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the award of the degree.**

**Including Fathers in Childbirth:
A Grounded Theory Inquiry of the
Midwife's Perspective**

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A thesis submitted in fulfilment of requirements of
the degree of
Doctor of Philosophy

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DECLARATION

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

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I believe that this thesis is properly presented, conforms to the specifications for the thesis and is of sufficient standard to be, *prima facie*, worthy of examination.

.....principal supervisor

ABSTRACT

Changing social, cultural and professional attitudes have encouraged paternal birth attendance in most industrialised countries. In Australia, fathers currently play a fundamental role in supporting their partner during childbirth. Notions of family centred maternity care are located in contemporary midwifery discourses. Such notions reinforce the importance of caring for fathers in their capacity as the main supporters of labouring woman. In contrast to these notions recent evidence suggests that midwives fail to integrate expectant fathers into the childbirth process. Although midwives occupy the optimum position to support expectant fathers, what is not evident in the literature or discourse is how midwives interact with fathers in parturition.

The central aim of this inquiry was to generate a substantive theory from and grounded in, data of paternal - midwife interactions in childbirth. To discover and conceptualise midwives' perspectives, this inquiry used a symbolic interaction approach with grounded theory methods guiding both the data collection and analysis (Glaser & Strauss, 1967). The inquiry was undertaken with fourteen midwives and two student midwives from three childbirth settings currently available to Australian women including hospital labour wards, birth centres and private homes. The main source of data was the transcribed in-depth interviews, with the published literature being used as an additional data source.

Midwives have a distinctive approach to working with fathers in childbirth, described as *Establishing an Inclusive Relationship*. Thus, midwives attempted to meet expectant fathers' support needs, through building a rapport with the fathers, assessing their needs and supporting them individually throughout their partners' labour and birth. The findings from this inquiry provide an unprecedented understanding of the midwives' professional role and their relationship with fathers in childbirth. The findings have significance for

midwives involved in supporting the couple throughout their child's birth as they demonstrate how midwives attempt to include fathers in the birth process.

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LIST OF ABBREVIATIONS

ACMI	Australian College of Midwives Incorporated
AIMS	Association for the Improvement in Maternity Services
CEA	Childbirth Education Association
CTG	Cardiotocograph
HMA	Home Midwifery Association
ICEA	International Childbirth Association
NCT	National Childbirth Trust (United Kingdom)

STYLE KEY

(001-016)	'Code number' for each participant
<i>italics (000)</i>	Indicates the participant's words
<i>Memo:</i>	Indicates a theoretical memo

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CHAPTER 1

THE INQUIRY

It seems now that fathers' birth attendance has become the norm. There are relatively few comparable instances of such dramatic role changes in modern society occurring with little apparent negotiation with the relevant role partners (Johnson, 2002, p.174).

This thesis reports an inquiry into the paternal-midwife relations in parturition from the midwife's perspective. The inquiry adopts a grounded theory approach. The approach was selected because of the need to generate theory on this topic and to contribute to midwifery knowledge and practice. While this inquiry could have focused on the father's perspective, it is the midwife's perspective of their actions and interactions with the fathers that is the central issue for this inquiry. The purpose was to learn more about the meanings underpinning paternal-midwife interactions in childbirth. This chapter sets the scene for this inquiry by identifying the background, purpose, guiding question and in clarifying commonly used terms and the significance of the inquiry. The chapter concludes with a brief overview of the thesis.

Background of the Inquiry

The decision to examine the topic of paternal-midwife relations in labour and birth was set against a background of increasing expectations on fathers and midwives during the birth process. In 1968, anthropologist Mary Douglas predicted that as family structures changed, fathers would be present at the birth of their children in increasing numbers and society would become increasingly preoccupied with paternal influence over their children's mental health (Douglas, 1975). Contemporary literature demonstrates increasing societal pressure on fathers to be involved in their partner's pregnancy, labour, birth and in the postnatal period. The literature suggests that community expectations are

strong and are often based on stereotypical images that can act as barriers to men increasing their positive participation in childbirth (Hall, 1995; Lavender, 1997). From the late 1990s, new societal pressures have developed. Now, not only are fathers in western countries experiencing pressure from friends, their partners and family members, midwives are also expecting the father to at least observe the birth process. Despite the increasing prevalence of paternal attendance, little is known of the intrapartum relations between midwives and expectant fathers. The current childbirth discourse fails to provide a coherent theoretical framework that provides health care professionals a connection with the reality of professional practice with fathers in childbirth.

The ambiguity surrounding paternal attendance and participation has inhibited the development of substantive theory development and a congruous body of knowledge. Rather, the available work on fathers and midwives and the birth process has arisen indirectly from other work, such as maternal studies (Richards, 1982). Previous studies have suggested that fathers struggle to understand their role in labour and birth (May, 1982; Lewis, 1986; Burgess, 1997). Work by May (1980; 1982; 1991), Jordan (1990) and Palkovitz (1985, 1987) has provided important insight into paternal experiences of labour and childbirth. Given that their role has changed dramatically over the last three decades it is arguably little wonder that fathers are unsure of their role in childbirth. Callister (1995) notes that the role of the father during childbirth and the quality of his childbirth experience are among the least understood features of family dynamics. Indeed, Jordan (1990) asserts that to provide true family-centred care to the expectant family, midwives need to conceptualise fathers as parents with legitimate needs.

Historical and Contemporary Context

In Australia the presence of expectant fathers during childbirth is a contemporary phenomenon. Historically, paternal attendance during childbirth was particularly rare and often viewed by health professionals and society as an

aberration. The origins of midwifery and childbirth management are intimately linked with the caring roles assumed by women. For centuries childbirth was considered 'women's work' (Graham, 1960) until the advent of a new medical specialty, obstetrics. With scientific progress in the nineteenth century, male doctors with their 'scientific' knowledge, skills and tools began to take control of childbirth. By moving childbirth into hospitals, excluding women from university training, denigrating midwives practice and by their use of forceps and similar instruments they legitimised and maintained this control (Donnison, 1977, 1988).

In Australia, hospitalised childbirth began around the 1920s, when medical practitioners assumed the role of gatekeeper of childbirth, from community based midwives. As a consequence, not only were women subjected to exceedingly medicalised and anaesthetised births, they usually laboured alone, with many unable to recall particular aspects of the birth. Bittman and Zalk (1978) observed that a woman was powerless during her birthing experience, as her participation in birthing and even her consciousness of it were minimal.

Amid a changing social climate, the post war era and changes in attitudes towards childbirth management, family roles were also altered. Accompanying these changes were major technological advances in childbirth management and challenges to the biomedical approach to pregnancy and childbirth. As a result, childbirth slowly became a safer, albeit experimental medical event (Llewellyn-Jones, 1979). It was during this time that women began demanding not to be left alone during their labour and birthing.

Around the late 1960s more importance was also being placed on antenatal education, with antenatal educators seeking to include fathers in some aspects of their classes. Indeed, fathers began to question why they were permitted entry for the labour but required to leave during the birth. It was during this time that some independent childbirth educational organisations began to lobby for

paternal attendance in labour and birth. In Queensland this was particularly facilitated by the support of organisations such as the Childbirth Education Association (CEA), which lobbied maternity hospitals and the then health minister, for paternal admittance into labour wards (Wayper, 1974). In Australia, the reasons underpinning paternal presence in hospital-based childbirth varied from State to State, this is discussed in further detail in Chapter Two.

Paternal attendance in hospitalised childbirth became common practice around the 1970s in most developed nations, with Pawson and Morris in 1972 reporting a 74% paternal attendance rate in the United Kingdom. By the 1980s, there was a rapid increase in paternal attendance. In Australia the rate was estimated to range between 60-80% (Harper, 1980; Russell, 1982). Glezer in 1990 reported in a survey of ten private and ten public Victorian hospitals an attendance rate over 90%. Current paternal attendance figures are unknown in Australia because the collection of such data is not mandatory.

It is often assumed that decisions with potential social, personal or medical implications are made on the basis of the best available evidence (Upton, 1999). The decision to allow fathers into childbirth was an exceptional case because limited empirical evidence existed. Several authors believed the paternal role and the paternal childbirth experience were poorly understood features of the birthing process (Pawson & Morris, 1972, Callister, 1995; Bartels, 1999). Despite this lack of information, no inquiries have been undertaken from the midwives' perspective related to the phenomenon of paternal attendance.

There has also been a growing awareness of the benefits associated with paternal presence. Today, the expectant father's role in childbirth involves a broad range of activities, interactions and emotional responses. Their role includes the provision of emotional and physical support, interactions with health professionals and providing family and friends a connection with the

event. The impact of these expanding role expectations is an inevitable increase in pressure on fathers, who require support to meet their role in labour and childbirth (Vehvilainen-Julkunen, & Liukkonen, 1998). What is unclear is how midwives can enhance the father's role and participation in labour and birth.

Inquiry Purpose

The purpose of this inquiry was to generate a substantive theory to explain paternal-midwife interactions during labour and birth. This involved exploring the meanings of the social processes, actions and interactions between fathers and midwives in different birth settings, to define the variables, which influence paternal-midwife interactions in parturition and to construct a grounded substantive theory. An additional aim was to appeal for future inquiry by demonstrating effective inquiry directions that could generate further theories. It is anticipated that the emergent theory will contribute to midwifery knowledge and enhance midwives' knowledge and understanding of paternal-midwife interactions.

The Guiding Question

The grounded theory method has an emerging design that begins with a broad purpose of determining what is going on in a particular area of interest. The area of interest in this inquiry was paternal presence in childbirth. Stern (1985) highlights the need for a guiding question to assist the grounded theorist in their search for factors related to the topic. The guiding question for this inquiry was:

What are the social processes associated with paternal-midwife interactions perceived by midwives during labour and birth?

Significance of the Inquiry

Theory generation about paternal-midwife interactions during labour and birth is significant for several reasons. Currently there is an absence of conceptual understanding of paternal-midwife interactions in childbirth, which has limited the development of a congruent body of knowledge in this field. While there is an abundance of literature on the maternal-midwife relationship, this inquiry is

the first to examine the midwives perspective of the paternal-midwife relations in childbirth.

The theoretical constructs of this inquiry will directly contribute to the scarce literature on paternal-midwife relations during parturition. Although some studies on expectant fatherhood have produced some salient issues, few have been Australian and fewer still have included health professionals. Consequently there is a need to examine the issue of the paternal-midwife relationship in an Australian setting. It is anticipated that the findings will be applicable to all types of childbirth settings and for midwives locally, nationally and internationally.

This inquiry provided a timely examination of the paternal-midwife relationship and up-to-date information on the role of midwives in supporting expectant fathers. The significance of this inquiry to midwifery practice is echoed in the voices of midwives. Their voices provide a wide range of perspectives of the social processes involved with paternal-midwife interactions during labour and childbirth. Increasingly, midwives are committed to enhancing consumer satisfaction and it is anticipated that the findings from this inquiry will identify several strategies for achieving this. It is expected that the conclusions of this inquiry will inform midwifery praxis and contribute to this emerging field of knowledge.

Clarification of Terms

Specific terminology used in this thesis is defined to enable the reader to effectively interpret the thesis and in particular the review of the childbirth discourse. The term *inquirer* is used to denote the author of this thesis while the term *researcher* is generally used where the inquirer has cited other authors. For the purposes of this thesis the words *father*, *husband*, *partner* and *paternal* are used synonymously to refer to the expectant father who accompanies his partner during labour and childbirth. These words are used to denote fathers, regardless

of age, race, number of children and marital status. The labouring woman is generally referred to as the *woman*. The *midwife* refers to the health professional involved in the intrapartum care for the couple. In American discourse the word 'nurse' or 'nurse-midwife' is often used to denote the main caregiver for expectant couples in childbirth. The word *doula* is used in the discourse reviewed in Chapter Three. Doula has a Greek derivation meaning an experienced woman without medical experience who guides and assists the labouring woman (Nolan, 1995; Hunter, 2002).

In this inquiry, the terms *intrapartum*, *parturition*, *perinatal*, *labour*, *birth*, and *childbirth* are used interchangeably to denote the time period of focus of this inquiry. The time period extends from the onset of labour until the end of the third stage of labour, which includes the birth of the newborn and placenta. A further discussion on specific terms is given in the section on roles and relationships in Chapter Three and in the context section in Chapter Five.

Specifically, this inquiry is concerned with paternal-midwife interactions during vaginal childbirth. The concepts of caesarean section childbirth and couvade are not included in this inquiry for the following reasons. Caesarean section childbirth has been omitted because of the lack of contact with midwives during a labour period and the medically controlled atmosphere of birth management in the context of the operating theatre. Couvade is the term generally given to a variety of customs applying to the behaviour of fathers mainly throughout pregnancy and birth. This concept has been well documented since it was first recorded in 60BC by Diodorus Siculus (Licht, 1935) and is traditionally thought of as a non-western tradition. The reason for its exclusion is that this inquiry is located in a western society, with a limited codified historical tradition of such rituals.

Overview of the Thesis

Having outlined the inquiry background, purpose, guiding question, significance and clarification of terms this chapter concludes with a guide to the thesis. This thesis is organised into eleven chapters.

This chapter has presented the basis for this inquiry. As such the introductory chapter provides an outline of the background, aims and overview of the inquiry. The guiding question was outlined to illustrate the focus for this inquiry. The chapter has also presented a brief historical account of paternal involvement, which establishes the long held belief that the centrality of childbirth is 'women's business', where fathers have experienced no traditional place or specific role. Subsequently, with many changes in society and midwifery practice, this belief continues to be modified. Further, the chapter also highlights the significance of this study for midwives and midwifery practice.

Chapter Two reviews nursing, midwifery and medical literature from the 1920s to the present and provides information about the historical context of the topic. In order to understand the midwife's perception of paternal presence it was necessary to view paternal involvement in childbirth in its historical context. Through a structured questionnaire, designed by the inquirer and distributed nationally, the necessary background information on the issues surrounding the change to permit fathers into the traditional female domain of childbirth were obtained. The findings from this survey are presented and interpreted in light of the ambiguities of the extant literature. The findings also provide a national perspective of this emerging phenomenon.

Chapter Three examines constructions from previous inquiries related to the inquiry topic. An examination of specific childbirth discourses, including midwifery, medicine, obstetrics, nursing, health, sociology and psychology revealed a dearth of literature related to the inquiry topic. Indeed, childbirth

discourses were monopolised by the maternal-midwife relationship and maternal-offspring dyad. This chapter examines the literature on paternal presence and pain management in labour and birth, maternal experiences of paternal presence, paternal experiences of childbirth attendance, paternal-midwife interactions and concludes with an analysis of paternal and midwife roles and relationships in childbirth.

Chapter Four presents an explanation of grounded theory methods and their use in guiding this inquiry. The nature of the phenomenon deemed that a theory generating approach was essential to gain an in-depth understanding. From the previous chapter it is clear that few conceptualisations exist on paternal-midwife interactions in childbirth. A discussion on the chosen methodology includes thoughts on the sociological theoretical perspective of symbolic interactionism, as the theoretical underpinning for grounded theory, the relevance for nursing inquiry and practice and the case for grounded theory in this inquiry.

Chapter Five considers the contextual influences on the inquiry phenomenon. The chapter provides a profile of the participants and an insight into the structures in which they provide intrapartum care. The contextual influences of the home birth, labour ward and birth centre environments on midwives' perceptions and behaviours are identified and discussed.

Chapter Six presents a description of the methods used in this inquiry. Specifically, the methods of data collection and analysis are discussed, along with the methods used to augment the integrity of the inquiry process and findings. How the inquiry was planned and conducted to ensure a quality outcome is explored and a discussion of the ethical precautions undertaken in this inquiry to prevent and minimise risks to the participants concludes the chapter.

Chapter Seven outlines the conceptual framework, which emerged from the data. A framework for understanding the emergent theory of establishing an inclusive relationship, which can help explain paternal-midwife interactions from the midwife's perspective, is also provided. The chapter also discusses the relationships between the core category and supporting categories.

Chapters Eight, Nine and Ten discuss the inquiry's findings in detail. The findings provide an analysis of the midwives insights into their attitudes toward paternal involvement and how these attitudes influence their professional practice to include expectant fathers in the childbirth process. The midwives defined the nature of paternal-midwife interactions as establishing an inclusive relationship. Such an inclusive relationship can be found in the following categories: midwives' attitude towards paternal presence, personal and professional experiences, building a rapport, advocating paternal involvement, the supporting partnership and the boundaries of the birth environment. The relationships connecting these categories emphasise the uniqueness of the data. To be faithful to the participant's interpretations the data are presented using their narratives. The findings and constructions of the data are integrated with the constructions from previous work.

These findings have implications for how health professionals work with fathers, how they think about fathers and how they include them in intrapartum health care. Chapter Eleven draws the thesis to a close with a review of the inquiry process and implications for childbirth practices and education. This final chapter considers the limitations of the findings from this inquiry and makes several recommendations for future inquiry.

CHAPTER 2

CHILDBIRTH: WOMEN'S BUSINESS

In ancient mythology the goddesses were present at deliveries, but not the gods. No matter how bad things were, no man was ever called (O'Dowd & Philipp, 1994, p.3).

In seeking to understand the historical context relevant to this inquiry emphasis has been placed on the father's role in childbirth throughout history. Contemporary conceptualisations related to paternal involvement in childbirth are reviewed in Chapter Three. A review of published medical, midwifery, nursing, anthropological, sociological and psychological literature demonstrates the indifference of these disciplines to paternal involvement in childbirth. Traditionally, childbirth has been universally regarded as a female 'mystery', a female rite of passage of which women alone had special knowledge and understanding (Donnison, 1977, 1988). Historians claim that for centuries women predominately birthed at home with the assistance of female relatives and then, more recently, with the assistance of midwives (Litoff, 1978). Histories also suggest that men were traditionally excluded from the birth process (Bydlowski, 1991; O'Dowd & Philipp, 1994).

The course of the role of the father, from its origins in earlier centuries to their entry into labour wards in the 1970s and the changing role since the 1970s are traced here. To interpret such sudden changes in concepts and behaviour, the changes must be located in their historical context. This review examines specific changes in childbirth practices during the twentieth century, such as the medicalisation of childbirth, the separation and exclusion of fathers from labour wards, the consumer movements and the eventual admittance of fathers into labour wards. To elicit historical data of the factors associated with the entry of fathers into Australian labour wards the inquirer developed a one-page national survey (Appendix E). This survey was conducted to inform this inquiry and

ethical approval was obtained from Flinders University - Ethics Committee. The survey findings and discussion are presented within the following sections of the chapter, which concludes with an overview of societal expectations on fathers during childbirth. Before the review of pertinent literature, consideration is given to the use of relevant literature in this inquiry.

The Use of Relevant Literature

Unlike other traditional inquiry approaches, grounded theory requires that extant literature should not be extensively reviewed before commencing data collection. Glaser (1978) recommends reading widely while avoiding the literature most closely related to the inquiry topic. His rationale is that it may constrain coding and memoing. Instead, relevant constructions emanating from previous literature should be used as a source of data to compare, verify and expand categories during theory generation. Glaser and Strauss (1967) caution the grounded theorist in their use of extant literature, to ensure that openness during data collection and analysis can occur:

An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas (Glaser & Strauss, 1967, p. 37).

The grounded theorist turns to an entirely new body of literature following the generation of the grounded theory. This review links existing theory with the properties of the emerging theory. The major examination of literature is prompted as a result of themes emerging from the data.

Glaser (1992) notes that there are three types of literature in grounded theory studies: non-professional, popular and pure ethnographic descriptions, professional literature related to the inquiry topic, and professional literature that is unrelated to the inquiry topic. The inquirer was cautious in the use of extant literature. In writing this thesis many forms of evidence, including archival documents, oral history recordings, health department memorandums, newspaper articles, journal articles and secondary sources have been used. The

analysis of the childbirth discourse related to the topic is presented early in this thesis for three reasons: to provide the reader with an understanding of the extant literature, to gain an Australian and international perspective of this inquiry and to justify the need for such an approach to this problem. The following section provides an analysis of the historical literature on paternal attendance during childbirth.

The History of Paternal Birth Attendance

Never allow the husband to be present. If he is man of sense and delicacy, he will not desire it and if he is not, the more reason you should keep him out of your way (Maunsell, 1842, p.122).

Historically there has been little documented about fathers and their role in childbirth. Although histories of childbirth abound in anthropology, sociology, psychology, midwifery and medical discourses, there are few references or studies of paternal birth attendance and fewer studies identifying the midwife's perspective of this attendance. Demos (1982, p.425) observed, 'Fatherhood has a very long history, but virtually no historians'. In searching the indices of many key historical medical texts on childbirth, the words husband or father are rarely located. Historical evidence suggests that fathers in western cultures have been largely excluded from childbirth until the twentieth century.

Historical birthing literature is largely a feature of twentieth century literature (Haggard, 1929; Graham, 1960; Radcliffe, 1967; Wertz & Wertz 1979; Meltzer, 1981; Bogdon, 1990; Trevathan, 1993; O'Dowd & Philipp, 1994). Although there are numerous histories of childbirth, medical texts dominate the historical literature, clearly under the guise of obstetrics. Medicine used the term obstetrics to avoid the nomenclature of midwifery, which had long been considered the 'Cinderella' of medicine. Historical scholars of obstetrics have focused on several issues, including poor childbirth management practices of midwives such as the over emphasised Sairy Gamp (Graham, 1960; Patrick, 1987), the debates by obstetricians about the need to claim exclusive domain

over childbirth practices (Haggard, 1929; Forster, 1967), and the achievements in decreasing maternal morbidity and mortality rates (Mein Smith, 1986). Arney (1982) observed that there are two histories of the profession of obstetrics, the professions own interpretation of its past and the critics of the profession.

Exploring the marginalisation of women from the management of childbirth, such as the subordination of midwifery by medical control is not the focus of this inquiry. Rather, it identifies some of the implications this struggle may have had on the evolution of the father's role in childbirth. Donnison's (1977) principal British work, *Midwives and Medical Men* and her more recent work, *The Decline of the Midwife* (Donnison, 2000) provide an in-depth analysis of midwives' struggle to maintain their practice. Willis (1983) provides an Australian perspective on this topic in his work *Medical Dominance: The Division of Labour in Australian Health Care*.

Few of the twentieth century histories provide any discussion of the father's presence or absence during childbirth. Graham's *Eternal Eve* (1960) is one of the few medical histories that discusses, albeit briefly, the father's role during childbirth. His discussion ranges from ancient times to the twentieth century with limited supporting evidence for his suggestions. He summates that for mixed magical and social reasons birth was a purely feminine business and a thing to be kept from male eyes. In his discussion of childbirth in the twentieth century, Graham (1960) fails to address the separation of fathers from childbirth, consumer dissatisfaction and the challenges arising against the medical model of care. Instead, he dissects Dick-Read's theory on labour pain and attributes antenatal care and the impetus for the (British) Midwifery Act of 1902 to the work of male physicians. His work is typical of the medical histories written in the early part of the twentieth century.

In terms of evidence, many stories of childbirth were passed from generation to generation without documentation. Consequently many gaps appear in the

history of childbirth, leaving authors to rely on assumptions. Some authors claim that it is possible that husbands' participation in childbirth occurred in isolated instances throughout history, without the occurrence having been recorded (Suitor 1981; Gelis, 1991). Further, Wilkins (2000) notes that until the sixteenth century, midwives had almost always been women. Generally, it seems that childbirth has been portrayed as almost exclusively the province of women throughout recorded history up to the twentieth century.

Contemporary historians claim that, until recently, fathers were traditionally excluded from childbirth. Bydlowski (1991) observed that men (fathers and male doctors) had been traditionally excluded. For example Barlow (1994) suggests that until the 1600s it was a widespread practice for labouring women to surround themselves with other women. Interestingly Rooks (1997) contends that until the late eighteenth century it was considered indecent for European men to have any role in childbirth. Similarly Suitor (1981) found that an examination of midwifery/obstetrics texts, written in the 1600s and 1700s, did not yield any mention of paternal attendance.

Some authors claim that fathers were attending the births of their children during the nineteenth century, albeit with indeterminate frequency. Gelis (1991) observed that from the beginning of the eighteenth century some obstetricians observed the practice of having the husband present to hold up his wife, including Mauquest de La Motte, when it was a case of the birth of a dead baby or performing a caesarean section. Some authors argue that before the nineteenth century fathers had a predefined role in preparing the birthing environment (Hines, 1971; Bedford & Johnson, 1988; Gelis, 1991; Summersgill, 1993). Considering the paucity of primary sources, it is difficult to make an appraisal of the knowledge surrounding childbirth and the presence and possible participation of fathers.

Childbirth in the Twentieth Century

During the twentieth century major changes in childbirth practices occurred. Prior to the twentieth century most births took place in the home, usually with the help of an untrained woman (Clayton, Lewis & Pinker, 1980). During the early decades of the twentieth century, Australian women were moved from their homes into hospitals for the childbirth process. Willis (1983) refers to this period as 'the takeover period'. The opinion was that women's health should be 'safe-guarded in the interests of family and nation' (Reiger, 1985, p.86). With an increasing emphasis on maternal morbidity and mortality and a decreasing birth rate, the governments of the time sought to promote maternal welfare. The establishment of several hospitals represents the importance of this to the government at the time (Selby, 1992). Reiger (1985) claims that these developments altered public attitudes and behaviours concerning childbirth and women turned to hospitalisation and anaesthetised labour to avoid the risks associated with giving birth.

Thus, childbirth was placed under the medical gaze in the public sphere of the hospital. Selby (1992) observed that from 1922 the choices for pregnant women, other than to use a government maternity hospital, were greatly reduced. With this move, childbirth progressed from being a private home event to a highly ritualised and supervised medical event. Capitula (1998) identified that this change to physician-assisted births carried with it a total change in the philosophy of birth primarily related to the medical model of care. The institutionalisation of childbirth enabled the obstetrician to take on the role of gatekeeper of childbirth processes. Thus, centuries of prohibition of the male gaze at childbirth had ended.

This move greatly assisted medicine's control over birthing practices and in time over the practices of midwives (Patrick, 1987). Still the initial interventionist ideology of obstetrics did not prove successful in promoting the safety of childbirth. Coupled with the development of obstetric technology, the

transfer was based on the assumption that hospital and medical care would provide a safer environment for women to give birth and thus lower the maternal and infant morbidity and mortality rates. Instead, in the early years of the change, experience proved this hope to be false (Llewellyn-Jones, 1979; Selby, 1992). For example, Mein Smith (1986) argued that, in Australia, evidence showed injury and sepsis rates were lower in midwife assisted births in the early 1920s than in the births managed by hospital-based physicians. Similarly Australian doctor, Sydney Morris, in a detailed report on maternal morbidity and mortality, stated that:

...the greatest improvement in the death rates from puerperal septicaemia has occurred in those States where the influence of legislation controlling midwives has been least marked or entirely absent (Morris, 1925, p. 311).

In Australia the change to hospitalised birth gained impetus in the 1940s and, within a decade, most women gave birth in hospital, under the care of obstetricians or general practitioners (Llewellyn-Jones, 1979). In her historical thesis on the eclipse of the community midwife in South Australia, Summers (1995) noted that most women were reluctant to make the transition from home to hospital. On entering the hospital, the expectant mother was subjected to a highly ritualised environment, little of which was explained. Women were forced to give birth in the company and control of strangers.

Hospital Exclusion of Fathers

The separation of fathers from childbirth was perpetuated with the transfer of childbirth from the home to the hospital. One must be cognisant that home birth in the early decades of the 1900s did not necessarily mean that the father was there. Zwelling (1996) suggests the exclusion of fathers from labour wards and their labouring partners was to prevent infection. Indeed, evidence suggests that most American, British and Australian hospitals were reluctant to admit fathers into labour wards until the 1970s (Richman, 1982).

The practice of including fathers in childbirth was not perceived in a positive light, for most physicians this intrusion was problematic. Still, the literature is unclear on the exact reasons for exclusion. From the 1970s the central concern in the literature was the notion that the father was a possible source of infection (MacFarlane, 1977; Affonso, 1981; Parke, 1981; Richman, 1982). Previous studies such as the International Childbirth Education Association (ICEA) study in 1965 did not support this concern. The ICEA study surveyed 45,000 husband attended births and found that no reported incident of infection could be linked to the father's presence (ICEA, 1965). It seems that the notion of infection went unquestioned in light of the then high rates of maternal and infant morbidity and mortality. The fervor for the risk of infection continued even after fathers were admitted to labour wards. For example, in 1979, in a memorandum, the Manager of the Royal Women's Hospital, Brisbane, Queensland, wrote the following to the Under Secretary, State Department of Health on the presence of fathers in postnatal wards:

The medical staff is adamant that any relaxation of the present rules would increase the risk of infection to mothers and babies¹.

Other less cited causes of exclusion included: the limited spatial birthing area, or the fainting or illness of fathers (Sasmor, 1972), that it was sadistic perversion to watch childbirth (Lomas, 1966), that it may inhibit future sexual relations (Hartman & Nicolay, 1966; Lecky-Thompson, 1985), that the physician's authority would be questioned (Bing, 1972), and the possibility of complications and litigation threats.

Aldridge (1970, p.489) described the impact of paternal presence on the physician's authority and behaviour:

We felt uncomfortable when the father was present. So we have protected ourselves behind such statements as 'it's against hospital policy' or 'it is not allowed by the Health Department'. The author's favourite excuse was the honest belief that he couldn't do his best for the mother, if the father was there 'looking over his shoulder'.

¹ Memorandum, The Manager of Royal Women's Hospital to the Under Secretary, State Department of Health. 22nd March, 1979.

According to one of the few references to paternal participation in midwifery literature, the NSW Midwives Association (1984) claims that, with increasing hospitalisation of labouring women, restriction of family visiting rights occurred. These restrictions were implemented because the fear of infection was uppermost in the minds of hospital administrators. They surprisingly also summate in a dismissive manner that, in the mid-century period, the average Australian male could not get away quickly enough after bringing his wife to hospital and that social change eventually altered that attitude (NSW Midwives Association, 1984).

The involvement of fathers in childbirth quickly became the subject of controversy within the medical profession, as Matthews identifies.

The functions of a husband in relation to his labouring wife have never been clearly defined though they have recently become the subject of much controversy (Matthews, 1961, p. 863).

While some believe that the main cause of paternal exclusion was medical reluctance (Bing, 1972), there were also sympathetic medical practitioners who supported the change to paternal inclusion (Dick-Read, 1933, 1942, 1944, 1947, 1950a, 1950b, 1954, 1966; Bradley, 1962, 1965; Miller, 1964; Goetsch, 1966). In reply to the debate over exclusion, American physicians Goetsch (1966) and Miller (1964) negated the reasons for exclusion of fathers at birth. They claimed that neither had ever had an untoward incident in the years they have permitted paternal attendance.

In their observation articles (Goetsch, 1966; Miller, 1964) neither state the frequency nor the motives of paternal attendance, rather, both claim that infection and legal action are not valid arguments. Importantly, their practices paved the way for consumer pressure and the eventual admittance of fathers into labour wards. Given the backlash imposed on these authors and their revolutionary practices it is not surprising that limited midwifery literature exists on this topic at that time.

Consumer Pressure and Paternal Admittance

It is not clear from the literature that any single policy or event was primarily responsible for the admittance of fathers into hospital labour wards. Although it would be easy to follow the path that suggests that the entry of fathers into labour wards was a direct result of the women's movement, limited evidence exists to support such a notion. What is evident is that there were several developments that may have impacted on the change. Various authors have differing perspectives on the reason behind the change to permit fathers into labour wards. For example May and Perrin (1985) posit that paternal admittance was the result of the benefits recorded of paternal presence, whereas Barbour (1990) believed it was the result of social or partner pressure.

Lewis (1986) is one of few authors who noted that documentation about the rapid change in hospital policy is lacking and many possible explanations for the inclusion of fathers have been offered without clear substantiation. It could also be suggested that factors, such as consumer expectation and attitudinal changes of women and to a lesser extent health professionals, drove such an alteration in childbirth practices. In examining the underlying forces behind this change in attitude one is led to the many social movements of the 1960s. For Rooks (1997), consumer criticism of aggressive medical management of childbirth occurred within the context of other significant social and cultural forces of the civil rights movement, the women's movement, the consumer movement and the antiwar movement. Crouch and Manderson, (1993) also contend that the 1960's witnessed the rise of consumer, civil and family rights, which changed women's experiences of childbirth. Rather than identifying one single movement as the cause of the change, what is noted is that for differing reasons women began to challenge some of the once accepted hospital procedures and policies.

For Zwelling (1996), the women's movement of the 1960s and 1970s had a major impact on the attitudes of women concerning their pregnancy and birth and the right to shape their childbirth experiences. Harcombe (1999) also contends that the origins of the consumer groups lie in the early feminist movement. Oakley (1992) contends that the period from the early 1970s to the late 1980s stands out as an era of the consumer movement in maternity care. Central to this era was the notion that women wanted their childbirth experiences to be satisfying and medically safe.

One possible explanation for paternal inclusion in childbirth is the increasing concern for a natural childbirth. The ideology of natural childbirth began to appear in the U.S.A. in the late 1940s. Dick-Read (1944) defined natural childbirth as normal physiological childbirth. The goals of natural childbirth are to reduce the mother's level of fear and pain, to decrease the use of analgesia and anaesthesia and to minimise the need for obstetric intervention. For May & Perrin (1985) the origins of today's paternal involvement is the result of the natural childbirth movement. Natural childbirth proponents included Dick-Read, whose 1933 work *Natural Childbirth* was one of the first texts to locate fathers in the context of the hospital birth.

Dick-Read's publications spanned a period from 1933-1966. Although he promoted paternal attendance, in most of his works it was usually only the last two pages which were devoted to the father and his role in pregnancy, labour and birth. In his final work Dick-Read (1966) observed that the days of isolation of the husband are passing and he has a place to fill and a responsibility to share. Thus began a philosophical base for new attitudes towards childbirth. Organisations, such as the ICEA and National Childbirth Trust (NCT), promoted Dick-Read's ideology to a larger audience. Although his books were widely read and he gained support from other physicians, it was nearly a decade before his theories were widely circulated.

In Australia, Alwyn (1977) claimed that there was general agreement that the initiation for the introduction of the husband into the previously restricted area of the labour wards stems from Dick-Read's 1933 publication. Working from the same theoretical stance, Wonnell (1971) suggests that it is important for us to keep in mind that fathers first appeared in our hospitals' labour wards because women were objecting to being left alone and they felt that they were not getting the support that they needed to cope with labour from the midwifery staff. Additionally she contends that the concept of preparation for childbirth is not new, but the popularisation and the widespread application of the concept may be largely attributed to Dick-Read and the proponents of both natural childbirth and psychoprophylactic preparation for childbirth, who followed him (Wonnell, 1971). Similarly, Brook (1976) identifies that Dick-Read did much to liberate women from the exclusively male chauvinist attitudes of the medical profession and from what men thought childbirth should be. Arguably the ritualistic procedures and policies of medicalised childbirth assisted the proponents of the natural childbirth movement in their approach toward participatory roles for parents in childbirth.

Others were soon to follow Dick-Read, including Bradley who in his 1965 text, *Husband Coached Childbirth*, emphasised the need for fathers to be with their wives during labour and birth to strengthen their bonds instead of strengthening the bond between the mother and the obstetrician. Like Dick-Read, Bradley also believed in the notion of natural childbirth and outlined the advantages of natural childbirth from the standpoint of the obstetrician. Some accused Bradley of promoting a superior male alliance between the obstetrician and husband, to keep the 'little woman' in line and behaving properly for the health of her child (Edwards & Waldorf, 1984). In general Bradley (1962, 1965) demonstrated limited consideration for the midwife's perspective of paternal attendance.

In the late 1990s Bradley's method continued to attract attention, mainly in the U.S.A. Earlier in 1970, Bradley co-funded the American Academy of Husband-

Coached Childbirth® to provide education and instructor training. The press release on his death, Christmas Day 1998, was titled *The Man who Changed the Face of Childbirth in the World and Got Husbands into the Delivery Room*. This tribute was a very public acknowledgement of Bradley's effort to involve husbands in labour and childbirth.

With the advent of routine obstetrical anaesthesia and analgesia, many believed that women were no longer involved in the process of giving birth (Rooks, 1997). Consequently, through the haze of anaesthesia, women were drawn to the appealing images of natural childbirth and the liberating images of consumer groups. Active consumer groups primarily emerged in America and the United Kingdom. Organisations such as the ICEA, Association for the Improvement in Maternity Services (AIMS) and the NCT emerged in response to the increasingly medical focus on childbirth. These organisations provided women with the support to question the value of the medical model of care (Harcombe, 1999). Gaskin (1991) writes that women had the support of the organisation when they requested permission for their husbands to be present during labour and birth. It is argued that it was women, their partners and supportive consumer groups that supported the transition to paternal attendance in the birth setting.

For example, in Queensland the Brisbane branch of the CEA was instrumental in motivating local hospitals to permit paternal attendance (C. Elliot, personal communication, March, 1998). Wayper (1974) reports that hundreds of letters from CEA members and others were delivered to the Board of the Royal Women's Hospital requesting it to alter the long-standing policy which refused to allow husbands to be present at the birth of their baby. Not only was the Brisbane branch of the CEA instrumental in gaining access for fathers into labour wards, they also continued to fight for the right for fathers to have more access to their infants in the postnatal period in 1979 and to attend caesarean sections in 1984 (Wayper, 1974). The CEA also influenced other organisations to assist them in their causes. For instance, the Association for the Welfare of

Children in Hospital, Queensland Branch, and The National Council of Women of Queensland also lobbied, on behalf of the CEA, for fathers to have increased access to their infants in the postnatal period (Memorandum 21 September, 1979²; Memorandum 21 November, 1979³).

A further factor, which influenced the evolution of fathers into childbirth, was the practice of other hospitals, including Boothville Mothers Hospital (Brisbane) and some interstate hospitals. In 1973 a group of representatives from the Royal Women's hospital were sent interstate to identify the practices of paternal attendance at Sydney maternity hospitals (C. Elliot, personal communication, March, 1998).

In 1924, the Salvation Army founded Boothville Mothers Hospital in Brisbane, which was originally set up to care for unmarried mothers. It was a twenty bed home-like establishment under the management of three doctors. Gradually, with the acceptance and safer practice of abortion, the need decreased and so privately insured couples became the main consumers. In 1992 Elliot asserted that Boothville's clientele consisted largely of private patients who preferred a 'safe, shared, gentle and fulfilling experience of birth' (Elliot, 1992, p.613). Boothville permitted paternal attendance in 1968, six years before both the Royal Women's Hospital and the Mater Mothers Hospital. Suey (1970) claimed at the time, that Boothville was the only hospital in Queensland where fathers were permitted during labour and birth. Boothville hospital was only two kilometers in distance, but six years ahead in practice, from the main women's hospital in Brisbane.

² Memorandum, The Manager of Royal Women's Hospital to the Under Secretary, State Department of Health. 21stSeptember, 1979.

³ Memorandum, The Manager of Royal Women's Hospital to the Under Secretary, State Department of Health. 21stNovember, 1979.

The following section discusses the self-developed survey used by the inquirer to provide an Australian perspective on the admittance of fathers into hospital-based childbirth.

The Admittance of Fathers into Australian Labour Wards

This section reports the findings of an Australian survey conducted by the inquirer on the admittance of fathers into Australian labour wards. In generating a grounded theory historical influences of the phenomenon must be both discovered and considered. Midwives' understanding of the contemporary entry of fathers into labour wards has the potential to influence their philosophy of care and the perception of that care. The inquirer undertook this Australian wide self-developed survey to gain a national perspective of the change in Australia to permit paternal attendance in childbirth. This section examines the question: What factors were instrumental in changing the attitudes and practices of Australian health professionals regarding paternal presence in Australian labour wards?

