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Access or Egress? Questioning the “Ethics” of Ethics Committee Review for an Ethnographic Doctoral Research Study in a Childbirth Setting

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Abstract

In this article, we discuss the principal difficulties in gaining ethics approval for an ethnographic midwifery doctoral research project in a hospital setting in South Australia. The research focus is on the various personal, social, institutional and cultural influences on women making a choice about whether or not to use epidural analgesia in labour. The obstacles encountered in gaining human research ethics committee (HREC) approval are discussed within the wider context of the benefits of ethnography as a research methodology, as well as the potential consequences to ethnography when assessed by quantitative research standards. By sharing our experience, we add to the current literature debating the “ethics” of ethics committee review in qualitative research approval. Engaging with the academic debate surrounding “ethics creep” – the increasing jurisdiction of ethics committees over research design – we consider the possibility of moving beyond principle-based ethics towards an ethical theory that more fully addresses the complexities of ethnographic research.

Keywords: Research ethics, doctoral studies, ethnography, qualitative research, midwifery.

Introduction

Ethics committees, whose role is to review proffered research proposals for potential ethical breaches, are commonly situated in institutions such as universities and hospitals. They are referred to in Australia and the UK as Research Ethics Committees (REC), in the US as Institutional Review Boards (IRB) and in Canada as Research Ethics Boards (REB). In this article, we discuss the challenges encountered in gaining Human Research Ethics Committee (HREC) approval for a doctoral research study in midwifery being undertaken by Elizabeth Newnham (prin-

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principal researcher, midwife, PhD candidate), supervised by Jan Pincombe and Lois McKellar. First, we outline the effectiveness of ethnography and its relevance to midwifery as a research method that captures data not readily available with other research methods. Next, we address the challenges regarding ethical concerns in qualitative research, with reference to the growing disquiet among qualitative researchers

regarding HREC barriers to qualitative research methods. The hospital HREC review process of the doctoral research proposal is then described, with particular attention to their concerns over “consent” and “bias”. Finally, we highlight proposed adaptations to HREC processes and ethical models from the current literature and, using these and our own experience, suggest a move towards an understanding of ethics that is more fitting for qualitative research methods.

The aim of our research is to discover the personal, social, institutional and cultural influences on women in their choice to use or decline epidural analgesia in labour. Given the cultural influences on this decision, such as wider social perspectives on birth and pain, as well as the micro-culture of the hospital setting, an ethnographic approach was adopted. As the study of human society and culture, ethnographic research can provide rich data, though limitations include its lack of generalisability. Seventeen women were recruited for a series of three interviews and, with consent, the presence of Newnham in the labour room. In keeping with ethnographic method, a general period of observation in a large metropolitan hospital labour ward was undertaken by Newnham, including informal interviews with members of staff, the taking of field notes, and document analysis. By highlighting the problems encountered in the ethics approval process, which took eight months out of a three-year program of study, we hope that other doctoral students and researchers will gain some insight from our experience. We also seek to contribute to the continuing debate regarding ethics approval in qualitative research.

Cultural Influences on Birth

There is increasing understanding of the influence of cultural beliefs on women’s experiences of labour and the birth process (Davis-Floyd & Sargent, 1997). Cultural norms and accepted understandings of childbirth, technology and medical expertise help to shape not only women’s knowledge of the birth process, but also their attitudes towards their bodies, their babies, and their birth experiences (Davis-Floyd, 1994; Heinze & Sleight, 2003; Jordan 1980). These understandings necessarily extend to the use of analgesia in labour; therefore, an exploration of these influences goes some way to increasing our knowledge in this area, and an appreciation of cultural assumptions would also appear necessary for articulating and implementing areas of change. Ethnographic research thus has a specific and important role in identifying change requirements in health care institutions:

Ethnographies have a key role to play in creating a more efficient, more effective, more equitable and more humane health care system, particularly in illuminating the organizational and interactional processes through which health care is delivered. They offer important information, to policy makers and practitioners, about factors that compromise or promote high quality care, particularly the ways in which well-intentioned actions may have unanticipated negative consequences (Murphy & Dingwall, 2007, p. 2224).

