail.com
Other local investigators (list all at this site):	None

Contact details:

Part Two: Locality Issues

To be completed by the principal investigator for this locality and signed by the authorised locality representative.
(See the Guidelines (NAFG-2009-v1) (pages 13–15) for more information and examples.) Identify any local issues
and specify how these issues will be addressed.

1. **Suitability of local researcher**

   For example, are all roles for the investigator(s) at the local site appropriate | X | Yes | | No
   (for example, has any conflict the investigator might have between her or his
   local roles in research and in patient care been adequately resolved)?

2. **Suitability of the local research environment**

   a) Are all the resources (other than funding that is conditional on ethical | X | Yes | | No
   approval) and/or facilities that the study requires appropriate and available
   (for example, is staffing adequate? Is this site accessible for mobility-
   impaired people where necessary)?

   b) Have all potentially affected managers of resources such as patient | X | Yes | | No
   records or laboratory managers been notified?

3. **Have issues such as cultural issues specific to this locality or to** | X | Yes | | No
   people being recruited at this locality been addressed?

4. **Have the local investigator contact details and other important** | X | Yes | | No
   contact details been provided to the locality organisation for checking?

Part Three: Declaration by locality organisation

I am authorised to complete locality approval on behalf of this locality organisation. I understand that I may
withdraw locality approval if any significant local concerns arise. I agree to advise the principal investigator and then
the relevant ethics committee should this occur.

(Questions 1–4 at Part Two above must be completed prior to signing.)

I confirm the organisation has sufficient indemnity insurance to compensate participants for harm that does not
qualify for compensation under the Injury Prevention, Rehabilitation and Compensation Act 2001

Signature: _M/O-de_   Date: _24/9/2011_

Name: _M Garde, AFCM_   Position: _Actf Cu._

Contact details:

APPENDIX E

Academic Research Committee (ARC)
Subcommittee of Academic Board

≋CPIT
CHRISTCHURCH POLYTECHNIC INSTITUTE OF TECHNOLOGY Te Whare o Ōtautahi

Research Approval Application Form
Research Project

Chris Rhea
Chris Rhea (Jun 18, 2014)

This application is to seek approval of an individual, discrete project with a specific research output, within a specified timeframe. Submit application to relevant School Research Committee Chair. If applicable, the proposal will need approval from the ARC Ethics Subcommittee before final approval can be given. An Ethics Section is included for this purpose. Research involving Māori requires endorsement from CPIT's Kaiarahi.

1) Researcher Details

Name	Lorna Davies	
Faculty/Division	Health, Humanities and Science	
School	Science and Allied Health	
Phone	940 8713	
Employment	X Full time - tenured	Permanent part time: State hrs/yr:
	Full time – contract State expiry date:	Casual part time: State hrs/yr:
	Degree/Graduate teaching Yes	

2) Associated Researchers (if any)

Name	Institute	School/Faculty/Department

3) Support – research supervisor/mentor/colleague available for support/advice on this research

Name	Institute
Dr Anne Scott	University of Canterbury
Dr Lee Thompson	University of Otago

3) Qualification

Is this research part of study towards a qualification?	Yes
If Yes, state qualification	PhD
Institute	University of Canterbury

4) Previous Research Outputs

Attach print out from Research Website of your research outputs within the last 3 years (to provide details or your experience and past productivity) Research Outputs is not currently accessible online

5) Project Overview

Title	Midwifery: A model of sustainable healthcare practice?

Category of Research	Fundamental / Strategic / Applied / Scholarship / Creative Refer Research & Scholarly Activities policy for definitions
Proposed Start Date	1.8.2010
Proposed Finish Date	31.7.2016

6) Project Details
Maximum 2 pages. If your research is part of a qualification, attach the research proposal approved by the institution, including ethics clearance if relevant.

6.1 Overall research question (what you are trying to find out)

What do midwives think and feel about the concept of sustainability?