The partners of labouring women are now freely admitted to Australian labour and birthing rooms from which they were excluded until the 1970s. The reasons for exclusion are varied and today at the start of the twenty-first century, almost seem eccentric. These exclusions range from a lack of toilet facilities for fathers to litigious concerns, as well as other peculiar beliefs, such as partners having voyeuristic tendencies about their need to observe the birth of their child. As with many other health and hospital policies, the medical profession, with the support of midwives, continued to deny fathers entry with an unquestioning belief in hospital and medical supervision during parturition. Indeed, health professionals continue to speculate on paternal participation:

It is clear that the participation of the father was as an adaptation to unprecedented situations: it had not happened before in history of mankind that women has to give birth in large hospitals among strangers; the nuclear family was unknown in any other culture and midwives had always been independent (Odent, 1999, p. 23).

In searching for historical evidence the inquirer was limited by the Australian government's privacy rule of access to certain government documents less than thirty years old. As the transition of fathers into labour wards occurred in numerous hospitals less than thirty years ago, it was necessary to gain evidence in another form. Therefore, a self-developed one-page survey form (Appendix E) was designed to elicit historical data of the factors associated with the change to enable fathers into Australian labour wards.

The survey was sent to every Australian hospital (n=160) with an annual birth rate greater than 30 births. Newly established hospitals were excluded as the practice of including fathers was instigated with the opening of the hospital. Hospitals included in the survey were selected from the Australian database of hospitals. The survey was sent to the Director of Nursing at each hospital with a covering letter explaining the purposes of the survey and seeking their permission to access midwifery staff. The introductory letter also included the inquirer's contact details and emphasised that participation was voluntary and confidential. Each letter also contained a reply paid envelope to assist in the ease of return.

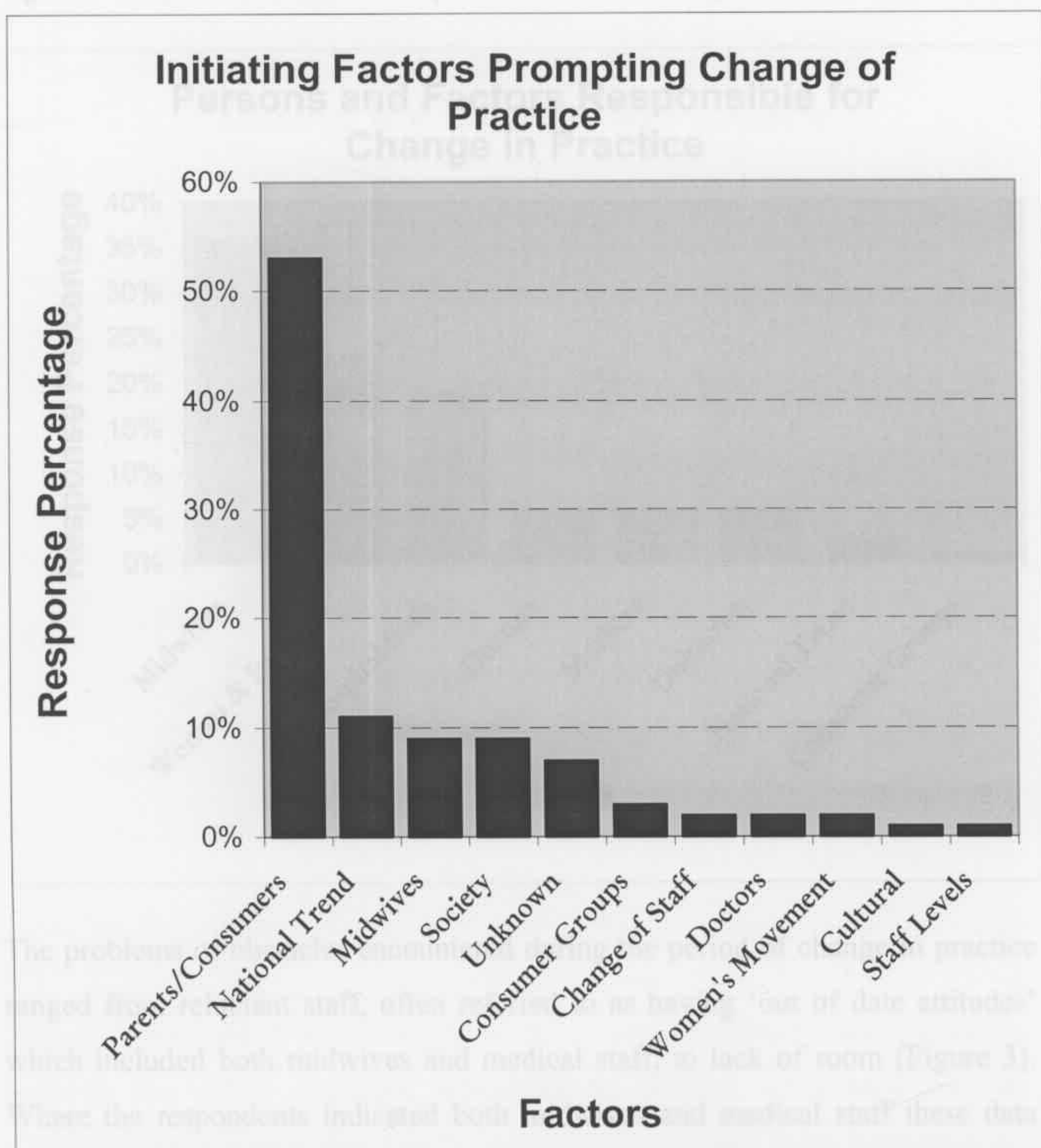
Numerous surveys were returned with additional and unasked for information, such as the contact details of relevant retired health professionals. The inquirer responded to these forms with a thank you letter and the provided contacts were telephoned directly. Informal interviews were then conducted with these respondents, who were mainly retired midwives, general practitioners and obstetricians. The inquirer traveled to Brisbane, Sydney, Adelaide and Perth to conduct the interviews. Additionally, telephone interviews were conducted with contacts from Tasmania, Northern Territory and Victoria. This approach proved to be a valuable exercise with many of these contacts providing a strong recall of the change in policy and associated issues. Some of these interviews also resulted in the inquirer accessing historical documents that would not normally be available. These documents included hospital board minutes, hospital memoranda, newspaper articles and audio recordings.

The study was first piloted with a total of ten surveys sent to a variety of hospitals in different States to determine the value of the survey questions. All ten surveys were returned completed with the appropriate data. The survey showed that the questions retrieved the appropriate information therefore the main survey was distributed by post. Although, not specifically requested several hospitals also sent the survey to retired health professionals. The Statistical Package for the Social Sciences (SPSS, version 9) was used for the statistical analysis.

The survey responses provided significant information on the admittance of fathers into Australian labour wards. The main data required for the current inquiry involved the reasons behind the change in practice and the factors involved during the change in practice. Thus, the following discussion centres on these issues to provide an understanding of how the change in practice to admit fathers into labour wards evolved in Australia.

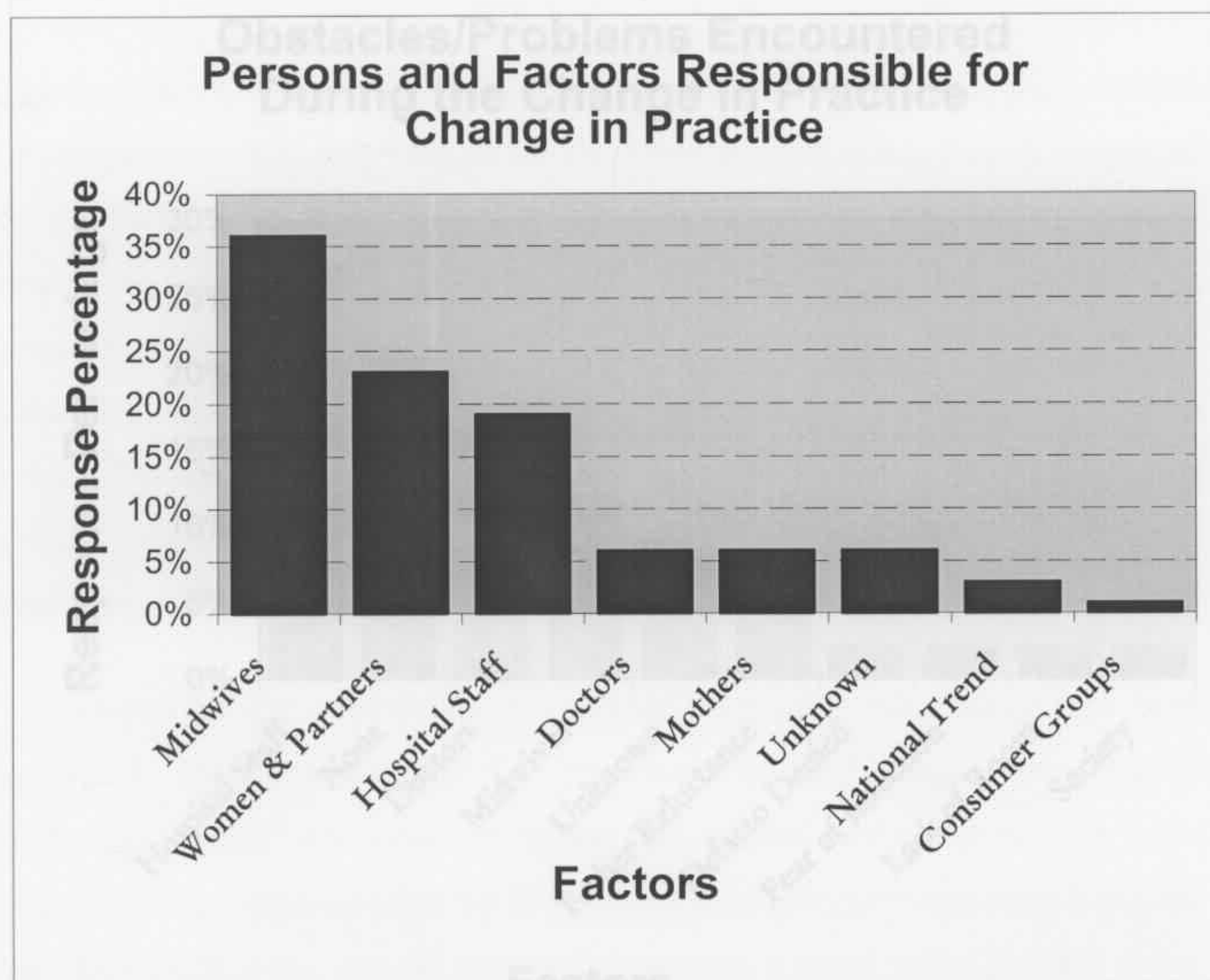
There were numerous factors designated by the respondents as prompting the change (Figure 1). In the survey 52% of the respondents indicated that parents and consumers were the main factors involved in prompting the change. The second major factor was that the practice was considered part of the national trend (11%). Other factors included: medical and midwifery staff, a change of staff, consumer groups, the women's movement, social and cultural beliefs.

Figure 1: Initiating Factors Prompting Change of Practice



Several groups of people and factors were indicated as those responsible for the change allowing fathers to be present in the labour ward (Figure 2). A higher proportion of midwives (36%) were indicated as those responsible for the change, with, women and their partners (23%) and hospital staff (19%).

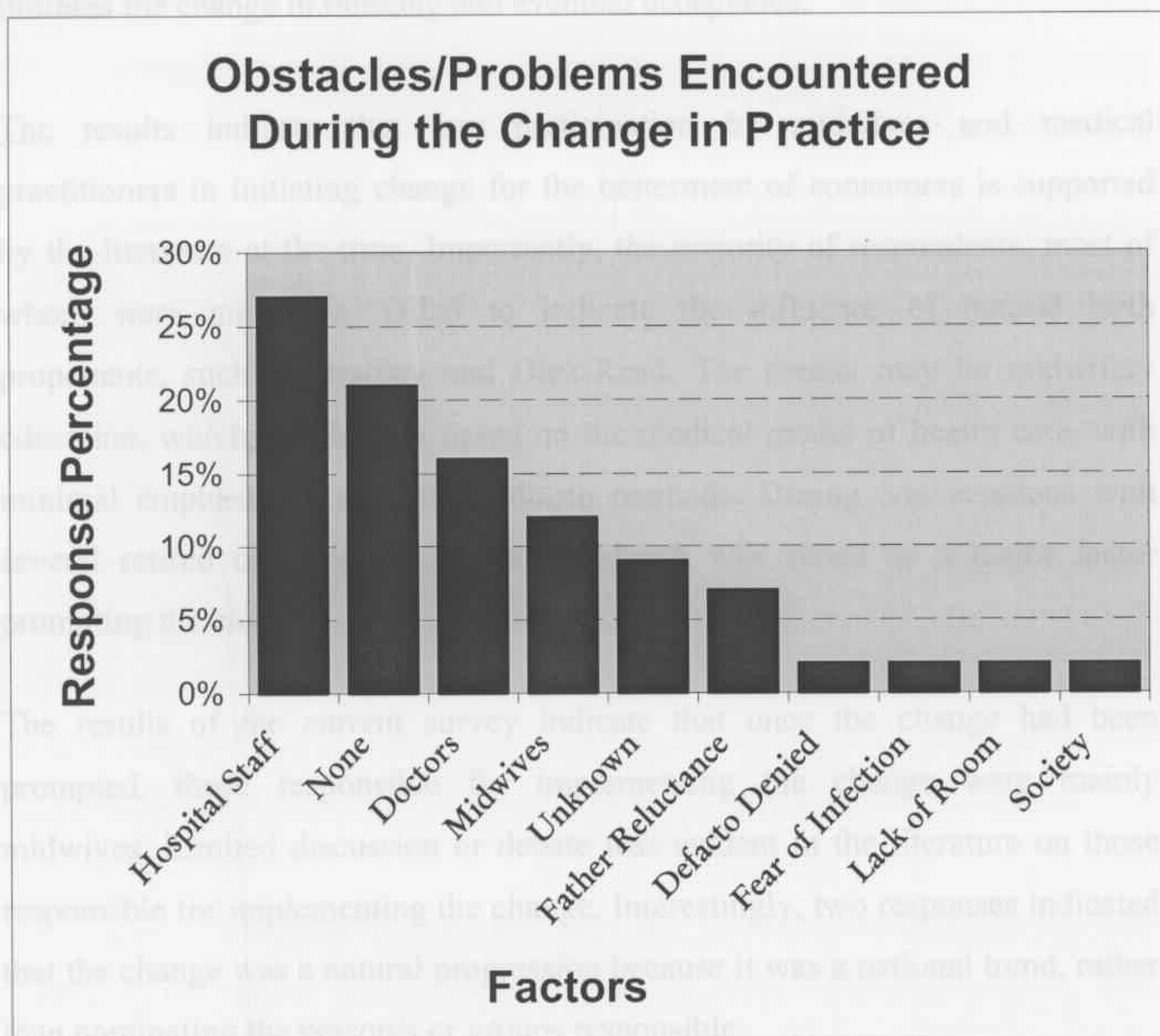
Figure 2: Persons and Factors Responsible for the Change in Practice



The problems or obstacles encountered during the period of change in practice ranged from reluctant staff, often referred to as having 'out of date attitudes' which included both midwives and medical staff, to lack of room (Figure 3). Where the respondents indicated both midwives and medical staff these data were entered as hospital staff (27%). Combining hospital staff with the percentages for doctors (16%) and midwives (12%) comprised the highest percentage of obstacles (55%). The other notable frequencies were the none category (21%) and the unknown category (9%). Father reluctance was considered by a small number of respondents (7%). The respondents did not indicate why fathers were reluctant to be present at the birth.

consumer groups such as the CEA. Many responses indicated that very persuasive parents gained entry for fathers into labour wards. Although it would seem logical that hospital staff would be the group responsible for the

Figure 3: Obstacles/ Problems Encountered During the Change in Practice



The above analysis of the survey demonstrates some differences and similarities between the extant literature references to paternal admittance and the Australian perspective. The results indicated that fathers were permitted into labour wards in different States and Territories for a variety of reasons.

The results indicate that the majority of respondents identified consumers as the main factor prompting the change (52%). Women and their partners form the largest group of persons initiating this change. For example, in Brisbane, the impetus was evident in the form of petitions and requests, supported by consumer groups such as the CEA. Many responses indicated that very persuasive parents gained entry for fathers into labour wards. Although, it would seem logical that hospital staff would be the group responsible for the

actual change, according to the survey results it was the consumers who initiated the change in thinking and eventual acceptance.

The results indicate that low participation by midwives and medical practitioners in initiating change for the betterment of consumers is supported by the literature at the time. Importantly, the majority of respondents, most of whom were midwives, failed to indicate the influence of natural birth proponents, such as Bradley and Dick-Read. The reason may be midwifery education, which was largely based on the medical model of health care, with minimal emphasis on natural childbirth methods. During conversations with several retired obstetricians natural childbirth was stated as a major factor prompting the change.

The results of the current survey indicate that once the change had been prompted, those responsible for implementing the change were mainly midwives. Limited discussion or debate was evident in the literature on those responsible for implementing the change. Interestingly, two responses indicated that the change was a natural progression because it was a national trend, rather than nominating the person/s or groups responsible.

Most investigations of major transitions observe that it is normal for some problems or obstacles to be encountered. The extant literature has listed many documented obstacles and problems arising during the transition, including dated attitudes of health professionals, including midwives and medical staff, the concern of infection and litigation as well as privacy issues. Health professionals were nominated as the main obstacles during the change in practice transition.

In one of the few studies identifying midwives' perceptions of changes in maternity practices Stolte, Myers and Owen (1994) assert that limited literature can be found about 'nurses' responses to changes in birth practices. This descriptive study only provides a limited discussion on the father's role. The

random sample of 'nurses' does provide, however, a wide range of 'nurse' perspectives from fifty states of the U. S. A. The 'nurses' in the study described the inclusion of family members as exciting and challenging. In particular, Stolte, Myers and Owen (1994, p.606) stated that one 'nurse' reported 'family involvement in the birth process has been the most positive aspect in maternity nursing'. All the 'nurses' reported that none of the changes were easy to make (Stolte, Myers & Owen, 1994).

This is the only available study that describes how 'nurses' responded to the change and inclusion of the family (including fathers) in childbirth. However it failed to explicate the perceptions of 'nurses' beyond the degree of change. Interestingly, Brown (1982) reported that acceptance among hospital staff of paternal presence indicated no discernable difference relating to age or the relative conservatism or liberalism of individuals. Nevertheless differences were identified in opinions related to paternal presence during minor procedures.

Some studies indicated that doctors were the principle obstacles in allowing fathers in the labour ward (McNurlen, 1972), with medical personnel, who discouraged paternal presence, arguing that they would increase the risk of infections, encourage malpractice suits, cause confusion if they get in the way or faint and make hospital personnel uncomfortable. It was also argued that if emergency resuscitation was needed, fathers might witness medical procedures that might frighten them (Phillips & Anzalone, 1978). Indeed, there is literature on the untoward effects of paternal presence in labour and birth, which supports one of the commonly used reasons of exclusion, fainting fathers. Crosby (1989), in his Canadian study of fainting fathers in the labour ward, found that 2.9 percent fainted during the procedure of epidural insertion. Similarly, DeVore and Asrani (1978) report a highly quoted case study of a paternal skull fracture as a complication of obstetric anaesthesia.

The results demonstrate that when implementing a change in practice, it is

essential to integrate strategies to support the transition. The associated literature, however, fails to identify any such strategies. The results of the current survey indicate that the response categories 'none' and 'unknown' also represented a high proportion of overall responses. There may be several reasons why the respondents considered and gave these responses. It may be the result of time lapse since the change in practice or that the problems encountered were minor and not considered significant by the respondents.

In summary, the findings demonstrate that there is empirical support that health professionals were not as supportive of the change as previously assumed. In addition, they presented the largest obstacle to the transition period of paternal participation throughout Australian labour wards. Instead, consumers and their partners were the main group underpinning the impetus for paternal participation. This survey has highlighted the historical influences on Australian midwifery practices and arguably establishes the impact this change had on current maternity and associated medical practices.

Societal Expectations

The final section of the history of paternal attendance focuses on societal expectations. According to Brannon (1986) a person's behaviour, at any moment in time, is very often guided and determined by social norms and expectations, instead of the personal thoughts and personality of the individual. With the rapid increase in paternal attendance and the development of childbirth consumer groups, societal expectations were also evident. Indeed, there was overwhelming support for the general expectation that fathers willingly attend the childbirth process and support their labouring partner. This expectation was clearly visible, for example many authors have documented the strong pressure for fathers to conform (Brant, 1985; Seel, 1994; Lavender, 1997).

In Australia, Alwyn (1977) observed that some husbands participated because of external pressure to do so. In an American survey of 225 laypersons' attitudes, Palkovitz (1985) proposed that birth attendance and bonding are

important for fathers. The majority of the sample surveyed agreed, 'most people today expect fathers to attend the birth of their child' (Palkovitz, 1985, p.393). This stereotyping of fathers participating in childbirth continues to permeate the media and childbirth literature.

In supporting the new father's role, popular women's magazines and newspapers featured approving articles on paternal presence in labour wards throughout Australia (Edmonds, 1987; Wedsweiler, 1974; Abrahams, 1976). Most of the literature argued for the need of acceptance of the father's role in supporting his partner throughout labour and birth. For example, Lavender's (1997) study acknowledged that fathers felt it was possible to feel coerced into attending and participating in childbirth, with the media and peers seen as the main avenues of this persuasion.

Conversely, there were also those who believed that fathers have the right to choose rather than be expected to conform to society's expectations. Hall (1993) assumes that midwives will want to persuade society to accept that fathers may not want to be present at the birth of their child. May (1982) also contends that not all fathers are suited to the birthing experience while Burgess (1997) suggests that paternal participation during labour and birth must remain an option rather than a rule. The majority of the childbirth literature supports the father's role in childbirth. Despite the increasing pressure to conform to society's expectations the father's role in childbirth remains confused and ambiguous.

Summary

Because of the diverse nature of childbirth discourses the review of literature was divided into two chapters. This chapter considered the history of paternal birth attendance, including reference to childbirth in the twentieth century, the hospital-imposed exclusion of fathers during labour and birth, consumer pressure and paternal admittance. Additionally the chapter provided an

overview of the history of paternal attendance during childbirth. The results of a self-developed survey revealed that various factors were involved in the change in practice to permit paternal attendance into Australian labour wards.

Paternal attendance has contributed to and mirrored the changes in social behaviour. The literature suggests that social expectations are supportive of paternal presence. The following chapter reviews the research literature on paternal attendance including an examination of research on midwives and fathers and their respective roles and relationships.

CHAPTER 3

**CONCEPTUALISATIONS OF PATERNAL PRESENCE IN LABOUR AND
BIRTH**

*The meaning of certain experiences is not always explicit
(Bondas-Salonen, 1998, p.787).*

The previous chapter discussed the history of paternal attendance in childbirth. Because paternal attendance in childbirth is a recent phenomenon, little guidance exists in the literature on paternal-midwife interactions during labour and birth. In particular there were very few references made to paternal presence in the historical childbirth literature. In addition a review of midwifery literature reveals that during the forty years since the admittance of fathers the development of theoretical knowledge has been slow. Lamb (2000) notes that we have learned a great deal over the last several decades on fatherhood and father involvement, yet it is clear that we have achieved a relatively narrow understanding of the phenomena. In contrast to the abundance of literature describing the maternal-midwife relationship, there is relatively little literature describing paternal-midwife interactions in labour and birth.

This chapter provides an overview of the studies on the paternal role in childbirth. The main theme of this review is the contemporary nature of the phenomenon of paternal attendance as an emerging topic of inquiry and discourse. The current review focuses on the key elements of the paternal-midwife interactions in childbirth. In doing so it provides an examination of the role expectations and experiences of both fathers and midwives. A review of the relevant literature is divided into several themes: paternal presence and pain management in labour and childbirth, maternal experiences of paternal presence, paternal experiences of childbirth attendance, paternal-midwife interactions and roles and relationships.

Paternal Presence and Pain Management in Labour and Birth

Traditionally, pain and pain management methods have been common themes in childbirth literature. In spite of the high level of interest this concept remains poorly understood. Sir James Simpson of Edinburgh introduced the use of chloroform in 1847 for the relief of pain during labour and birth. The use of general anaesthesia in obstetrics increased after Dr Snow administered chloroform to Queen Victoria in 1853 (Clayton, Lewis & Pinker, 1980). In this era debate on the use of pain relief resulted with some believing women were destined by the 'curse of Eve' to experience pain during childbirth, whereas medical humanitarians and practitioners believed that there were technical and moral reasons for alleviating pain in childbirth (Woolcock, Thearle & Saunders, 1997). Changing attitudes on the topic of pain management began to impact on the processes of childbirth and assisted the legitimisation of the medical control of childbirth.

Many differing theories of pain in labour have been proposed. For instance, Dick-Read (1933) indicated that the pain of 'normal' labour was due to a lack of knowledge, to fear and to the fact that pain was expected. Following his initial work on the concept of pain, many others were soon to follow. Consequently various theories as well as distraction and relaxation methods from differing countries and disciplines were introduced to expectant couples. Additionally, the notion of paternal presence was also gaining interest. Thus, initial studies aimed to legitimise paternal attendance and focus on paternal support and pain management in labour and birth. The aim was to demonstrate that partner support was related to a reduction in the use of pain relieving methods and increased birth satisfaction (Block & Block 1975; Henneborn & Cogan 1975).

The paucity of appropriately controlled trials concerning pain management and paternal attendance means that the findings of the few studies undertaken, despite their limitations were considered credible. Additionally, several

assumptions were made concerning the father's role with limited empirical supporting evidence. The following is an analysis of the scarce studies of paternal attendance and pain management in labour. Block and Block's (1975) study was one of the first studies on the effects of paternal attendance. Their study found that paternal presence assisted women to cope with labour pain. They studied 84 women's experiences using narrative accounts of their childbirth experiences. Like many childbirth studies the women were recruited from childbirth education classes, in this case the couples were attending Lamaze's childbirth preparation classes. The Lamaze programs emphasised breathing and relaxation techniques intended to reduce the need for chemical pain relief during labour. However, the authors contend that their hypotheses were based on Dick-Read's and Lamaze's original hypotheses. As expected the results indicated that the expectant father was effective in helping his partner cope with the pain associated with labour and birth.

Block and Block's (1975) results draw upon a synthesis of childbirth education philosophies and the woman's individual interpretation of pain, rather than focusing on the father's specific labour role. Recent research has indicated that there is a possibility that satisfaction with pain management during labour may be influenced by experiences during the antenatal period (Monto, 1996; McCrea & Wright, 1999), such as childbirth education. Specifically Monto (1996) identified that the content of prenatal education may alter the childbearing couple's approach to childbirth. Indeed Monto found that those who attended Bradley (husband coached educational) classes were more likely than those who attended Lamaze classes to criticise aspects of the conventional hospital birth experience, such as routine electronic fetal monitoring and episiotomy and to accept the validity of alternatives, such as home birth.

In the same year Henneborn and Cogan (1975) studied two groups of couples, group one had 38 couples with the partner present during labour and birth and group two had 11 couples with the partner present for only part of the labour

and not the birth. Using survey methods, Henneborn and Cogan (1975) found that fathers in the first group acted as a labour coach throughout labour and birth. The women in this group reported less pain throughout most of the labour than did women whose partners were present during labour only. The authors fail to provide details on the specific pain management methods used in labour and birth. Further, the midwives acted as the labour coaches during the birth for the women in group two. The women from this group reported their midwife as being less active as compared with the women from the paternally supported group.

A limitation of Henneborn and Cogan's (1975) study was the exclusion criteria, which provided a small sample (n=49) out of the target population of 317, yet there was no discussion on the significance of the sample size. In addition, there was inadequate explanation and consideration of the roles and expectations concerning the comparison of the midwife as labour coach in contrast to the father as labour coach during the second stage of the birthing process. Regardless of the differences between these two studies it is obvious that paternal attendance did have an impact on women's experiences of labour and birth.

Significant differences were discovered between these early studies and the more recent studies. In contrast to Henneborn and Cogan's (1975) results, Niven's (1985) larger study found that the presence of the husband was neither directly nor indirectly related to the intensity of labour pain. Yim (1997) also examined paternal attendance and pain management. The results demonstrated that paternal presence was significantly related to the administration of higher doses of analgesics during labour. Consideration must also be given to the cultural differences and the fact that paternal attendance is a very recent phenomenon in Hong Kong and, as yet, this practice was not a widespread phenomenon. Only two hospitals had revised their policy of paternal attendance at the time of Yim's (1997) publication.

Paternal presence during labour has been found particularly helpful in providing women with support in the use of pain coping strategies. Copstick, Taylor, Hayes & Morris (1986) studied partner support, the use of coping mechanisms and the use of epidural anaesthesia during labour. Their results indicated no reduction in the intensity of pain or in the use of epidural anaesthesia. Although, the use of psychological pain control techniques did correlate with reduced frequency of epidural anaesthesia, when women were consistently supported and encouraged throughout labour and when the labour was relatively short (Copstick, Taylor, Hayes & Morris, 1986). Bennett, Hewson, Booker and Holliday (1985) also concluded that women who rated their partner's support more positively were less likely to have used epidural anaesthesia and more likely to use non-pharmaceutical pain management methods.

Studies have indicated that labour companions (doulas), midwives and fathers provide differing methods of labour support (Klein, Gist, Nicholson & Standley, 1981; Bertsch, Nagashima-Whalen, Dykeman, Kennell & McGrath, 1990). Several studies have been undertaken on the role of the doula and the effect on labour and birth outcomes (Sosa, Kennell, Klaus, Robertson & Urrutia, 1980; Klaus, Kennell, Robertson & Sosa, 1986; Hofmeyr, Nikodem, Chalmers & Kramer, 1991; Kennell, Klaus, McGrath, Robertson & Hinkley, 1991; Campero, Garcia, Diaz, Ortiz, Reynoso & Langer, 1998; Langer, Campero, Garcia & Reynoso, 1998). These studies were generally located in Mexico, Guatemala, Texas and South Africa, areas in which many women are not permitted to have family support, largely due to overcrowding in the hospitals and thus the results may reflect the desire of women not to labour and birth alone. It seems that having a doula present when family members were not permitted had a positive impact on the birth process, particularly in relation to the length of labour, use of pain management methods and favourable birth outcomes. Scott, Klaus & Klaus (1999) claim that research findings suggest positive obstetrical and postpartum benefits of continuous support provided by a doula during

childbirth. It has also been suggested that labour support by fathers fails to produce similar obstetrical benefits (Bertsch et al., 1990; Chalmers & Wolman, 1993; Scott, Klaus & Klaus, 1999).

Paternal support has also been linked with maternal choice of pain management methods, including the use of non-pharmaceutical methods (Copstick, Taylor, Hayes & Morris, 1986). Block and Block (1975) and Henneborn and Cogan (1975) found that partner support was related to reduced medication use and greater birth satisfaction. Overall, women perceived paternal presence as the most important support provided during labour and birth (Fein, 1978; Shannon-Babitz, 1979; Klein, Gist, Nicholson & Standley 1981; Chapman, 1992).

Indeed paternal presence and support is rated more positively than professional support. Bennett et al., (1985) reported that women rated their partners as providing more practical help and support than any of the medical staff. They also concluded that women who rated their partner's support more positively were less likely to have used epidural anaesthesia and more likely to use non-pharmaceutical pain management methods. Psychologists, Klein, Gist, Nicholson and Standley (1981), using one hour observations of interactions between fathers, midwives and labouring women, found that fathers were perceived by their partners as more helpful than expected and the midwives less helpful than expected. Interestingly, the majority of mothers indicated that the most helpful thing was the husband's presence. The most useful activity undertaken by midwives was to converse with the labouring woman.

Moran-Ellis (1989), in her qualitative study, found that some of the fathers had played a role in controlling access to pain management (Moran-Ellis, 1989). Gate keeping was seen as one of the components of their multifaceted role. One example was seen with the avoidance of pain management methods such as an epidural. Midwifery research demonstrates that labouring women often feel vulnerable and powerless (Kirkham, 1992; Halldorsdottir & Karlsdottir, 1996;

Harcombe, 1999), giving rise to concerns that paternal presence may undermine any control the labouring woman may have over her labour experience. The concept of power relations between labouring couples has not been extensively debated or investigated.

There is evidence suggesting that other psychological factors play a role in modulating labour pain. Variables considered include previous experiences with pain, the couples relationship and communication with health care professionals and prenatal preparation. Niven and Gijbbers (1984) reported that women who have experienced severe pain before childbirth usually experienced comparatively less pain during labour and childbirth. However, work by Rajan (1993) demonstrates the difficulties in assessing the perceptions of pain and pain management in labour and birth. Indeed the level of agreement between the perceptions of health professionals and labouring women on the effectiveness of pain management methods is quite low. In contrast Niven (1988) reports that trusting the midwifery staff was associated with significantly lower levels of labour pain on a large number of measures of pain. Furthermore, trusting the staff was not only related to the pharmacological interventions but also with the use of various coping methods.

There are many factors that influence a woman's actual experience of pain during labour and birth. Factors include: physical factors, such as variations in the intensity of the contractions, the woman's fatigue level, the position of the baby; and previous life experiences, such as unresolved physical, emotional or sexual trauma and family dysfunction (Simkin, 2002). The nature of pain perception and pain control in relation to paternal participation are complex issues and remain difficult to investigate.

Maternal Experiences of Paternal Presence

In contemporary childbirth discourses there are conceptual emphases on maternal experiences of childbirth. Given that women are the primary

consumers of midwifery and obstetric services it is important to investigate their experiences. In particular the focus has been on maternal satisfaction and dissatisfaction with midwifery services and childbirth experiences (Health Department of Victoria, 1990; O'Meara, 1993; Waldenstrom, 1998; Morgan, Fenwick, McKensie & Wolfe, 1998; McCourt & Pearce, 2000; Chen, Wang & Chang, 2001; Gibbins & Thomson, 2001; Harvey, Rach, Stainton, Jarrell & Brant, 2002). In contrast, there is little knowledge of the labouring woman's perception of paternal presence. More importantly, indirect knowledge of paternal attendance and participation has been derived from maternal studies (Tanzer, 1967), often leading to paternal inquiry in its own right (see Henneborn & Cogan, 1975). In her thesis Tanzer (1967) compared births where the husband was or was not present during the second stage of labour. Her findings identified that paternal presence had a remarkable effect upon the women's birth experience. In every case in which the woman reported 'raptures' and a 'peak' of experience during birth, her husband had been present for the birth (Tanzer, 1967).

Evidence suggests that different attitudes seem to affect the nature of the woman's experience of paternal presence. For example, investigations have revealed that positive maternal experiences are closely related to paternal attendance (DeGarmo, 1978; Bennett et al., 1985; Cunningham, 1993; Somers-Smith, 1999). In an Australian study Cunningham (1993) confirmed that paternal presence was noted to have a positive influence on the maternal experience of birth, with 88% of women perceiving their partner's presence during labour and birth as essential. Favourable factors associated with paternal presence were practical help, support and encouragement (Cunningham, 1993).

It seems that the physical presence, rather than physical support, can be viewed as being just as important to labouring women. Callister, Semenik and Foster (1999) reported that orthodox Jewish women expressed a sense of being supported by their husbands, who, because of religious prohibitions regarding

touching when there was vaginal bleeding, or when she was immodestly exposed, are unable to provide physical support for their wives. Instead the husband supports her through praying and reading psalms.

Entwisle and Doering (1981) compared births in which the husband was present during the second stage of labour with births in which he was not present. The father's presence increased the mother's emotional experiences at the birth. For example, the mothers reported the birth as a 'peak' experience more often if the father was present. Not surprisingly, being present and being actively involved in the birth also affected the quality of the father's experience. Willmuth (1975) observed that many women stressed the usefulness of having either a coach or husband present. The presence of a familiar person was helpful in combating a sense of isolation and alienation. The husband or coach frequently served to corroborate the position of the woman since they shared a common orientation learned during the preparation period. In this way the woman could maintain a belief in the validity of her own perceptions and opinions and this increased her sense of control. Marut and Mercer (1979) concluded that women who had their partners present had a more positive perception of the birth than those who did not.

Beaton and Gupton (1990), in their study on maternal childbirth expectations and responses to their childbirth experience, found that all the participants expected their husband to be an active participant throughout the labour and birth. These women expected their partner to be a source of encouragement and support and, in some cases, this was simply by their presence. They were considered as the orienting agents who would tell the woman what was going on and act as a go-between for her with the hospital staff. Using qualitative inquiry methods Somers-Smith (1999) observed that support provided by the male partner evoked very positive responses from the women. Conversely, DiMatteo, Kahn and Berry (1994), using focus group responses of new mothers, found that

the partner's emotional reactions to the medical aspects of birth often interfered with his effectiveness.

For some women paternal presence is extremely beneficial whereas others have ambivalent feelings about the topic. While there are advantages of paternal attendance, so too are these limitations. Keinan and Hobfall (1989) indicated that paternal presence caused less psychological distress among more dependent women, but not among less dependent women. Given the political and social climate of the location of the study (Israel), such findings may be culturally specific. Similarly, Oakley and Rajan (1991) reported that emotional support and company were thought by women to be the most important of all social support methods. Their findings indicated that fathers living with working class women were less likely to attend labour and birth. This finding may represent the constraints of their partner's job rather than an apathetic attitude toward attending the birth of their children.

Bondas-Salonen (1998), using a phenomenological (Colaizzi) approach, identified that Finnish women felt their partner's presence during childbirth was of the utmost importance. This study was unique in two ways: it provided longitudinal data (two and a half years) and identified differences from previous findings. These differences included maternal beliefs that when nursing staff had participated more intensively in the labour and birth the staff treated the fathers as outsiders. Secondly, the findings indicated that the women understood that their partner played a dual role: a support person and a father-to-be.

Variations in maternal experiences of paternal attendance and participation are evident. There are also various demands and expectations placed on fathers during the childbirth process. In general, the evidence from maternal studies indicates that fathers may be expected to take on many different roles.

Paternal Experiences of Childbirth Attendance

Traditionally, father's experiences of birth have been less well documented than those of mothers. Despite the increasing rate of paternal attendance and changes in professional attitudes, relatively few studies have been published on this topic. Pivotal work by Chapman (1991, 1992, 2000), Jordan (1990) and Palkovitz (1985, 1987) has provided some important insight into paternal experiences of labour and childbirth. Chapman's work is discussed in more detail in the roles and relationships section in this chapter. The small amount of published work represents the use of various inquiry methodologies. The early studies were primarily empirical, whereas, contemporary nursing and midwifery studies have used various qualitative methods. For example, grounded theory methods have been appropriately used to guide the theoretical development of specific childbirth phenomena (Jordan, 1990; Chapman, 1991; Donovan, 1995; Barclay, Donovan & Genovese, 1996).

Reports of women's experiences of labour are of two kinds related to what happened to them during the birth process and their sense and exercise of choice during labour (Bradley, Tashevskaja & Selby, 1990). The literature is less clear on paternal experiences of parturition. The scarce studies of paternal experiences of labour and childbirth reveal positive paternal experiences. Despite the type of methodology used, most of the studies have indicated that fathers generally report a favourable experience (Dragonas, 1992; Nichols, 1993; Hall, 1995; Rykowska-Pierzchala, Smolen, Wislocka-Stawarczyk, Wojtowicz & Jakiel, 2001; Newburn & Singh, 2003). In some studies the usefulness of the father's support was highlighted. Somers-Smith (1999) reports that fathers perceived that they were very helpful to their partner during childbirth. Nichols (1993) also reported that fathers perceived that they were most helpful to their partner during labour.

Indeed, Entwistle and Doering (1981) found that many fathers were enthusiastic about the experience. Similarly, Cronenwett and Newmark (1974) noted paternal responses to childbirth and reported that men, who attended formal preparation classes and the birth, rated their overall experiences significantly higher than did the other fathers. Pawson and Morris's (1972) empirical study, using a large sample (n=730), found that fathers were glad to be present and the majority (92%) thought their presence was beneficial for their partners. The significance of the results is, however, limited by the lack of detail of the statistical analysis tools used to analyse the data. This limitation may be a consequence of the nature of conference papers.