Ethnography in Midwifery

Ethnography, as a qualitative research method, has been used to gain insight into Western culture including, in recent decades, cultural analyses of medical and health care settings (Liamputtong & Ezzy, 2005). With respect to midwifery specifically, ethnographic research has been useful in demarcating the juxtaposition of cultural norms: those of women, of midwives, of medical staff, and of the institution. A number of studies provide clear examples of this.

Hunt and Symonds’ (1995) ethnography of English labour ward culture provided insight into the assembly-line, industrial nature of labour in the hospital system which, along with working inside a masculine medical system, leads to a lack of autonomy for midwives—although this is offset somewhat by their status as skilled professionals. In addition, Hunt and Symonds (1995) found that midwives pursued ways of increasing control of their environment, including attempts to

“slow down the production line” (p. 144), by using admission criteria that separated those women in early labour from those in established labour. On the other hand, women in the study were in the position of possessing the least power and had very little control over their birth experience. Conversely, in an ethnographic study of a free-standing birth centre in England, Walsh (2006) has described how the intimate nature of a small unit is able to circumvent industrial or assembly-line care and, by doing so, is “putting women before the system” (p. 1338). The valuing of relationships over tasks, and the structural and temporal freedoms described in Walsh’s (2006) study benefited both the women and the midwives.

Kirkham’s (1999) ethnography of midwifery practice in the United Kingdom identified a divergence in cultural norms whereby midwives support women through their pregnancy and birth process, encouraging autonomy and control, but have little access to similar support, autonomy and control themselves. Equally, while promoting trusting relationships between midwives and women, there was a decided lack of trust within institutionalised midwifery, with midwives identifying a culture that emphasises self-sacrifice, guilt and blame, leading to a lack of solidarity between colleagues and a resulting horizontal violence. Midwives wanting to make changes felt they had to do so secretly for fear of being targeted as a misfit or deviant. Kirkham (1999) noted that this kind of behaviour, associated with feelings of powerlessness, is symptomatic of oppressed groups, therefore any attempt to make changes in the maternity system, she argued, needs to first address culture.

An ethnographic study by Dykes (2005) that examined interactions between breast-feeding women and midwives in English postnatal wards, found that the structure of the institution impinged on midwives’ ability to spend “relational” time with women, causing breast-feeding encounters to be technical directives (how to hold the baby, correct attachment) or hands-on intervention (which was viewed by the women as inappropriate). Although relational and supportive care did occur, it was often compromised by temporal restrictions of the institution. Machin and Scamell (1997, p. 83) described how medical interpretations of birth in the United Kingdom lead to a self-fulfilling situation whereby birth intervention is now perceived as safe and reassuring.

Pervasive cultural understandings of birthing practices and how these are reproduced has been described by Craven (2005) in an ethnography of homebirthing women in the United States. Craven (2005) delineated a medical discourse that equates homebirth supporters with “undesirables” such as child abusers and drug addicts because they do not conform to “normal” or mainstream motherhood practices. A recent study by Scamell (2011) identified how midwives reproduce medicalised “risk” culture in their language and use of surveillance techniques in labour, even as they profess to operate from a paradigm of “normal birth”.

Each of these studies demonstrate the value of ethnography as a means of providing rich, meaningful data that are not obtainable using quantitative research methods. Together, these studies point out the impact of culture on midwifery practice and therefore also on the women they care for. Most of these ethnographies were conducted in a maternity system that had yielded a number of government reports recommending policy changes this has occurred both in Australia and in the United Kingdom – prioritising midwifery care; in particular, continuity of midwifery care, and more choice for women in birth. However, although policies can provide positive impetus for change, it is also evidenced that culture – both institutional and wider social norms – guide practices and behaviours that may inhibit positive change (Cronk, 2000; Johanson, Newburn & Macfarlane, 2002; Kirkham, 2004; Reiger, 2006). By engaging in ethnographic research existing practices can be observed and analysed, and both positive attributes of, and barriers to, woman-centred care can be identified. A deeper understanding of the culture of maternity care institutions in an Australian context can supplement current midwifery theory by identifying midwifery practices within a specific cultural environment, and how these practices are simultaneously impacted

by culture, and how they then impact on the experiences of women, who bring their own set of understandings and beliefs to the encounter.