6.2 Background (brief summary of current literature/information related to the proposed research; cite references)

There is a near unanimous consensus amongst the worlds scientific community that climate change is currently occuring on a global scale. It is also largely accepted that the effects of climate change will, if left unchecked, gain further momentum that will lead to considerable impact from global warming and other climatic changes, that will inevitably dramatically alter the way that our societies and our lives function. (Bauer & Singer 2009, McMichael et al 2006) It is believed that climate change will have a marked effect on health trends and outcomes (Haines et al 2006). Experts project that this will include increasing morbidity and mortality from; thermal stress resulting from extreme hot and cold; changes in air and water quality and changes in the ecology of infectious diseases. (Patz et al 2005) It is anticipated that climate change will lead to mass migration from regions where famine, water shortages, flooding and other related factors resulting from the change, have made habitation untenable (Bauer & Singer) This is likely to lead to unprecendented demographic changes with associated psychosocial and cultural ramifications (Myers 2006).

It is espoused that health care is beginning to take on board the magnitude of the potential effects of climate change on the health of populations and that public health is taking a leading role in this recognition (Muir Gray 2010). McCartney and Hanlon (2009) state that health professionals are ideally placed to both contribute to and lead actions required for sustainability. However, in order to achieve this, they claim that we need to step outside what they describe as our 'outmoded forms of thinking' and see the threats within the context of our own lives and practice areas.

An editorial in the Lancet in 2009 identified that the number of research studies and articles relating to this challenge are conspicuous by their relative absence (Campbell Lendrum et al 2009) They suggest that research within this area is complex because of the multi-factorial issues and for the "potential magnitude and range of health consequences". An evidence-informed body of work is therefore urgently required to enable health care to predict and address the wide range of health impact that climate change may bring.(Campbell Lendrum).

Sustainability is viewed as being about attention to the future. The Brundtland Commission, defines sustainablity as 'meeting the needs of the present without compromising the ability of future generations to meet their own needs.' (World Commission on Environment and Development 1987: 43). Reproductive health could be said to be the physical embodiment of our commitment to the future. It could therefore follow that the shape of maternity services and the place of midwives within that service is vitally important. Midwifery could theoretically have the potential to provide a valuable contribution to the sphere of sustainable healthcare. Yet within the field of midwifery, there is little evidence of any discourse around subject area of sustainability and a dearth of any research evidence.

This recognition led to conversations with several international experts within midwifery around the subject of sustainability and resulted in the submission of a proposal for a book around the subject area of sustainability & midwifery. The proposal was accepted by Routledge and I co-authored the book with my colleagues, Rea Daellenbach and Mary Kensington. It is currently at the point of release following recent publication.

This project has whetted my interest in the subject and I have now enrolled for a PhD with the School of Social and Political Sciences at the University of Canterbury.

Arbor, A. (2007). Community Health Scholars Program goals and competencies. Available from:
http://www.sph.umich.edu/chsp/program/index.shtml retrieved 13.09.10
Bauer, H., Singer,M. (2009. *Global warming and the political ecology of health*. Left Coast Press. Walnut Creek CA
Green, L.W. & Mercer, S.L. (2001). Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities? *Am J Public Health.* 91(12):1926-9.
Davies, L. Daellenbach, R. Kensington, M (2010) *Sustainability, midwifery and birth*. London. Routledge
Haines,A,. Kovats, R.S., Campbell-Lendrum, D., Corvolan, C. (2006) Climate change and human health: impacts, vulnerability and mitigation. *Lancet.* 367: 2101-09
McMichael, A.J., Woodruff, R.E., Hales, S. (2006). Climate change and human health;present and future risks. *Lancet* 367: 859-69
Myers, N. (2005). "Environmental Refugees: An emergent security issue", 13 Economic Forum,
Prague.
Patz, J.A., Campbell-Lundrum, D., Holloway, T., Foley. J.A. (2005). Impact of regional climate change on human health. *Nature*. 438 doi:10.1038/nature04188
United Nations World Commission on Environment and Development. (1987).*Our Common Future*, Oxford: Oxford University Press

6.3 Methodology (how you plan to answer your research question)

It would seem that the methodology best suited for this research study is participatory action research (PAR)as in many ways it reflects the philosophy of partnership which is the cornerstone of midwifery practice here in New Zealand.