Finnish hospitals have permitted paternal attendance during childbirth since the 1960s. Vehvilainen-Julkunen and Liukkonen (1998) surveyed 107 Finnish fathers on their childbirth experiences, specifically, what they felt during childbirth and how they understand the meaning of childbirth. The factor analysis of the feelings experienced was based on four factors: discomfort, pleasure and pride, feelings related to staff members and feelings related to the maternity environment. The results included unpleasant and pleasant feelings, for example, 53% of the fathers said that they had experienced tension and excitement during the labour and birth. Additionally, in an open-ended question fathers were asked to identify aspects of midwifery care in need of improvement. The fathers believed that the midwives ought to listen to their opinions and that it would be good if they had not felt that they were in the way (Vehvilainen-Julkunen & Liukkonen, 1998).

The literature on paternal experiences of childbirth reveals contrasting dimensions of this experience. On closer examination fathers also have some concerns with their role in labour and childbirth (Berry, 1988; Chapman, 2000; Johnson, 2002; Buist, Morse & Durkin, 2003; Newburn & Singh, 2003). Some studies reported less favourable paternal birth experiences, with fathers reporting feelings of anxiety and helplessness during labour and childbirth

(Pawson & Morris, 1972; Teichman & Lahav, 1987; Vehvilainen-Julkunen & Liukkonen, 1998; Somers-Smith, 1999; Chapman, 2000; Johnson, 2002). For many these feelings were associated with the inability to relieve the pain suffered by their partner. Frequently fathers perceived their participation in childbirth as more demanding than expected. For example, a Swedish study found that fathers were unprepared for an unpredictable process, the woman's actions and their own reactions (Hallgren, Kihlgren, Forslin & Norberg (1999).

The attendance at antenatal classes and the possible effects on paternal childbirth experiences was also examined (Klein, Gist, Nicholson & Standley, 1981; Lemmer, 1987; Moran-Ellis, 1989; Nichols, 1995; Hung, Chung & Chang, 1996; Diemer, 1997; Hallgren, Kihlgren, Forslin & Norberg, 1999; Greenhalgh, Slade & Spiby, 2000; Turan, Nalbant, Bulut & Sahip, 2001). These results, however, must be viewed carefully to fully determine the usefulness of the data. Variations of studies exist between the type of classes, education methods, married and unmarried couples and study tools. Additionally some classes focused on the couple (Nichols, 1995; Hung, Chung & Chang, 1996), others were father focused (Campbell & Worthington, 1982), while others focused on both (Diemer, 1997; Turan, Nalbant, Bulut & Sahip, 2001). One study included methods designed to be used with women rather than partners because such tools have yet to be validated with fathers (Greenhalgh, Slade & Spiby, 2000). However, validations of tools used on men but designed for women are beginning to gain momentum. For example, Matthey, Barnett, Kavanagh and Howie (2001) recently conducted a validation of the *Edinburgh Postnatal Depression Scale* for men.

Current institutionalised midwifery care in Australia is directed to the wellbeing of the woman and infant. As a result, differing perceptions of childbirth expectations and experiences exist between midwives and fathers. An Australian study reported that fathers felt that maternity services focussed on their partner's labour and the birth of the child and neglected their concerns,

such as their transition into fatherhood (Barclay et al., 1996). Even with the philosophical changes in family-centred maternity care and the inclusion of fathers in labour and childbirth, it seems fathers still feel that they have no input into the birth experience. Fathers have been permitted access to the birth experience, but are they really integrated?

Paternal-Midwife Interactions

Maternal-midwife interactions have been well documented, but relatively little work has been conducted on the interactions between fathers and midwives. Language and tradition play a major role in understanding paternal-midwife interactions. For example, the meaning of midwife, 'with woman', has long been emphasised in midwifery education, texts and practices, giving the perception that the role is exclusively devoted to the care of the pregnant woman. More recently midwifery language has been modified in an attempt to include other family members in the midwifery care. Despite these revisions evidence suggests that fathers still remain isolated from the experience. The traditional practice of paternal exclusion still impacts on certain aspects of midwifery management. Contemporary evidence suggests that fathers report that they are requested to leave for certain procedures and during difficult labours (Barclay et al., 1996).

Brown (1982) notes that labouring women and health professionals have clearly articulated roles, whereas the father neither experiences labour nor has the level of knowledge of the health professional. Bondas-Salonen's (1998) relatively recent findings also support the lack of a clear position for fathers in childbirth. Spiby, Henderson, Slade, Escott & Fraser (1999) found that those who accompany women in labour need a more considered acknowledgement and facilitation in their role. An Australian study demonstrated that fathers felt that maternity services focussed on their partner's labour and the birth of the child and neglected their greatest concerns, which are their changing identity, their relationships and their future role as fathers (Barclay et al., 1996). It is argued

that health professionals do not understand the role and importance of paternal presence.

The work addressing the interaction between fathers and midwives is incomplete. Rather, knowledge of this relationship is gathered indirectly from studies on paternal and maternal experiences of labour and birth. Draper (1997) contends there is little inquiry, which has specifically explored the way in which midwives relate to, use, help or support expectant fathers during labour and birth. The assumption is that health professionals, particularly midwives, should assist the father during his partner's childbirth experience (Bozett & Hanson, 1986; Beaton & Gupton, 1990; Chandler & Field, 1997; Lavender, 1997; Lester & Moorsom, 1997; Newburn & Singh, 2003).

Only two studies were found that dealt with midwives accounts of fathers in the labour ward (Aldridge, 1970; Brown, 1982). Aldridge (1970), in his evaluation study of the initial experiences with fathers in the birthing room claims to have presented questionnaires to mothers, fathers and physicians and interviewed midwives. Nevertheless the midwives perspectives are not identified in his article. Instead, a very brief statistical report considers maternal feelings of the change and highlights the physician's viewpoint. In the second study Brown (1982) clearly identifies the medical perspectives (n=8) and lay perspectives (n=15). While, the midwives' (n=10) perspectives were not made explicit throughout his report. Nevertheless, the central emphasis is on paternal presence and the attitudes of the medical staff. The findings demonstrate that prospective fathers are not seen as part of the health care culture, whereas labouring women and infants are clearly accepted into the medical model of health care.

Despite these limitations, findings from indirect studies provide valuable insights into the relations between midwives and fathers. In general, midwives reactions to paternal attendance tend to be positive (Barbour, 1990; Stolte, Myers & Owen, 1994). Barbour (1990), during her observational work,

established that midwives subscribed to the belief that paternal presence was a good thing. Conversely, fathers often felt excluded from the childbirth experience by some health professionals. Bluff and Holloway (1994) and Romalis (1981) have suggested that health professionals rendered labouring fathers silent and captive. Indeed, Bluff and Holloway (1994), in their study of maternal perceptions of midwifery care, found that women expected that their partners would take an advocacy role. Their findings also indicated that midwives largely undermined this role. Shannon-Babitz (1979), a family 'nurse' practitioner reported one father's dissatisfaction with the experience of labour:

...I think fathers are treated third rate. Often I felt as though my maleness and non-medical background were the basis of a subtle discrimination and abruptness. My needs were considered last-if at all (Shannon-Babitz, 1979, p.379).

Kitzinger (1983) fondly refers to the husband as the 'optional extra'. While Richman and Goldthorpe (1978) claim that there is an expectation that the father should play only peripheral and background roles and be prepared to accept token acknowledgement from midwives. Similarly, Jordan (1990) and Chandler & Field (1997) claim that fathers feel that their presence is tolerated rather than being made feel part of the event. Australian scholars have also reported that fathers' felt excluded from the birth experience by health professionals (Barclay et al., 1996).

Beyond the focus of the father's role, several studies have found that health professionals influence the couple's experience of labour and birth (Simkin, 1991; Kirkham, 1992; Walker, Hall & Thomas, 1995). Barnhill, Rubenstein & Rocklin (1979) reported that most fathers did not expect the 'nurses' to go out of their way to include them in the birth experience, but when they did, it seemed to leave a very positive impression. Helpful gestures of 'nurses', such as bringing coffee or juice to the husband while he is at the bedside, and sending him off for short periods of rest, were seen as indicators that the midwifery staff accepted him. Likewise Brown (1982) reported that both medical and nursing staff considered that they made deliberate efforts to alleviate the father's feeling

of peripherality. Furthermore, several obstetricians believed that midwives were more successful than medical staff in their attempts to relate to husbands (Brown, 1982).

More recent literature suggests that fathers are beginning to feel welcomed into the birth arena. Newburn and Singh (2003) reported that fathers found midwives more welcoming than general practitioners and hospital doctors. Nevertheless, there remained some concerns, with one third of participants in the study believing that the midwives often ignored them (Newburn & Singh, 2003). Vehvilainen-Julkunen & Liukkonen (1998) in their questionnaire study found that just under three quarters (73%) of the fathers reported having had a satisfying experience with the birth event. Most fathers (99%) expressed confidence in the midwives and were very pleased with the current midwifery practices followed during childbirth. However, it was also felt that more attention ought to be paid to supporting and providing guidance to the father at this time.

Midwives, however, have been instrumental in involving fathers in prenatal classes, labour and birth and in assisting fathers with infant care (Bozett & Hanson, 1986). Brown (1979), a psychologist, asserts that doctors, psychologists and others, in line with changing orientations among parents, have begun to study fathers and their capacity and willingness to be involved in the lives of their children from a very early age. The brief journal article was aimed at midwives and other health professionals, with a clear message to assist the father to attend and share the childbirth experience with his partner.

Current obstetric and midwifery practices fail to emphasise any 'real' role for fathers during labour and childbirth. Specifically, fathers often reported that they were not asked what role they would like to undertake rather they were relegated to a supporting role (Chandler & Field, 1997). Johnson's (2002) study confirms previous findings that confusion still exists as to the nature and purpose of men's presence at childbirth.

The father is disadvantageded by the lack of a clearly conceptualised role. Given the trend of ever-increasing numbers of fathers participating in all aspects and stages of their partner's childbirth, midwives need to be clear on their expectations for father. While each of the studies reviewed above provide some understanding and information of specific aspects of fathers' and midwives' childbirth experiences, these studies fail to provide insights into the paternal-midwife interactions in childbirth.

Roles and Relationships

A number of factors may determine the processes involved in paternal-midwife interactions in childbirth. Most importantly roles and related responsibilities need to be explored and understood. This section will define the characteristics of paternal and midwife roles and relationships using the symbolic interactionist approach.

Roles

The notion of role is a perplexing one, particularly in relation to the paternal role in childbirth. Fathers are not strictly known as patients, or visitors, rather they occupy a vague role, not specified by hospital processing, processing aimed at controlling, and in keeping with, their duty of care for patients. They are exempt from the stripping and the restriction of mobility (Coe, 1978) that their partner is subjected to as a hospital patient. Further, they may be seen as being marginalised and afforded no status during parturition.

The concept of role is central to the relationship midwives have with labouring couples and in particular prospective fathers. According to Brannon (1986), the concept of role was originally borrowed by social science from the performing arts (the term itself is derived from the 'roll' of paper, which contained an actor's lines). While, there are several theoretical approaches to understanding the concept of role, the most appropriate for this study was symbolic interaction. In choosing grounded theory methodology to guide this study, symbolic

interaction was the logical theoretical approach to study the concepts of role and relationships. The symbolic interactionist interpretation of roles and role behaviour focuses on the meaning that the actions and symbols of the actors during the process of interaction have for each other (Hardy & Hardy, 1988). A more detailed discussion of symbolic interaction is provided in the following chapter.

Symbolic interactionism is an effective theoretical framework for understanding the dynamic situation and examining a process of interaction from the perspective of a particular person or group of people. Thus it is a useful framework with which to study the paternal-midwife relationship during labour and birth. The midwives in this situation would be expected to create a symbolic understanding, or reality. That is a reality shaped by the shared meanings from within the birth environment, the labouring couple and by the larger context of the world outside the birth setting.

The interactions between fathers and midwives are influenced by what each is thinking and what they think the other person thinks. These internal dialogues influence the interactions and expectations and meanings of such actions. Some midwives may be more confronting in their actions with fathers than others. Therefore, persons (midwives) acting together can change the aims of another (the father). The notion of self plays an important part in the roles taken by both actors. Having the ability to embrace the concept of self forms the basis for formulating meaning about social interaction and experiences of the world.

Hardy and Hardy (1988) contend that symbolic interaction is especially relevant to the health caregiver's role. Specifically, understanding the meanings of interactions between patients and the caregiver is important to the outcomes of such interactions. For example, the maternal-midwife relationship is expected to be therapeutic in nature. Each party knows their role and responsibilities as part of the relationship. They know the patterns of behaviour and how they should

ideally perform in a given situation. The midwife has clearly defined roles and responsibilities. The midwife's role has developed and now incorporates a wider sphere of practice, including relationships with family members such as the father. Conversely, the expectations of the paternal-midwife relationship have no clear definitions, established patterns of behaviour, role boundaries or meanings.

The Paternal Role in Childbirth

There has been a dearth of inquiry exploring the intrapartum role of the father in Australia and internationally. During the early days of paternal involvement fathers were expected to take on roles as adviser, advocate and coach. Since then, paternal participation has evolved to a place where many fathers are assuming a more ambiguous role during labour and childbirth.

Although there were several types of roles to 'choose' from, the overwhelming paternal response in the literature was that of the coaching role. Reed (1996) observed that physicians interested in natural childbirth, such as Bradley and Lamaze, created roles for fathers as 'coaches'. This role usually included the timing of contractions and supporting and encouraging the partner in the use of structured breathing techniques. Chapman (1992) contends that the amount of controversy that surrounded the father's entry into the labour and birthing units has forced fathers the role of coach. Leading the way was Bradley (1965). It seems that if husbands were to be part of the childbirth experience they needed to play a useful role rather than be in the way. Typical of this thinking was Wonnell (1971) who wrote extensively on the father's role as supporter and his ability to effectively coach his partner. Campbell and Worthington (1982) were also emphatic in their support for fathers as childbirth coaches. These authors tend to describe the antenatal preparation of father as coaches using childbirth education ideologies rather than exploring the practicalities and pitfalls associated with this role.

For Strauss (1966), a coaching relationship exists if someone seeks to move another along a series of steps, when those steps are not entirely institutionalised and invariant and when the learner is not entirely clear about their sequences (although the coach is). Given Strauss's interpretation of coach, it seems unrealistic to assume an expectant father, with limited childbirth knowledge experience and role modelling, could effectively take on such a role. Further, the coaching process cannot be isolated from the structure. Thus it would be more difficult for an expectant father to coach within the confines of a highly institutionalised setting such as that of the hospital.

Fathers have often deemed the expectations of the labour coach unrealistic. Berry (1988), in her descriptive, retrospective study of 40 fathers, noted that fathers suffered immense stress during their partner's labour. The results indicated that there was considerable concern expressed about their role as coach. The fathers questioned their ability to help, while wrestling with trying to hide their own feelings. Leonard (1977) reported that fathers had feelings of helplessness concerning their role during labour and birth. Indeed it has been suggested that difficulties arise for fathers when they continue to act in ways to support the pre-birth goals, especially when labour is markedly different from expectations (Moran-Ellis, 1989).

The differences in the level of participation have been the focus of many studies. For example, a transnational study of Japanese and Canadian families found that Canadian fathers participate in labour and birth to a higher degree than do Japanese fathers in Montreal and Tokyo (Steinberg, Kruckman & Steinberg, 2000). Other, empirical, studies have proposed that fathers offer support and encouragement during labour and birth (Fein, 1978; Shannon-Babitz, 1979; Klein, Gist, Nicholson & Standley, 1981). The literature suggests that childbirth profoundly affects those witnessing it (Brower, 1998). Indeed, the discourse and evidence on childbirth indicates that paternal presence is an individual experience and the role/s undertaken are influenced by several factors.

In response to changing inquiry paradigms, contemporary midwifery and nurse scholars have applied qualitative methods to study childbirth. These studies have provided valuable insight into paternal perceptions of labour roles and experiences (May, 1982; Chandler & Field, 1987; Moran-Ellis, 1989; Jordan, 1990; Chapman, 1992; Donovan, 1995; Walker et al., 1995; Barclay et al., 1996). Findings drawn from studies using a range of qualitative methodologies suggest that fathers experience mixed emotions during labour and childbirth. These studies usually involved in-depth interviews, with a focus on the father's labour and birth experience. For example, May (1980) was the first investigator to identify that fathers take on various roles during pregnancy. Using grounded theory, she proposed a substantive theory describing these roles as observer, expressive or instrumental (May, 1980).

In 1990, Jordan generated a theory of paternal attendance *Labouring for Relevance*. From her study, three processes emerged relating to paternal attendance, grappling with the reality of pregnancy and the child, grappling for recognition as parent and role making of involved fatherhood. Chapman (1992), using grounded theory methods, found that fathers adopted one of three roles during labour and birth: coach, team-mate and witness. The majority of the participants indicated that they took on the role of witness. This role included observing the labour and witnessing the birth of their child. Jackson (1984) also identified different types of fathering roles during the prenatal, perinatal and postnatal periods. These were: rather not be there, observer, sharer, and those who totally identified with the woman (Jackson, 1984).

Differences in perceptions of the father's role are common. Lewis (1986) highlights the couple's differences of perception of the father's role, moreover, most couples studied perceived the father as becoming part of the medical team. Richman (1982) also identified the father as occupying a status gap between the medical staff, the midwives and the mother and child. Beaton and Gupton

(1990) noted that labouring women expected their partner to act as a go-between for her with the hospital staff. This evidence is suggestive of an inadequately defined father role.

Simply entering hospital creates its own set of factors, which impact on the childbirth experience. These factors include the numerous rules and regulations, the impersonal hospital setting and the relationship with health professionals. Brown (1982) claims that the hospital setting further determines the roles adopted by the various actors involved in childbirth. In general, fathers will have limited understanding of the hospital rules and protocols, may have never met the staff and be unfamiliar with the medical jargon (Robertson, 1997).

Spatial and knowledge limitations also influence the father's role. Architectural changes, such as birth centres, have been constructed to reduce the medicalised birth setting. Many birth centres, nevertheless, remain located in hospital grounds. Vehvilainen-Julkunen and Liukkonen (1998) reported that fathers (73%) found the birth centre environment quiet, comfortable and the atmosphere unhurried. Conversely, Perkins (1980) found that fathers felt inhibited, in the hospital environment, from performing even simple tasks, such as moving a chair into a more appropriate position. Some fathers coped better in the medicalised environment. Westreich, Spector-Dunsky, Klein, Papegeorgiou, Kramer and Gelfand (1991), found that fathers who attended the birth in a conventional setting demonstrated more helping behaviours than fathers in a birth centre. Perkins (1980) notes that a lack of knowledge of, and familiarity with, the high technology environment of modern obstetric units also places severe restrictions on the father's childbirth role. As such, the territorial dictates of hospital birthing can have a significant impact on childbirth experiences.

In contemporary birth settings there are no codified guidelines for fathers to follow during the perinatal period. Instead, the father is often relegated as a visitor within the confines of intrapartum processes. The visitor role is generally

regarded as having very little or no status in the biomedical model of health care in Australia. Visitors are strictly regulated in their access to the patient and more specifically hospital staff. Visitors are expected to adhere to hospital regulations, such as visiting hours, restrictions on numbers of visitors and are expected to leave during many procedures or treatments. They are provided with limited space and minimal access to nourishment and toilet facilities. The unpredictable timing of labour and birth further compromises the father's access to facilities, with many facilities restricted to business hours. These are just some of the restrictions influencing the father's role within a hospital environment.

Seemingly, there are differences in the roles and experiences of expectant fathers during labour and birth. Contemporary work has explored the father's experience of birth but, despite the level of this work, there is still no coherent definition of the father's role in childbirth. While it is commonly acknowledged that men's experiences are generally positive, health professionals and labouring women demonstrate differences in the perception of the father's role.

The Midwife's Role in Childbirth

In Australia the midwife's role and functions have evolved from a community-based midwife to an institutional based midwife. The latter is largely under the control of obstetricians and the biomedical model, which predominantly dictates their practice. Midwifery in Australia has an interesting history. Consequently, several theses exist on the history of midwifery and motherhood in Australia (Willis, 1981; Turner, 1987; Selby, 1992; Summers, 1995). Historians and social scientists, rather than midwives, have authored most of these works. The main premise underlying these works is that the traditional practice of midwives effectively served pregnant women and their families more than the interventionist approach of the medical profession.

The midwife has a central role in the provision of maternity care in pregnancy and childbirth and the midwifery profession in Australia considers itself to be

'women focused'. Accepted definitions of the midwife continue to focus on woman-centred care and the safety of the fetus/neonate. According to the Australian College of Midwives Incorporated (ACMI, 2001, p.1), a midwife is:

A professional who, in partnership with the woman provides care, education and support during the childbearing cycle. The midwife works with women, partners and families, during prenatal, pregnancy, birth, postnatal and early parenting. Authorisation as a midwife is dependent upon successful completion of an accredited midwifery education program.

The ACMI (2001), in their definition of midwifery practice, emphasise midwifery practice as women centred practice, which occurs in an open environment in which the woman and the midwife negotiate a partnership to achieve the best possible health outcomes. The scope of midwifery practice is acknowledged by the ACMI (2001, p.2):

The actual scope of practice of individual midwives is influenced by the settings in which they practice, the care needs of the woman and infant, the level of competence of the midwife and the policy requirements of the service provider. The midwife may practise in the home, hospital, birth centre, community or other care settings.

Throughout the ACMI philosophy and position statements, specific reference is made to the woman, newborn and family, with minimal reference to fathers or partners. Arguably the terminology reflects a maternal focus in midwifery practice. Although such definitions are plainly articulated in literature, the literature related to the intrapartum role of the midwife is not as specific.

There have been several reports undertaken in the United Kingdom demonstrating the ways in which the midwife's role is restricted (Robinson, 1989), particularly by the medical profession. Restricting the care provided by midwives has major implications for midwives and the care given to childbearing couples. In Australia, most midwives currently practice under the guidance of medical practitioners, with the exception of home birth midwives and birth centres. Indeed, even today the Royal Australian College of

Obstetricians and Gynaecologists plays a role in the endorsement of the role and definitions of the midwife. Similarly, Lecky-Thompson (1994) reports that during the 1980s and early 1990s Australian States and Territories, with the exception of Queensland, reviewed maternity care, under the control of obstetricians or epidemiologists.

Lawler (1991) observed that there is a general trend in research in health care disciplines, which results in nurses being ignored, undervalued or invisible. Traditionally midwives' work has been generally undervalued and their practice poorly documented. For example, Barclay (1986) reported that midwives' own description of their role and function was not manifested or acknowledged. The actuality of the midwife's role in childbirth practice thus remains indistinct.

In an Australian study, Lane (2002) explored midwifery self-identity in relation to two major competing discourses: medicine and midwifery. The discourses were defined as ways of understanding and knowing. Twenty-two midwives, working in different settings, were classified as 'hybrid', in the sense that their clinical practice drew variously on each of the major discourses, according to contextual factors. Lane's study reinforces previous findings from international literature (Scoggin, 1996). Scoggin's (1996) study indicated that nurse-midwives identify occupationally with midwifery, rather than nursing or medicine, even though there is some alliance with both of the other occupations. Although midwives might, in their practice, draw on medical discourses, it seems that medical students fail to understand fully the role of the midwife in intrapartum care. Quinlivan, Thompson, Black, Kornman & McDonald (2002), in an Australian study examining how medical and midwifery students perceived their respective learning roles while working with labouring women, found that some medical students reported a lesser role for their professional colleagues than they identified for themselves, and a smaller number did not feel that student midwives should observe or perform a normal birth.

Brodie (2002) examined the barriers and current problems in the organisation of maternity care in Australia from the midwife's perspective. She observed (p.5):

The system of maternity care was identified as being dominated by medicine, not evidence based and restricting of women's choices, with midwifery autonomy not recognised or supported. The invisibility of midwifery within the community was identified as a significant barrier which, in conjunction with the occupational imperialism of obstetrics, ensures ongoing strategic control of maternity services and a denial of the rights of consumers to access midwifery care.

Newnham (2001) also notes the fragmentation of maternity care currently operating under the medical system. Additionally Brodie and Barclay (2002) and Fahy (1998) report a lack of consistency and evidence of discrepancies in the standards of Australian midwifery education and practice. For Fahy (1998) there is need for concern regarding midwifery, as a discipline, being subsumed into techno-rational science and away from the 'with woman' focus. James and Willis (2001) also observe the current status of midwifery in Australia. For them, the midwifery profession is redefining itself, specifically in its national initiative to separate from nursing. They warn the midwifery profession of the need to be conscious of the political, legal, educational and professional levels, to avoid similar problems encountered by nursing when it introduced nursing education into tertiary education, which was overtaken by political and economic reforms within the health care sector (James & Willis, 2001).

Several authors (Homer, Davis & Brodie, 2000; Brodie & Barclay, 2002; Byrne, 2000; James & Willis, 2001; Watson, Turnbull & Mills, 2002) also note the contribution of midwives in seeking to develop a separate profession and new models of care that increase midwives' autonomy and level of accountability. For Watson, Turnbull and Mills (2002), the results of the first phase of an evaluation of the extended role of the midwife, in two acute care settings in the Northern Territory, suggest that recognition of the extended role of the midwife has the potential to deliver high level continuous midwifery care to women, to increase work satisfaction for the midwives and to enhance

professional autonomy and responsibility in the workplace. One of the aims of the proposed extended role of the midwife is to satisfy consumer demand for a less medicalised experience. It is thought that, for midwifery practice to become more visible in Australia, midwives need to move their practice from the dominant biomedical model, and consequently begin to value other forms of knowledge and other models of care and respect, and respond to the knowledge of consumers.

Contemporary work has also centred on the support role midwives provide to women in labour, commonly from the consumers perspective (Simkin, 1992; Callister, 1993; Bryanton, Fraser-Davey & Sullivan, 1994; Corbet & Callister, 2000; Manogin, Bechtel & Rami, 2000; Peltier, Schibrowski & Westfall, 2000; Zadoroznyj, 2000; Bowers, 2002). However, variations exist in the labour support offered to labouring women by midwives. McCrea, Wright and Murphy-Black (1998), using non-participant observation, reported that midwives' approaches to pain management differed from 'a cold professional' to 'a disorganised carer'. In the middle of these two extremes was the 'warm professional'. The warm professional approach was reported to have had a positive influence on the woman's experience of labour pain.

Some studies sought to identify specific aspects of the midwife's role. For example, supportive care was commonly operationally defined within four categories of activities: emotional support, physical comfort measures, instruction/information and advocacy (McNiven, Hodnett & O'Brien-Pallas, 1992; Peltier, Schibrowski & Westfall, 2000; Chen, Wang & Chang, 2001). Findings from other studies also confirmed these behaviours. Callister (1993) reported three domains of midwifery support: emotional support, information support and tangible support. Corbet and Callister's (2000) study also confirmed these results. Tumblin and Simkin (2001) reported that midwifery care is made up of physical comfort and emotional support, informational support and technical nursing care.

Work has also been undertaken on the amount of time devoted to caring and supportive behaviours in labour and birth. McNiven, Hodnett & O'Brien-Pallas's (1992) aim was to determine the proportion of time the average intrapartum midwife spends in supportive care activities. The findings revealed that the proportion of time midwives spent in a supportive role, versus all other activities, was 9.9 percent, based on a sample of 616 random observations of 18 midwives. Gagnon and Waghorn (1996) found that the percentage of time midwives spent in supportive care was 6.1 percent, based on 3367 observations. Whereas, Miltner (2002), using observational methods, reported that midwives' spent an average of 58.9 percent of the observed time in direct or indirect care of the patient, based on an average of 169.9 interventions. This supportive care was frequently done in conjunction with other, more technical interventions. Gale, Fothergill-Bourbonnais & Chamberlain (2001) found that midwives spent only 12.4 percent of their total time providing supportive care to labouring women, based on 404 observations. Miltner's (2000) previous work, using a three-round Delphi technique, noted that midwives distinguished between supportive nursing care and the assessment and technical aspects of their job. The participants also identified the overall goals of intrapartum care as assuring a safe outcome for the newborn and the mother (Miltner, 2000).

Peltier, Schibrowski & Westfall (2000) explored the role midwives play at different stages of the birthing process from the woman's perspective. They report differences in the role throughout the stages of childbearing. Prior to the birth the role is one of communicator, during birth it is more a support role, and in the postpartum period the role takes on more a decision making nature, particularly pertaining to the care of the newborn (Peltier, Schibrowski & Westfall, 2000). These results should be viewed with some caution as there were several concerns related to this study. For example, differences within the sample characteristics are not reported, leaving one to assume that the experiences of consumers having a caesarean section birth are the same for those having an uneventful vaginal birth. Secondly, some of the sample received the questionnaire a year postpartum. Consequently, the study had a very low

response rate (38%). Moreover, there was no description of the validity of the tools used. It is interesting to note that the authors are marketing academics and not health professionals, who appear to be more interested in identifying how to market health care services for women, rather than establishing or providing knowledge on the role of the midwife.

Most research on the midwife's role in labour and birth has centred on the consumer's perspective (Peltier, Schibrowski & Westfall, 2000; Tumblin, & Simkin, 2001). Observational studies offer varying degrees of insight into the midwife's role in labour and childbirth. Few studies, however, have elicited the midwives perspective on specific areas of midwifery practice. No published research has specifically addressed the midwife's role in relation to paternal involvement in labour and birth.

Relationships

Generally, roles are dependent upon others for their meaning. For the purpose of this current inquiry, a relationship exists where there is a connection between two or more roles. Contrary to the lack of nursing literature on roles, relationships have been more closely studied and defined. In particular, contemporary nursing inquiry has highlighted the various components of the nurse-patient relationship (Morse, 1992; Ramos, 1992; Gilbert, 1993; Larson & Ferketich, 1993; Williams & Irurita, 1998). Morse (1992) identified four types of mutual nurse-patient relationships: clinical, therapeutic, connected and over-involved. According to Kim (1987), client-nurse interactions are situations in which information, feelings and energy are directly transferred or exchanged between clients and nurses. Given the level of increasing interest in nurse-patient relationships, few studies have yet to examine other relationships, such as the paternal-midwife relationship. The dearth of inquiry on the paternal-midwife relationship is possibly symptomatic of the contemporary nature of paternal attendance.

In midwifery practice, the encounter between midwife and father has limited relationship boundaries. Whereas, being in a caring therapeutic relationship with the labouring women, the midwife and the woman have certain therapeutic responsibilities in that relationship. Midwives need to consider the type of relationship that is required by the partner as well as other support persons. Like any new relationship, the characteristics, needs and aims of the relationship necessitate identification. Several factors play a role in the establishment of a successful relationship between fathers and midwives. The cultural and contextual influences will largely determine the type of relationship experienced by both actors. Additionally, environmental issues can also influence relationships.

What is not stressed in the childbirth discourse is the dynamics of the paternal-midwife relationship. The father needs a relaxed atmosphere, where he is able to freely participate and make his needs known. The opening approach by health professionals is crucial as with everyday experiences. Richman and Goldthorpe (1978) contend that within the hospital birth setting, first time fathers, in particular, suffer from 'entrance trauma'. When the couple attends the birth environment, they are often separated, with the woman being removed by the midwife for examinations and relevant procedures. It is during this time that the father can feel isolated from the event and his partner.

Terminology too plays a part in relationships. Certain words or phrases may be used as indicators of proposed roles and relationships. Some terms or the way such terms are used, may indicate that a father has a subservient, marginalised or peripheral role in the relationship. For example, it has been suggested that fathers often felt isolated and marginalised by health professionals during labour and birth (Jordan, 1990; Chandler & Field, 1997). A recent Swedish study used observation techniques to identify patterns in midwives' and new parents' ways of relating to each other in ante- and postnatal midwifery consultations (Olsson & Jansson, 2001). The findings indicated that the midwives appeared to steer

the consultations by adopting a basic pattern of communication in which the new fathers mostly had a minor role.

Conceptualising relationships between midwives and fathers is difficult for four reasons. Firstly, fathers have no clearly defined roles as part of the relationship. As MacLaughlin (1980) observed, fathers demonstrated a need for behavioural guidelines during childbirth. Secondly, every couple has different labour and childbirth expectations and experiences, which impacts on the type of roles and relationships anticipated by the father and his partner. Thirdly, midwives have differing perceptions, behaviours and ideals towards paternal participation. Proctor (1998) compared the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services. Similarities between midwives and women included beliefs about the importance of the maternal-midwife relationship, desired attributes of staff and the environment of care. A key difference was the importance of the involvement of the woman's partner in the delivery of care. The final reason relates to the context of birth. Each birth venue has a different philosophy, which constitutes different roles and relationships for fathers and midwives.

Understanding roles and relationships facilitates the illumination of patterns of behaviour and interactions. In particular, behaviours identified by midwives as helpful and supportive to fathers during parturition need to be made explicit. The literature fails to illuminate the processes and patterns of behaviour between fathers and midwives in the intrapartum period. The aim of this current inquiry is to fill this gap in the knowledge of the paternal-midwife relationship.

Summary

Studies on paternal involvement in childbirth have addressed several factors related to the antecedents of paternal attendance and acceptance in childbirth. During the last two decades, paternal participation has received greater attention. A critical review of the previous studies on the paternal role in

childbirth reveals that the father's role in childbirth remains a poorly conceptualised and poorly understood phenomenon in most western countries. There has been comparatively limited inquiry, particularly in Australia, on paternal-midwife intrapartum relations. In addition, the majority of the emergent research provides a single perspective rather than establishing a connection with extant research. Currently there are no published studies specifically exploring the midwives' perspective of paternal-midwife interactions in birth. Given the increasing focus on fathers, it is surprising that the midwife perspective has not been considered. The available evidence has provided valuable insight into paternal roles and experiences. In summary, there are several conclusions that can be drawn from the literature.

First, with the reluctance to admit fathers into labour wards the majority of the early studies aimed at negating the alarmist warnings, which kept fathers excluded for forty years. The early studies, despite their methodological limitations, demonstrate a positive relationship between pain management and paternal presence. The concept of pain remains a difficult topic to investigate, due to the various factors and characteristics of pain and childbirth processes. The second conclusion, derived from the literature, is the effect of paternal attendance on maternal birthing experiences. Maternal expectations of paternal participation vary significantly between studies. Research findings have provided an understanding of the paternal participation from maternal and more recently paternal perspectives only.

The final and most significant issue in this literature review is the lack of inquiry exploring the roles and relationships of perinatal paternal participation from the midwives' perspective. The work to date suggests that fathers take on various roles resulting in various experiences. In hospitals fathers are not exposed to the same rites, rituals and responsibilities of incorporation as his labouring partner. Qualitative studies have provided an understanding of the father's experiences and roles undertaken. The findings exposed the range of

paternal roles, including witness/observer, teammate and coach. However, not all fathers feel comfortable with their new role in labour and birth. Rather, evidence suggests that fathers may feel anxious during labour and unable to identify the role expected of them by their labouring partner. The literature is laden with the call to pursue research in this area. Despite the increasing interest in paternal participation, fathers are still not provided a coherent identity for their childbirth role. In the twenty-first century, paternal participation remains in a state of flux.

The midwife's role in Australia remains largely silenced and invisible. The literature focuses largely on the erosion of the midwife's role from competition from obstetricians and the increasing medicalisation of childbirth (Donnison, 1977, 1988, 2000; Murphy-Lawless, 1998). Although there are clear definitions and guidelines of practice, Australian midwives still lack professional accountability and autonomy, while they struggle to separate from nursing. There are few conceptualisations of the midwife's role, rather the majority of contemporary work focuses on consumer perspectives of midwifery care. Childbirth discourses also focus on the historical struggles of midwives against competing forces.

The following chapter provides an extensive discussion on the inquiry methodology. A discussion on the selection of the grounded theory method in this inquiry is presented. The premises of the underlying theoretical framework of symbolic interactionism and grounded theory method are explained and the relevance of grounded theory studies to nursing and midwifery research is explored. The second part of the chapter reviews the inquiry processes involved in the grounded theory method.

GROUNDED THEORY METHOD

It is not to see something first, but to establish solid connections between the previously known and hitherto unknown that constitutes the essence of specific discovery (Selye, 1956, p.6).

This inquiry was designed to discover the processes involved in intrapartum interactions between prospective fathers and midwives. The purpose was to generate a substantive theory to explain midwives perceptions and conceptualisations of their interactions with fathers during labour and childbirth, based on grounded theory rather than dated abstract theoretical assumptions. In considering the nature of the phenomenon, context and lack of theoretical knowledge the inquirer decided that the most appropriate method to guide this work was the grounded theory method.

The chapter begins by providing an overview of the different methods of inquiry (or world views) which then leads into a discussion of the theoretical framework symbolic interactionism that underpins grounded theory methodology. Following this, the key concepts of the grounded theory method are described, including a discussion of the significance of grounded theory studies for nursing and midwifery discourses. An extensive rationale considering the issues related to the use of grounded theory for this inquiry concludes the chapter.

Methods of Inquiry

The pursuit of knowledge has been traditionally dominated by the empirical paradigm. The beginnings of this world view can be found with ancient Greek philosophers such as Pythagoras, as early as 500BC. The philosophical orientation of empirical inquiry is embedded in the conception that all knowledge is based on observations. Thus, for empiricists, exploring any

phenomenon, observation, measurement and hypothesis testing are the only methods of knowledge development. Following the Cartesian approach to understanding mind and body, the goal of this paradigm was to rid metaphysical elements from the sciences and to show that all sciences are reducible to the method of induction. During the twentieth century, a number of empiricists became known as logical positivists. Positivism originated with the work of Auguste Comte (1798-1857), who proposed a 'positive philosophy' based on the six sciences of mathematics, astronomy, physics, chemistry, biology and sociology (Emden, 1991). Social scientists including Comte, Durkheim and Spencer believed that the scientific methods of observation, experiment and careful comparison could be applied to the study of social phenomena (Cuff & Payne, 1984). Positivist philosophers particularly from the Vienna Circle around the 1930s, promoted the term and the notion of the 'received view' of science. Generally, positivism failed to acknowledge any other forms of knowledge development.

In the mid 1900s, the failure of the received view to adequately explain many social phenomena presented as a difficulty for many philosophers. The scientific world's absolute faith in knowledge based on observations was beginning to be disrupted. Guba (1990) observed that the methodology of post-positivism was less reductionist and acknowledged the need to do inquiry in more natural settings, sometimes using more qualitative methods, that depended more on grounded theory and re-introduced discovery into the inquiry process. Thus philosophers began to question the usefulness of such rigid methods of inquiry (Dewey, 1938; Merleau-Ponty, 1945; Heidegger, 1962). Along with other twentieth century philosophers, Dewey in his 1938 *Logic: The Theory of Inquiry*, rejected positivism and sought to formulate the most general rules of scientific discovery. Dewey criticised attempts to provide a foundation of knowledge based on the priority of the thinking self and directly experienced impressions (Hickman, 1998). Significantly, as a pragmatist, Dewey's work was

based on the belief that society, in general, is the laboratory in which all thought occurs (Delacampagne, 1995).

As a result several different schools of thought and inquiry developed around the 1950s. The re-emergence of qualitative inquiry occurred. In contrast to the scientific methods where research is carried out in highly controlled environments, qualitative research can be used to demonstrate how people interact, feel and think in everyday environments. Specifically, the methods of inquiry developed during this time aimed to describe the world of the person or persons under study. It was during this time of upheaval in thinking and knowledge development that the grounded theory method was developed (Glaser and Strauss, 1967). According to Denzin (1992), it was during the 1960s that Strauss studied American cities and their images, death and dying in the modern hospital and the status passages in complex, industrialised societies, while formulating a new Chicago method, called 'grounded theory'. Grounded theory is only one example of the interpretive methods to evolve during this time.