There is less research on the impact of culture specifically on the choice to use analgesia in labour. Heinze and Sleigh (2003) found that a woman’s choice to use analgesia in labour is more closely linked to her personal “birth ideology” than to the actual level of pain experienced. The ubiquity of technology, and the way in which this pervades birth culture, has been explored by Davis-Floyd (1994) in the United States. In addition, Walsh (2009) has commented that the rise in epidural rates in the United Kingdom (which is also mirrored in Australia, see Lain et al., 2008) could be due less to an increased requirement for analgesia than to a fragmented maternity system that leaves women feeling unsupported. Given that epidural analgesia carries certain risks with use (Anim-Somuah, Smyth & Howell, 2005; Gaiser, 2005; Rahm, Hallgren, Hogberg, Hurtig, & Odland, 2002; Jordan et al., 2009; Wang, Shen, Guo, Peng & Gu, 2009) and women are not always well-informed of these (Heinze & Sleigh, 2003), there is therefore a need for further investigation in this area, which our research aims to address.

Ethics in Qualitative Research

Leaving as little scope as possible for investigators to think for themselves about ethical dilemmas that inevitably arise in the real world, the cage that the IRB system creates preempts not just action but thoughtful ethical response (Bledsoe et al., 2007, p. 638).

In Australia, research ethics is guided by two comprehensive publications published conjointly by National Health and Medical Research Council (NHMRC), the Australian Research Council (ARC) and Universities Australia: *The Australian Code for the Responsible Conduct of Research (Research Code)* and the *National Statement on Ethical Conduct in Human Research (National Statement)* (NHMRC, 2007a, b). Earlier revisions of these documents, published by the main research funding bodies in Australia, placed ethical review requirements on social research, and these were firmly in place by the late 1990s (Guillemin & Gillam, 2004). While government and legislative regulation in qualitative research is now the norm, Katz (2006) has outlined various ways in which individual universities in the United States have variously negotiated ethics exemption for graduate students, or ethnographic research, or qualitative research involving data that is de-identified, where the names of participants have been removed. There is the possibility for this also within the *National Statement* (NHMRC, 2007b), for institutions to engage in a non-HREC review of low- or negligible-risk research. However, these levels of risk are subject to interpretation, and it is unclear whether the parameters described by Katz (2006) would fall under either definition of risk. The *National Statement* defines these thus:

Research is ‘low risk’ where the only foreseeable risk is one of discomfort. Where the risk, even if unlikely, is more serious than discomfort, the research is not low risk.

Research is ‘negligible risk’ where there is no foreseeable risk of harm or discomfort; and any foreseeable risk is no more than inconvenience. Where the risk, even if unlikely, is more than inconvenience, the research is not negligible risk. (NHMRC, 2007b, p. 18)

Even if such exemptions are possible at a university level, ethnographic research occurring within health care institutions will almost certainly need to be scrutinised by the institution’s REC. As our research focused on pregnant women, considered a vulnerable population (NHMRC, 2007b), our research proposal was automatically allocated to a higher risk level.

Ethical considerations in research do not begin and end with HREC approval. They are a consideration throughout the research design, data collection, analysis, and publication (Karnieli-Miller, Strier & Pessach, 2009; Blee & Currier, 2011). This is made quite clear in ethnographers’ accounts about negotiating ethical conundrums as they appear, quite unpredicted in the field

(Goodwin, Pope, Mort & Smith, 2003; Ellis, 1995; Stacey, 1988; Blee & Currier, 2011). There is a sense, in reading ethnographic studies, in which ethics needs to permeate the whole process. Despite the use of reflexive tools that inform ethical behaviour, on paper, this behaviour appears to be individualised to the researcher and his/her ethical conscience, and is difficult to explicate to HRECs used to strict medical or applied ethical guidelines. In fact, although HREC proposals and various ethical guidelines are in place to protect the public, ethics approval itself does not necessarily guarantee an ethical study (Haggerty 2004), as “[r]ules, rights, or responsibilities cannot shape ethical conduct if motivation, behavior, values, attitudes, beliefs, and interpersonal processes are not consciously analyzed” (Hewitt, 2007, p. 1156).