The underpinning philosophy of a PAR approach is about facilitating action towards social change (Reason 2001). PAR is about inclusiveness in the construction of knowledge which leads to action (Koch 2006)

The intention is to invite midwives, as a community of practice, to actively participate in a participatory action research study which explores their existing knowledge and understanding of sustainability and sustainable health care practice. The introduction of a self defined intervention may enable the participants to further examine the concept of sustainable midwifery practice.

I am currently working on the proposal which will be submitted to the Ethics Committee in due course.
See attached proposal Pea

6.4 Significance of the research (what it adds to the current body of knowledge/discipline/field of inquiry)

The underlying philosophy of the midwifery profession is essentially aligned with sustainability. Midwifery practice is about community-based primary health, strengthening family relationships and promoting normal birth (International Confederation of Midwives 2005). A midwifery model approach thus promotes low resource use and the minimising of unnecessary intervention. The contribution that midwifery could make to sustainability by helping to safeguard the health and well-being of new families by modelling less exploitative health care practices is considerable. By supporting a sustainable approach to practice philosophy, resource management and personal and professional sustainability, midwifery could ultimately lead the field in health care as a truly ecological and socially responsible profession.

6.5 Timeline (likely breakdown of major steps/milestones for the project)

Currently undertaking literature review
December 2010 –complete & submit proposal
February 2011 – submit ethics application
April 2011 - facilitate Sustainability Workshop (Data collection commences)
May 2011 –begin data analysis
June 2011 - identify PAR group practices
July – November 2010 – Academic Leave granted to work on project
September 2011 – convene with PAR group practices (Data collection continues)
November 2011-ongoing –continue with data analysis

6.6 Expected Outputs (how you plan to disseminate the results of the research, eg journal publication, report, exhibition, performance, conference)

PhD Thesis

Conference presentations:
International Confederation of Midwives in Durban SA in June 2011
Australian College of Midwives Biennial Conference Sydney October 2011
New Zealand College of Midwives Conferences in September, 2012

Journal articles:
Midwifery,British Journal of Midwifery or similar international peer reviewed midwifery journal; New Zealand College of Midwives Journal

6.7 If your research involves any significant group (for Māori go to Section 7) eg Pasifika, people with disabilities, state how you have undertaken appropriate consultation

Consultation is pending with Te Komiti Whakarite at Nga Ratonga Hauora Maori

6.8 Describe how this research will inform/enhance your teaching and/or other roles at CPIT

The study will enhance my research profile which will benefit the PBRF process. The work will inform a body of knowledge in a developing area within midwifery. It may also provide knowledge that could be utilised in a cross disciplinary context which means that my work may benefit the wider polytechnic and health care community.
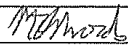
7) Consultation with Māori

If your research involves Māori, consultation will be required and endorsement given by our Kaiarahi. Contact CPIT Research Co-ordinator for confirmation of consultation procedures.

This confirms that consultation with Māori has been carried out and any issues addressed:

Kaiarahi signature:	Date: 14 / 12 / 2011
Comment: Approved.	

8) Faculty/Division Approval

8.1 The School Research Committee endorses this application for forwarding to the ARC Ethics Subcommittee - complete if ethics clearance is required

Chair signature: MEdwards	Date: 10 / Nov / 2010

8.2 Tick applicable box and complete accordingly

☐ The School Research Committee endorses this application for forwarding to the ARC for approval
or (required if applicant teaches on new degree under ITPQ monitoring or if School requires additional scrutiny/ guidance)
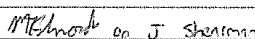
☐ The School Research Committee approves this proposal

Application approved by (list names): R Dhellenbach, D Aid., J Shenrman, M Edmonds
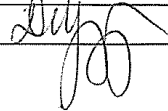Date approved:

Copy of application approved by School Research Committee must be forwarded to the ARC

Chair signature: MEdwards	Date: 10 / 11 / 2010
Comment: Literature review approved, Approval of rest of proposal dependent on Kaiarahi and ethics approval	

8.3 This confirms the time allowance given for this research is appropriate and available to the researcher/s:

Time Allowance:	
HOS signature: MEdwards on J Shenrmn	Date: 11 /11/2010

8.4 This confirms that all administrative matters related to this research (including any contractual obligations, intellectual property or copyright issues) have been considered and addressed:

Dean signature:	Date: 11 / 11 / 2010