Symbolic Interactionism

The philosophical roots of grounded theory methodology are embedded in the theoretical framework of symbolic interactionism. The principal proponents of this perspective were George Herbert Mead, John Dewey, Robert Park and Herbert Blumer. Mead, like Dewey, was part of the school of philosophy known as pragmatism. Pragmatism is the framework with which Mead was to establish symbolic interactionism.

The theoretical perspective of symbolic interactionism focuses on the creation of meaning of social interaction. Denzin (1992) suggests that the traditional function of symbolic interactionism is to offer a theory of self, interaction and socialisation, which speaks to the question of how the human being is formed out of the interaction order. Mead (1934) proposed that the self was one of the

most important symbolic objects. This work has since been extended by many theorists, most notably Blumer (1969). It was Blumer who proposed the term symbolic interactionism and the social theory, which focused on the nature of social interaction. Three main premises were articulated that outlined the basic position of symbolic interactionism. First, Blumer argued that 'human beings act toward things on the basis of the meanings that things have for them'. Second, 'the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows'. His final premise suggested that 'These meanings are handled in and modified through, an interpretive process used by the person dealing with the things he (sic) encounters (Blumer, 1969, p.2)'.

Additionally Blumer (1969) described the distinctive nature of human relationships as having the ability to construct and share meanings. The suggestion was that humans act toward things which include everything that the human being may note in their world, such as physical objects, other human beings, categories of human beings, institutions, guiding ideals and situations that an individual encounters in daily life. In this current inquiry, the meaning of a midwife, what a midwife is, is derived from how others act toward midwives. The language used to articulate this social world is termed the *object world*. Objects can indicate anything that is referred to, including a book, a legislature and a midwife. Objects that are of consequence to midwives include midwife, health, family, illness and professionalism. In symbolic interactionism, objects have no inherent meaning (Bowers, 1988). Rather, objects are viewed as social creations, as being formed in and arising out of the process of definition and interpretation, as this process takes place in the interaction of people (Blumer, 1969).

Symbolic interactionism was chosen as the framework with which to construct a social theory to explain paternal-midwife intrapartum interactions. This theoretical framework provides an analytical scheme for considering the

definitions, decisions and behaviours undertaken by midwives in the social action of establishing and maintaining an effective relationship with fathers during labour and childbirth. In applying this theoretical framework, the interview data aimed to provide midwives' perceptions of the relationship and specific situations, as well as their negotiated responses of the self and others within the relationship. Symbolic interactionism is the theoretical underpinning of the inquiry method known as grounded theory. Glaser and Strauss (1967) developed grounded theory as an inquiry approach derived from the assumptions and theoretical underpinnings of symbolic interactionism and pragmatism.

Grounded Theory

Grounded theory is an analytic inductive technique, based in the interpretive tradition, with an emphasis on individual power, choice and construction of meaning (Znaniecki, 1934). It is a method used to uncover the basic social and structural processes of a situation at both the symbolic and interactional levels. Sociologists Barney Glaser and Anselm Strauss from their initial work *Awareness of Dying* (1965), proposed the term grounded theory. Their evolving methods were developed during an observational study of hospital staff's handling of dying patients. Grounded theory is an inquiry method developed for the purpose of studying social phenomena from the interpretive perspective of symbolic interactionism. At the time Glaser and Strauss were both academics, influenced by the Chicago School of Sociology (1920s-1950s), at the Department of Sociology of Columbia University. Glaser (1992) articulates this influence:

It is vital to note that the fundamentals of Grounded Theory, the underlying analytic methodology, are in very large measure drawn from the analytic methodology and procedures of inductive quantitative analysis laboriously discovered by researchers and students at the Department of Sociology and the Bureau of Applied Social Research at Columbia University in the 50's and 60's (Glaser, 1992, p.7).

The focus of grounded theory is the discovery of theory from data, using field methods, documentation of action, interaction and the experience of complex phenomena. Glaser and Strauss's 1967 foundational text, *The Discovery of Grounded Theory*, differed from previous texts on social research by its lack of emphasis on theory verification. Rather, grounded theory was deemed a reaction to the increasing emphasis on theory verification. The aim was to provide an alternative to the traditional approach to scientific inquiry of hypothesis testing, verification techniques and related forms of analysis.

Grounded theory methodology differs from other methodological traditions in that theories are grounded in data generated through the inquiry act and not developed before or after data analysis. Being a qualitative research method grounded theory offers the opportunity to implement specific procedures to develop an inductively derived-grounded theory about a phenomenon. The grounded theorist is interested in patterns of action between and among various types of social elements. Central to grounded theory methods are the participants' interpretations of their social world, and their actions and reactions to it. For example, grounded theory methods enabled the inquirer to gather rich descriptive data about the contexts, philosophy and actions of midwives with fathers during childbirth. In doing so it enabled the inquirer to capture the complexity of the health care context and multifaceted nature of the health care professionals involved in childbirth management.

Relevance of Grounded Theory for Nursing and Midwifery Discourses

The construction of the grounded theory methodology was distinctly grounded in a nursing context. In the development of the grounded theory methodology Glaser and Strauss were engaged to assist nursing students in their research. Since its introduction in the 1960s, grounded theory has been readily accepted in nursing and health studies. Nurses have embraced qualitative methods that enable them to discern the characteristics, nature and essence of nursing knowledge (Leininger, 1985). Qualitative methods are helpful to nurses because

of its congruence with the holistic approach that many nurses have sought to adopt in nursing care (Meleis, 1991). The following discussion traces the development of nursing knowledge throughout the previous century.

Nurses are turning to the qualitative methodologies and the extent to which these sciences can overcome the limitations of empiricism and, therefore, contribute to the development of nursing knowledge and practice. Several inquiry methodologies are rooted in the interpretive paradigm, including grounded theory. Interpretive paradigm methodologies enable nurse researchers to study social phenomena that have shaped and continue to shape nursing knowledge and practice.

Critique of the development of nursing knowledge has been the focus of contemporary nursing scholarship (Kidd & Morrison, 1988; Cull-Wilby & Pepin, 1987; Lumby, 1991; Street, 1992; Morse, 2001). Specific theoretical models have been used in these analyses. For example, Belenkey, Clinchey, Goldberger and Tarule (1986) provided an analysis using the five stages of women's knowing. The first stage is characterised by what they termed as silent or silenced knowing. In nursing this was characterised by blind obedience to medical authority, the biomedical model and the empirical method of inquiry. Lumby (1991) contends that empiricism also enforced silence in nursing by devaluing the everyday, the self-understanding and the subjective knowledge that women have and develop so well.

Nursing was prompted to adopt this ideology by the success of medicine in establishing itself as scientific and, hence, a legitimate provider of health care. The influence of the biomedical model of the body has been profound in western culture. Its dominance and power have been such that other ways of understanding the body have become silenced or confined to the fringes (Cull-Wilby & Pepin, 1987). This dominance is demonstrated through the medical profession's control over the Australian health care system, largely due to the

social acceptance, attitude and power of scientific knowledge upon which it is based.

The basic tenets of empiricism assume that knowledge is waiting to be uncovered by empirical inquiry rather than created by inquiring minds. Empiricism is seen as a self-legitimizing, self-justifying philosophy, hence it has become one of the most powerful ideologies and dominant forms of knowing in the twentieth century. It was largely accepted as the only legitimate form of knowing.

The empirical method of inquiry has consistently prevailed as the primary and most highly valued approach to nursing inquiry. The tenacity of the nursing profession's commitment to empiricism parallels the commitment to it of all western human sciences. The degree of commitment can be understood to some extent, when one recognises that claims to knowledge are also claims to power. While dominating thought and inquiry in nursing, this method also devalued the potential contribution of the so-called non-scientific approaches to research and theory development. Cox-Dzurec (1989) contends that most modern nursing contemporaries learned a single way of doing science without any awareness that this was but one of many possible approaches.

The second phase of knowing is termed the 'received' view. From the late 1940's nurses entered courses in education in large numbers leading to a bias in educational knowledge and processes in theorising nursing. During the 1950's nurses began to explain and define nursing and make sense of their existence. In numerous epistemological discussions nurses have sought to clarify the meanings of nursing. Without a distinctive knowledge paradigm of its own, nursing integrated 'borrowed' knowledge from other disciplines, such as anthropology, education, sociology, physiology and psychology, which resulted in the theory of these disciplines heavily influencing theorising in nursing. The problem associated with using this borrowed knowledge was that research and knowledge development of nursing practice was almost nonexistent. Most of the

research conducted by nurses at this time was educational or sociological research undertaken in the health care setting (Kidd & Morrison, 1988). Thus nursing knowledge and practice moved from a position of silenced and silent knowing to one of 'received' knowing.

Having gone through the stage of assimilating medical knowledge and using borrowed theories, nurses began to value the development of nursing knowledge and practice from a nursing perspective. They identified problems with the use of this borrowed knowledge and science and a new sense of internal authority emerged which led nurses to the third stage of knowledge development termed 'subjective knowledge' (Kidd & Morrison, 1988). Again clinical inquiry and knowledge development were limited, because research focused on theory and model development, rather than nursing practice.

In 1988 Kidd and Morrison claimed that nursing was, at that time, in the fourth stage of knowledge development, 'procedural knowledge'. This stage was characterised by separate and connected knowledge. The empiricists in nursing represent separate knowers, whereas connected knowers were known as the phenomenologists. Separate knowers included Levine, Roy, Henderson, Abdellah and Newman, who developed theory through theoretical model testing. Connected knowers were Paterson and Zderad, Parse and Watson and Rogers, who induced theory by exploring the human experience (Kidd & Morrison, 1988).

The use of separate knowing in nursing theory has been subjected to much criticism. The main problem with the use of empiricism in nursing is that it seems inappropriate for a humanistic profession. Pearson (1989) claims that while nursing practice incorporated a valuing of the person and subjectivity, its attempt to formalise knowledge through explicitly articulating its theory has been driven by the positivistic paradigm. He further suggests that this sort of theorising has been seen as that which epistemologically fits the natural and

physical sciences and, therefore, focuses on distance from action and the world of practice. Street (1992) supports this claim in her assertion that this knowledge is derived from an epistemology that was developed to deal with the physical world and ignores those elements that belong to the psychosocial aspects of nursing practice. Kidd and Morrison (1988) claim that, in their haste to prove the credibility of nursing as a profession, nurse scholars have emphasised primarily reductionism and empirical validation, consistent with the first stage of procedural knowledge. Concern has been raised that such approaches to knowledge inquiry do not reflect practice and fail to contribute significantly to the development of nursing practice.

Nursing must move from this position of 'procedural knowledge' to the last stage of knowledge, that of 'constructed knowledge'. 'Constructed knowledge' is a position from which nurses perceive all knowledge as contextual, experience themselves as creators of knowledge and value both subjective and objective strategies for knowing (Belenkey et al., 1986). Hart (1991) contends that an important challenge for nursing and nurses is the creation of opportunities whereby the majority of nurses are actively able to contribute to a body of professional knowledge. Thus, the focus is to have nursing knowledge that is clinically grounded. Such a focus allows nurses to be more responsive to societal needs, more successful in humanising the highly technological milieus of health care, more caring and compassionate, more creative, more capable of critical thinking and better able to bring scholarly approaches to consumer problems. In summary Morse (1994, p. 41) proposes that

We must no longer tolerate the handicap of importing concepts and theories from other social science disciplines and expecting these concepts to fit clinical phenomena, to provide satisfactory explanations for the experiences of our patients and to predict the outcome of health care.

The nature of nursing knowledge and practice has progressed through several stages of development. The prevailing influence has been, however, from the

empirical paradigm, and certainly one cannot dismiss the value this paradigm has within the development of nursing knowledge and practice.

During the last two decades nurse researchers have been socialised to the value of qualitative research methods. In addition, nurse researchers have taken more interest in grounded theory research. Indeed, an increasing number of grounded theory studies can be located in nursing research journals. According to Schreiber and Stern (2001), a review of the nursing database CINAHL revealed that grounded theory is the second most popular qualitative research method published in nursing. In addition, postgraduate nursing degrees now incorporate qualitative research subjects. In Australia, there has been a recent influx of research using grounded theory methods (Donovan, 1995; Barclay et al., 1996; Rogan, Shmied, Barclay, Everitt & Wylie, 1997; Williams & Irurita, 1998; Schneider, 2002a, 2002b; McCann & Baker, 2003).

More recently a bifurcation of the grounded theory method has evolved. Towards the end of the twentieth century Glaser and Strauss developed different viewpoints on the techniques involved in the data analysis of grounded theory research. The focus of the debate between the founders of grounded theory seems to rest with the use of axial coding. This division has caused many nurse scholars to demonstrate an allegiance to either of the authors. Stern (1980, 1985, 1991, 1994), a strong supporter of grounded theory studies in nursing, contends that she is a strict Glaserian, whereas Corbin, who worked on and published texts in grounded theory with Strauss, is firmly entrenched with the Straussian approach (Strauss & Corbin, 1990, 1998; Corbin & Strauss, 1990). Before his death in 1996, Strauss mentored a large number of nurse researchers and scholars.

According to Schreiber (2001), those who were mentored by Glaser and Strauss, or their students, claim that one cannot learn to do grounded theory without appropriate mentorship. In 1994 Stern first raised this issue, which she termed

'minus mentoring', meaning poor quality or nonexistent mentoring. In addition several nurse scholars have raised concern regarding the standards of grounded theory research (Stern, 1994; May, 1996; Morse, 2001; Schreiber, 2001). Morse (2001) suggests the need for the inquirer to understand grounded theory as a method before undertaking grounded theory. This understanding may be achieved through mentoring, participating in forums or reading examples of published grounded theory research (Morse, 2001). During this current inquiry the inquirer has worked closely with experienced published grounded theorists, undertaken grounded theory workshops and currently participates in an online international grounded theory forum. The next section specifically considers the suitability of grounded theory methods for the inquiry into paternal-midwife interactions during parturition.

Selecting Grounded Theory

It is commonly accepted that the most appropriate research strategy should be used for the problem to be investigated. The previous chapter confirmed that despite the emerging research interest in expectant fathers, the paternal-midwife relationship remains largely absent from research and poorly understood. It was shown that much of the research on expectant fathers has been empirically and internationally based. Some have argued that surveying fathers with general questions of need seems to produce limited useful data (Fletcher, Silberberg & Baxter, 2001). Although some information has been generated, there is a comprehensible need for a different approach and paradigm to study paternal-midwife intrapartum relationships. May (1990) called for nurse researchers to consider theory development of nurse-patient relationships from empirical research into specific nursing contexts using methods such as grounded theory to overcome the limitations of the technocratic proscriptive approach to the study of such relationships.

The literature review demonstrated many weaknesses of the existing research associated with utilising the positive paradigm. Largely, the variables studied

were detached from the context. Studies were generally surveys, small samples of married, Caucasian childbirth class attendees recruited with minimal regard for their motivation of attendance. Research from the midwives perspective has been undervalued and rendered invisible in the childbirth discourses. The specific needs of the research called for open access to data, rather than the use of a conventional survey instrument. Unfortunately surveys tend to constrain the data to predetermined categories and often limit participants input to presupposed structured answers/knowledge. Additionally, it is clear that insufficient information is known of the research question for quantitative methods to be an option.

The methodology was chosen with Glaser and Strauss's (1967) original aim in mind, of eliciting rather than verifying knowledge. The objective of the research was to generate new theoretical understandings of the paternal-midwife relationship. For these and other methodological issues, the grounded theory method was considered an appropriate approach to enable midwives themselves to describe the relationship using their own thought-forms. Hence the inquirer has less control and influence on the categories, while participants have more control over their input. This approach was considered to be more sensitive to the needs of the research question and the diverse contexts in which paternal-midwife relationships are experienced.

The aim of midwifery research is to discover the nature of midwifery through an explanation of nursing knowledge and practices that will benefit present and future women and their families. In the selection of a theory generation methodology the inquirer considered the research question, the nature of the knowledge to be derived and the contextual factors, which influence the topic of exploration. The next section describes the background to the selection of grounded theory for this inquiry.

Fitness

The central reason for selecting grounded theory for this inquiry was the fit between the method and the requirements of the research question. It is contended that grounded theory is a valid research method with which to research the social processes involved with the relationships of fathers and midwives during childbirth. The nature of the topic prevented an in-depth understanding from historical documents or quantitative methods. The attraction of grounded theory method was that substantive theory emerges from the data as no *a priori* theory could encompass the multiple realities that were to be encountered with this inquiry. Grounded theory also provides a method for developing theories about organisations, their people, structures, cultures and behaviours (Chenitz & Swanson, 1986).

There were several accompanying reasons why grounded theory was selected to guide this inquiry. According to Field and Morse (1990), the choice of method and research design is dependent on various factors, including, the phenomenon, the maturity of the concept, constraints of the setting and the inquirer's agenda. The research question required a method, which effectively accessed the midwife's perspectives of the meanings of their interactions with fathers in childbirth. The aim of this inquiry was the generation of a data-grounded theory, which could explain the process and outcomes of paternal-midwife relations and generate knowledge directly useful in midwifery practice.

The Phenomenon

Strauss and Corbin (1990) defined the phenomenon as the central idea, event happening, which a set of action/interactions is directed at managing, or to which a set is related. Childbirth is a universal human phenomenon, whereas, paternal involvement in childbirth is a relatively recent phenomenon in most developed countries. While this phenomenon has strong social expectations, little is known about how midwives perceive this contemporary phenomenon. In developing the design for this inquiry, the problem dictated the method of

investigation. There was a need to choose methods that uncovered the contextual meanings of paternal-midwife interactions, from the midwife's perspective. Despite increasing research attention, such an inquiry has yet to be published.

Paternal attendance occurs in the childbirth settings in institutions, birth centres and in the home. The grounded theory approach provides a framework for research, which allows the inquirer to develop theory from a range of data in diverse settings. Additionally, these techniques can be modified and developed in response to the inquirer's requirements and or the study's changing contexts. The concerns of this inquiry required a method, which accessed the insiders' views about the meanings of the interaction between fathers and midwives. As such, symbolic interactionism is an appropriate framework to explain the meanings underpinning midwives' behaviours and attitudes in the social action of interacting with fathers during the birthing experience.

The Maturity of the Phenomenon

A second justification for the selection of grounded theory methods was the maturity of the phenomenon. The phenomenon is an emerging one and lacks a comprehensive body of knowledge. Grounded theory method is suitable for situations that are not well understood, such as the human interactions between midwives and fathers. The strongest case for grounded theory is in investigations of new phenomena, where salient variables, theory and hypotheses have not been identified (Stern, 1980; Lincoln & Guba, 1985; Field & Morse, 1990). Midwifery practice lacks theoretical understanding and research of roles and behaviours during the childbearing process. The previous chapter highlighted the lack of comprehensive theory development related to the salient variables involved in paternal-midwife relations during labour and birth. The selection of grounded theory methods aimed to provide fresh insight into the paternal-midwife relationship in labour and childbirth.

Constraints of the Setting

The third consideration in the selection of a guiding methodology involved the constraints of the setting. Grounded theory methods enable data collection and analysis to explore meaning and process in the situational context. Field and Morse (1990) observed that the setting itself influences the way in which behaviour is evidenced and must be taken into consideration during data analysis. The inquirer needed to choose a methodology that uncovered the contextual meanings inherent in the midwife's role from the midwife's perspective, linked to the derived theoretical understandings of midwifery practice in different childbirth settings.

Several constraints of the setting ruled out direct participant observation. Firstly, the inquirer did not want to intrude on an important life event. Many researchers claim their presence to have no effect on the participants or the event. However, the inquirer believed that the relevant theory generation could be effectively achieved through in-depth interviews with midwives. Grounded theory methods enabled the inquirer to access the perceptions of the participants with minimal inquirer intervention. Additionally, interviews are considered a superior method for in-depth data collection (Minichiello, Aroni, Timewell & Alexander, 1995). Secondly, the research literature is characterised by the confusion many fathers feel during the birthing experience and the inquirer did not wish to add to this confusion. Thirdly, consideration was also given to the inquirer's potential impact on the event or persons related to the event when a participant observer is present. Finally and more importantly, the inquirer was not prepared to gain data covertly. Accordingly, ethnography was deemed an inappropriate approach to meet the aims of the inquiry.

Midwives are in a unique position to support fathers during labour and birth. Due to the cursory nature of written documents and clinical records and difficulties associated with direct observation of childbirth, it was decided to

interview midwives directly about their interactions with fathers. By adopting this grounded theory approach it allowed for the examination of the context, the implications in the setting and the social and political forces, ideologies and events that shape behaviour, since the meanings within the situation are maintained (Blumer, 1969; Denzin, 1989).

The Inquirer's Agenda

Understanding the inquirer's agenda is crucial to interpreting the emerging theory. In qualitative studies the inquirer is the primary data-gathering instrument. A central part of the grounded theorist's role is to become immersed in the research process, to improve the inquirer's access to participants' experiences and to enhance the validity of the research. In addition, the inquirer must be aware of their preconceived beliefs and values about the phenomenon, which is articulated in the aims and selection of research methods for the inquiry. The inquirer carries into their research the sensitising nature of their training, reading, research experience, work experience and explicit theories that might be useful, if played against systematically gathered data, in conjunction with theories emerging from an analysis of these data (Glaser, 1978, 1992).

Qualitative inquiry is, nevertheless, value laden. Lincoln and Guba (1985) observe that qualitative inquiry is influenced by the inquirer's agenda in several ways, including the choice of the problem, the guiding paradigm and the inherent contextual values. The inquirer chose grounded theory to allow the data to dictate the categorisation of concepts and the eventual development of a data-grounded theory. The final sample for this inquiry was selected according to the theoretical needs of the inquiry. Thus, the final grounded theory was more responsive to contextual values than the inquirer's values. In grounded theory research, the purpose of the inquirer is to understand the objects (phenomena) and the object worlds from the perspective of the subjects themselves, as they understand them (Bowers, 1988).

Glaser and Strauss (1967, p.39) observed the role of the grounded theorist when generating theoretical meaning: ‘...the researcher is no longer a passive receiver of impressions but is drawn naturally into actively generating and verifying his (sic) hypotheses through comparisons of groups’. The grounded theory researcher attempts to discover what that world is like and how it is constructed and experienced (Glaser & Strauss, 1967; Blumer, 1969; Chenitz & Swanson, 1986).

Theoretical sensitivity, or the knowledge and experiences that the inquirer brings to their inquiry are crucial to effective theoretical construction. Glaser (1978) maintains that the first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible. The procedures of data collection and analysis are inextricably linked with theoretical sensitivity. For example, the processes of sample selection and interviewing are centred on theoretical relevance. Bowers (1988) contends that instead of attempting to remain detached and objective, grounded theorists become immersed in the world of the research subjects. Before data collection, the inquirer recorded her preconceptions of this topic and personal and professional experiences with fathers during childbirth and compared these with the findings.

In addition, to enhance the rigour of analysis and to examine personal feelings and reflections, which may influence the inquiry process and outcomes, the inquirer kept a reflexive journal (Appendix G). Lincoln and Guba (1985) defined this technique as an introspective journal, which displays the inquirer’s mind processes, philosophical position and bases of decisions made during and about the inquiry. This journal kept the inquirer responsive to the changing needs of the inquiry. Being aware of the influence of the inquirer’s own values, the choice of problem and paradigm is an integral part of the inquirer’s agenda.

Generating Theory

According to Blumer (1969), theory consists of concepts and propositions that relate concepts. Grounded theory methods can be used to generate two basic types of theory: substantive and formal. Glaser and Strauss (1967) described the different purposes of each type. Substantive theory refers to that theory developed for a substantive area of sociological inquiry, such as patient care, while formal theory refers to theory developed for a formal or conceptual area of sociological inquiry, such as socialisation or social mobility (Glaser & Strauss, 1967). Substantive theories assist in the generation of new formal theories and may question or reformulate existing formal theories.

There are specific procedural steps in the development of a data-grounded theory. This approach originates from the strategies advocated by Glaser and Strauss (1967). It emphasises theory as process and describes the elements of theory that are generated by comparative analysis as conceptual categories and their conceptual properties, and generalised relations among the categories and their properties. Categories and properties are concepts indicated by the data and as they emerge and develop, their accumulating interrelations form an integrated central framework – *the core of the emerging theory* (Glaser & Strauss, 1967).

The grounded theory approach to theory construction was implemented to specifically discover the theory from the data. In recent times Glaser and Strauss in their separate works reflect different viewpoints of grounded theory methodology and its use. Glaser in his 1992 work *Emergence Versus Forcing: Basics of Grounded Theory Analysis* provided a chapter-by-chapter critique of Strauss and Corbin's 1990 work *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. The differences in the ways the inquirer conceptualises and operationalises the two methods are significant. Because of this divergence, which some nursing scholars term the erosion of the original method, it is essential that the inquirer is explicit about the approach taken when

using grounded theory methods. The grounded theory approach adopted for this inquiry is that of Glaser and Strauss (1967). This approach was chosen to enable the inquirer to focus on theory generation using the original methods proposed by the developers of grounded theory.

When generating theory using the approach proposed by Glaser and Strauss (1967), the stages of the literature review, question and hypothesis generation, data collection and analysis, occur simultaneously, rather than in a linear fashion. As part of the theory generation process, interview questions, hypotheses and theoretical questioning change to lead to the emergence of the grounded theory. In addition grounded theory encompasses particular features of data collection, such as theoretical sampling, constant comparison, categorising, theoretical memoing, identification of a core category and sorting of theoretical memos that ensure rigorous conceptual development. This approach provides a framework for research, which allows the inquirer to develop theory from a range of data in diverse settings. Additionally, these techniques can be modified and developed in response to the inquirer's requirements and/ or the study's changing contexts.

The articulation of the key concepts of the data analysis processes is defined in Chapter Six, following the identification of the research context and participants in Chapter Five. Specifically the processes leading to the emergence of the core category, *Establishing an Inclusive Relationship* is discussed in detail, including an examination of the processes used to ensure integrity of the emergent theory.

Summary

This chapter presented the inquirer's rationale for using grounded theory methodology for this inquiry. It began with an overview of the methodological approaches to inquiry and ways of knowing. Continuing exploration of these methodologies led to an exploration of the theoretical underpinning of the grounded theory method, symbolic interactionism. The chapter concluded with an extensive rationale for the choice of the grounded theory method of data

collection and analysis to discover a substantive theory of the paternal-midwife relationship from the midwife perspective. The method was chosen because of its suitability for the research topic, the flexibility to study the phenomenon, the lack of existing research and the constraints of the setting, as well as to meet the inquirer's agenda to generate knowledge on paternal-midwife relations. The inquirer's self-positioning concerning the inquiry's aims and objectives was presented to explain the immersion process within data collection and analysis.

The following chapter explores the research context and process of participant recruitment. A profile of participants is presented, including an overview of their qualifications and professional experience. The chapter concludes with a discussion on the ethical precautions related to this inquiry.

THE INQUIRY CONTEXT AND PARTICIPANTS

The dominance of the medical model of procreation influences the behaviour of individuals in two ways. Not only does belief in its legitimacy affect the status and function of those involved, but also this belief in itself argues for the hospitalisation of birth. The hospital setting, as will be seen, further determines the roles adopted by the various actors (Brown, 1982, p.105).

The first section of this chapter provides an exploration of the contextual background and a profile of participants involved in this inquiry. In generating grounded theory the inquirer needs to explore the meanings underpinning the historical, personal, professional, contextual and interactional factors involved in labour interactions. This includes an analysis of the historical and current issues located in conventional and alternative choices of Australian childbirth environments. In particular, the philosophies underlying the natural and medical models of childbirth are emphasised. In using the theoretical underpinning of symbolic interactionism the phenomenon is explored in its natural setting. Thus this analysis provides an understanding of the main factors involved in the processes, language and thought-forms used by midwives to negotiate their role when working with expectant fathers in the given contexts.

The second section of this chapter provides a description of the methods of theoretical sampling and composition of the research participants. The composition of the research participants represents the three main birth contexts in Australia. The sample was recruited from a large urban tertiary care hospital and from a home birth organisation operating in the same community area in Queensland. Given that generally the sample size is small in grounded theory studies, it was essential to incorporate participants who could provide rich and vast descriptions of their perceptions and who would be accessible to the inquirer. The chapter concludes with an overview of the ethical precautions for this inquiry.

Midwifery in Context

The context in which the inquiry was undertaken is an important consideration in the interpretation of data and theory generation. It is essential that the phenomenon be contextualised to gain an understanding of the interactional processes involved in the paternal-midwife relationship. The specific contexts of paternal-midwife relationships vary from country to country. In Australia women have three main choices of birth venues: labour wards, birth centres and home births, with hospitalised childbirth considered the normal practice in Australia. In selecting their choice women will experience differences in not only birth location but also more importantly in the type of provider and the philosophy of care. Brown (1982) reported that the complexities of the context and accompanying philosophy have significance for the associated meanings of the childbirth experience. Understanding a phenomenon requires an understanding of the context in which it occurs.

Addressing what constitutes the context and theoretical differences of the place of birth provides the inquirer with insight into factors influencing the interactions and perceptions of the participants. This is important in light of the primary focus of this inquiry that is to investigate the social process of midwives engaged in childbirth settings and their interactions with prospective fathers. To generate a grounded theory based on the participants' experience it was necessary to examine how a midwife negotiates, establishes and adapts their role within the confines of the birth venue.

This inquiry is set in the city of Brisbane, Queensland, Australia. The participants were selected from three different birth settings within the Brisbane area: a conventional hospital labour ward, a hospital based birth centre and a home environment. All three were represented in the research data and concluding theory. The three birth venues provided different models of maternity care, with midwives having distinct roles and spheres of practice. The

models incorporated a different set of policies, facilities and provider attitudes. These different birth contexts are now considered separately below.

The Labour Ward Environment

The typical Queensland labour ward environment usually consists of midwives working as government employees, of whom the majority are female shift-workers. The selected site for access to labour ward midwives was a large teaching hospital located in Brisbane, Queensland. The hospital is one of the oldest in Brisbane, having opened in 1842. Following the Maternity Act of 1922, an increase in publicly funded maternity hospitals and services was proposed. The options for pregnant women other than to use a government maternity hospital, was severely reduced as a result of this Act (Selby, 1992). Additionally, legislation was introduced to restrict the practices of community-based midwives. Maternal and newborn services were established in this hospital in 1938, funded by the Golden Casket Art Union. The chosen site is the largest Queensland hospital specialising in women's health. The services provided by this hospital cater to all categories of pregnant women and their newborns.

The main catchment area is the northern metropolitan Brisbane area, although, as a tertiary hospital, it also serves as a referral centre for most of Queensland and northern New South Wales. With a current birth rate of 4,000 births per annum, the hospital caters for a broad range of patients. Approximately 25% (1000) of these patients are deemed high-risk patients (Davies, 1999). This publicly funded hospital offers pregnant women a choice of two models of health care. The first is the traditional care from the medical and midwifery clinic and labour ward birth, the second comprises midwifery managed antenatal preparation and birthing in a birth centre. The labour ward environment actively promotes the biomedical model of care for pregnant women.

The labour ward environment provides a twenty-four hour service for pregnant women. The unit currently has sixteen beds. Each labour ward offers single room accommodation, with some rooms also having an ensuite. A new facility is currently being completed, with a number of larger rooms with ensuite facilities. Midwives are the main care providers, supported by rostered medical staff. Midwives are rostered according to potential client numbers and available beds. As a tertiary training hospital, medical students also have access to birthing women. Midwives working in labour wards usually have no involvement in prenatal care and tend not to meet labouring couples until they arrive for the birth. Because of their allegiance to the medical model of care, labour ward midwives have often been referred to as obstetric 'nurses' rather than midwives (Rooks, 1997; ACMI, 1999). Flint (1992) notes that some midwives simply want to be obstetric 'nurses' to avoid carrying responsibility for decision making without clinical or supervisory support. As a result, fragmentation of care occurs where different midwives attend women during antenatal visits and perinatal care.

A medical model of care determines the current care and management of the majority of patients presenting to this labour ward environment. Cunningham (1993) contends that the medical model assumes that childbirth demands medical expertise and thus invokes the patient and doctor roles, taking the responsibility for health out of the individual's hands and placing it with medical science. For example, when labouring women attend the labour ward, they are assessed by a midwife, then reviewed again by a medical officer and may also be possibly assessed by a senior medical officer.

In response to increasing consumer expectations, advances in medical technology, economic rationalism in health care governance and changing social conditions, midwifery practices have become more complex and business orientated. All of these changes in health care delivery have implications for the midwives' role and in particular their relationship with the expectant couple.

This is particularly evident in the hospital context. Unfortunately hospitals, in an attempt to provide optimal health care for childbearing families, have overlooked the need for individualised care. While patients are the central focus of hospital services, hospital rules and regulations are enforced for the benefit of hospital personnel in treating large numbers of patients. Policies and procedures are usually strictly adhered to in large tertiary hospitals and the implementation of regulations and policies tend to depersonalise the hospital environment. According to McDonnell (1991), maternity settings fail to meet the needs of pregnant women and the midwives who practice in them.

The contextual influences of the birth setting provide couples with differing experiences. Not only can the experience of hospitalisation be traumatic for labouring women, fathers may also experience this situation. The hospital environment can cause major concerns for the expectant couple. Indeed, unfamiliar surroundings, as well as the language and rituals surrounding labour and childbirth can cause isolation and potential alienation. As Coe (1978) observed, hospitals have certain processing techniques for controlling patients during their hospitalisation. Labouring women are not excluded from such techniques, however, their partners are not faced with the same degree of regulation and, therefore, are not afforded any form of status. In summary, the labour ward option offers women and their partner limited control over their birth experiences. Indeed the health professional's role within the biomedical model is considered to be one of decision making and action, whereas the patient's role is one of passive acceptance (Edwards, 2000). The birth venue significantly affects the level of satisfaction of care, as Cunningham (1993) found, once women have given birth in a labour ward, they are much more likely to reject that option in favour of the birth centre or homebirth.

Fathers were first permitted entry to the labour ward of the chosen hospital in March 1974. Since that time, regulations on dressing, such as the wearing of gowns and masks have come and gone. Nevertheless, many rules and

restrictions still apply to expectant fathers during their partner's labour. Fathers are given the opportunity of previewing the labour ward environment with a tour offered during antenatal classes. They are also permitted access to the labour ward environment while their partner is in labour and shortly after birth. They are generally not permitted to stay overnight with their partners after the birth. There are minimal facilities for partners during parturition. Unlike the relaxed environments of the birth centre and home birth settings, fathers are not provided with comfortable chairs or beds, or use of a bathroom. The expectant father is limited to the role of support person. Apart from the opportunity to cut the umbilical cord (which is dependent upon the childbirth situation and health professional(s) present) they are not encouraged to assist with the birth in any way. Although fathers are permitted in the labour ward environment, it is generally not welcoming for expectant fathers.

The Birth Centre Environment

The chosen birth centre opened in 1995 with two rooms. Due to increasing demand the centre now has four rooms and seven full-time midwives. This centre is attached to the publicly funded hospital mentioned above. Birth centres may be free standing or attached to a hospital. In this birth centre a team of midwives provides antenatal, perinatal and postnatal care for women and their partners. Ten midwives (part-time and full-time staff) currently staff the birth centre, each works a varying number of shifts and also carries a pager for 24-hour contact with their patients. Each midwife has a caseload of 4-5 predicted births per month. The birth centre has transfer arrangements with the labour ward staff and obstetricians in the event of complications or complex pain management requirements during labour and childbirth.

This midwife run birth centre has strict eligibility criteria. Potential consumers require clearance by a medical officer to attend the birth centre for maternity care. In addition, the size of the centre and staffing levels prohibits more than 45 low risk women per month having access to this model of care. Therefore,

places are decided on a monthly basis by ballot to ensure a fair and equitable allocation system. The couple, their family and support persons can remain in the birth centre room for up to twenty-four hours following the birth.

The impetus for the birth centre came from the backlash to the depersonalisation of the conventional birth experience. Growing consumer demands prompted health-care providers to search for a compromise to the extremes of home birth or conventional hospital birth. In his 1982 report of Queensland Obstetric Services, Campbell (1982) recognised the backlash to the increasing use of medical technology in obstetric care. He asserts that as part of this backlash, a number of groups recommended the development of 'birthing centres', which were in effect luxury motel-type units within a hospital where none of the modern medical equipment is in evidence (Campbell, 1982). During the 1970s and 1980s most births continued to occur in hospitals. Although according to Hayes and Bayliss (1984), there was a strong interest in freestanding birth centres and a resurgence of interest in home births.

Accordingly, the development of birth centres was to achieve a relaxed non-medical home-like atmosphere. The philosophy of midwifery care was affected by the design of these birthing centres. Because the birth centre promotes natural childbirth, natural methods of pain management are encouraged. The birth centre is more closely aligned with a 'natural' model of childbirth, compared with the labour ward environment. For example, the promotional flyer for this birth centre states:

The midwives working in the Birth Centre strive for continuity of care. They respect a woman's right to choose and to retain control over their unique life event, giving birth (Royal Women's Hospital, 2000, p.2).

Women in this birth centre give birth in a quiet, hushed bedroom like atmosphere that is maintained by all midwives and the couple.

In 1987, approximately one percent of all births in Australia were in recognised birth centres (Commonwealth Department of Community Services and Health, 1989). Current Australian figures for all birth centre births are unavailable. The selected birth centre caters for approximately 480 births per year providing 12% of the total birth rate (4,000) for this hospital. Thus, the majority of the women attending this hospital give birth in the conventional birth setting of the labour ward.

Since the opening of the birth centre in 1995, fathers have been actively included in the antenatal, perinatal and postnatal care of their partner. Fathers are encouraged to attend the birth centre from the first antenatal visit through to the birth and about six weeks following the birth for postnatal debriefing discussions. There are minimal rules and regulations for fathers, family members and support persons in the birth centre environment. The birth centre environment caters for expectant fathers, providing comfortable chairs and access to a bed, if required. In addition they are able to use the ensuite bathroom and some sustenance is supplied. The fathers are encouraged to actively participate during labour and childbirth. Because of the reduced medical intervention and personnel involved in the birth centre environment fathers are given more freedom to participate.

The Home Birth Environment

The home birth environment enables women to birth at home in a familiar environment. As such it differs significantly from the concepts of biomedicine and a hospitalised/medicalised birth. A home birth has been defined as a birth that, at the onset of labour, was intended to occur at home with the assistance of a home birth practitioner (Bastian, Keirse & Lancaster, 1998). As an alternative model of care only a minority of women tend to have a planned home birth. According to Bastian and Lancaster (1992), planned home births comprised only 0.5% of all Australian births during 1985-1990. Home birth practitioners can include a variety of assistance, such as midwives, medical practitioners and

lay support persons. However, many medical practitioners are unwilling to provide intrapartum care in any setting other than a hospital (Smith, 1996). Home birth midwives usually practice independently, but there are also team approaches in practice throughout most Australian States. For the purposes of this inquiry the inquirer approached a locally based home birth group to access practicing home birth midwives.

Relevant in this context is the importance of a family and home atmosphere. According to Bastian (1993) and Rooks (1997), women choose non-hospital births for many reasons, including economics, lack of access and transport in rural areas, religious beliefs, previous negative experiences with hospital births, concern of high intervention rates and the opportunity to experience birth in a more nurturing environment. An Australian inquiry found that home birth mothers were older, more educated, more feminist, more willing to accept responsibility for maintaining their own health, better read on childbirth, more likely to be multiparous and gave a higher rating of their midwives compared with those who gave birth in a hospital labour ward or birth centre (Cunningham, 1993).

The notion of natural childbirth is the main approach to childbirth at home. The philosophy usually includes a non-medicated labour and birth. Arms (1975) advocated that home birth is the only option for women who wish to retain control over their childbirth experience. For home birth mothers emotional or psychological factors are important aspects of the birth setting. According to Morison, Percival, Hauck & McMurray (1999) being able to develop a supportive relationship between couples and the home birth midwife is viewed as essential during this transition to parenthood.