Ethnographic research depends on the building of trust and relationship with the participants of the study. Although this does not guarantee a complete awareness of all ethical considerations (Fine, 1993), it does have an impact on behaviour in the field, because in ethnography, “caring interactions are established and maintained over time rather than a contract that once signed is forgotten” (Milne, 2005, as cited in Librett & Perrone, 2010, p. 745). In fact, there is a danger rather of over-sympathising with the group in question, or “going native” (Fine, 1993). It has also been proposed that the closer the relationship between researcher and participant, the more likely it is that sensitive data is disclosed, increasing the risk to the participant of revealing more than they would have otherwise (Hewitt, 2007). The relational and empathic relationship building in qualitative research requires moral sensitivity and self-reflection, and the ability to anticipate potential situations that will require ethical consideration (Hewitt, 2007). These considerations will not necessarily have been foreseen prior to data collection, or written into ethics proposals, but the recognition that ethical concerns are ongoing can enhance the ethical direction of the research (Cutcliffe & Ramcharan, 2002). We recognise that field-site ethics is an intricate and thorny ethnographic question (for example, see Ellis, 1995; Blee & Currier 2011), and we do not mean to diminish the complexities of ethics in ethnography here. There is certainly no guarantee that ethnographers have an inbuilt ethical compass. However, we think that the central tenet of this paper, that of shifting focus from principle-based ethics, will aid the reflection of such complexities when they do arise.

Consent in Ethnographic Research

Consent in traditional medical trials is generally clear-cut. The population to be studied is identified, and their role in the trial is quite defined – for example, a particular intervention or treatment is introduced – and it involves a particular time frame, or prescribed set of circumstances. Risks and benefits can therefore usually be plainly laid out, and this has been necessary because medical trials so often involve people’s bodies, such as the taking of tissue, or the addition of a drug, that side effects and potential harm need to be clearly addressed.

The issue of consent, as it is commonly understood in medical research, is essentially turned on its head in ethnographic research. The definition of a participant can be unclear: for example, when does a casual conversation become “data”; what about when members of the public enter the field (Librett & Perrone, 2010, p. 733)? As ethnography is, by nature, the study of culture, how does one go about gaining written consent from all members, and would this not impact on the research process itself (van den Hoonaard, 2001)? Ethnographic studies have used various forms of consent in the past, along a spectrum from no consent (for retrospective data and personal experience, public spaces, covert research), implied consent and verbal consent, or consent from an institution to study the individuals within it (de Laine, 1997; Katz, 2006; Thorne, 1980). The emphasis on written informed consent was not a typical approach of ethnographers until the formalisation and institutionalisation of the ethics process by RECs (Thorne, 1980), in part, because it is counter-intuitive to the ethnographic method. It has been proposed that the use of consent forms, based as they are on Western notions of ethics that favour individualism, can be det-

perimental in cultures that value collectivism, can be considered too formal for ethnographic purposes, and can rupture the trust relationship between researcher and participant (van den Hoonaard, 2001).

In addition, because ethnographic research is not a one-off event or discrete episode, consent is more often seen as a process, an ongoing contract of negotiation, as experiences develop in the field (Cutcliffe & Ramcharan, 2002; de Laine, 1997; Murphy & Dingwall, 2007). Essentially, the researcher often does not know in advance the course the research will take, making it difficult to outline the full nature of the research, as requested by HRECs (Cutcliffe & Ramcharan, 2002; Karnieli-Miller et al., 2009). Qualitative methodologies are emergent, adaptive, and less predictable than biomedical research methodologies (Cutcliffe & Ramcharan, 2002; Flick, 2009; Katz, 2006), therefore setting out precise written consent forms can be problematic, but it does not then follow that the study is *ipso facto* unethical (de Laine, 1997). Furthermore, by regulating research within stringent guidelines of informed consent, critical research methodologies can be severely restricted, leading to the possibility that critical inquiry is abandoned by academics in favour of more amenable forms of research (Haggerty, 2004), and may also limit new knowledge production by curtailing academic freedom and creativity (Bledsoe et al., 2007; see also Hammersley, 2009)