Contemporary literature, academic debate and medical opinions on home birth focuses largely on the negative effects on the newborn. Specifically, perinatal mortality and morbidity are highlighted in Australian medical literature and

discourse. A West Australian study demonstrated that neonatal mortality was more common in hospital births compared with home births (Woodcock, Read, Bower, Stanley & Moore, 1994). Similarly, Potter, Lumley and Watson (1996), in an Australian study of the place of birth, found positive links with home birth. In their study they identified that home birth infants were fully breast-fed almost exclusively, compared with 50% of infants in other groups studied. International literature also supports the safety of non-hospital births (Tew, 1990; Edwards, 2000).

Because they are in their own home environment, home birth fathers are generally expected to actively participate in the labour support and childbirth. The home birth environment is unique to the expectant couple. Home birth midwives generally accommodate the couple's wishes regarding the father's role and activities in labour and childbirth. There are generally minimal restrictions and regulations exercised in the home birth environment.

Philosophical Differences in Birth Venues

The values, practices and policies of the dominant ideology of birth are deeply embedded in both its practitioners and the wider culture (Edwards, 2000, p.71).

Philosophical differences of Australian birth settings can be identified by the historical, political and societal acceptance of such. Although there is no universally accepted theory of midwifery, most practitioners would agree that there is some overlapping of midwifery approaches to care and the medical model of birth practised by most physicians. For Schneider (2002b) elements of three models of care exist: the medical/technocratic model, the midwifery model and the feminist perspective model. Simonds (2002) refers to the childbirth models as the masculinist medical orthodoxy, the dominant perspective and the naturalist/feminist midwifery model. Differences are evident in birth care philosophies, interactions, structures and power

relationships. The central difference lies in the domination of the biomedical model approach to pregnancy, birth and the postpartum period.

In relation to midwifery practices, the biomedical approach to health care has a history of being patriarchal, elitist and exclusionary. It is important to understand these historical characteristics and how the current roles of midwives have emerged. Currently in Australia, medical practitioners care for pregnant women within the biomedical model of care. Within this model caring for pregnant women can only be done so properly by viewing the female body as a machine to be supervised, controlled and interfered with by technical means, science or reason (Oakley, 2000). Childbirth in western society is commonly treated as a clinical phenomenon. Lewis and McCaffery (2000) suggest that birth with medication, medical technological intervention, use of pharmaceutical resources and managing the birth without a close social and emotional relationship, built up between the midwife, family and community, have all become synonymous with the medical model of childbirth.

In contrast, home and birth centre environments have adopted an approach that includes a more holistic, non-medical approach to maternal care. The belief systems adopted by each environment vary considerably. Edwards (2000), in her research on women's experiences of homebirth in Scotland, identified the differences of the technocratic or medical view and the holistic philosophy of childbearing. Under the technocratic or medical approach, the health professional's role is one of decision making and action and the patient's role is one of passive acceptance. Conversely, within the holistic approach, the emphasis is on the woman's well-being and the relationship of trust between her and her care-givers, who support and facilitate the process through attentive nurturing (Edwards, 2000).

Midwives practicing in birth centres and home births actively promote the philosophy of birth as a normal process rather than as an illness. Medical

intervention is not encouraged, in contrast to the pathological approach to childbirth in the conventional birth setting. Regardless of the physical setting, midwives have the ability to incorporate the midwifery philosophy of care, yet in the conventional setting this may be more constrained compared with the other birth environments.

The current goal of midwifery practice is to enhance the expectant couples' health and competence in their transition through childbirth and parenthood. The contemporary provision of midwifery services is the result of various evolutionary changes in models of midwifery care. Consumer expectations are continually changing in response to societal, medical and technological trends. Each couple has different expectations with many preferring to choose options outside of the biomedical model. Consequently, birth settings have slowly changed in response to consumer needs and partner and family involvement. It is important to remember that it is not simply a choice of birth venue, rather it is about a choice of the philosophical approach to childbirth.

The Sample

Fourteen midwives and two student midwives from three different childbirth contexts participated in this inquiry. In congruence with grounded theory methods a purposeful sample was chosen. Sampling focused on the needs of the inquiry:

In grounded theory reliability is established by ensuring the appropriateness of the sample and the adequacy of the data. The use of a purposeful sample ensures appropriateness. The sample should be selected according to the theoretical needs of the study, the willingness of the participants to participate and the ability of the informants to describe their insights (Morse & Johnson, 1991, p.9).

The objective of this process was to sample a cross-section of the phenomenon under study (Glaser, 1978). The sample comprised a group of midwives who were willing to discuss their understanding of paternal participation in labour and birth. The inquiry sample consisted of eight labour ward midwives, five birth centre midwives and three home birth midwives. All of the participants

were female and currently working in a birthing environment. No male intrapartum midwives were available from the chosen settings for inclusion in this inquiry, which reflects the small population of male midwives currently practicing in this female dominated occupation. To ensure anonymity, code numbers, rather than names, are used in this thesis to denote individual participants.

Recruitment

Following approval from the relevant ethical committees, the process of recruitment of participants was initiated. The recruitment of midwives commenced in October 1999 and ceased in July 2000. The following section identifies the different recruitment methods employed for each of the research environments.

The recruitment of the labour ward midwives took place in an in-service environment. The inquirer was provided an hour in which to discuss the inquiry's aims and details on participation and possible outcomes of involvement. A large number of staff attended the in-service session organised between a change of shift to prevent disruption to nursing care and to encourage attendance.

The recruitment of birth centre midwives was different from that used with labour ward midwives. The Nursing Unit Manager was notified about the inquiry and attended the labour ward in-service. She then notified the midwifery staff from the birth centre and encouraged staff to contact the inquirer for inclusion in the inquiry. Six staff members made contact with the inquirer and agreed to participate in the inquiry.

The recruitment of home birth midwives took place with the assistance of the Home Midwifery Association (HMA). Mindful of ethical guidelines the inquirer approached the HMA for access to midwives who practiced in the home birth

setting. Permission was given to phone midwives to discuss the inquiry's aims and their potential involvement in the inquiry. The inquirer discussed the inquiry with eligible midwives and, after they had indicated a willingness to participate, a suitable time was arranged for the interview. Before the interview participants were provided with a consent form (Appendix A) and information sheet (Appendix B). Each home birth midwife approached agreed to consent to becoming a participant in the inquiry.

Interviews were conducted in the informants' homes and workplace. Interviews with home birth midwives took place in their homes. As home birth midwives are generally on call for their clients the inquirer was aware that the interview could be ceased at anytime to accommodate the needs of their clients. Each interview was recorded using an audiotape recorder for ease of transcription. The participants were given the opportunity of having the recorder turned off at any time during the interview. None of the participants chose to have the recorder turned off at any time. All participants were sent a thank-you letter for their participation and invited to provide any comments about the research process.

Demographic Data

As part of the demographic questionnaire, participants were questioned on their age, qualifications, number of years in each area of midwifery practice and current position. No two participants shared specific common factors. Although all midwives, the participants had different professional work experiences, age, training and academic qualifications. The age range of informants was 26-52 years of age, with the average being 35 years. The number of years as a practising midwife ranged from 1-30 years. Several informants had experience in both labour ward and birth centre environments. The participants varied greatly in their level of experience. Midwives in senior positions were included as were midwifery students. Two midwifery students included in the sample

were in their final phase of their master of midwifery program and had recent experience working in all three birth venues.

Although lacking in experience, informants with one year were not excluded from the inquiry as they provided a perspective of how fathers are incorporated in their course curriculum. In particular they provided descriptions of their observations of how fathers are included in the three different birth environments by other midwives, and what they believed were the most common characteristics of the paternal-midwife relationship. Despite these participants lack of experience, they provided a rich informed understanding of the topic and suggested changes for future midwifery practice. The current role held by most of the participants was level one and level two midwives. All of the participants were involved in the care of couples in labour and childbirth, they either practiced as part of a midwifery care team or practiced independently.

The participants, as a collective group were a highly academically qualified. Ten had degrees, which were nursing related (Bachelor of Nursing, Bachelor of Applied Science (Nursing)), several had a diploma in nursing administration, while the remainder had nursing and midwifery certificates.

Participants Perception of their Practice

Participants were asked to complete a short questionnaire on several aspects of their practice to gain additional information on their work environment (see Appendix D). The majority of the sample indicated that they cared for all types of clients, including women at risk, older women, adolescents, those who are privately insured and women of ethnic origins. Common themes among the home birth midwives were clients with strong religious beliefs and middle class backgrounds as well as professional women.

All participants agreed that the majority of fathers attend the birth, although many are being pressured to do so. The main sources of pressure were the

woman herself, friends and other family members. Few midwives were aware or questioned fathers on antenatal class attendance. The question of orientation purposefully followed that of class attendance, because if fathers had been unable to attend an antenatal class it was likely that they had not been to the birth environment before their partner's labour. All participants indicated that they orientated fathers to the birth environment either prior to labour and or at the time of the birthing process.

Most of the participants felt that the fathers relayed their concerns to the midwives throughout parturition. The final question addressed the overall term the participant would use to describe the nature of the father's participation in the intrapartum period. The term teammate was the most commonly chosen term to describe father attendance and participation in childbirth. Only two participants chose the term coach, although they did not choose this term alone, they also chose to include a second term to describe the father's participation, such as witness or teammate.

This questionnaire enabled the inquirer to elicit information that may have been implicit in the interview processes. The written format provided participants with an additional way of presenting data that may have been difficult to divulge or not thought of as important data. The participants welcomed the opportunity to complete the simple questionnaire. Most participants wrote additional comments for each of the questions. Each questionnaire was completed at the end of the interview process, to avoid bias or leading the participant throughout the interview. The next section provides an overview of the ethical precautions associated with this inquiry.

Inquiry Ethics

Several ethical precautions were addressed before commencing data collection, including approaching ethical committees, informed consent, confidentiality and

the storage of data. These precautions aimed to prevent participants suffering any harm during, or as a result of, participating in the inquiry process.

Ethical Committees

Ethical approval to carry out the inquiry was sought and obtained from several relevant ethical committees. First the inquirer gained approval from the University of Sydney's Ethics Committee to conduct the research. Following this approval, the inquirer approached the ethical committee of the selected hospital and a home birth association within the Brisbane region. Approaches to all committees were successful. Once written permission was received from the chosen sites and the University's Ethics Committee, the recruitment process commenced.

Informed Consent

Upon their arrival at the interview, participants were again briefed on the purposes of the inquiry and provided with a written information sheet (Appendix B) detailing the inquiry. This sheet provided the participant with a plain language statement detailing the aims and nature of the research and their rights as a participant. It contained the inquirer and supervisor's details should the participant have required any further information. All the participants agreed to the conditions with few questions. None of the participants refused to participate or to have any parts of the transcripts erased. Before their interview participants were required to sign a consent form agreeing to participate in an individual audio taped, semi-structured interview (Appendix A). The participants were reminded that the interview would be audio taped and transcribed verbatim.

Confidentiality

Participants were assured that the final report would not contain any personal references, thus maintaining their anonymity. They were informed that a copy

of the thesis would be placed in a major medical library in Brisbane as per ethical protocol of the hospital approached.

Throughout the transcription and data analysis all participants were assigned a code number and the data kept in such a way that individual participants could not be identified. In addition, a computer coding system was used to maintain the confidentiality of the participants. The inquirer used the data for the purposes of this inquiry only. Disseminated information does not include any identifying data rather it presents the participants as a collective group of midwives.

Storage of Data

The University of Sydney's policy on storage of data was followed throughout the research process. The temporary storage of audiotapes in a locked cabinet at the inquirer's home occurred during the active transcription phase of the inquiry. Only the inquirer had access to the audiotapes during this phase. The inquirer transcribed all the interviews, minimising the potential for a breach in confidentiality. Following completion of the transcription phase, all audiotapes will be kept in a locked cabinet and kept for five years before being erased. Data files will be kept for the duration of the inquiry. These files will be accessible only to the inquirer through a password-protected personal computer located at the inquirer's home. The inquirer was the only person to have access to the entire contents of the audiotapes and transcripts. Throughout the data analysis all hard copies of data, including theoretical memos and the reflexive journal were kept in a locked cabinet at the inquirer's home. At the conclusion of the inquiry the transcripts will be securely retained in permanent storage at the University of Sydney for a minimum of five years. All these measures aim to maintain the confidentiality of the participants in this inquiry.

Summary

This chapter explored the contextual influences on the birth experience. In doing so it highlighted the three types of birth venues currently available in

Queensland, including the conventional hospital labour ward, the hospital based birth centre and the home birth environment. To ascertain the meaning behind the interactions of midwives and fathers it was necessary to examine the characteristics of these different birth venues and their contextual influences. The second part of the chapter presented the main characteristics of the research participants. The sample consisted of fourteen female registered midwives and two female student midwives currently working with labouring couples. The participants were selected from three different birth contexts. All freely provided their individual perceptions of the paternal-midwife relationship. The chapter concluded with an in-depth discussion on the ethical precautions related to this inquiry.

The following chapter will present the journey of discovery of the core category and theoretical framework for this inquiry. The chapter will introduce, explore and analyse the procedures of theory generations, with special emphasis on the methods aimed to ensure the rigour of the inquiry process. Specific data analysis methods and the use of an audit trial are highlighted, providing examples of coding, category development and theoretical conceptualisations of the data.

PROCEDURES OF THEORY GENERATION

The excellence of the research rests in large part on the excellence of the coding (Strauss, 1987, p.27).

This chapter describes the procedures for collecting, coding, analysing and presenting the data and theory for others to evaluate the interpretation of data. The intimacy of the inquirer with the research process in qualitative studies proves a difficult process to ensure a balance of impartiality and sensitivity. For example, the inquirer's level of understanding and sympathy for the participant's life may permit sufficient trust in the inquirer so that they are not cut off from seeing important events and perhaps seeing important documents, if they fail to develop such trust the analysis (Glaser & Strauss, 1967) and emergent theory may suffer.

In clarifying the research process, this chapter provides an explanation of the mechanisms used to ensure rigour during the inquiry process. To ensure acceptance of their findings, grounded theorists employ certain control mechanisms in the pursuit of objectivity and credibility. Although, there are no fixed rules and procedures, there are several specific techniques available, these techniques are explored throughout this chapter. For example, graphical representation of an audit trail (Figure 4) and a written recording in the form of a methodological log (Appendix F) are provided. The purpose of the methodological log is to document reflective thought processes involved in the decision making during data collection, the coding process and the final processes of theory generation.

Rigour in Grounded Theory Analysis

The rigour of the inquiry process is observed through maintaining objectivity and credibility throughout data collection and analysis. In grounded theory studies these are considered an important part of the theory generation process. These terms are used for establishing the trustworthiness of the findings. The standards of objectivity and credibility offered in quantitative methods are inadequate when applied to qualitative studies. As Leininger (1994, p. 105) warns:

...qualitative researchers should not rely on the use of quantitative criteria such as validity and reliability to explain or justify their findings. Such dependence reflects a lack of knowledge of the different purposes, goals and philosophical assumptions of the two paradigms.

The rigour of the inquiry process is essential to achieve an impartial interpretation of the data provided by the participants. Glaser and Strauss (1967) discuss the notion of rigour throughout their text and discuss, in detail, the issues of credibility (Chapter IX, *The Credibility of Grounded Theory*). They recommend criteria of judgement be based on the details of the actual strategies used for collecting, coding, analysing and presenting data when generating theory as well as on the way in which people read the theory (Glaser & Strauss, 1967).

Additionally, Glaser and Strauss (1967), offer five criteria of evaluation of the grounded theory inquiry process. These criteria are: that a grounded theory has codes fitting the data and a practice area from which it is derived, the emerging theory explains the main behavioural and interactional variations of the substantive area, the emerging theory must possess relevance to the core category, it is possible for the theory to be modified to fit other settings and lastly the theory is dense and integrated into a tight theoretical framework.

The Audit Trail

Auditability replaces the notion of reliability in grounded theory analysis. The auditing process involves documenting and substantiating that the inquiry findings are grounded in the data. Qualitative researchers suggest the use of an audit trail, decision trail, methodological log or inquiry audit. Lincoln and Guba (1985) originally recommended the concept of the audit trail as a method of judging credibility and rigour in qualitative studies. An audit trail refers to the recording of research activities over time from which others can follow the inquirer's thought processes and conclusions reached throughout the research process (Lincoln & Guba, 1985). In this way, the inquirer achieved confidence that the findings were characteristic of the variables being studied rather than indicative of the research process itself (Sandelowski, 1986).

Miles and Huberman (1984) write at length on comprehensive methods for establishing rigour in qualitative studies. Few contemporary texts have offered a more complete analysis of ensuring rigour in qualitative studies. In line with Miles and Huberman's (1984) suggestions, the inquirer made persistent checks to ensure objectivity within the research process. In addition to Miles and Huberman (1984), Bowers (1988) offers an eleven-point criteria process for reviewing grounded theory research reports. The process includes choosing a phenomenon that has not been extensively researched previously, providing an in-depth background of the phenomenon, including a review of extant literature, being clear on the purpose of the inquiry, ensuring that an adequate description of the sampling process was conducted, providing a detailed description of the procedures used to generate and analyse the data, in addition the findings and discussion sections should be predominately narrative and reflect that the theory generated was grounded in the data, lastly the conclusions and implications for practice should be based on the importance of understanding rather than prediction and control. This inquiry applied the codified methods proposed by

Glaser and Strauss (1967), Miles and Huberman (1984) and Bowers (1988) to ensure rigour throughout the inquiry.

Observing objectivity and credibility throughout the inquiry process will assist in the applicability of the grounded theory. This faithfulness to the coding of data is a powerful condition for the usefulness of the theory. According to Glaser and Strauss (1967, p.3), grounded theory is one that will:

...fit the situation being researched and work when put into use. By *fit* and *work* we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by *work* we mean that they must be meaningfully relevant to and be able to explain behaviour under study.

For example, the substantive theory has credibility for other midwives and health professionals working with fathers, in that it actually describes their experience of the paternal-midwife relationship. The substantive theory needs to be congruent with the meanings other midwives have for their experiences with fathers in childbirth. Credibility of the substantive theory was enhanced by the use of three birth settings, which helped to identify variations and similarities across different midwifery contexts.

Validation of the research interpretations by participants has its own inherent problems. Bloor (1978) raised doubts about the process of the ability of participants to follow the research report sufficiently and the adequacy of their commitment to the exercise. Similarly, Hammersley (1990) had concerns about informant validation and believed it should not be used as a definitive test of validity, due to the assumption that the participants both know or can recognise the relevant facts about each situation and behaviour and are willing to admit it. Silverman (1993) suggests that participant validation does not fully validate the findings, but may indicate that the interpretations may only be acceptable to the participants.

Power issues also impact on the participant's inclination to accept the inquirer's interpretations (Riley, 1990; Silverman, 1993; Hewitt-Taylor, 2001). Riley (1990) suggests that participants should not be given too much power in relation to defining the research interpretations. The inquirer was not aware of particular power issues relating to the conduct of this research. The credibility of the research lies in the systematic effort put into the research process, biases were carefully acknowledged and examined to ensure that theoretical findings arose from the data rather than being borrowed from existing theories.

Procedures of Theory Generation

The main focus of the data analysis in the grounded theory inquiry is the conceptualisation of data into theory. Theory generation, according to Glaser (1978), involves the inquirer's quest for the essential element of the theory, which illuminates the main theme of the actors in the setting and explicates what is going on in the data. In generating a grounded theory the data analysis phase consists of specific steps. The first step is to ensure that grounded theory methods are suitable for the area of investigation. The case for grounded theory described in Chapter Four emphasised the suitability of grounded theory for the investigation of the processes involved in the intrapartum paternal-midwife relationship.

After determining the suitability of the method for the area of investigation, the next step involves data collection, which can be in the form of transcriptions, field notes, observations or historical documents. Although the inquirer collected several historical documents and oral history recordings, the majority of the data were interview transcriptions from interviews with fourteen midwives and two student midwives. Multiple data collection techniques allowed the inquirer to examine processes, which may have been overlooked by previous research. These techniques also provide for further internal verification of data.

Data Collection

The inquirer used a variety of methods to explore the participant's perceptions of paternal presence and their interactions with expectant fathers. This section describes the intricacies of data collection using grounded theory methods. The data comprised interpretations provided by participants or located in other sources. Grounded theorists commonly collect data from interviews, observations or documents, or from a combination of these sources (Schatzman & Strauss, 1973). Inherent in these methods is the inquirer's specific techniques and interpretations during interview, document and record analysis and non-verbal cues.

National Survey

The inquirer began data collection with a nation wide survey (Appendix E). A questionnaire was designed for the purposes of collecting background historical data on the entry of fathers into Australian labour wards. This information also provided the inquirer with enough information on the historical influences to begin the in-depth interview process with midwives. The findings represented views from both retired and practicing midwives on the historical aspect of paternal attendance. The survey focused on the factors involved in this change, the person or persons responsible for initiating the change and the obstacles and/or problems encountered because of the change. The findings indicate that fathers were permitted into labour wards in different States and Territories for various reasons. A detailed analysis of the survey results was provided in Chapter Two.

Theoretical Sampling

The sample type used in this inquiry was based on the 'saturation of categories' (Glaser & Strauss 1967). In the grounded theory method, data collection involves a theoretical sampling technique. The aim of the theoretical sampling was to discover categories and their properties and to suggest the interrelationships into a theory (Glaser & Strauss, 1967). As with most

qualitative methodologies, sample selection in grounded theory is purposeful rather than random, with no predetermined sample size. Sample sizes in grounded theory studies are generally smaller than those used in quantitative studies, since each participant has the potential to provide vast amounts of data. For the grounded theorist to appropriately manage and interpret the data a rigorous sampling method is required. Thus, participants are selected, based on their theoretical relevance to the inquiry. Glaser and Strauss (1967) define theoretical sampling as the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses data and decides what data to collect next and where to find them, so as to develop theory as it emerges. Specifically, data collection is controlled by the emerging theory. Participants for this inquiry were selected on the characteristics required for the inquiry. Thus the aim of this sampling technique was to select participants working in diverse birth environments who could provide an in-depth explanation of the phenomenon. Saturation of the data is reached when no new codes are identified in any of the transcripts and it signals to the inquirer that no further participants are required. Saturation was achieved in this inquiry with a sample size of sixteen consequently no additional participants were required.

In-depth Interviewing

The most important method of data collection in this inquiry was the semi-structured in-depth interview technique. Little has been written on the most appropriate interview style for grounded theory studies. However, most grounded theorists use in-depth interviewing as a form of data collection. In-depth interviewing was used in this inquiry as the basis for collecting raw data for theory generation. Minichiello, Aroni, Timewell and Alexander (1995) identify in-depth interviewing as a conversation with a specific purpose which focuses on the participant's perception of themselves, their life and their experience. Grounded theory methods provide for a flexible and sensitive model of interviewing to gain the important aspects of human behaviour. Hutchinson (1993) contends that interviewing is foundational for grounded theory research

and, where suitable, may be the only source of data. In-depth focused interviews were used to explore the participants' perceptions of their interactions with prospective fathers during labour and birth. This interview style is significant in the exploration of issues relevant to the inquiry and to give participants a voice in the research.

The in-depth interviews focused on the participants' professional observations of their interactions with fathers in the perinatal period. Swanson (1986) recommends that the nurse-researcher be fresh to the clinical area to avoid overlooking important aspects of the experience of the participants, taking information for granted or analysing the data from their own experience. The inquirer was new to the clinical areas selected in this inquiry. The main purpose of the interview data was to highlight the participants' specific interactions with fathers during childbirth. The format of the interviews was simple open-ended questioning. The participants were selected in an ongoing manner as described in theoretical sampling.

In this phase of the data collection, semi-structured in-depth interviews were undertaken with fourteen practicing midwives and two student midwives. Prior to the in-depth interviews, the inquirer obtained demographic information in a separately designed survey (see Appendix C). Stern (1985) suggests collecting demographic data, to record such things as age, sex or demographic variables related to the inquiry, which assists in the description of the sample. In this study the information collected included age, years of experience, qualifications and current position. This initial data provided the inquirer with grounding from which to proceed to collect further data, through questionnaire and interview techniques. The interviews were conducted from October 1999 to July 2000. Each midwife interviewed was asked a series of questions and prompted where necessary. The questions aimed at collecting data on the philosophy, interactions and interpretations of midwives towards fathers during the perinatal period.

Fundamentally, skilful interviewing is characterised by three core elements. May (1991) highlights these as the process by which the inquirer can establish rapport, elicit information without excessive control and record it accurately. Thus, systematic preparation for each interview was undertaken to ensure flexibility and consistency between each interview. The inquirer kept a schedule of guiding questions to ensure the collection of each participant's perspective. The interview schedule or as Burgess (1984) termed it, the *aide memoire*, usually consists of a general list of topics to guide the inquirer during the in-depth interview process. This list changed in accordance with the change in the inquiry's focus. Open-ended questions were used throughout the interviews and a conscious effort was made to avoid the use of research jargon or unfamiliar terms. The interview was started with a few warm-up open-ended questions with the central focus surrounding the participants' interactions with fathers during labour and birth.

At the end of each interview the inquirer requested participants to complete a small questionnaire on their professional perspective of particular aspects of current practices during parturition (Appendix D). Data from this questionnaire were integrated with data collected from the interview transcripts.

Immediately following each interview the inquirer transcribed the tapes verbatim, including descriptions of non-verbal factors. Most participants were interviewed only once, usually lasting an hour. This time was deemed adequate to establish the necessary rapport and topic coverage. In line with in-depth interviewing procedures prearranged informal conversations with the participants occurred in their setting of choice. The majority of participants chose to be interviewed in their workplace before, during or after work. The home birth midwives were interviewed in their homes. This choice of setting was important to the participants and had significant relevance to the context of the topic.

In generating grounded theory, coding procedures, including theoretical sampling, theoretical questioning, constant comparative analysis, concept development and related relationships enable the inquirer to listen to the interpretations of participants rather than relying solely on their own interpretations. Additionally, interview data were compared across the participants to determine the consistency of the data. Codifying qualitative procedures enables the reader to fully understand how the theory emerged from the data and thus became a grounded theory.

*NUD*IST Vivo (Nvivo)*

The use of the data analysis software package NUD*IST Vivo (Nvivo) was crucial to the data analysis, in particular the coding phase of this inquiry. Nvivo is produced by an Australian company, Qualitative Solutions and Research (QSR), for the specific purpose of data management and qualitative analysis. Nvivo has many uses and it is the most appropriate software for grounded theory data analysis, due to its ability to assist the inquirer to code, develop theoretical memos and graph data. Richards (1999), a co-developer of Nvivo, claims it is useful for recording and linking ideas in many ways and for searching and exploring the patterns of data and ideas.

At the completion of each interview, the inquirer transcribed the interviews using a personal computer into a word processing document. These files were entered into Nvivo using ASCII format. The transcriptions could then be coded. Specific coding procedures are outlined below and the use of Nvivo is described.

Substantive Coding

The first stage of data analysis involves the process of open coding. This part of grounded theory analysis is concerned with identifying, naming, categorising and describing the phenomena located in the interview transcripts. Each line of

text is read with the inquirer questioning what each line, or sentence is about and/ or what is being referred to in the text. According to Glaser and Strauss (1967), there are several rules governing open coding. The first rule involves asking a set of questions related to the data. The questions are: what is this data a study of? What category does this incident indicate? (or what category or property of a category or what part of the emerging theory, does this incident indicate?), and what is actually happening in the data? Glaser and Strauss (1967) argue that these three types of questions keep the analyst theoretically sensitive during data collection and analysis. Discovering the characteristics of the objects and identifying the salient objects in the object world are vital steps in developing a grounded theory (Chenitz & Swanson, 1986).

During the coding process, the inquirer read through the transcripts several times to obtain a *sense* of the issues. This first level coding involves analysing the transcript line-by-line and applying relative codes. In this level of coding it is common to use *in-vivo* codes, which are the participants' own words to code the data. Thus, the grounded theorist identifies and develops basic ideas and concepts expressed by the participants'. The aim is to produce a range of concepts that closely represent the data. During this stage each concept is individually coded. Coding means labelling raw data to record the substance of that data. The aim is to remain open to generating as many codes as possible. After further analysis several concepts were derived from the *in-vivo* codes.

During this process the inquirer examined the data for common themes. The process of coding enables the inquirer to become immersed in the data, thus enabling the initial phases of theory development to be established. Coding of the transcripts was undertaken both manually, using a print-out of the transcriptions, and then on-screen, using the Nvivo software. The following figure (Figure 4) is an example of manual coding. The paragraph is a sample from one of the interview transcripts. The information section was underlined

and a coded label written in the right hand column. Glaser and Strauss (1967) note that coding need consist only of noting categories in the margins.

Figure 4: Text Fragment - Open Coding Analysis

<p>... <u>In the birth centre we include the husband or father in the antenatal visits.</u> We <u>explain</u> to him as well as to the woman what is <u>actually happening to the woman's body and the changes that are taking place.</u> We even talk to them about the reasons for <u>scans.</u> They come to our classes and we <u>encourage</u> that. I don't think that we have ever had anybody not come in the birth centre; <u>they know that is part of the deal here.</u> Because the <u>women</u> are <u>motivated</u> here, so it does make it easier for us. <u>The fathers are included</u> right from the beginning, in classes and they <u>know when it comes to the birth process what their role is.</u> And so I see the <u>midwife</u> as being <u>the teacher</u> for the husband and even a <u>support</u> for them.</p>	<p><i>Inclusion</i></p> <p><i>Antenatal relationship</i></p> <p><i>Explaining</i></p> <p><i>Informing</i></p> <p><i>Providing rationales</i></p> <p><i>Encouraging participation</i></p> <p><i>Tacit knowing</i></p> <p><i>Motivated women</i></p> <p><i>Included</i></p> <p><i>Role delineation</i></p> <p><i>Role perception</i></p> <p><i>Teacher</i></p> <p><i>Supporting fathers</i></p>
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In this sample text fragment, the informant explains how she includes fathers in the context of the birth centre environment. The labels for each line, sentence or paragraph are provided in the right hand margin. This sample demonstrates the importance this informant places on including fathers in the antenatal period through to the labour and birth processes.

Because of the large amount of codes generated it is necessary to cluster them into a manageable size by grouping them by their similarities and differences (Swanson, 1986). These clusters were then labelled with appropriate descriptors, for example the category titled 'Midwives Attitude Towards

Paternal Presence', which clustered midwives attitudes about paternal participation the original codes, included 'Fathers are great,' 'Fabulous involvement,' 'Essential involvement'. Glaser and Strauss (1967) call these clusters families of codes. These categories formed the basis on which to compare and contrast all data and existing theory. After the final analysis of the data from the last interview, the theoretical categories had been saturated. The core category also emerged at this time. The linkages, process and model emerged quickly.

Constant Comparative Method

In conjunction with data collection, categorisation is taking place using the constant comparative method of data analysis. The constant comparative approach to data collection and analysis has been used in this inquiry to explain how midwives perceive their interactions with fathers in childbirth. Glaser and Strauss (1967) developed this method as an inductive approach for developing theory. They describe the four phases of the constant comparative method: comparing incidents applicable to each category, integrating categories and their properties, delimiting the theory and writing the theory (Glaser & Strauss, 1967). The grounded theorist begins the coding by categorising each incident with the use of grouping codes according to common properties and patterns into a smaller number of conceptual categories. Through constant comparison the inquirer compares and contrasts each label with all other labels to distinguish between similarities and differences among the participant's accounts, which forms the basis for the generation of the grounded theory.

This level of comparison enables the inquirer to identify the variations in the patterns of data (Holloway & Wheeler, 2002). Developing concepts from participants' experiences is a complex task. After analysing the first few interviews, categories began to emerge. When categories emerged, existing theories were examined for their relevance to the categories and concepts and, if links were found, they were elaborated and integrated into the data analysis.

The grounded theorist's purpose is to explain a given situation by identifying the core and subsidiary processes operating in it. Baker, Wuest and Stern (1992) contend that the core process is the guiding principle underlying what is occurring in the situation and dominates the analysis because it links most of the other processes involved in an explanatory network. During the analysis the category of 'Inclusion' emerged, in which all the cases of midwives attempting to include fathers in the birth process could fit. In reviewing the data and checking for all incidents of *inclusion*, and with continued interviewing, incidents of this category continued to emerge. The next step was to compare incidents in this category with one another. This step involved asking in what ways were the participants' experiences of inclusion similar and in what ways were they different. In doing this, subcategories began to emerge from the larger category. Glaser and Strauss (1967) define these as theoretical properties. When incidents emerged that did not fit, interviewing was pursued to develop more on such incidents, this is known as theoretical sampling (Glaser & Strauss, 1967).

The following figure (Figure 5) represents the category development and highlights their properties. Theory generation is an inductive process, with the categories emerging from the data. Concept formation involves the phases of coding and categorising. This process aims to link the categories by the relationships. In this process the number of categories is reduced to a significant relevant level for the framework. Therefore, during this phase, a temporary conceptual framework is generated. This enables the inquirer to question the data, to explicate the meaning of the codes and categories. The process is part of theoretical saturation which is indicated when coding changes from a process of minutely analysing data and generating categorical dimensions to a process of skimming the data because nothing new is emerging about a category or its properties (Strauss, 1987). The constant comparative method (Glaser & Strauss, 1967) of data analysis was implemented to develop clusters of similar meaning. Category generation involves the comparison of the data and conceptualisation of commonalties. Thus, categories are clustered according to emerging

meaning. The constant comparative method enabled the inquirer to analyse the data within the categories.

Figure 5: Category and Core Category Development

	Core Category	
<p><i>Midwives Attitude Towards Paternal Presence</i> <u>Concepts</u> <i>Woman's work</i> <i>Essential involvement</i> <i>Couple's relationship status</i></p>	<p>I</p> <p>N</p> <p>C</p>	<p><i>Building a Rapport</i> <u>Concepts</u> <i>Orientating</i> <i>Needs assessment</i></p>
<p><i>Personal and Professional Experiences</i> <u>Concepts</u> <i>Personal experiences</i> <i>Observing role changes</i></p>	<p>L</p> <p>U</p>	<p><i>The Supporting Partnership</i> <u>Concepts</u> <i>Instilling confidence</i> <i>Just being there</i> <i>Caring for the father</i></p>
<p><i>Advocating Paternal Involvement</i> <u>Concepts</u> <i>Limiting intrusion</i> <i>Informing & advising</i> <i>Collaborative decision making</i></p>	<p>S</p> <p>I</p> <p>O</p> <p>N</p>	<p><i>The Boundaries of the Birth Environment</i> <u>Concepts</u> <i>Facilities</i> <i>Tacit rules of birthing</i></p>

The final step of analysis involved the identification of a core category. This part of the analysis involved the selection of one category to be the core category and relating all other categories to the chosen category. The discovery of the core category is an essential element for a credible grounded theory. This core variable accounts for most of the variation in the data, integrates the categories and generates theory, which is relevant and works (Strauss, 1987). Hence, from the reduction technique, the core category or core variable is the central theme that emerges that unifies the codes and categories and underpins the theory. According to Glaser and Strauss (1967, pp.224-225):

When the researcher is convinced that his (sic) conceptual framework forms a systematic theory, that it is a reasonably accurate statement of the matters studies, that it is couched in a form possible for others to use in studying a similar area and that he (sic) can publish his (sic) results with confidence, then he (sic) is near the end of his (sic) research.

Writing the theory is the final step of the constant comparative method. In the generated grounded theory, it is necessary to collate the theoretical memos on each category and then the researcher can easily return to the coded data to validate a suggested point, to pinpoint data behind a hypothesis or to identify gaps in the theory and provide illustrations (Glaser & Strauss, 1967).

Memo Writing

The act of theoretical memo writing is essential to the coding process (Appendix F). Theoretical memos refer to specific types of written records containing products of analysis or directions for the analyst (Glaser & Strauss, 1967). These include the inquirer's thoughts, feelings and insights about the relationships in the emerging theory. Theoretical memos are kept separate from the raw data and referred to during theoretical conceptualisation. Theoretical memoing affords the inquirer with an ongoing record of theory development. Memos were written throughout the research process. N-Vivo provided the inquirer with an efficient method of memo writing during category development and final theory development.

Use of Existing Theory

The generation of new theory usually occurs in consultation with existing theories. In this inquiry the use of existing theory gave a contextual grounding for examining the themes from the interview transcriptions. Most grounded theorists are cautious in the use or review of literature prior to data collection. Rather, in line with the grounded theory approach, the review of relevant literature was an ongoing process during the data analysis. The use of existing literature assisted the inquirer to learn what existing knowledge there was on the emerging concepts. This is usually literature which could not have been anticipated before the discovery of the core variable and its ensuing theoretical coding of concepts (Glaser, 1992, p.xiv). Relevant theories were integrated with the emergent theory during data analysis, where it filled gaps and assisted in the completeness of the theoretical description of the emerging theory.

This literature was also used to validate the accuracy of the findings and to provide an impetus for deeper analysis of the data. As Stern, Allen and Moxley (1984) posit, existing literature, when carefully scrutinised, helps expand the theory and relate it to other theories. Medical, midwifery and nursing literature on paternal-midwife relations is limited to studies on the paternal experience of pregnancy, labour and childbirth with little consideration given to the midwives' perspective. Consequently, the inquirer reviewed literature from other disciplines to offer explanations and fill in the gaps in the emerging theory.

Summary

This chapter described the methods used in this inquiry to ensure rigour throughout theory generation. The aim was to provide the reader with an audit trail of the research process. Each stage of the data analysis was elucidated to demonstrate the decision making processes involved for the purposes of determining the credibility and trustworthiness of the emerged theoretical constructs. The constructs and categories that emerged during the data analysis

were supplemented with theoretical memos and pertinent existing theory. The inquirer used existing theory concurrently during the data analysis to validate and elaborate the emerging concepts and categories. This chapter is the second of two chapters to consider the methodology and design of this inquiry. It closely follows Chapter Four, which described the development of grounded theory, its theoretical underpinning and the inquirer's rationale for its use in this inquiry.

The next chapter is the first of four, which address the representation of the data and categories that led to the emergence of the core category, *Establishing an Inclusive Relationship*. The following chapter presents a discussion of the substantive theory. The core and associated conceptual categories are outlined and explained. In addition three theoretical themes provide theoretical explanations of the substantive theory of establishing an inclusive relationship.

ESTABLISHING AN INCLUSIVE RELATIONSHIP:
THE EXPLANATORY FRAMEWORK

So I think that the midwife should include them [fathers] as much as they can. And get them familiar with the environment and with the people in the room (013).

The findings of this inquiry are presented and developed over four chapters. In this chapter the foundation for understanding the central categories and the theory of establishing an inclusive relationship are presented using an explanatory framework. The following three chapters examine in detail the core category, the three main themes and six categories. The core category, *Establishing An Inclusive Relationship*, describes how midwives working with couples in labour and birth attempt to include fathers in childbirth as part of their professional practice. For the participants, inclusion is perceived as an enabling process used to enhance paternal involvement in childbirth. The aim of establishing an inclusive relationship is to include fathers so that they can feel accepted and comfortable about being an active participant in the birthing processes. In this explanatory chapter, and throughout the findings chapters, the participants' words will be in italics to facilitate the reader's understanding of the proposed theory and related constructions.

The Explanatory Framework

The principal implications of the substantive theory are integrated into the following explanatory theory. This theory is based on interpretations from a large volume of coded data, analytical memos and existing literature. Three main themes emerged: the midwives' personal and professional values, working with fathers and working within the boundaries of the birth environment.

The Core Category

Glaser and Strauss (1967) refer to the core category as accounting for most of the variation in the behaviour and integration of other categories. The core category has three essential characteristics: it recurs frequently in the data, it links the various data together and it explains much of the variation in the data. These three characteristics were evident in *Establishing an Inclusive Relationship*. This process occurred frequently in the data, it integrated the interrelated categories and explained the variation in the data. Establishing an inclusive relationship emerged as the central theme for all categories and their properties and accounted for the most variation in the behaviour and integration of other categories. Establishing an inclusive relationship explains how the midwife perceives their relationship with fathers in childbirth.

The core category defines the main purpose of the midwives actions and interactions with fathers. The central core process involved general themes of personal and professional values and experiences, working with fathers and working within the boundaries. The process connected the data and defined relationships between the major categories. *Establishing an inclusive relationship* was considered to be the category that accounted for the most variation in the pattern of behaviour and provided an integrative scheme of the other categories.

Having outlined the core category the main themes underlying this theoretical framework are now presented. These themes represent the relationships among the concepts in the inclusion explanatory framework.

Theme 1.

The midwives attitudes and values guide their actions/interactions in their intrapartum practice with expectant fathers.

The antecedents of the midwife's practice and interaction may directly influence inclusion and interaction in paternal-midwife interactions. These attitudes and

values guide the interactions of midwives within their practice with expectant fathers. The practice of midwifery by an individual is shaped by a combination of thoughts, feelings, interactions, and by previous experiences and observations, both personal and professional.

Theme 2.

Intrapartum midwifery practice involves working and interacting with fathers.

Midwives implement specific inclusive strategies when with working fathers in childbirth. Establishing an inclusive relationship includes focusing on the father and his needs through rapport building. Including fathers in childbirth processes involves respect of the partner's choices, autonomy and individuality. Assuming the role of advocate for both the labouring woman and her partner is considered a vital component of the midwife's role. The participants identified a strong need to work in partnership with the father to support the labouring women.

Theme 3.

The practice of including fathers in childbirth takes place within the boundaries within the birth environment.

The inclusive relationship is bound by specific boundaries of the birth environment. These boundaries influence the dynamics of the paternal-midwife relationship. The midwives practices are bound by the facilities and tacit rules of the birth environment. Each birth environment has differing boundaries and impacts differently upon the supporting nature of the paternal-midwife relationship.

The Categories

In defining the paternal-midwife relationship numerous interrelated concepts emerged to describe the informants perspective of their interactions with

expectant fathers in labour and childbirth. Table 1 lists the six categories and their related concepts.

Table 1: Categories and Concepts of the Substantive Grounded Theory

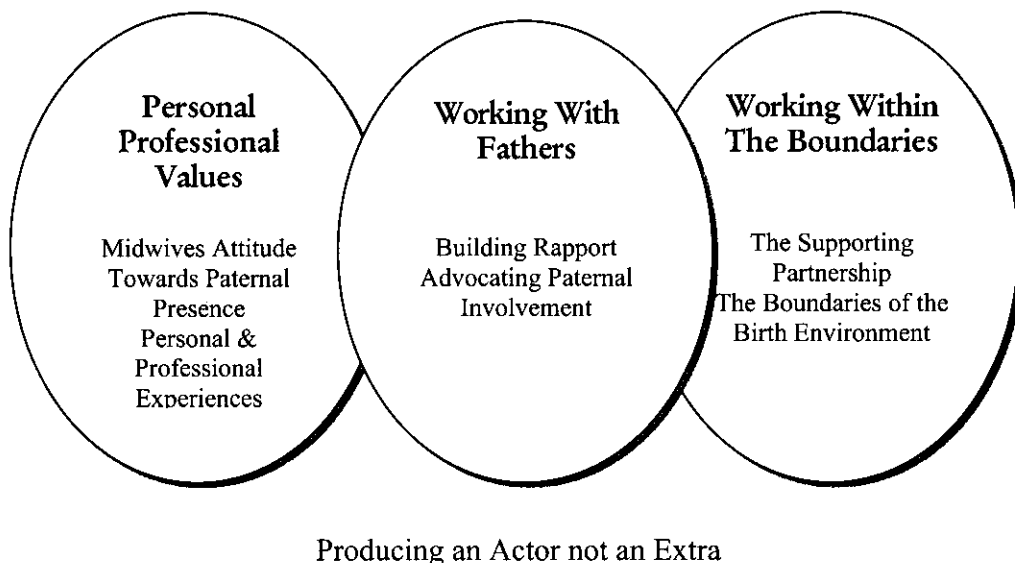
Categories	Concepts
Midwives Attitude Towards Paternal Presence	Women's Work Essential Involvement Couple's Relationship Status
Personal/ Professional Experiences	Personal Experiences Observing Role Changes
Building a Rapport	Orientating Needs Assessment
Advocating Paternal Involvement	Limiting Intrusion Informing & Advising Collaborative Decision Making
The Supporting Partnership	Instilling Confidence Just Being There Caring for the Father
The Boundaries of the Birth Environment	Facilities Tacit Rules of Birthing

These conceptual categories emerged from the inquirer's interpretation of the data during the search for the social processes involved in paternal-midwife actions and interactions. In this inquiry the participants sought to include fathers throughout labour and birth. This process recognises that consumers of health services need to be included in the health care relationship and to actively participate in their own care. The integrating theme of the data was the importance of including fathers in labour and childbirth, by building a rapport, offering choices, giving relevant information to make informed decisions,

demonstrating caring behaviours and fostering feelings of usefulness within the boundaries of the birth environment. This interrelated set of categories contributes to understanding how contextual factors influence inclusion processes and also how perceptions affect behaviour.

Figure 6 depicts the main themes and categories, which make up the theoretical framework. The paternal-midwife relationship represents the midwives connection to the father through their attitudes, personal and professional experiences and relationship building strategies of rapport building, supporting and advocating paternal involvement within the boundaries of the birth environment. This relationship is characterised by the act of producing an actor as an important player in the birthing event, rather than an extra, a position that could be filled by anyone. As one participant observed: *it is like a little play she is the star and they are [fathers] the supporting actors, they are there to help her shine (010)*.

Figure 6: Establishing an Inclusive Relationship



Throughout the following three chapters the major conceptual categories will be discussed, although they are separated into discrete chapters the relationships

connecting these categories will be made explicit. A detailed explanation of the action and interaction strategies designed to include the father in the birth process is presented. This explanation is provided to facilitate understanding of the proposed substantive theory.

Summary

This chapter presented an explanatory discussion of the substantive theory. The core and associated conceptual categories were outlined and explained interpretations based on the participants descriptions of paternal-midwife interactions in parturition. These theoretical explanations of the substantive theory of establishing an inclusive relationship aim to reveal the meanings of the interactions between fathers and midwives.

Chapter Eight identifies the participants underlying values and attitudes towards paternal presence in childbirth. This chapter explores categories Attitudes to Paternal Presence and Personal and Professional Experiences. These categories emerged as a result of participants expressing their feelings and attitudes toward paternal presence in birth.

ESTABLISHING AN INCLUSIVE RELATIONSHIP:
MIDWIVES PERSONAL AND PROFESSIONAL VALUES

But in my mind I am not just caring for her but I am looking at part of my responsibility is caring for her partner. They are just part of it. They are a package deal (006).

This chapter is the second of four chapters presenting the findings of this inquiry. During the interview process each participant was asked several questions about their professional practice regarding paternal presence in the intrapartum period. Several antecedents emerged through constant comparison of the data. These categories underpin the participants' professional behaviours in their attempt to include fathers in the childbirth experience. Blumer (1969) observed that humans act towards things on the basis of the meaning those things have for them, that the meaning of such things is derived from, or arises out of, social interaction with other humans and that these meanings are handled in and modified through an interpretive process used by humans in their interactions with the things they encounter. Using his theory would suggest that the way in which midwives act towards fathers is based on the meanings that working with fathers in childbirth has for them. These meanings are derived from the interpretive process used by midwives when working with fathers in childbirth.

Participants in their perceptions of including fathers in childbirth articulated the importance of their attitudes toward paternal presence, and their personal and their professional birthing experiences. Understanding how personal perspectives and experiences may shape professional practices and behaviours is particularly important to the establishment of an effective paternal-midwife relationship. Related categories and constructs from the participants' own words, analytical memos and related literature are used to identify the

antecedents of the inclusive relationship. The first category considered is that of the *Midwives Attitude Towards Paternal Presence*.

Midwives Attitude Towards Paternal Presence

Throughout the interviews participants spoke of their attitudes towards paternal presence. This category identifies the participants' interpretations and values that midwives attach to the concept of including fathers in childbirth. The type of attitude midwives have towards paternal involvement may have a direct effect on their actions and interactions, including their care of the woman, her partner and family.

Chenitz and Swanson (1986) observed that symbolic interaction focuses on the meaning of events to people in everyday settings and relates to how people define events or reality and how they act in relation to their beliefs. The data from this inquiry suggest that midwives bring to the childbirth experience their philosophy, their personal experience, professional knowledge, including knowledge of the birth setting policies and regulations and previous experience from caring for other labouring women.

In enacting the processes of including fathers during labour and birth, the participants discussed specific attitudes toward paternal presence in childbirth. These attitudes were congruent with their personal perceptions and experiences of childbirth. Such attitudes were also evident in the participants' description of their behaviour and interactions with fathers during childbirth. In the context of their relationship with fathers, midwives sought to include fathers and expressed their perception of paternal attendance and participation. Specific properties of this category include *Women's Work*, *Essential Involvement* and *The Couples Relationship Status*.

Women's Work

Constant comparison of the data interpretations of the participants' words led to the emergence of the concept of women's work. This concept is important to the establishment of the inclusive relationship and the placement of this discussion has been positioned to reflect this. Historical literature and recent histories of childbirth view childbirth as a traditional female domain and some participants described similar thoughts. These thoughts would seem contrary to establishing an inclusive relationship. However, further examination of the conceptualisations demonstrates that, while some midwives believe that it is ultimately up to the women to give birth, they still attempt to include fathers in labour and birthing.

Participants describe childbirth as women's work. That includes the notion that the labouring woman needs to get on and birth, with minimal interference from others, including her partner. *The woman, who really gets into the home birth, knows that she has got this knowledge. She knows that her body has got this knowledge. And it is not the man's business to support her in the labour (014).* Although paternal encouragement was viewed as important to managing well with labour and birth, Mackey (1995), in her evaluation study of women's childbirth experiences, identified the women's own performance as the most important component of the childbirth.

To assist women in birthing, some participants acknowledged that women support persons may be more suitable. Several participants suggested that fathers really do not have the same nurturing, caring and intuitive responses required during labour and childbirth. *In the main, females are better support persons than males; I have seen plenty of evidence to support that. Especially when a woman support person has had a baby before and she can read the signs and act on them and respond appropriately (004).* Female support was also viewed as having the ability to offer caring and intuitive responses required during labour and childbirth. *Female support persons are better with the power*

of touch. It is amazing how a woman just knows the power of touch, the point the knowing when to back off. It is like this female intuitive thing (016).

Although limited research has been undertaken on paternal influence on labour progress and outcomes, there have been several studies investigating support provided by females (Hofmeyr, Nikodem, Chalmers & Kramer, 1991; Kennell, Klaus, McGrath, Robertson & Hinkley, 1991; Langer, Campero, Garcia & Reynoso, 1998). Scott, Klaus & Klaus (1999), claim that research findings suggest positive obstetrical and postpartum benefits of continuous support provided by a doula during childbirth. It has also been suggested that labour support by fathers fails to produce similar obstetrical benefits (Bertsch et al., 1990; Chalmers & Wolman, 1993; Scott, Klaus & Klaus, 1999).

Participants expressed intrapartum support and care as part of the female culture of caring. Participants acknowledged the importance of women caring for the woman in birth. For example, the majority of participants recognised the importance of the woman's relationship with her mother. *I think that labour is women's business; it links mothers and daughters together. For me I just like to have mum and dad and me and grandma. I think that it is nice to have a grandma there. I think it is nice for mothers and daughters to share in that experience. I think that I prefer to have that sort of relationship in the birthing suite than maybe even fathers. I do not think that has occurred to me before. I like to see mothers and daughters you know in that sort of woman to woman set up, you know very traditional sort of set up (004).*

Although the maternal grandmother was viewed as being a suitable support, some participants had reservations about their helpfulness. *I find that there doesn't seem to be very much middle ground. They are really good or they are dreadful. And there have been times when I have had to ask mothers to go, to leave the room, because they were just too destructive. And distressing the woman too much and not everyone wants anyone else except their partner in*

with them (006). Participants conceptualised that maternal grandmothers can be useful but also overbearing with their daughters.

Contemporary theoretical understanding of the relationship between mother and daughter during labour and childbirth is extremely limited. With fewer restrictions on family involvement in childbirth, the participation of the maternal grandmother may become commonplace. Since, midwives are not required to collect data on the incidence of family participation in childbirth, it is difficult to understand the effects and outcomes of such presence. However, most of the participants observed the presence by the maternal grandmother as highly supportive for the labouring women.

Determining the effects of paternal presence on birth outcomes has yet to be studied effectively. Rather, in this inquiry some participants conceptualised paternal presence as hindering labour and birth processes. The issue of paternal presence impeding progress of labour was considered as further evidence to support childbirth as women's work. *I have seen them fight, leave me alone, get out of my space, pushing him away and those sort of things. In one instance we suggested to the man, they needed milk or something, so we suggested to the man to go down to the shop and get the milk and come back in your leisure everything is fine. Well she just motored while he was away. It is not always so obvious and sometimes it is just subtle (008)*.

For some authors it seems the issue of fathers at birth remains contentious. This notion is confirmed by Odent (1999), who observes that most women believe that they need their partner present during labour and birth, but during the birth the same women can express exactly the opposite in a nonverbal way. For example he remembers a number of births that were progressing slowly until the time when the father was unexpectedly obliged to get out. When her partner had left, the labouring woman started to shout out and the baby was born after a short series of powerful and irresistible contractions (Odent, 1999). *Because sometimes the father can leave and she will get back into regular contractions*

and actually it is amazing how many times the father walks out of the room and the woman says I am ready to push now (016). The impact of paternal presence on the progress of labour is poorly articulated in current childbirth literature. Although, minimal research exists on paternal presence and progress of labour, Richman and Goldthorpe (1978) claim it is obvious that the father being part of the social network encapsulating the birth must have an influence on the course of labour.

Participants described how some of their clients questioned the presence of their partner. One participant observed a home birth client questioning her husband's presence at the birth. *A lot of time in my practice a lot of women tell me and ask me what do you think about me not having my husband? Naturally she delayed her labour a lot and she was right. The energy that he was bringing in every time he would come in the labour would slow down. And she acknowledged after that it would have been his presence that slowed [her labour] down (014).*

Not all of the participants articulated this perception. Rather, the perception that childbirth is women's business was strongly articulated by participants from the home birth setting and traditional labour ward settings. One participant reflected on the interactions of midwives and fathers from observing behaviours in the labour ward. She commented: *I find some midwives are very feminist in their practices. Like it should be that men should not be there, as it is women's business and get out. But there are two schools of thought, 75% think that the father should be there for everything and anything. And the other 25% get him out (016).* This response is particularly directed at the interactions from labour ward midwives, although this participant had recent experience in the three particular birth settings used in this inquiry.

The perception of childbirth as woman's work could be perceived as contrary to the belief of establishing an inclusive relationship. The notion of childbirth as woman's work is largely determined by the midwives persona, personal and

professional experiences and knowledge. The concept of woman's work could be viewed as an exclusionary attitude, yet the majority of the participants overwhelmingly supported paternal presence as an essential one. No participants' viewed paternal presence as unnecessary, rather it seems for some intrapartum midwives working with women, and their mothers may be preferable.

Essential Involvement

When questioned on the impact of paternal presence in childbirth, the participants' overall response was favourable. The participants commented during the interviews that paternal involvement in labour and childbirth is an essential aspect of the childbirth experience. *I think that they are essential. I really think that labour is probably or giving birth is probably the second most intimate time in a couple's life and it is really fairly important for the guys to be there if they want to be there and their partner is comfortable with them to be there (010).*

Paternal participation involves the midwife ensuring that fathers feel welcomed and included both in the antenatal period and during the birth. *I think that we need to encourage fathers to come to antenatal classes with their wives. Because if they are going to be part of the experience, it is a whole experience the pregnancy is a whole experience and the labour is the beginning of their new life. You need to be involved in all the experience to go on together (007).*

Comments on paternal presence emerged through each interview with the participants describing the positive aspects of paternal presence. *We even encourage fathers to be part of the process, from the antenatal appointments when they come along. We think it is great, the women seem to cope a lot better having the number one person in their life there (005).* The participants appreciated the women's need to have their partner present. *I think it is great. I*

would encourage them to be a participant because they are usually closest to the woman (002).

Midwives identified the need for the father to be involved in the birth to support and advocate for their partner. *I think it is their place to be there in the labour ward. They should be there to support them [labouring woman] and to be her [labouring woman] advocate (012)*. Although the participants acknowledged that paternal involvement is essential throughout pregnancy and birth, involvement in birth is seen as the most important. *They need to do what ever is necessary to do help her through probably one of the toughest days of her life (010)*.

Essential involvement was also conceptualised as assisting the midwife in their care of the labouring woman. *I personally love it. I find that it is great to have fathers present in the labour ward. They are there to support the needs of the lady. They are able to massage her lower back, or get her a drink when she needs one. The husband can sometimes be the outlet you need. She can yell at him at it is not transferred to you. And it is surprising how many women use the father as the middle person. They may be too shy to speak up, or they may be in too much pain to say they do not want this. Or they want her in and him out. So sometimes the husband can be the middle person between it all (016)*.

While for some midwives childbirth may be viewed as women's work, these same participants also noted and respected the needs of the labouring woman and acknowledged that most women do want the father involved. *Women still want the father there regardless of what their relationship is like. It is a weird situation (004)*. Despite any problems with the couple's relationship, paternal involvement remains essential for the woman.

With increasing expectations of intimate relationships and the decline of the extended family in western cultures, childbirth expectations and care continue

to focus more on the birthing couple. For some midwives essential paternal involvement is partly the result of the increasing societal expectations of the paternal role in birth. *I think that there is a big societal pressure for fathers to be present. Particularly from fathers [the paternal grandfather] who never got to see their own children being born. Like it is not an option, it is like that is your role. Like it was our role never to be in there for the birth. It is actually your role to just stay there (016).*

Midwives observed that paternal presence and involvement is viewed by society as a normal part of childbirth. *It is part of life. Nobody would make any qualm about it, as it is just routine. I don't know how many fathers want to be here. I think some are here by peer pressure. Peer pressure by society. Society thinks that fathers should be there now. I just wonder if every father really wants to be here. Probably 90% of fathers want to be there. But there is a certain percentage that does not want to be there. They are there by coercion. Feel they have to (003).* Some participants had some concerns about paternal presence being forced upon men. One participant put it this way: *I think as long as they want to be there I love them to be there really. I think they are very important and very well needed (013).*

Midwives were also acknowledged as pressuring fathers to be involved. *Like the midwife will say well where is your partner? That will cause comment, rather than oh you are having your partner in. It has probably gone a bit too far the other way, where there is too much pressure on men to be present. For those small few who this is too much they kind of get caught up in that too much (006).* Participants often expected that fathers would be present and involved in the event as much as possible. *And they can be involved, as they want to be. I guess that is how I see my role as a midwife. So I let them work as a couple as well as they can and to fill in if they need any little help with any area. And to intrude as little as possible in what is one of the most intimate moments of their lives (012).*

Conceptualising paternal presence as an essential involvement demonstrates how the participants clarified meaning for the paternal role in childbirth. The participants were extremely positive in their perception of paternal participation in birth. *All in all I think it is just wonderful that they now have the opportunity to participate. Participate in that whole gamut of parenthood. Right from the word go (006)*. Indeed paternal presence is perceived by intrapartum midwives to be an essential part of the birthing process. It has become an accepted part of the birthing experience for both midwives and expectant couples.

Couple's Relationship Status

During their experiences with childbearing couples, several of the participants commented on the couple's relationship status, largely by observing their actions and interactions with each other. The midwives discussed how the depth of the couple's relationship becomes an indicator of how the couple and, in particular, how the father will cope with the birthing processes. *The image of the couple's relationship is a compilation of information gathered by midwives through observation and some questioning. I insist at the first meeting when the woman wants to have a home birth. I insist that the woman come with her partner. So that I can have a good talk with the partner and see how he is seeing the whole pregnancy and how he sees his role as a father. How he sees his role as a supporter at the time of the birth (014)*.

The following participant describes the lack of depth of some relationships. *A lot of them have not got the depth of the relationship; they have not got the history in the relationship. As we all know a lot of these relationships are only five minutes old when they come in here. And the couple have got absolutely nothing to show for it when they come in here. And it really becomes quite evident during the course of the labour process (004)*. For some participants the status of the relationship directly effects the father's role in labour and birth. *I*

think it depends on the relationship the man and woman actually have, as to what the father does, or the partner does in labour (008).

The type and extent of support provided by the participants depended on the nature of the relationship between the couple. In particular, midwives questioned the newness of the relationship and the impact this has on the ability of the father to cope with his partner's reaction to pain during labour and childbirth. *It is not always the happy husband and wife first time married first baby and here we go. They sometimes can become a detriment to the whole process rather than being a good thing. I think that makes it difficult when you are trying to do your job and you have the bigger picture in your mind and all they can see is the woman's pain (016).*

The participants conceptualised that a strong relationship between the couple is an integral ingredient for overcoming stressful situations and achieving a satisfying birth experience for the labouring woman and her partner. *If they have a very close loving relationship they tend to be more focused on each other and everyone else is excluded, almost to the point of being excluded. Whereas if they have got an ok relationship but it is not very close relationship it is usually then that the husband or father doesn't usually know what to do with this woman who is having to cope with these contractions. And to deal with what is going on in her body. And he really doesn't have a clue what to do with her. Even though he doesn't like to see her in pain, he doesn't know what to do. You know it is quite obvious that he does not deal with her when she has got pain other than when she is in labour. And has never learnt how to soothe her or support her in any pain situation. You know which relationships are very close and which relationships are very knowledgeable about each other and the ones that who are not so close in that way (008).*

For fathers to effectively support their partner, participants acknowledged that there must be some substance to their relationship. *I think it depends on the*

person. There have been so few fathers I have seen over the years that I genuinely believe will be great fathers. Isn't that sad. I think that comes from their level of understanding of their wife (004).

One participant recalled a previous birthing experience in which one father was questioning his relationship with his partner. *I can remember this couple I looked after in labour ward. She was labouring really well and they had not been together too long. They kind of met and married fairly quickly and she fell pregnant very quickly. And really as a couple they had not had a lot of time together. Anyway I saw him come out of the room. He looked distressed, not quite teary but distressed. And I said what is wrong? And she was going through transition. This was textbook scenario. Such as: you did this, this is all your fault kind of thing. And she was using him as some kind of verbal bouncing ball. And I realised that she was in transition and I knew that we had to get him back there. And he said she does not love me anymore. I knew he wasn't going back in for love nor money. She doesn't love me it is all over. It was really distressing and you do not know these people and I was upset for him. I had only known them for a couple of hours. And I was thinking what sort of relationship have they got. I said its ok, this is transition, it means that she is going to have the baby soon. Please just trust me, come back into the room. She needs you this is the time she needs you. But she hates me. They were probably in their mid-late twenties. He was quite a mature lad, anyway I convinced him to go back in the room. I said once that baby is born and she has that baby in her arms, she will be all lovey dovey again. This is just transition. It is pretty typical, it is normal behaviour come back in (006).*

For the participants, fathers knowing and understanding their partner is crucial to their ability to support the woman throughout the childbirth process. From the scenario above, it is obvious the midwife assumed that the father, who had not been in the relationship long, had limited understanding of the birth process and how his partner would respond to pain. The transition period tends to be an

emotional period of the birthing process. The labouring woman is experiencing intense emotions and pain during this period, often the father feels emotionally and physically helpless.

Participants generally perceived fathers to have a knowledge and experience of the birthing process. Pawson & Morris (1972) suggest that most men are more ignorant than women about elementary details of reproduction. However, it seems that men draw more on their knowledge of their partner's body than other ways of knowing. Draper (2002), in her investigation of men's experience of pregnancy confirmation, observed that men drew more on their knowledge of their partner's embodied experience and less upon visual and medical ways of knowing. Similarly, the participants from this inquiry identified that men's knowledge of their partners' bodies assists their understanding of the processes at work during pregnancy and birth.

Pregnancy and birth have the potential to impinge on the couple's relationship. While conceptualising about the couples relationship the issue of abuse was raised by several of the participants. Specifically, participants observed the couple's relationship as being a destructive one. *I quite like having the dads in, because the women relate so well to their partners. Obviously they need to have a fairly good relationship already. Not a very destructive one or anything, or abusive one. Women rely on their partners so much during labour (006).* Moreover, several participants described the relationship between marital dysfunction and the impact on the midwives' practice. Midwives frequently described fathers as uncaring and over-controlling, which challenged the midwives role when attempting to include the father in labour and birth. *I think that the worst ones are when it is quite obvious when the man and the woman are going through stages of difficulty and if she is at term at going into labour and they have been having lots of fights and things like that. That makes it very difficult. You are not quite sure what to do and because my philosophy is being with woman and I know the family belongs to the woman but my focus is on the*

woman who is labouring and having a baby. And her partner is part of that and he is on a different level (008).

Although midwives are aware of the woman's needs, responding to those who may be at risk from abuse from their intimate partner is sometimes difficult. *And I guess you would have those situations where you would try to find out as soon as you can what the woman wants. And what I would probably do is take her down to the toilet and find out exactly what she wanted me to do. And then try and help her achieve that in whatever way I can do it (010).* Although, intimate partner violence against women has received considerable research attention, very few guidelines on screening and intervention strategies for midwives exist in private and public institutions in Australia.

Intimate partner violence is a prevalent public health problem in many countries. More recently several researchers have reported the prevalence of violence in pregnancy (Webster, Sweett & Stolz, 1994; Hedin, Grimstad & Moller, 1999; Stenson, Saarinen & Heimer, 2001; Barker, Rhoades & Brandt, 2002; Richardson, Coid, Petruckevitch, Chung, Moorey & Feder, 2002; Janssen, Holt, Sugg, Emanuel, Critchlow & Henderson, 2003). In Australia there is a remarkably prevalent, yet often hidden, problem of intimate partner violence during pregnancy. Webster, Sweett and Stolz's (1994) results indicate that 30% of the sample reported a history of abuse, with 9% admitting abuse during pregnancy. Medical treatment was sought for injuries related to domestic violence by 31% of those who reported abuse during the pregnancy (Webster, Sweett & Stolz, 1994). Hegarty and Roberts (1998) reported that twelve-month prevalence estimates of partner abuse in Australia varied from 2.1 per cent to 28.0 per cent.

As discussed in Chapter Two, the use of relevant literature is a contentious issue in grounded theory research. Chenitz (1986) suggests, however, that the literature should also be reviewed during the inquiry process to elaborate

categories as they arise. In this inquiry, during the discovery of categories, the inquirer was drawn to seeking appropriate literature not considered in the preliminary review. As mentioned in Chapter Two the grounded theorist turns to an entirely new body of literature following the generation of the grounded theory. The review of domestic violence by the intimate partner is one example of the inquirer turning to a new body of knowledge to become more informed about this specific category as it emerged.

Despite the status of the relationship, midwives still attempt to include fathers in the event. *While I explain to both of them in labour, I know you have got to include them [fathers]. And it's their child, it's going to be their child afterwards, so it doesn't matter how bad their marriage is (011)*. Most of the participants commented on the connection between the couple's relationship and the impact on the birth. *Very occasionally, you may be aware of situations where there is a lot of tension between the partner and the labouring woman. Very occasionally they may not be working very well together and you may have to ask the father to go outside and talk through a few things. There is no one we try to exclude and we certainly do not use any criteria. If they are a dad, they are a dad and they are in (005)*.

Midwives seem to have an innate sense of the couple's relationship status. Given that some birth experiences may be very short in length, midwives still have the ability, through observation, knowledge and experience, to perceive difficulties in the couple's relationship. *Determining relationships it is like this intuitive thing you can walk into the room. The father could really want to be really involved in the labour but yet he is sitting with a magazine or newspaper and there is no communication happening. But yet there is a lot of communication happening. And I would say that within the first few minutes that I have got the whole scene sussed (016)*.

Childbirth discourses fail to consider the status of the expectant couples relationship at the time of birthing. While this issue is not a focus of literature, the participants described the importance of assessing the status of the couple's relationship to determine how to support and include the father in the birthing experience. Even where there were difficulties in the relationship midwives still attempted to include fathers in the event.

Personal and Professional Experiences

An individual's personal history, family background and personality can affect the way a health professional practices in their professional life. The personal experiences of the midwife, such as their own childbirth experiences and those they witness and participate in as a health care professional, can affect their attitude toward their midwifery practices with expectant couples. The category of *Personal and Professional Experiences* emerged from the data analysis to explain how the participants' perceive their intrapartum interactions and behaviours related to paternal presence in childbirth.

Personal Birth Experiences

Although the participants were not directly questioned on their personal experiences of paternal presence in childbirth, when questioned about paternal presence most participants described their own experiences of paternal presence and participation in childbirth. This concept explains the influence of personal experiences of paternal presence on the attitudes of midwives when including fathers in labour and birth.

The majority of participants identified their personal perspective using examples from their own births, their children's births, their family and friends. *I never really asked my husband what he thought. But I know he had very set ideas about wanting to be there. And he felt that if this baby was part of him, then he had a right to be there. And I think there has been a major change and it is good that we do allow that (001).* The midwives personal birth experience

of paternal presence was generally positive. *I remember with my own children and they are nearly thirty down to twenty-four, I wanted my partner there. So I guess it has gone back a long way. And he was able to be present purely because of our personal situation. He was able to be there because he was in the medical field. And it just felt right that he should be able to be there. I don't see why I should have been more privileged than other women, to be able to have him there, if I should want him there. So I guess I have been of that opinion for a long time that they [fathers] should be able to be there (010).*

Many of the participants described the event clearly. The memory of their partner's role in labour and birth is significant in how they perceive the fathers role in childbirth. *I remember my first birth. My ex-husband massaged my back for about six hours the next day he could not move his hands. And at the time he was the only one that was supporting me during labour. So I was expecting him to do a lot and I suppose that is what is normal (014).* One participant presented a strong opinion on paternal presence as she discussed her own births in a time of father exclusion. *I had had two children myself before the change took place. And I was alone, completely alone while I was in labour. And I just had the attendants with me when I was actually giving birth. So I can see this phenomenon from a mother's point of view and a midwife's point of view. It did help me to realise how alone a woman feels and how vulnerable a women is when she doesn't have that support person, even just the support person not only the husband. For those girls who don't have a partner it is very important that they be allowed to have their choice of support person, whether it is their mother, sister or brother even (009).*

Personal experience included the participants describing birthing experiences, such as their own mother's birth experience, whom they recalled as not having been given the opportunity of support from their fathers. *I look at men from my fathers generation and see how he relates to us and he missed nine of us. He was never allowed into any of our births. And I think that did have an impact. I*

mean there are a lot of other socialisation issues. But I often wonder how different our relationship would be different if he had been able to see exactly what my mother went through. As he has no perception of what childbirth is about (006).

Not being a mother herself, one participant noted how her father's interest in being at her birth influenced her practices. *I think it is wonderful for fathers to be part of it. As I can remember my dad saying that when I was born in 1972, 26 years ago, that he was working when I was born and he wasn't allowed in labour ward anyway. But he was at work and when I was born he came in and saw me at 10 o'clock at night and matron came in and ripped open the curtains and said what are you doing in here? Women are in their nighties and it is past visiting hours and get out. He had just had his first baby and it was a bonding moment and he had to leave and mum was left with a new baby. He was sent home and there was no attempt or effort to integrate them as a family. I think it is wonderful that fathers are now integrated into childbirth. It is a really good thing (002).* This perspective also demonstrates the rigidity of the hospital system and the absolute intolerance of fathers in parturition and the postnatal period.

Thomas (1994, p.2) asks 'what do midwives bring to the birth arena?' Commonly they bring their memories of their personal lives. *My husband was there when our children were being born and I know from what he said that he could never anticipate what it would be like. And I think it changes your relationship as a couple because you then move on to being a family. And that does not happen if you are not here, but it just it is just a bond that you share. And it is something special for the midwife as well (007).*

Observing Role Changes

When discussing midwives experiences with expectant fathers during the intrapartum period, the participants emphasised the evolving nature of the paternal role in labour and birth. The participants observed changes in role

boundaries for both fathers and midwives. Some participants identified the change to allow fathers into childbirth as an important change in midwifery practice. *I think it is a marvellous thing that fathers are able to be present. I think it is one of the best things we have ever done (009)*. Participants conceptualised paternal presence as an essential part of intrapartum midwifery care. *Women rely on their partners so much during labour. I believe they are an integral part of labour. And being present in labour is important. How we ever thought that fathers had no place in birth in the past really staggers me now (006)*.

In addition to understanding the father's role in today's society, many participants reflected on the historical changes and described their understanding in an attempt to alter their practice to include fathers. *It is an intimate role. It has to be, the baby is part of the two of them. I don't even think about it because it just happens all the time it is a natural part of life. You just accept it. But I certainly did nurse at the time they were not allowed in. And no matter what procedure you did on the wife they were thrown out of the room. That does not happen now they stay for everything. It certainly has changed (001)*.

The abolition of the exclusionary policy seemed to be remembered for the controversy it caused. *I was working as a midwife at the time of the change. I was working in the delivery suite at the [named hospital]. I was very much for it those days. There was a lot of controversy at the time (009)*. Participants recalled the changes taking place and the negative aspects of paternal inclusion. *It is not as bad as it was, at one stage there it was very difficult it I think we went through a phase when we had the Childbirth Education Association, not the classes as such but CEA, when they were really new and they would come in with a very aggravated attitude, or a negative attitude to what they were going to find in hospitals. Fathers and mothers were both negative you know. It is not anything like it used to be. They were very strongly opinionated people*

(003). Participants noted the presence of the CEA in advocating for paternal attendance in this local area. Participants were aware of the changes to permit paternal entry and further support the evidence from the survey results in Chapter Two.

The experiences and memories of the participants regarding the admittance of fathers into Australian labour wards were consistent with national survey results identified in Chapter Two. Participants could identify the time of changes by linking it to a significant event in their life, such as the birth of child, marriage or career event. This was evident in the survey comments and is also highlighted by the following participant quote in which the participant qualifies the time period by stating she was a student midwife at the time. *I was only a student when it [fathers permitted into birth] first started here and I was not aware of most things and most of the CEA policies probably went over my head. I just know that it was all new that sort of thing (003).*

The participants commented on the attitudes and power relations that accompany midwives actions and interactions in labour and birth. Brazelton and Cramer (1990) observed that, despite great advances in involving fathers during pregnancy and birth, the forces that have historically excluded fathers are still strong. *I was 22 at the time. I look back and wonder how I could be so naïve and accepting and everyone else was at the time too. And to practice like that for some time and not really think about that. Hang on this is not right, like I said before, I was doing my midwifery training when men were first included in the birth process. And they were only barely tolerated and it was like, you are here under sufferance. And that was made perfectly clear to them from the word go. You are this child's father and you have a right and we are observing your right and respecting your right to be present. And you know like one quip out of you and you are out. And that power and control thing, I think how stupid and how sad. I think it still exists in some staff members (006).* Some participants

implied lingering traces of paternal exclusion still exist in some midwives actions and interactions with fathers in labour and birth.

Role changes have occurred for both the midwife and the father. The abolition of paternal exclusion had a marked effect on the majority of participants working with labouring women at the time. Specifically, changes have occurred to the boundaries of midwifery practice. Since the arrival of fathers into childbirth, the midwife's role in birthing has become largely one of surveillance or, as Miltner, (2002) suggests, contemporary intrapartum care should be considered as a supportive surveillance model of care. This involves the midwife undertaking activities such as interpreting fetal monitoring, monitoring maternal vital signs, documenting, administering analgesia and epidural anaesthesia care (Miltner, 2002). Thus, the midwife's role has been reduced to assisting with the technological aspects of birth, to the detriment of their supporting role. *I think the woman is much more relaxed, because she has got someone there who cares for her and who knows her and can speak for her if she feels unable to speak for herself. I think fathers give that emotional support you would have to give if he were not there to support her (007).* Odent (1999) supports this, claiming that paternal participation has largely contributed to the role of the midwife being reduced nowadays to one of technique. *He came in supported her and he basically did all the support. She had other support people there. But he was the one who did the main supporting. He was the one she held on to and wanted around (006).*

Moreover, the concept of surveillance has also been linked to the operation of power as Foucault (1972) posited an increase in surveillance leads to an increase in disciplinary power. Surveillance is made more powerful (Fahy, 2002) and legitimised through technical gazing, such as the use of monitoring technologies. Hence, although midwives may have reduced their level of physical support for the woman because of paternal participation in birth, their power and possibly status are preserved through the power of surveillance. The

importance of technological care is seen in Miltner's (2002) observational study in which midwives described the importance of women ambulating to facilitate labour, yet during her observations only 2 of 75 women in her study were allowed to ambulate, out of the room without the fetal monitor. Similarly, Bondas-Salonen (1998) reports that women described midwives as only coming into the room now and then to enquire how they were, in contrast the women reported the positive presence of their partner throughout the entire labour and birth.

More recently fathers have been allocated basic primary tasks, such as assisting with showering, massaging and general comfort measures. Being assigned primary tasks is conceptualised by some participants as including fathers in the birthing process. *We actually focus on the role and importance of support. And we do look at roles and we look at comfort measures in the class. And that comfort measures are nature's pain relief mechanism (006)*. Allocating primary tasks to fathers is also conceptualised as allowing the couple to experience the birth with minimal interruptions from others, including health professionals. *But the dads who come love it. And they can be involved, as much as they want to be. I guess how I see my role as a midwife if that is of any interest to you is fill in the gaps. So that to let them work as a couple as well as they can. And to just fill in if they need any little help with any area. And to intrude as little as possible in what is one of the most intimate moments of their lives (010)*. As one participant observed it allows them to bond together more easily. *I think that they have a very important part not just in their physical presence at the birth but also in that they do things for the women. They provide all those nurturing things like understanding and a bit of tenderness and all that kind of stuff, that women need. We [midwives] also provide that but that coming from their support person is very important. I think it even helps bond them even closer [together](006)*.

Intrapartum midwives, who work with fathers, discuss the role of the father in labour and birth as a supporting one. The supportive nature of the paternal role

is reflected in the words of one participant who values her unique role in the couples birthing experience. *I think it is fabulous it is great. They know the woman far better than us. They discussed what they want to do before hand. And he is there to support her it is their experience really. And we as midwives are part of that. I feel privileged to be part of the process (007).*

The participants viewed the paternal role as taking on a status gap between midwives and health professionals and the labouring woman. Participants perceive this essential involvement as necessary when acting as an advocate for their partner. *They definitely take on a status gap. They are the kind of guys who attuned to the woman and anticipate their needs and will support. You have rapport with them as the midwife, instead of just the woman. Instead of having to ask them they will do it. They offer you more help and seem to be more interested and anticipate the midwife and the woman's needs more (002).* Previous findings have also conceptualised the paternal role as an essential 'go-between' (Richman, 1982; Lewis, 1986; Beaton & Gupton, 1990).

The concept of forcing fathers to participate was raised as an important issue for the participants. The participants were cognisant of the need to limit the pressure on fathers to participate. *Because it seems to me that in the last thirty years, when I had my children fathers were not allowed in, to be present at all. And we have expected them to do a complete reversal to the point that we are now expecting them to be there. And now we are almost forcing unwilling subjects to be there. So that I think it has got to be very flexible and it has got to be up to the couple to decide what they want (010).* Although midwives observe that it is the norm for fathers to attend and participate in the birth of their children, they also perceived that fathers should not feel compelled to be present simply because they can. *But if it has been a decision that mostly the woman wanted then not the man, then the man sometimes feels pressured and they give in or allow it to happen. I don't think that they should feel as though they have to be there (008).*

The father's role in labour and birth is still being defined, yet midwives expect paternal participation and work hard to allay the father's concerns related to participation. Currently few guidelines exist on the paternal role and responsibilities in labour and birth. However, participants identified that if the midwife includes fathers in the antenatal period then fathers will know what their role is during the labour and birth. *So I think that the midwife should include them [fathers] as much as they can. The fathers are included right from the beginning, in classes and they know when it comes to the birth process what their role is (011).*

Summary

The focus of this chapter was the antecedent conditions of the paternal-midwife relationship in childbirth. The categories of the *Midwives Attitude Towards Paternal Presence* and *Personal and Professional Experiences* were discussed. As part of their perspectives on attitude, the participants identified their personal and professional perspectives of paternal attendance and participation using examples from their own births, their children's births, family and clients. It was evident that these perspectives were also consistent with their descriptions of their own practice relationship with fathers in their current practice.

Chapter Nine considers the processes midwives use when working with fathers in childbirth. Paternal-midwife interactions arise out of the complex interactions that connect the meanings and experiences from everyday practices within the context of labour and birth. The categories that described the participants' interactions when working with fathers include: *Building a Rapport* and *Advocating for Fathers*. These categories are discussed and supported by the participants' observations of the main themes involved when interacting with fathers in labour and childbirth.

CHAPTER 9

THE INCLUSIVE RELATIONSHIP:
WORKING WITH FATHERS

All the way through it is very important to include fathers and our role is that we are encouraging that all the way through. And even so some men will ask us for some odd funny things and so what. I had one guy who wanted to put candles all around the room. So that is fine I just took the oxygen out. And I didn't question him as to why he wanted to do this. As this was something they had decided to do between them, so I wasn't going to say no you couldn't do that (009).

This chapter presents the findings related to the processes used by midwives to determine, deliver and communicate with fathers in childbirth. During the interviews participants' were questioned on how they act and interact with fathers during childbirth. While there may be some differences in the midwives attitudes towards paternal presence in childbirth, the participants consistently described the supportive nature of their actions and interactions with expectant fathers. The chapter explores the actions and interactions of midwives when working with fathers in childbirth.

According to Mead (1938), the interpretation of symbolism occurs by taking the role of the other. In relation to this inquiry, his theory suggests that the midwife observe the acts of the expectant father, take the role of the expectant father, interpret the symbolism and adjust her responses. While there are minimal codified policies or guidelines for paternal participation, several themes emerged to explain the strategies midwives use to include fathers in the birthing process. This chapter discusses the two of these themes *Building a Rapport* and *Advocating For Fathers*.

Building a Rapport

Midwives determine how to act and interact with fathers based on their attitudes, values and their ways of knowing based on previous personal and professional experiences. They deliver through communicating by building a rapport with him to assess and respond to his needs, they communicate as an advocate to support him in his role. The participants perceive building a rapport with the father as an integral part of establishing an inclusive relationship. Rapport building is critical in effectively negotiating and implementing midwifery care for the woman and her partner. For midwives rapport is a means of working with the couple and assisting them in the birthing event. *You have rapport with the father as the midwife, instead of just the woman. Instead of having to ask them they will do it. They will have a joke with you. They offer you more help and seem to be more interested and anticipate the midwife and the woman's needs more. They are the fathers who are really excited afterwards and often cry and are genuinely interested in. Not just because they are pressured by their partners (002).*

To assist fathers participating to their full potential the participants spoke about building a rapport with fathers. The rapport building strategies exist as an integral part of this relationship. Building a rapport involves the midwife orientating the couple to the birth environment, and assessing the couple's expectations and individual needs. The participants in this inquiry were cognisant of the limited time, resources and opportunity to develop the kind of supportive and continuous relationship in which fathers are able to discuss their concerns about childbirth. *I think one can make rapport very readily. I think it is an unspoken and spoken kind of thing. A snapshot of six hours is ok (012).* During the data analysis two concepts emerged, *Orientating* and *Needs Assessment*.

Orientating

The participants perceived orientating as essential to getting to know the couple, their expectations and needs. The orientation session is largely context based and is the first step in forming a working rapport between midwives and the labouring couple. Getting to know the midwife and the birth environment is also an essential element of orientation sessions. Participants identified the need to have some degree of familiarity with the couple prior to the birth. *I think she (sic) [the midwife] needs to explain to the couple everything that is going on. I think they [midwives and fathers] build a rapport quickly. Rather than just focusing on the woman, she (sic) [the midwife] needs to address both of them to tell them what is happening, what they are doing and what they are planning (012).*

Orientation is grounded in the belief that midwifery care is viewed as a partnership between the couple and the midwife. Midwives orientate the couple to the physical aspects of the birthing room. *Just even have fathers come up to labour ward to have a look around. And if you do it in small enough groups then you should be able to get a conversation going. Then you could talk about what goes on in labour ward, what is normal and what is not normal (007).* Participants viewed sensitising the father to the birth environment as an important orientating consideration.

Knowing the physical environment may reduce what Richman and Goldthorpe (1978) describe as 'entrance trauma', commonly experienced by first time fathers within the hospital birth setting. For example, when the couple arrive at the birth venue for the impending birth, the couple are often separated, with the woman being removed by the midwife for examinations and relevant procedures. It is during this time the father can feel isolated from the event and his partner.

Childbirth orientation processes involve activities such as hospital tours, which

usually include a visit to labour ward, birthing room, nursery and postnatal wards. The type of orientation activities varied between the three birth settings. Home birth midwives and midwives working in birth centres discussed how they commonly meet fathers during antenatal visits and classes or information sessions. *Certainly we encourage them to come to classes and attend [prenatal] visits as much as they are able. And that will vary, some will come for the first visit and maybe the labour plan and others will come for every visit and asking questions and getting involved. Once again it is individual cases you need to cater for. And the dads will have different needs. Some will have done quite a lot of reading before they attend. Others will be absolutely the new kid on the block and terrified and so you just have to work with them as individuals (010).*

Midwives realise that childbirth and transition to parenthood can be stressful to some couples, demonstrating that others have had similar experiences is often viewed as being helpful to alleviate some anxieties. *We stress to the partners how that they are an integral part in how women cope with the intensity of her labour. As well as your physical presence and I stress how important their physical presence is and relate an interesting story, one of my anecdotes from my labour ward days (006).* Sharing personal information is a commonly used communication tool by midwives.

The presence of fathers at birth creates unique opportunities and challenges for the midwife while caring for the labouring woman. The midwife must address issues of the father's role and responsibilities within the birthing processes, while also maintaining a focus on the woman. Thus, midwives identified the importance of building a rapport prior to the onset of labour and establishing the father's role in labour and birth. *We always try to meet the husbands before the labour. And usually we have spoken with the couple about what the husband may do in labour and delivery (005).* Having established a rapport with the father before the onset of labour eliminates the need to build a rapport during

labour. *Fathers also participate in the birth plan, because we encourage them to come to as many [prenatal] visits as they can. Or as many [prenatal] visits as they are able to, so that they are comfortable with us. So they do not have to try to build a rapport with us during the labour. I quite like having the dads there, because the women relate so well to their partners (006).*

Orientating the couple helps maintain a better rapport with fathers, as familiarity promotes a close working relationship with them. Midwives understand that labour and birth carry significant meaning for the woman and her partner. Underpinning the midwives actions and interactions with the father is the importance of his support to the woman. Midwives described how knowing the couple before labour assists the midwife in involving the father in the birth. *As much involvement as possible is good but it would be a lot easier if you could meet the couple antenatally. Like any birth that I have participated in it is the woman who births the baby. And it is like the midwife is just the observer (016).*

During the orientation session midwives attempt to ensure that fathers feel comfortable with the birthing event. *You try and inject a little bit of relief into the classes so that they can feel a little bit more comfortable with the whole thing. They have been waiting for this moment for so long and to see it all, it is just the most amazing time (010).*

Midwives viewed themselves as the orientating agent. They would provide the couple with necessary information to prepare them for the birth and postnatal period. *When they are in labour I tend to introduce myself and sort of make sure that they the labouring couple, know who the carer is. I also firmly believe in getting the partner to do as much as possible. Because of the belief that I am not the one who needs to be there. I need to be there for a certain degree. But I believe that my support is helping the partner to know what to do. Rather than me massaging I would prefer to show him what to do and he massage the labouring woman (013).*

Most midwives do not meet the childbearing couple until they present for the impending birth. Thus, it is a difficult process to establish a relationship among the many variables they are confronted with during labour and birth. The time period can last from under an hour to more than twenty-four hours. So, for some, it is part of a routine. Although the orientation process usually occurs for both, tasks were mainly allocated to fathers. *It's a routine. I show them where to put the luggage. I make sure that they are right with the car. Like where have they put it? Is it in the right place? What hours are they able to leave it? So they know they don't get a ticket. Other than that it is your job to mop the brow and look after the water, other than that I just play it by ear. I always make sure that the fathers are fed and watered. Make sure you go and get some lunch, or meal at that time of day, so that they do not pass out. You have to look at it as they are individuals. You have to treat it individually (003).* Through informal conversation and observation midwives form a rough judgement of the tasks that may be allotted to the partner (Somers-Smith, 1999).

The orientation routine is also part of the midwives interactions in the birth centre environment. *In the birth centre we include the husband or father in the antenatal visits. We explain to him as well as to the woman what is actually happening to the woman's body and the changes that are taking place. We even talk to them about the reasons for scans. They come to our classes we encourage that. I don't think that we have ever had anybody not come in the birth centre they know that is part of the deal here. Because the women are motivated here, so it does make it easier for us. The fathers are included right from the beginning, in classes and they know when it comes to the birth process what their role is (009).*

In contrast to previous findings, which suggest fathers are isolated from the birthing experience (Barclay et al., 1996; Newburn & Singh, 2003), the participants described labour support techniques and strategies implemented to

include fathers. Participants described the use of orientation sessions to develop a rapport with the father. Participants identified specific skills implemented to involve and include the father, while maintaining the focus of care on the woman. These skills include building rapport with the father and identifying the father's individual perspectives and expectations and encouraging participation by listening to and addressing the father's concerns. A fundamental concern in the establishment of an inclusive relationship is the need for the midwife to establish rapport and maintain a trusting relationship with the father. Rapport is critical in effectively negotiating a plan of care with the woman and her partner.

Needs Assessment

Participation in labour and birth is often more demanding than expected for expectant fathers. Identifying and anticipating needs is an important aspect of the establishment of an inclusive relationship. According to Mead (1938), life proceeds on the basis of people anticipating what others are about to do, and by observing the incipient acts in the gestures of others. The data in this inquiry suggests that midwives not only observe the incipient act but also complete it or demonstrate to the other how to complete it. Midwives support fathers by assisting and completing acts on their behalf. Specific acts include supporting the father emotionally and physically. The extent to which these acts can be performed determines the level of inclusion in the establishment of an inclusive relationship.

Needs identification by midwives originates from their attitudes to paternal participation in birth, their knowledge of birthing processes, personal and professional birth experiences. These experiences enable them to consider how they can best respond to the fathers needs. Anticipating and responding to father's needs in childbirth involves a combination of strategies. Most midwives described how they assessed the father's knowledge of labour and childbirth. Determining the father's level of knowledge was important to establishing what level of support may be needed. *A lot of people are well read and they know an*

awful lot. So they will want a different level of knowledge and some people you can just blow them away if you give them too much technical detail. They do not want to know that they just want to know that they are safe. And that you are going to care for them and keep a safe environment and be happy. So I think that you have to assess everybody (007).

Participants described ways of gathering information to determine the father's needs. *So how to assess their needs, I have a list of potential discussion topics which are just your common pregnancy, growth of the baby and stages of labour and vaccination those sort of things. And pain management in labour and parenting after the birth. I have a library of books I carry in the car. The parents are quite welcome to read them and give them back next time. So maybe with the list of things, for the couple to go through and identify of which of the topics do they want more information about. Which ones they would like us to talk about. Most of them because they choose to do a home birth have done a lot of reading already. Before they choose their midwife they know a lot of information about pregnancy, about birth about labour (008).*

Somers-Smith (1999) suggests that the expectant father's needs should be assessed regularly during childbirth, as some fathers may need more support than others. Participants recognised that assessing paternal labour and birth needs is challenging to midwives. *I think that assessing everybody is a challenge. I think that is what makes labour ward and midwifery so exciting. I think most people rise to the occasion. Are there specific things that you assess, when you are assessing that level of knowledge. It is just a routine thing you do as part of your care. You usually ask them to find out how much they know. And just say ok and then from watching them and seeing their reaction you then know if they want any more knowledge or if they are going to be glassy eyed and that you are going over their level. I think it is just a communication process. We all communicate differently, you are doing it all the time, assessing (007).*

Assessing paternal needs is commonly undertaken prior to labour. *Their level of knowledge is something I want to find out before the actual birth (016).* Identifying paternal needs prior to labour is perceived as an integral part of the preparation for birth by the couple. *We in the birth centre are in the fortunate situation where we get to know couples before hand. So it is very much easier for us than for midwives working in labour wards to tune into to what those needs are. Because we have plenty of opportunity to discuss those leading up to the birth, such as preparing birth plans and so on. So that you know the couples pretty well by the time you get around to it. I hope that we do it sensitively (010).*

The nature of paternal-midwife interactions differs from the therapeutic nature of the maternal-midwife relationship. During pregnancy a woman usually undergoes the rites of passage and this continues as she enters the final phase of the birthing process. During antenatal preparation, she has been socialised to the birthing environment and associated language, regulations and rituals. Jordan (1990) reported that fathers often feel excluded from the childbearing experience by health professionals and society.

Midwives often use antenatal classes to assess the father's understanding of his role in labour and birth and determine what his needs might be in this period. *That is why we particularly invite encourage them to a series of prenatal classes. We stress to the partners how that they are an integral part in how women cope with the intensity of her labour. And we do look at their role and the role of other support persons and the role of their midwife. And we identify what is it in their role that they do. How do they see their role in their partners labour? (006).*

In summary the processes of assessing the fathers needs are crudely implemented in relation to fathers in childbirth. The majority of the participants

indicated that they assess the father's needs, albeit in an informal manner. For example, home birth midwives indicated that they have a list of assessment questions to ensure that they are meeting the needs of the couple. The birth centre participants indicated that the father's needs are assessed from the first antenatal session and followed through and reassessed at the onset of labour, they are also continually reassessed throughout the labour and childbirth.

Rapport building strategies exist as an integral part of the paternal-midwife relationship. Such interventions serve to support and promote paternal participation in labour and birth. Participants actions and interactions through orientation activities and needs identification strengthen the notion of the establishment of an inclusive relationship between the father and midwife. Midwives support the father through his transition to parenthood by building a rapport and assessing his needs. Needs awareness informs the midwife of the support needed by fathers to effectively assist his labouring partner. The participants' rapport building and needs identification actions and interactions reinforce the importance of including fathers in all aspects of labour and birth including antenatal preparation.

Advocating Paternal Involvement

Advocating paternal involvement is pivotal to establishing an inclusive relationship with the expectant father. With the advent of paternal participation, advocating for fathers is viewed as a necessary part of the midwives role in assisting the father to meet his needs and his partners needs. *As a midwife I feel like an advocate for fathers. I think it is wonderful for fathers to be part of it (002)*. The participants are cognisant of the lack of status that fathers face within the current model of midwifery care in Australia. Although their role as support person is established, fathers are limited in their capacity by the constraints of this model of care. Because of their lack of status, fathers are placed in the vulnerable position of advocating for their partner with limited knowledge, status and support. From the participants perspective, midwives are

in an exclusive position to support and advocate for fathers as part of their provision of family centred care.

In enacting the advocate role for fathers participants observe the father and assess his needs. Then, through interpretation of their actions and interactions, midwives become familiar with the routine symbols of expectant fathers actions and interactions and respond to those needs. Playing an advocate role is viewed as attending to the identified needs. The three themes related to the advocacy role include: *Limiting Intrusion*, *Advising and Informing* and *Collaborative Decision Making*.

Limiting Intrusion

Midwives value the importance of not intruding in the couple's personal birthing space and not allowing others to intrude. By limiting intrusion the birthing experience remained unique for the couple. Limiting intrusion was accomplished by removing unnecessary intrusion from the birth process, such as overbearing family members or friends. *I usually ask if there are other support people, I ask the woman would you like everyone to leave, I say it quietly. I say to the support people I just need to do something can you pop out for a cup of tea. I will come and get you when I am finished (006).*

Birth in the twenty-first century has become a public event, for many it is an acceptable behaviour in which to be part. Boundaries have become blurred because birth has become a private event within a public arena. As well as being under the medical gaze, society also views childbirth as a public event. *It is not a private event anymore, it is public anyone can come into labour ward. It's a free for all. Come in and have a visit, help yourself. They would stay for the birth if you let them (002).* Birth centres and home birth environments offer more room to accommodate extended family members and friends. *Most fathers are welcomed to come in. Even when there is extended family, it is the father who will be chosen to stay (012).* Despite welcoming others to the event

midwives perceived that it is the fathers who should be there throughout the labour and birth.

The presence of other supporters and family members can influence the father's birthing experience. *I think they do get limited by having others around. I think that they take a back step, because I have seen women have sisters or mothers and then they take on the holding, stroking comforting and the husband stays there. And emotionally he may be supportive and he might say verbal supportive remarks but he is not doing the touching. So he is pushed back a bit. And perhaps that is just the family dynamics where he wants to please everybody else. I don't know we don't see these people very often and it is difficult to know (007).*

Having intruders in the birthing process also inhibits the midwife from effectively including the father in the birthing experience. *Because there is such a constant flow of traffic and you never get to just sit down and talk to them and just answering lots and lots of individual questions and people just walk out. You might not see them for a couple of hours and then more other people walk in. I think it loses the whole feeling of intimacy of the whole experience if there are a lot of people there (007).* Moreover, participants acknowledged that having more than just a couple disrupts the personal nature of the birthing experience for the couple. *When I was planning to have children they did not allow fathers in, but when I had my children, husbands were allowed in. And it was sweet and lovely and they cried. It was then just restricted to husbands and I think it was a personal thing. But it becomes very overpowering when you have grandmothers who come in and take over (001).*

The processes of limiting intrusion enable midwives to promote birthing as personal and unique to the couple. *But other cultures have vast numbers of people present, all the other women of the family. So it is up to each couple to decide what is right for them. That is what you have to do, try and make this*

birth special for them they are only going to do once, twice, three times in their lives. And it has got to be something memorable and it is our job as carers to make that as unique and special as we can achieve (010).

Midwives recognise that the birth should remain a private occasion, particularly, as many fathers view this time with much emotion. Attendance at childbirth can be considered as a potentially stressful situation for fathers. As previously noted in Chapter Three, fathers have reported feelings of anxiety and helplessness during labour and childbirth (Nichols, 1993). Opening the birth event to those, other than the labouring couple, has resulted in the midwife needing to act as an advocate for the couple. Midwives encouraged the expectant couple to make the birth experience theirs rather than an extended family and friends event. *We have had instances where the couple has really wanted to be on their own. And we have had relatives and mothers who have pushed them [father] to one side. It is those parents that I just feel so sorry (001).* Midwives spoke of overbearing family members interfering with the supportive role of the father. *And I think fine if you do want other support people. But you do have to watch that don't take over (001).* Midwives will 'remove' intruders when necessary. *And there have been times when I have had to ask mothers to go, to leave the room because they were just too destructive. And distressing the woman too much and not everyone wants anyone else except their partner in with them (006).*

Several of the midwives working in the labour ward environment spoke of the experience of tension between accommodating the extended family and trying to establish a relationship with the childbearing couple. The presence of additional family members limits the ability of the midwife to develop a relationship with the couple. *I think that some midwives feel it is a problem if you have a husband and support people as well. The room gets really crowded and there is a huge issue here [labour ward] about how many people you can have in the rooms. I think midwives get quite stressed out when there is lots of*

family and I think it is because the relationship never develops between the midwife and the woman and the husband (007).

The father's role, expectations and experiences of birthing depend largely on the midwives level of advocacy for his role in birth. The midwives in this inquiry illustrated how they act as an advocate for the father in labour and birth. Midwives balance the tension of including family members and the need to establish an effective relationship with the couple by limiting the number of people in the room. In particular midwives will reduce the number of family members and friends because of space, resource restrictions and more significantly their impact on the personal nature of the birthing experience for the couple.

Informing and Advising

Informing and advising before and during birth are processes midwives use to support a sense of paternal advocacy and inclusion in birthing. *I just think that antenatal education is very important, we need to give them books to read, get them included (013).* Chapman (2000) observed the importance of birth preparation for the father. She claims it is essential that fathers be informed on birthing processes, the women's responses to the pain of labour contractions and possible methods of support (Chapman, 2000). *We explain to him as well as to the woman what is actually happening to the woman's body and the changes that are taking place (009).* Knowing the normal responses to the effects of labour might reduce the father's levels of anxiety, frustration and sense of helplessness during birth.

Midwives inform fathers throughout the birth process of what is happening and advise them on certain aspects of their supporting role. *I think that it comes down to a knowledge thing. Fathers do not have enough knowledge in the labour ward. But we as midwives are here to tell them what they want to know. I think the skill of it all is to keep giving them little bits of information and to develop it as they ask (007).* Midwives described the importance of providing

just enough information for the father to feel comfortable in his role. *Deep down I do not make it such a habit of educating the father when they come into the labour ward. I am more inclined to do as we go along. Would you like to do this and if go to do something I say well you can take over this now. But just make sure that she drinks regularly. And when it comes to massaging I show them how to do it. If you just do it as the need arise then the father can then do it more effectively. And the fathers do not have to take so much on board then. They hopefully can do it fine then without pressures (004).*

Childbirth research has revealed the importance of informing and advising fathers on the processes involved in birthing (Barclay et al., 1996; Vehvilainen-Julkunen & Liukkonen, 1998; Newburn & Singh, 2003). In particular expectant fathers often seek information to help them understand physical birthing processes, clinical procedures and their partner's needs. The participants stressed the importance of informing and advising fathers of procedures during labour and birth. *Try and explain what you are doing to the woman all at times, explain the benefits and of course you have got to explain the side effects and try a make them a part of absolutely everything you do (011).*

Providing information has been linked with a favourable birthing experience, whereas a lack of or inconsistent information adversely affect a couple's birth experience. *It would be harder still if they have no knowledge of what they are doing. And that it is normal. It is just too scary for them. If they do not have any real knowledge about this then you have no expectations for this. Then it is going to be a shocking experience. Where it can be such a wonderful event [in which they] feel like that they have really contributed to helping their partner go through this birth. And help them to be able to tap into those natural resources that nature has provided (006).*

Informing fathers is recognised as an important aspect of including fathers in the birthing processes. Midwives provide information by identifying the level of

information required by each father. However, current research has suggested that midwives are not meeting all men's information and support needs (Newburn & Singh, 2003). Participants described the difficulty in knowing the appropriate level of information and advice required by each father. *But I don't really think, that unless it is happening to you a lot of people know all these things but they don't take it in as fully as until it happens. I think that you can get people pamphlets but I don't think it has that much impact on the fathers. So perhaps if you were giving information consistently all the way through then they would absorb it. Then when it comes to the event and you say this may happen, it still maybe a shock and they will have lots and lots of questions about it. But they would have constant information throughout (007).*

While midwives acknowledge that expectant fathers may be knowledgeable about the birth process they may lack insight into the specific stages of labour. *Although I think that most fathers are fairly knowledgeable of the birth process. I don't think that fathers are fully aware of the different stages of labour. Even though you talk about the different signs of first stage, transition and second stage of labour, it is usually in the transition phase that the man will usually want to move around and the woman doesn't. This is the time you sit still. They are not aware and the woman sometimes might tell them off and get quite ratty with them. Sometimes they get a bit offended with that and you have to keep reminding them that your do not take any personal offense to what the woman says during labour (008).* Hallgren, Kihlgren, Forslin and Norberg (1999) also observed that fathers often feel unprepared for the processes of birthing.

Lacking knowledge on specific aspects of birthing may be a result of limited availability of relevant literature. It was noted by the following participant that there is a lack of available literature to support the father, particularly in birth and postnatally. *You know the literature of fathers in labour and in the post partum period is just so dearth. Like that there is nothing out there. And even if a father wants to be proactive about what is expected of him. Or what is the*

father's role they can't even find out anyway. So it is just that they are going in there blind (016). Until recently literature specifically targeted at the father has been limited, however with increasing interest in fatherhood and paternal involvement in birthing, more literature focused on the father has evolved (Robertson, 2002).

Midwives discussed the importance of antenatal preparation and focusing education on fathers as well as their partner. *I just wish that there were antenatal classes for men as well, that talked about topics like do you want to be there? What are you going to see? Today a lot of fathers do not make it to the antenatal classes, because they are working or because they have other commitments and they just go in there blind. And you are not sure of their level of knowledge or what they understand. And although they are standing there nodding they really do not understand anything that you have said (016).* Informing fathers in the antenatal period also helps to reduce any fears the father may have. *So I think we need to talk to the husbands about their fears and gradually I think that if you do it right from the beginning like we do [in the birth centre]. By the time it comes to the birth, showing videos and explaining things in detail, then when it comes to the birth, they feel like they will be ok (009).*

Moreover, including the father in the teaching processes is viewed as integral to family centred care. *But I do think labour needs to be more family centred and more parent centred. Do not just teach a woman. The midwife should teach the couple (013).* Participants observed that it is important to keep the father informed regarding birthing processes and his partner's needs during childbirth. Informing and advising fathers on birthing processes, their partner's needs and supportive techniques enables midwives to promote the father's inclusion in birthing. Midwives described how they inform fathers of their choices and prepare them with relevant information.

Collaborative Decision Making

Informing and advising expectant fathers enables them to feel more confident in making decisions with their partner. The participants reported that fathers were more likely to use the information and advice they received to collaborate with them in the decision making process. Involving fathers in the decision making process was seen as part of their professional practice. Midwives welcomed the father's role in decision making. *They get very involved they are encouraged to ask questions. And they also are very encouraged to read books during the antenatal period if they want to. But we try to get them involved in the decision making as well so it is a more of a family thing, rather than an individual thing. Because part of our philosophy is to get the whole family involved (005).*

Midwives encourage fathers to ask questions and participate in decision making, particularly in relation to pain relief methods. *I think when you talk to a couple you should talk to them as a couple. And know them and not just focus on the woman. You need to involve them in the care, the support. You need to involve them in the decision making and asking questions such as and how you feel about her having a caesarean, or how do you feel about her having pain relief (013).*

Being informed is central to enacting an active role in decision making. *I think that if they are very informed they can be the woman's advocate. And they have spoken very much with their partners. But I can see that if they have not spoken too much about pregnancy and birth antenatally then I see that there may be a problem when they are confronted with a situation and they try to be an advocate but he does not really know the wishes of the mother (013).* Midwives were satisfied if the father's decision making was congruent with the labouring women's expectations and wishes. *I think that in the long term if you have not discussed it in great depth with your partner then all of sudden you are confronted with do we have the forceps? Do we have a Caesar? Do we have*

this? Or do we have that? Then he cannot make this decision because he has not been informed. But if he has been informed truly and he has read and they have discussed it then I think that he can make that decision because they have done their reading (013). Participants identified that being informed is crucial to being able to make, and be included in, decision making processes during the labour and birth.

Home birth midwives viewed providing information to fathers to assist them in decision making as a routine part of antenatal care. *What most of them want to know is on pain management. So we talk a lot about that but because most of them have done a lot of reading you really don't have a lot of antenatal education as such. You answer the questions they have got and provide other information so that they can make informed choices. On issues such as the newborn screening test, on vitamin K injection, routine use of Syntocinon and they make their decisions from the information you provide. It is mostly written information. You mostly say read it and we will talk about it afterwards (008).* Fathers are encouraged to be involved in decision making and to speak up if they have concerns regarding the birthing processes. *But certainly I always emphasise that things that may be happening are not always right. And it is up to the father to speak up (016).*

Fathers it seems prefer to have a shared decision making role with the midwife. Thus, fathers who seek active involvement in labour and birth achieve it through questioning and observing the midwife for cues. *Fathers involve themselves by watching the Cardiotocograph (CTG) and [by observing] what the midwife does and I think that they are just trying to find their place in the process. They are trying to fit it and it is very alienating. Men are always interested in technical stuff anyway. I think it is just a way of breaking the ice, they are interested in what the midwife is doing. I think it is a way of them assessing you, seeing if you know what you are on about. And then they can relax and get on with just being there and enjoying the experience. They look at*

midwives for cues on what they can and can't do (007). Fathers place trust in the expertise of the midwife when determining their role in decision making. That is definitely it. A lot of it is when the midwives are with them. To let the dad be involved and he will take cues from the midwife (002).

There is considerable debate regarding patient participation in medical decision making, particularly its effect on patient satisfaction and outcome. Several authors have studied the woman's experience of and satisfaction with, their involvement in decision making during their pregnancy and birth (Health Department of Victoria, 1990; Callister, 1995; Gibbins & Thomson, 2001; Harrison, Kushner, Benzies, Rempel & Kimak, 2003). Despite the level of interest, little is known of the level of participation by both the woman and her partner in decision making during labour and birth. Tait, Voepel-Lewis, Munro & Malviya (2001) claim the traditional paternalistic approach to medical decision making is moving towards a climate of greater patient and/or surrogate involvement. Despite changes to allow greater involvement in decision making by patients limited recognition is given to the paternal role regarding decision making in labour and birth.

The findings from this inquiry revealed that the participants would prefer fathers to play a more active role in decision making. They encourage this by informing fathers of the various options available for his partners care. Informing fathers and enabling them to make informed decisions is viewed as increasing the father's sense of involvement and inclusion in labour and birth. Midwives are in a unique position to advocate for paternal involvement, they have the knowledge and experience to advocate paternal involvement. However, a critical examination of the literature reveals that advocacy of the paternal role is not considered an essential component of the midwife's role.

Summary

This chapter described the processes by which participants enact their role in their relationship with the expectant father. The participants articulated several strategies aimed to assist, support and guide the father during labour and birth. The concepts of building a rapport with fathers and advocating for paternal involvement emerged as an important part of the inclusive relationship. Participants discussed how fathers sought help to make the event more private and personal by limiting intrusions, by asking for information and advice when necessary and turning to them for support in their decision making.

Chapter Ten considers the supportive nature of the paternal-midwife relationship within the boundaries of the birth environment. The participants explain the support strategies they use to include fathers within their work environment. These strategies are implemented despite the limitations of workplace restrictions in an effort to accommodate the couple's childbirth expectations and needs.

ESTABLISHING AN INCLUSIVE RELATIONSHIP:
WORKING WITHIN THE BOUNDARIES

Sometimes just changing the space changes the dynamics (008).

This chapter examines the impact of the birth environment on establishing an inclusive relationship. The importance of the birth environment and associated nuances cannot be discounted in the paternal-midwife relationship. Moreover, fathers are generally unaware of the nuances of the birth process, which serves to further isolate him from participating fully or being considered an integral part of the birthing event. In this sense, the birth context is an important determinant of collaboration and participation between fathers and midwives. To assist fathers participating to their full potential the participants discussed strategies aimed at reducing their fears and concerns and making the fathers feel comfortable during the labour and birth. The participants were cognisant of the limited time, resources and opportunities to develop a supportive relationship within the boundaries of the birth environment. The two main categories presented in this chapter are *The Supporting Partnership* and *The Boundaries of the Birth Environment*.

The Supporting Partnership

The notion of the supportive partnership was evident throughout each of the transcripts. The supporting partnership involves the father and midwife working together to assist the woman to achieve her expectations of birthing. The development of a supportive relationship between the couple and the midwife is viewed as an important component of midwifery care. *So I think you need to do it by a partnership, because the father is there (007)*. The participants believe midwives have progressed from the perception of a partnership with the expectant mother to one which includes the father. Supportive attitudes and behaviours towards fathers were demonstrated through their descriptions of

caring for the father. This category refers to the supportive nature of the paternal-midwife relationship. Midwives identified several ways in which they support the expectant father. The three main themes of the supporting partnership include: *Instilling Confidence*, *Just Being There* and *Caring for the Father*.

Instilling Confidence

One of the main properties of the supporting partnership between the midwife and the father was conceptualised as instilling confidence in the father. The participants acknowledged the importance of the father's role in labour and birth and therefore attempted to assist him by establishing a supporting partnership. Participants described how they would encourage participation by attempting to instil confidence in the father's role. *We try to give the dads a lot of confidence in their ability to do this. So in classes I would say to dads that you know your partner better than I do. So that what you are going to do will probably be more helpful than what I do. So you take the lead and do what you think is right because you love this woman. And no matter how much I care for her I am not going to be able to love her in the same way as you do. So that you know what her needs are and you need to be able to work towards fulfilling those needs at this really precious time. Fathers are wonderful (010).*

Instilling confidence was also achieved through explaining the processes of birth, particularly the process of transition. *I try and get them involved with both. Because the thing is that I don't know how his wife normally is and a lot of the time if they swear or tell them to get away, or leave me alone. I will explain to the husband and say don't worry is only a phase of labour. Try and support whatever she is doing, even though, if you say anything, if she says don't touch me, you don't touch her. Until she has gone through that phase and she starts the next phase, because some fathers find it a little upsetting (011).*

Thus instilling confidence occurs prenatally, as well as during the labour and birth. *And I guess that is the thing that is working with them as individuals and not treating them all the same. And identifying what their needs might be, so if we have got someone who is in labour and he is trying to do massage and he is doing a heavy vigorous massage. And she needs a relaxing type of massage what I would normally do in that situation is say do you want a break. And just do a little bit the way I would normally do it and the woman will say oh that is lovely and encourage the partner to do it that way. So that you kind of do it in a way that makes him feel he isn't doing it the wrong way. And it is really important in the antenatal period to try and encourage couples to work together to experiment with different techniques and to give each other feedback so that they get to know used to having feedback without being offended by it (010).*

Consequently instilling confidence in the father occurs by enabling them to feel part of the event. *Rather than me hold the shower I would rather that he hold the shower nozzle for her. But I will show them how to do this. And you know that in the overall scheme of things these are some of things that you can look back on later and say we did it together (013).*

Providing reassurance was perceived as an important aspect of instilling confidence in the father. Some participants, particularly birth centre and home birth midwives described debriefing the couple and reassuring the father regarding his role in labour and birthing. *Then I ask him, is that how you remember it? What would you do differently? Did you feel good about the things you did and some will say that I felt like a shag on a rock. I didn't feel like I was doing anything. And I can say that from my perspective you looked like you were so supportive and obviously what you were doing was working well. We try to provide them with support during the labour as well. Especially reassurance, we reassure them that they actually had a very big part to play. Even though they may feel like that they were useless (006). In the home birth*

and birth centre environments fathers are welcome to return for a post-natal debriefing session. Unfortunately the labour ward environment does not cater for a post-natal debriefing session for the couple.

The midwives agreed that one of the most important aspects of the paternal labour role is supporting the labouring woman. The support provided to the labouring partner was to assist him in his role of supporting his partner. One midwife articulated the importance of support. *And they have been valuable in that when we have to leave the room there is always someone there, which I think is really important...Where the patient may be inclined to be introspective and she just doesn't have the thought or force to ring the bell. But the fathers are certainly on the ball and they can inform you of what is going on, such as things going wrong (005).*

Participants made conscious efforts to include fathers by instilling confidence in their ability to support their partner through the labour and birth processes. Midwives used several strategies to create a supporting partnership in which the father felt included in the event. The second concept of the supporting partnership is that of *Just Being There*.

Just Being There

Supporting the father in *just being there* enables fathers to be present and to participate in the way that he feels comfortable. Just being there refers to fathers who are present but may not be necessarily active. *They are really there to just you know give a bit of a pat every once in a while. The good word and they are just there. They are just there. And I think that this is what the real role of the man at the birth is (014).* According to the participants they know that for some fathers their physical presence can be enough participation for them and their partner, they know this through the interpretation of the interaction in the unique birthing context. *And like I said before their physical presence is what is most important to their women (006).* When the father is not

present the midwife is aware that they are missing an important player from the event. *Sometimes I wonder what you would do without them. Like it is noticeable when they are not there (016).*

Klein, Gist, Nicholson and Standley (1981), examining one hour observations of interactions between fathers, midwives and labouring women, found that the majority of mothers indicated that the most helpful thing was the husband's presence. The participants also supported this notion. *I think it is very important for the woman that their partner is there. And often times the woman verbalises that too (005).* The participants also discussed how the woman influences how her partner will act during the labour and birth. *She told him that his job was to sit in the corner and read his book. And when he went to go to the toilet she just about fell apart. It was very humorous to me, but when I discussed this with them a few days later we did have a giggle about it. And he said, that she said my job was to sit in a corner and read a book and she did not want anyone near her. His physical presence was the most important and natural thing for her (006).*

By simply just being there, the father is being supportive to his labouring partner. *So the ones that stand out in my mind they know what their woman likes. And they know what they should do. They are just there they are not necessarily talkative or anything. They just sit there and they are with their partner. They may be rubbing their back, or just doing little things but they are there. You can see that they are a team it stands out (004).* Participants were aware that fathers do not have to actively participate to demonstrate support for their partner. The important thing was that they are just there. *I stress how important their physical presence is (006).*

Just being present was also connected to the father's ability to bond with his child. *I think it [paternal presence] is an excellent idea, considering they have been there through all her processes of being pregnant. I feel that then that they*

should be a part of the actual process of labour and birth process, so that they feel a part of this child's life (011). So much of the fatherhood discourse focuses on the father's impact on child development (Lamb, 1975, 2000; Russell, 1982; Marsiglio, Amato, Day, & Lamb, 2000; Williams & Radin, 1999; Boechler et al., 2003). *I would like to discuss what they would like to do in the actual birth process with the father as well as the mother. Well they are the ones that have actually conceived this child. They are the ones who have been there all the way through. They are the ones who are going to bring this child up so I see this as part of the process. Imprinting and bonding is so important. They should be involved in too (016).* Participants too believe that paternal presence is related to bonding with the child.

According to Robertson (1997), first time fathers often just expect to be there with little consideration for what this may involve. Similarly, midwives indicated that many women wished for their partners presence and nothing else. *Women do not seem to care what the father does as long as he is there (002).* Lavender, Walkinshaw & Walton (1999) found that 19% of fathers said that they just wanted to 'just be there in the labour room', their partners perceived this wish as equally special. Klein, Gist, Nicholson & Standley (1981) also found that the most helpful thing the fathers did was to be there. The participants also believed that fathers should be able to participate according to their needs. *Paternal presence allows the husbands to get involved in any way they want to. We certainly talk about that antenatally. We ask them what they want to do. I have certainly had fathers who have put their hands on the babies head as it was delivered (005).*

Allowing the father to feel comfortable with his level of participation is an important element of the supporting partnership. *Fathers need to decide what level of participation they are happy with and for us to do what they do not feel comfortable with. Now some dads actually want to catch the baby. And that is fine, other dads will say I am happy to be there but I will sit on the couch in the*

corner of the room. I think it has got to be right for them. And we don't want the situation where dads feel very uncomfortable being there (010).

It is difficult to know if some fathers are quiet and in-tune to the events or are what Wilson (1999, p.22) refers to as 'deer caught in the headlights'. Page (2000) contends that it is easy to be present without really *being* present. Similarly, Robertson (1997) asserts that, in general, people react in different ways to being present during labour and birth. The participants noted that fathers might engage in differing levels of participation. For example, the participants, in their responses to questions on their perception of their practice (Appendix D), described the term teammate as the most commonly chosen term to describe paternal participation in childbirth.

Research supports the notion of fathers adopting differing roles. Jackson (1984) observed different types of fathering roles during the prenatal, perinatal and postnatal periods these were: rather not be there, observer, sharer and those who totally identified with the woman. Chapman (1992) also reports that fathers adopt one of three roles during labour and birth. These were coach, teammate and witness, with the majority of fathers indicating that they adopted the witness role during labour and birth.

When the fathers are just being there and not overly involved the participants conceptualised that it was merely his presence that was important. *I suppose fifteen years down the track as long as the father can say I saw my baby being born and I was there for it and it makes the couple happy then that is important (013).* However, some midwives attempt to include fathers by allocating tasks if they appear to be present without *being there*. *I think as long as they want to be there I love them to be there really. I think they are very important and very well needed. But I think where there are situations where they want to be there, or they are scared I think it is difficult. I think they are scared I think that the midwife can help them to get over that fear by including them and showing them what to do (013).*

Previous studies have found that including fathers, who simply would prefer to witness, is a challenge for the midwife. Kaila-Behm and Vehvilainen-Julkunen (2000) found that working with fathers, who they considered as onlookers, presented as a major challenge to their work. *I spent some time working with them to try and desensitise him a little bit to something that he felt more comfortable with it. In fact he was there for most of the labour and he ended up leaving the room for just the birth and coming back straight afterwards (010).* Intrapartum midwives have some concerns about why fathers may not want to be present and attempt to locate the reasons *But I do think that fathers need to be there and we need to find out the answers to why they do not want to be there (013).* Midwives, through their questioning, will attempt to determine the reasons that the father may not want to be present and attempt to allay any fears he might have. *And then I will say how can we work around this to make you more comfortable or allay your [the father's] fears (006).*

The participants explained that they become familiar with the routine symbols, verbal and non-verbal language, of expectant fathers and constantly observe the couples actions and interactions. *Mainly you just get a feel, a lot is not said it just perceived. It is more what is un-spoken through the nonverbal body language rather than what they come out with it (016).* The father just being there provides comfort for both patient and midwife. It was evident that participants' interpretation of the paternal role was dynamic rather than fixed. The midwives role changed to respond to the situation and specific needs of the father and couple.

Caring for the Father

Childbirth is a significant time for many fathers. For many it is transition into parenthood for the first time. During this time fathers strive to support their labouring partners. However they also have physical and emotional needs. Participants identified specific ways in which they care for fathers during the

labour and birth. One participant described the ways in which she supports the father. *And so I see the midwife as being the teacher for the husband and even a support for them. That when the labour is long and hard, that the midwife support the man as well as the woman. And making sure that he has had nourishment and that he has had rest. And sometimes it is very nice to say hey it is a long labour how about you have somebody else in, such as your sister or somebody. Or I will just sit with her while you go and have a rest. So I feel our role is support fathers as well as the woman (009).*

The properties of other categories, such as building a rapport and advocating for paternal involvement, are closely related to those of the supporting partnership. Specifically the notions of caring, in which midwives need to have built a strong rapport, orientated the father to his surroundings, and assessed the father's needs in order to respond to those needs through caring interactions. When the majority of the informants were engaged in such activities they perceived themselves as being supportive to fathers. Fitzgerald (1993) observed that the evolution of the word 'nurse' evolved from notions of mothering, nourishment and caring. The participants demonstrated elements of nursing in their descriptions of caring for fathers. Although mothering was not mentioned within any of the transcripts, it is implied throughout the descriptions of caring.

The participants' level of concern and caring was evident in their actions and interactions with fathers. The participants demonstrated their concern for the general well being of fathers. Caring was exhibited by specific interactions, such as ensuring adequate nutrition and sustenance intake, ensuring that they obtained some rest, especially for long labours, and being available when the father needed to take a break. *Well I do. Like they need cups of coffee and cups of tea. And we need to send them off downstairs to have a cigarette and stay there. They do need to go to the toilet. They are human like we are. We do need to look after them. I think I like to care for them as well (001).* Chandler and

Field (1997) assert that fathers need to be encouraged to eat, and to take a break from their wives' labour, when appropriate.

Part of the supporting relationship is making sure that fathers are comfortable during the birthing processes. Many of the participants voiced their concern about providing sustenance and generally looking after fathers. *I encourage fathers to leave if they have been in the room a long time. Many fathers need a break and I will say it is time you had a break. Some of them have to be just about dragged kicking and screaming. But even if it is only for five minutes they need a break. Some fathers do not eat, do not drink and they do not even go to the toilet. It does make it easier to have a room with an ensuite because it solves the problem of fathers not wanting to leave the room. But some of the fathers won't want to leave. Some women have an alternative support person can replace them if they do go. But it does not really matter because there is always a midwife to support the woman should the father need to go (004).*

Supporting the father is important particularly when the woman may want him by her side throughout the whole event. *But then women need to have the expectation that their partner cannot go for twelve or twenty-four hours without a break, and that he needs to recharge his batteries from time to time. So that he is at his full capacity to support her at the really tough bit towards the end. During the transition phase and the birth (006).*

In caring for the father, participants expressed their need to help in sharing the supporting responsibilities. *If in the end they have an urge to have a break or something. And you will say, how about I have a massage for a while and you have a cuppa or sit down and watch. And you know hold her hand. And you can massage after me. So you share the responsibilities during labour (013).*

Even without a coherent policy on fathers, midwives actively encouraged and supported paternal participation in the labour and the birth. Midwives support

the father to be present throughout the event, they care for the father by offering emotional and physical support. Additionally, midwives were cognisant of the fathers desire to stay with his partner. *I have suggested that some fathers go out for some food or drink if they are obviously becoming stressed out and they are obviously are not comfortable and some men just need some space. Because some men are not comfortable with going, they feel that once that they are in there, they are there for the duration. And they do not eat and they do not drink (007).*

The father is encouraged to work with health professionals in the support and care of his partner through the development of a supporting partnership with the midwife. Participants illustrate this through the dimensions of the instilling of confidence and enabling the father to choose the role he is comfortable with, such as just being there. Additionally, the participants identified strategies aimed at caring for the father to enable him to actively participate in the supporting partnership with the midwife. The notions of the supporting partnership are inextricably linked with those under the umbrella of working with fathers.

The Boundaries of the Birth Environment

Knowing and understanding the boundaries of birthing is important. *The ones that I have had, it has been natural to have them there. They have not overstepped the boundaries (006).* The boundaries of practice are the parameters within which birthing takes place. They are largely determined by the practice setting. For example, the traditional labour ward birth setting operates within the boundaries, rules and regulations of the medical system. While these rules provide structure for safe, effective medical and midwifery practice, they impose certain restraints on resources available to incorporate family members in the birth event. The home birth setting offers a relaxed environment with the boundaries of practice being governed by the midwife in collaboration with the woman and her partner. *So I think that the big thing in*

the birth centre is that you have autonomous practice. You are involving the whole family and so it is a lot more satisfying (005).

Paternal involvement is limited by the restricted access fathers experience within the birth setting. Midwives accept the boundaries of their practice as the norm, but fathers do not have that same level of tacit knowing and understanding. The birth venue significantly influenced the participants' perception of the level of paternal participation in the birth process. To assist fathers participating to their full potential the participants discussed strategies aimed at making the fathers feel comfortable within the boundaries of the birth environment. The participants were cognisant of the limited time, resources and the opportunity to develop a supportive relationship within the boundaries of the birth environment. The concepts of this category are *Facilities* and *The Tacit Rules of Birthing*.

Facilities

The birth environment can challenge the nature of paternal inclusion strategies. The participants identified that the facilities available in each practice setting may influence the enabling processes involved in establishing an inclusive relationship. Despite the limited facilities available for fathers, midwives sought to include fathers in the birthing processes. For example, midwives will provide the father with sustenance because the facilities for fathers are limited particularly outside of business hours. *So I think that because of the economic thing these days, if you are seen sneaking up the corridor with a cup of tea or coffee you just have to be careful. I just do it on the quiet and don't tell anybody. But we do need to look after them. And certainly sometimes they are here all night and there is nothing open. The coffee machine is probably the only thing available and if they don't have change (001).* The labour ward environment does not offer any refreshment facilities rather the father is dependent on the hospital kiosk for nourishment, which is only available during certain hours. So some midwives secretly provide fathers with sustenance.

Publicly funded confinement facilities in Queensland are somewhat dated compared with some other Australian States. The chosen labour ward birthing rooms could be described as appearing similar to an operating theatre. They appear cold, white, sterile and impersonal. They consist of a single mechanical bed, nitrous oxide and pain relief machines, fetal monitoring equipment, resuscitation equipment and sterile materials. The rooms are small and offer limited seating for fathers, most available space is occupied by medical equipment. The view that space may restrict the father's role was considered and reconsidered by some of the participants. *From a personal viewpoint I do not feel that fathers are so restricted. Mind you there is not much room in the labour rooms, so that probably does restrict them (004).*

The participants identified that the labour ward environment does not offer much scope for working and including fathers in the childbirth process. *The surroundings because of the rooms the way they are there [labour ward] there is not a lot of scope (001).* For example, one participant specifically observed the impact of the restrictive layout of one birthing room on the father's involvement. *If there is nowhere to stand they will feel like they are in the way. One of the current labour wards is where the fire escape is. So you cannot have any chairs commode or trolleys near that side of the doorway. So with everyone else in the room they have almost barricaded the father in the room. The room limits how much the father can do. They literally just sit there and they are stuck (002).*

However, during the time of this inquiry a new maternity unit was being completed. During the interview phase this caused some participants to consider and reflect on the impact of the new facilities for fathers. *So it is still very clinical. We don't have more facilities where they could go and make a cup of tea, or put a couch in. It is probably worse than what we have got here. So its all about, space, time and money (001).*

Midwives acknowledge that currently there are minimal facilities available for fathers to stay with their partners. *They can't really stay because there are no facilities for them to stay and even in the new hospital they can't stay. There are no facilities (001).* The lack of facilities to enable the father to stay following the birth was seen as a result of limited resources and finances. *I don't know about improvements in labour ward but I think we should have rooms where fathers can stay and sleep as well. Because I think it is quite a shock to be in the birth and all the excitement and it is so happy and then it is off you go. Goodbye. I think that is difficult and then I think is a result of hospital surroundings, such as the limitations of spaces and resources and finances. I think that would be nice if they could perhaps stay somewhere together for a while (007).*

Some participants were confident that the new facilities would offer more space and amenities for the couple. *Hopefully, the new hospital the rooms will be more suitable. Hopefully the rooms will be a lot bigger the showers will be in each room so they [fathers] can be more active. Everyone can be more actively participating if that is what they want (002).* It was conceptualised that the new building will have bigger rooms and more space to accommodate the father in labour and birth. *I have been here since 1981 and there have been certainly lots of changes. And we will be changing a lot more over the next few years and I do not think that fathers will feel as restricted. I think that given the size of the rooms, I do not like a lot of people in the rooms when a woman is having a baby. But I think that it will probably be changing in our new building where the rooms are a lot bigger. I think that the midwives will be a lot more flexible (004).*

In contrast to the labour ward environment there are more facilities available for fathers in the birthing centre located in the same institution. The birthing centre has a lounge area with coffee and tea making facilities and an

educational area with appropriate reading materials are also available. Each birthing room has an ensuite for fathers to access, if necessary. The birthing rooms are much larger than the labour wards, with most of the medical equipment being stored outside of the room, thus offering a more relaxed non-medical environment for the couple. There is a double bed as well as ample room for the fathers to sit in comfortable chairs, and beanbags are available for the woman and her partner. These rooms generally offer more privacy for the labouring woman and her partner. Having this privacy affords the couple a more private birth experience. *Such as what we do in the birth centre, like catching the babies, holding the baby straight after birth. Having skin to skin with the baby. I often say to the husband to take his shirt off for skin-to-skin contact with the baby, whereas in the delivery suite that is not done. I think it is because it is much more open to the public, the doors are open a lot more and there is not as much privacy. I am actually hoping with the new building that there will be much more privacy. So the midwives can do more things (009).*

Some participants identified that responding to men's needs is easier for midwives working within birth centres compared with those working in traditional labour wards. *We in the birth centre are in the fortunate situation where we get to know couples before hand. So it is very much easier for us than for midwives working in labour wards to tune into to what those needs are (010).* The boundaries of the birth centre enable fathers more scope for involvement during labour and birth. *The dads in the birth centre are pretty involved from the word go. But also rubbing backs and during labour pouring water over mum's back during labour while she is having a bath. So there is nothing that they are excluded from. They get involved in everything. I am happy with the ways fathers are integrated into the birth process. I think it is good for midwives too (005).*

Including fathers in the labour and birth is an essential part of midwifery practice in the birth centre. *I certainly have had the experience where the mum*

was very keen to come to the birth centre and the dad was a little hesitant about it. I see my role in that case to try and make him feel a little more comfortable with it by the time we get around to the birth. And that is one of the special things about working in the birth centre you have the opportunity to do that. It would be a different situation in the labour ward where you meet people for the first time (010).

Midwives are aware of the differences in philosophies of labour ward midwives, compared with those working in the birth centre. According to the participants, the philosophy and woman centred focused care in the labour ward limits the use of paternal inclusion strategies. *I think that I love the birth centre because we focus on the fathers. And I think that is different from other areas in the hospital. In the delivery suite, I have worked in those areas, it used to be a situation where they are not as singled out, you meant to be looking at the couple and focusing on them. I do not think that the woman should be the entire focus. Ok she is having the baby but you are looking after them as they are in a relationship and as a couple. And I do not think it should just mean focusing on the woman (013).*

Despite the peculiarities of the birth environment participants envisaged their role as including fathers by their actions and interactions. These actions and interactions varied within each practice setting. *The men in the delivery suite are not as well prepared, whereas we prepare them very well for the birth process in the birth centre. We prepare them well antenatally for this event and tell them things are the things they may be able to do and what we will be doing. We actually practice different positions for the delivery when we are doing their preference sheet, when we fill out their preference sheet fathers have their say. When we are planning the birth plan the husbands are there whereas delivery suite staff do not get that opportunity (009).*

Participants acknowledged that, although the birth venue may seem foreign, technical and unfamiliar to the couple, they attempt to include fathers within the boundaries of each setting. The birth venue, if not in the home, can seem very foreign and unfriendly to the couple. According to Page, Cooke, & Percival (2000) the place of care is the most important determinant of the way a midwife practices. In this inquiry the participants identified that the more homely environment offers fathers more facilities and thus makes inclusion easier.

The Tacit Rules of Birthing

During birthing, couples are faced with certain boundaries of behaviour. What constitutes acceptable practice for one birthing environment may be different in another. Within most birth environments there are codified rules and unwritten rules. The concept *the tacit rules of birthing* refer to the unwritten rules of birthing. Tacit knowing is commonly equated with taken-for-granted understandings of something that may otherwise remain seemingly invisible. Here, Polanyi's (1967) 'tacit knowing' is relevant to conceptualise the idea of the inclusion strategies articulated by the participants. According to Polanyi (1967), tacit knowing is that which is used by all people, but may not necessarily be easily articulated. It is knowledge that is personal rather than formally codified.

Tacit knowing may involve knowledge about specific birthing practices, interactions and behaviours. Midwives with their vast birthing experiences and knowledge may have extensive tacit knowledge, which may not be easily understood by the birthing couple. Participants discussed using unwritten birthing rituals and routines to include fathers during birthing. One such routine is the overall inclusion of fathers. Including fathers in the childbirth process has become a taken-for-granted practice in midwifery care. *I don't even think about it because it just happens all the time. You just accept it. I have never looked on it as being different (001).*

The midwives in this inquiry are providing a service, either as an employee of a publicly funded hospital or as a home birth independent midwife employed by the woman to provide midwifery services. As such, they face the tension of balancing the needs and expectations of the childbearing couple and working within institutional and practice requirements. Institutional employment certainly complicates the paternal-midwife relationship. Nevertheless, midwives will change their routine to suit the fathers needs. *I just love it when the fathers get into the shower with the mother. I remember one couple, like she is in the shower naked and he is in the shower naked. And I thought why not who cares. I remember I got told rather promptly to suggest that he put some clothes on. And I thought why should he really (016).* Working within the boundaries is sometimes difficult.

Another participant observed the rigidity of midwifery practice such as the traditional rituals of demonstrating a baby bath, rather than allowing the parents to give their baby its first baby. *It is very rigid and very 70s and you have to do this way because this is the way we do it. And we have been doing this way since Adam was a boy. And watch out if anyone who dares to change this (006).*

The main reason that the participants spoke about the tacit rules of birthing is that midwifery practice has yet to effectively address regulations for partners at birth. However, the participants described the father's role and the tacit rules that guide his role. *I would like to give a role of the father to the person, who I know it sounds funny, very task orientated, like give the drinks, massaging, calming, trying to get them to hold her hand, getting to slow breathe. I try and get them involved in doing. So they feel involved (011).* By not having codified rules, midwives are able to include fathers in ways in which they feel comfortable. *I allow the husbands to get involved in any way they want to. We certainly talk about that antenatally, if they want to deliver the baby. We ask them what they want to do (005).*

Articulating the paternal role to fathers is viewed as the midwives responsibility. *I just think that there is a certain level of responsibility that you have as a midwife and so it makes it a clear and simple. And I think that there is a place in the antenatal classes to talk about what role does the father want to play. Does he want to be the chef? Or does he want to be the refreshments person or the communicator with the family going in and out? Stuff like that. I think that the father's role is definitely as a supporter (016).* Midwives have certain responsibilities that they expect fathers to undertake.

While some midwives articulated the father's role others use non-verbal communication. Further, the participants identified the non-verbal aspects of the midwives' tacit knowing of their practice. *You are there in the room and you are part of it. It is just getting a feel for the couple. It is more what is un-spoken through the nonverbal body language rather than what is actually they come out with it (016).*

When the father enters the birth environment he is often temporally and spatially disorientated. This reaction is more common in the traditional labour ward environment, in which he may be entering for the first, compared with other birth environments. He is often uncertain where to stand and with whom to communicate, what to touch and what to avoid. Midwives articulated that it may be the space that restricts the father's involvement rather than the midwife. *Perhaps the restrictions of where you are at, it may not be the midwives rather it is the space. It is not practical (002).* Commonly labour ward midwives spoke of the lack of facilities, space and resource restrictions, which influence their attempt to include fathers in the labour and birth.

One home birth participant observed how the differences in the home birth and labour ward environments impacts on fathers. *They [home birth fathers] have not got this unstable situation in the hospital, where they do not know what is*

happening. People are doing things to their wives and they do not know what is happening. They do not know what they are doing and why they are doing it. Where as home that does not happen. We go through all the possible situations. And because there are no drugs and no interventions it is easy, to just relax and go with the normal process. So it is easier I would say (014).

Birth centre midwives also describe how they are adaptable to the father's needs. Enabling the fathers the scope to do what he wants to support his wife is also accommodated within the tacit rules of birthing. *Some fathers see themselves as advocates and they have this plan of action and that is the way they are going to do it and they keep telling you we wanted to do this and we wanted to do that. And once you have settled down and you tell them that they can do whatever they want to do. And that we are very flexible then and we will just go with whatever you want. Then they relax and so they don't feel that this is our plan of action and this is what we are going to do. We are adaptable to their needs (007).*

From the above two examples it is evident that the tacit rules of birthing infiltrate through to the couples experiences, particularly through the midwifery care ethos. *I would like to see labour and birth more family relationship centred rather than being just woman focused. And I think that we are not the ones going home with the woman and the family needs to be well informed and the father needs to be well informed and that the fathers are able to do as much as they can for the woman. And I think we should try to do us much as we can for them. I think that in the birth centre that all the midwives and philosophy is couple centred (013).*

All health professionals working with labouring couples work within professional guidelines and policy requirements. Participants believed that there are fewer restrictions imposed on contemporary birthing practices. *I do not think they are restricted by rules and regulations. Maybe that is a perception of*

fathers. I have shoved beds out of the road for fathers. And I have done all sorts of things over the years. I suppose it is an individual thing. I suppose I can appreciate what fathers are saying. Hospitals do have rules and regulations. I suppose what they do not appreciate it that when you are having a baby it is not rigid not anymore. The length we go to sometimes when they want to be in a special position where they want to have their baby (004).

The midwives practices are not only informed by their attitudes towards paternal involvement, their own and their professional birthing experiences, they are also bound by the facilities and tacit rules of the birth environment. The shared supporting responsibilities of fathers and midwives function to connect them together. These shared roles form the basis upon which the supporting partnership is built. Including the father by instilling confidence, caring for him and allowing the father to take on the role he is comfortable with form part of the process of inclusion. For the inclusion to be successful, midwives need to share the tacit understanding of the birth environment with fathers, which enable them to identify with each other. It is these identifications that connect them in their endeavours to support the labouring woman and encapsulate notions of what midwives call inclusion.

Summary

This chapter described the processes by which participants support and include fathers within the boundaries of the birthing environment. The importance of the birth environment and associated nuances cannot be discounted in the paternal-midwife relationship. Within the childbirth discourse the dominance of the woman in midwifery care is obvious, equally the father is often rendered invisible and unnecessary in the conceptualisations of pregnancy and birth. Upon their entry into the birth environment fathers are faced with a strange environment, different health professionals and accompanying rules and regulations. Indeed, the organisational culture of the birth setting is familiar to midwives, but to the childbearing couple it may be overwhelming. A

comprehensive comparison of the data revealed contextual influences on establishing an inclusive relationship. The birth setting not only provides an environment for birth, it also has an impact on the collaboration between the midwife and the expectant father.

The final chapter presents concluding statements related to this inquiry. The chapter presents a discussion on the limitations of the inquiry and the key implications of this inquiry for midwifery practice, education and research.

CHAPTER 11

THE INQUIRY:
IMPLICATIONS AND CONCLUSION

Improvements could be made to midwifery practice by debriefing with fathers (016).

The previous four chapters discussed several significant concepts to emerge from this inquiry. The findings from this inquiry confirm previous findings, extend existing knowledge and provide new perspectives on paternal-midwife relations in the birth process. Specifically, the findings revealed that midwives working with labouring couples attempt to include fathers in the birth process. The participants identified several strategies implemented to support the father to be more involved in the care of his partner, to feel respected and contribute to his feelings of control and empowerment in the processes of childbirth. The participants acknowledged that fathers were generally included, but specific strategies implemented to include fathers' remain restricted by certain institutional constraints, such as the lack of resources, facilities, policy guidelines and time.

This final chapter presents a discussion of the limitations of this inquiry and the implications for midwifery practice, education and research. The midwives' perception of the paternal-midwife relationship in childbirth and the need for changes in midwifery practice to enhance the inclusion of the father in the birth process are explored in detail.

Limitations of the Inquiry

The findings of this inquiry must be viewed with prudence. The inquiry was limited to one area of Queensland and reflective of the intricacies of the Queensland health care system. In Queensland, maternity services in publicly

funded institutions are similar to those in other Australian States and Territories. Similarly, midwives are under the control of State health regulatory bodies. The participants in this inquiry worked within a traditional labour ward, a birth centre in a publicly funded hospital and independently within the home. It is within this context that the findings must be considered.

According to Glaser and Strauss (1967), generalisability may be achieved when comparing the facts, which are similar or different, and generating the properties of categories that increase the categories' generality and explanatory power. The theory of establishing an inclusive relationship is based on the data from sixteen interviews. The inquirer believes that the sample size provided saturation of the interview data. The gender bias of the sample may also be a limiting factor, given the low numbers of male midwives in Queensland and that there were no male midwives working at the interview locations, the inquiry was therefore restricted to an all female sample.

The final limitation involves the primary use of a publicly funded institution. Future research should consider a conceptual understanding of the paternal-midwife in private institutions. The dynamic interplay between fathers and midwives in private institutions may not be hindered by the same restrictions imposed in a publicly funded institution. This inquiry did not aim to represent both systems of health care.

In Australia, midwives are expected to assess and meet consumer expectations. As every birth is unique and every couple has diverse expectations there will be differences in their responses to relationship and maternity care practices. Although professional midwifery practices may differ between the three groups chosen, the participants described similar practices to include fathers in the childbirth experience. The findings of this inquiry revealed several issues affecting the effectiveness of paternal-midwife relationship, which have implications for midwifery practice, education and research.

Implications for Midwifery Practice

The main function of midwifery inquiry is to inform praxis. Contemporary midwifery practice has undergone several influential changes in response to societal expectations. A significant change in midwifery practice was the inclusion of fathers into the traditional female domain of institutionalised childbirth. Participants identified how their attitudes and practices have changed to incorporate the father in childbirth management practices, while some aspects of their practice remains restricted by dated institutional rules and regulations.

In this inquiry the participants sought to include fathers throughout labour and birth. This process recognises that consumers of health services need to be included in the health care relationship and to actively participate in their own care. The integrating theme of the data was the importance of including fathers in labour and childbirth, by building a rapport, offering choices, giving relevant information to make informed decisions, demonstrating caring behaviours, instilling confidence, fostering feelings of usefulness while working within the boundaries of the birth environment. This interrelated set of categories contributes to an understanding of how contextual factors influence inclusion processes and also how perceptions affect behaviour.

This thesis documents strategies used by midwives to include fathers in the childbirth experience. It is important for midwives to reflect upon these strategies, the proposed theoretical framework and on their own practices to ensure that the needs of both members of the childbearing couple are accommodated. Notions of including others in the care of a family member are clarified in this theory. Such knowledge is significant to health professionals who have interactions with family members as part of their professional practice. The conceptualisations of the paternal-midwife relationship have similar connections with a variety of health care situations. For example, community health professionals' have a unique relationship with individuals

requiring their services, such as with caregivers and new parents. Midwives must continue to provide midwifery care that meets the demands of clients. In particular midwives need to develop a new relationship with patients and their families to assist them to achieve a satisfactory birth experience.

The findings of this inquiry raises concerns about policy development on the paternal roles in childbirth. The need to standardise the inclusion of fathers, and in particular the assessment of their needs, language and communication methods employed and caring measures needed in unexpected situations, were considered. Building a rapport with the couple prior to labour was one of the major constraints. Midwives believed that building a rapport during pregnancy would assist the midwife in providing sensitive care and enable the couple to feel more relaxed. The participants felt that midwives need to have a relaxed forum to discuss expectations of the father's role, the midwife's role and the father's understanding of the birth process.

The proposed theory incorporates both the strengths of midwifery and the medical models of childbirth management practices, and identifies those aspects in need of change. It is anticipated that the proposed theory will assist both beginning and experienced midwifery practitioners to understand the processes involved in the inclusion of the expectant father in labour and delivery. While this thesis was limited to studying the childbirth period, it is vital that midwives consider the implications holistically and also consider the pre and postnatal periods.

Implications for Midwifery Education

Midwives have a responsibility to extend their focus of midwifery care to include fathers and other family members. The participants in this inquiry demonstrated a concern to provide sensitive and flexible care for fathers. Participants noted that fathers have their own labour expectations and experiences and it is necessary to assist them with their needs. The nature of midwifery practice and education is changing, not only to accommodate the

consumer's requirements and the funding arrangements of the health economy, but also to strive to provide holistic midwifery care to the couple and their families. Neuberger (2000) notes that mass education, mass media and mass consumerism have escalated in the twentieth century, putting an increasing amount of pressure on health care professionals to meet rising public expectations. In the consumer culture it could be argued that it has become easier for the health care professional to extend their focus of care beyond the patient to their partner and other family members involved.

Participants observed that prenatal education needs more consideration. Childbirth classes are offered after hours and on weekends to accommodate the needs of both the couple. However, the content of childbirth classes need more consideration to include information on the partner's role during childbirth. Paternal expectations of their role and the midwife's role in childbirth need to be discussed on an individual basis to meet the needs of each father. Understanding the father's expectations and incorporating them into prenatal education will assist midwives in meeting the needs of fathers in childbirth.

Knowing the midwives reaction to, and interaction with, expectant fathers can help midwives assess and understand the father's role in childbirth. A major finding from this inquiry related to the midwife acting as an advocate for both the labouring woman and her partner during parturition. Academics and health professionals need to design their course curricula to include fathers in all aspects of maternity care. Current educational material emphasises a maternal focus with limited recognition for the expectant father. Somers-Smith (1999), suggests that the father's needs and role should be regularly assessed during childbirth. Midwives must be supportive of fathers to assist them in offering continuous emotional and physical support to their labouring partners. Current midwifery curricula fail to reinforce such supportive behaviour. Australian theoretical models, suggesting a feminist approach to midwifery curricula,

continue to reinforce the centrality of the woman, with minimal recognition for the father (McLoughlin, 1997; Barnes, 1999, Brook & Barnes, 2001).

Recommendations for Further Inquiry

Furthering midwifery knowledge through inquiry is necessary to explicate the uniqueness of midwifery care. Fleming (1998) identifies, the power holders see documentation as legitimate and by not documenting aspects unique to midwifery care midwifery knowledge is perceived as less legitimate than medical knowledge. The participants' words throughout this inquiry demonstrate the power and importance of documentation. This thesis documents the actions and interactions of midwives, unique and specific to midwifery care. Moreover, this inquiry provides knowledge that no previous study has documented, namely the specific strategies midwives use to include fathers in the birthing experience.

The findings from this inquiry reveal several issues that necessitate further research. Recommendations for further consideration and inquiry include the paternal-midwife relationship, the issue of power in the paternal-midwife relationship, paternal perspectives of this relationship, benefits of paternal presence, the maternal grandmother and daughter relationship during labour and birth, the impact of the birth environment and an examination of the paternal-midwife relationship in private institutions.

The aim of this inquiry was to fill the gap in the body of knowledge on paternal-midwife relations in childbirth. Australian and international research was reviewed, although there were several studies on the paternal perspective of childbirth none addressed the dynamics of paternal-midwife relationship during parturition, or provided a theoretical framework for the application of midwifery practices aimed at including fathers during labour and childbirth. The proposed framework aims to assist in the development of guidelines to advance this body of research.

Traditionally, the midwife's role has involved caring, nurturing, comforting and supporting the labouring women. When caring for more than the woman in labour, the role of the midwife becomes less clear. The midwife's role in relation to the expectant father in childbirth is a relatively new phenomenon. This relationship will need further exploration to ensure that midwifery care remains sensitive to the needs of the expectant couple. The issue of power in the paternal-midwife relationship also needs to be considered. The concept of power is important in this relationship, for example the issues underlying the lesser status of the father and the decision making power of the midwife require further exploration.

Further inquiry is warranted into the effectiveness of the midwives actions to include fathers in the birth process from both the paternal and midwife's perspective. Such an inquiry would provide midwives with insights into this relationship from the paternal perspective. Most midwifery research focuses on consumer satisfaction and/ or dissatisfaction with care (Brown & Lumley, 1998; Halldorsdottir & Karlsdottir, 1996; Proctor, 1999). Rarely do these studies question the father's perception of care rather they tend to survey women. While improvements in care and service provision can be enhanced by such studies, gaining a paternal perspective and understanding is crucial in developing sensitive services for the expectant father.

There is little evidence to associate paternal attendance and participation with better birth outcomes. However, with further research and review of the midwife and father's role the potential to establish such links may be possible. Similarly, the influence of the presence of the maternal grandmother on the paternal-midwife relationship is unknown. There is also a dearth of knowledge on the maternal grandmother's influence on the childbearing couple. The participants in this inquiry acknowledged the maternal grandmother's presence

as something more than a support person. The issue of the mother-daughter relationship and the impact of paternal presence require further exploration.

The issue of advocacy also requires further investigation. The findings from this inquiry are not consistent with the literature on advocacy. While it is argued in the literature that advocating for the woman is challenging enough, midwives supported the notion of advocating for fathers. Advocacy remains a contentious issue for health professionals (Cameron, 1996; Hewitt, 2002; Schwartz, 2002). The participants acknowledged the need for them to act as a paternal advocate and spoke of the challenges this role poses for midwives. Although the extent to which a midwife can act as advocate for the father is somewhat limited, midwives view advocacy as positively complimenting and contributing to the paternal-midwife relationship.

The impact of the context of the birth environment on the paternal-midwife relationship also needs to be examined. Specifically, questions arise such as what are the perceptions of the father's experience of the context? In what way does the biomedical model affect the relationship? How does the home birth environment influence the father's role in childbirth? The impact of the birth environment and its associated rules and regulations needs further exploration to identify strategies to prevent specific feelings of exclusion caused by institutional constraints.

The final consideration for further research lies with the primary use of a publicly funded institution for this inquiry. Future research should consider a conceptual understanding of the paternal-midwife relationship in both private and public institutions. The current private health care system in Australia generally offers couples a less restrictive birthing environment. To develop further knowledge on this topic, research should be carried out to include the perspectives of midwives working in private health care facilities.

Conclusion

This thesis has uncovered the meanings, understandings and insights midwives have regarding paternal participation, which until now have been kept silent by midwives as personal knowing. The documentation of such knowing is important to midwives and the future of midwifery. It is important that midwives voices, their knowledge, experience and personal philosophy are valued and validated. The findings from this inquiry have provided new insights and understandings of the paternal-midwife relationship during the birth process.

APPENDICES

A: CONSENT FORM

The University of Sydney
Faculty of Nursing
88 Mallett Street
Camperdown
NSW 2050



The Expectant Fathers Role in Childbirth

I have read the information statement and understand the purpose and risks of the participating in this study. My questions about the study have been answered and I am aware that I may ask further questions at any time. I understand that I have right to withdraw from this study at any time without penalty or prejudice. I also understand that the researcher can guarantee no direct or indirect benefits from participation in a study.

I give my permission for the use of an audio tape recorder but I have the right to ask at any time for it to be turned off or to have the tape deleted if I am unhappy with the content. I understand that any publications involving the research findings, such as a dissertation and journal articles or books in the future will not contain my name or any identifying information. The researcher has explained to me the methods that will be used to protect my confidentiality.

I agree to participate in this study within the conditions described in the information sheet.

Signed: _____

Name: _____

Date: _____

Witness: _____

Name: _____

B: INFORMATION SHEET

The University of Sydney
Faculty of Nursing
88 Mallett Street
Camperdown
NSW 2050



INFORMATION FOR INTENDING PARTICIPANTS

My name is Catherine Cameron, I am a registered midwife undertaking this study in order to complete my Doctoral thesis. I have been interested in the area of family-centred maternity care for several years. During my years as a midwife I have witnessed many changes in childbirth practices. One major change has been the admittance of fathers into labour wards. Limited research has been undertaken identifying how midwives perceive this change. Therefore, in this research I want to explore how midwives perceive and interact with expectant fathers during labour and delivery.

During this study my intention is to interview each participant in which you will be free to discuss your thoughts on this topic. The length and number of interviews will be negotiated with you. Should you agree to participate in this study, I would like to audio tape the interviews. You will be free to have the tape recorder turned off or any recordings deleted at any time. Should you wish to withdraw from the study you may do so at any time without penalty or prejudice. Upon withdrawal you will be given the transcriptions and or the tape recordings of your interview.

During the transcription phase the tape recordings will be kept in a locked cabinet in the researcher's home, accessible only to the researcher. A typist will sign a confidentiality agreement and assist in the transcription of the recordings. Following transcription, you may choose to keep your recordings; alternatively the researcher will destroy the tape recording to ensure your anonymity in the study.

The researcher with your approval may also include selected excerpts from the recordings in the final report of the study. With your permission the results of the study may be included in other publications, however, for privacy reasons no identifying information will be included any reports or publications. My supervisor Dr Maureen Boughton and I will be the only persons to have access to the entire contents of the transcripts. At the conclusion of the study the transcripts will be securely retained in permanent storage at the University of Sydney for a minimum of five years.

Please note that any person with concerns or complaints about the conduct of this research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.

Catherine Cameron
 Phone: (07) 5594 8937
 Facsimile: (07) 5594 8526
 Email: c.cameron@mailbox.gu.edu.au

Dr Maureen Boughton
 Phone: (02) 9351 0626
 Facsimile: (02) 9351 0659
 mboughto@nursing.usyd.edu.au

C: DEMOGRAPHIC DATA QUESTIONNAIRE

Please answer each question as best you can. All answers will be kept confidential.

PERSONAL DETAILS

Female Male

Age:

Formal qualifications in nursing:

General Certificate

Neonatal Intensive Care Certificate

Diploma of Nursing

Bachelor of Nursing

 pre-registration post registration

Midwifery Certificate

Post graduate qualification in Midwifery

Other (Please specify)

How long have you worked in

Labour Ward

Birth Centre

Home Birth

Thank-you for your time
Catherine Cameron.

D: PARTICIPANTS PERCEPTION OF PRACTICE

Please answer each question as best you can.
All answers will be kept confidential.

1. Please describe the major characteristics of the couples you mostly care for (e.g. at risk, ethnicity, age, privately insured, etc).

2. Do you believe that all fathers have the right to be present during labour and delivery?

Yes

No

3. During what situations would you prefer the father was not present?

4. In what ways do you try to include the father during labour and childbirth?

5. Please describe the important skills and characteristics a midwife/ birth assistant requires to interact with fathers.

6. In what ways does your workplace place restrictions on your working relationship with fathers?

7. Briefly describe some of the behaviour patterns of fathers during labour and delivery?

8. Are there any particular roles that you have noticed fathers taking during labour and delivery?

9. Are there specific needs of fathers that you believe midwives/birth assistants are unable to meet?

Thank you for your time and participation.
Cath Cameron.

E: NATIONAL SURVEY

Fathers Attendance at Birth Survey

This survey is part of a PhD study. It is an Australian wide survey of all maternity units. The survey aims to gain background information on the changes that took place to enable fathers to be present at the birth of their children. Thank you for completing the following questions.

If you are unsure about any questions please contact me (07) 5594 8937.

1. ***What year were fathers first permitted to be present at the birth of their children in your institution?***

2. ***What factors prompted the change in your institution?***

3. ***Who do you believe initiated this change in your institution?***

4. ***What problems/obstacles were encountered during the implementation of this change of policy?***

If you would like to discuss this further or have any additional information or documentation, please complete the following.

Name:

Hospital:

Contact Ph:

Thank you for your time.

Please return to Catherine Cameron in the reply paid envelope supplied.

F: METHODOLOGICAL LOG

The purpose of this log is to document information necessary to assess the credibility of the procedural and interpretive processes during the research process. A major criticism of qualitative methods continues to be the issue of inquirer bias during data collection and analysis. To demonstrate that the data collection and analysis were analytically and methodologically sound is to offer credibility to the emergent theoretical conceptualisations.

Theoretical Memoing

The methodological log and the reflexive journal demonstrate the inquirer's attempt to ensure that the research process was carried out in a systematic and consistent manner.

Memo: The relationship between the couple has a lot of bearing on how the participants perceive the fathers participation in labour processes. Midwives were aware of the superficial or deep relations of the couple. For example: they would speak of fathers not knowing which bag had the toothbrush etc.

Memo: It seems that for some woman having their partner present can interrupt the energy flows and getting into herself and perhaps impede her progress in labour.

Memo: The facilities have some bearing on the father's involvement. It appears that the labour ward environment is very restrictive. The midwives observed that the size of the room impacts on the father's role.

Memo: There is an issue of violence in the partnership. For many midwives the notion of intimate partner abuse was a concern. Including fathers when there is such a notion is challenging for some midwives. But they still seem to assist fathers to be present and participate how they feel comfortable. However, it is up to the woman to decide if she wants her partner present and the midwives will question her on this.

G: REFLEXIVE JOURNAL SAMPLES

3.10.99: I have just completed two more interviews. The first was very structured and the participant seemed restrained in some of her answers. I focused on trying to put the participant at ease and found myself focusing on the central question more than anything else. The second interview was so much easier the participant hardly drew breath and responded to each of the questions with an amazing insight. This participant raised several different expectations of the study phenomena, which will enable me to explore in-depth with future participants.

Two issues evolved from these interviews. First the context of the setting has so much impact on the midwife's own philosophy of care. A large number of the midwives seem to be aware of their philosophy. Why is it that some do not recognise their philosophy and others can? The second issue is that some midwife's seem to play down the impact of the context of on the childbirth experiences, while others seem to focus on it.

27.10.99

My regular debriefs and telephone discussions with Anne (pseudonym) have been very useful. Anne has enabled me to bounce off certain issues, which we usually debate. Today identified certain categories of the data with Anne and following our discussions have come up with a couple of conclusions.

While reading through three of the transcriptions I have observed that midwife's interactions with fathers is just part of their natural workday. They seem to take it for granted that fathers will be there and participate. Even though there is some recognition that some fathers would prefer to not be there. But the midwives would try to try to relax them.

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