Harm

Harm caused by ethnographic research is most likely to be at the time of publication, although there is also a possibility of psychological harm during data collection if difficult or sensitive topics are shared (Murphy & Dingwall, 2007). Harm can be caused by the researcher publishing findings that are distressing to the participants, or the possibility that, despite anonymity, a person is identified, perhaps by another member of the community (Librett & Perrone, 2010; see also Ellis, 1995). In addition, the close nature of the relationship between researcher and researched can also lead to harm, misunderstanding, or regret (for example, if the participant feels in hindsight they have revealed too much information) and thus needs to be at the forefront of the ethical researcher’s awareness (de Laine, 1997; Hewitt, 2007; NHMRC, 2007b; see also Stacey, 1988).

These potential harms are valid, and raise additional ethical issues, such as whether to publish findings that are potentially harmful or exposing, or the ethics of undertaking research that will not then be published or disseminated in other ways. Paradoxically, some ethnographers state that written consent might actually present another aspect of harm; participants can feel uncomfortable with signing an official document, or anonymity can be compromised by doing so, particularly when investigating sensitive areas such as criminal behaviour or workplace bullying (Librett & Perrone, 2010, p. 740; see also Bledsoe et al., 2007, p. 637). However, though it is an analytical and potentially critical methodology, ethnography is finally a method of “non-intervention”, and “in reality the risks to participants of observational research do not begin to approach the risks inherent in most forms of clinical or biomedical experimentation” (Murphy & Dingwall, 2007, p. 2231). In addition, levels of harm can potentially be dependent the distribution of power between researcher and participant.

Power

Differentiations of power are complex when studying one’s own culture. There is an obvious power differential between the doctor and patient in medical/clinical research, the effect of which is precisely what the principle of informed consent in biomedical research is designed to minimise (Murphy & Dingwall, 2007). Although there is most often a power differential between researcher and participant (Hewitt, 2007), it is also the case that qualitative research aims to create more egalitarian relationships (Karnieli-Miller et al., 2009). With this doctoral research project, there are multifaceted power differentials to take into consideration – such as the fact that Newn-

ham is a midwife, a role that is specified as being in partnership with women, and that Newnham and the interview participants are also all women – that obscure the lines that delimit relationships of power. Even though power relationships will be apparent in most social settings, and these need to be duly considered in conducting ethnography as in any other ethical research method, fundamentally, the ethnographer is a guest in the field. The ethnographer is reliant on the continued hospitality of the group, and this can also decrease the power differential. Participants have the choice to stop talking to the researcher at any time and exercise a degree of autonomy in that, to an extent, they decide what they say or do in the researcher's presence (Murphy & Dingwall, 2007).

Furthermore, the concept of vulnerable populations is contradictory and complex. While certain populations, such as prison inmates, have historically been exploited due to their lack of power, the situation now arises where researchers are put off examining vulnerable populations due to the extra time and aggravation of submitting such a proposal (Bledsoe et al., 2007). This is worrying, as not only does ethical research into vulnerable populations provide valuable knowledge and insight, but it can also be welcomed by participants (Haggerty, 2004). The women involved in our study were asked about their experience of the research process in their final interview. All of them saw it as a positive experience, the main impetus being altruism (helping women in the future; participating in knowledge production) but also the opportunity to talk about their experiences. While the hospital HREC acknowledged the “vulnerable population” status of pregnant women, their construction of junior doctors as the most vulnerable participants in this setting highlights the medical perspective from which it was viewing the research.

Ethics Approval Process

It took five months to negotiate in-principle support from a hospital before HREC approval could be sought. Once field access was provisionally gained, an ethics proposal was submitted to the university HREC. Whereas the university HREC did require some points to be addressed, largely around consent, the application was resolved within a three month period. Once university ethics approval was gained, the proposal was then submitted to the hospital HREC, with which we encountered difficulty in conveying the rationale and the benefit of ethnographic research. This process took another five months, leading to a total of eight months to get ethics approval. Added to the five months it took to get initial approval for access to the field, gaining access and ethics approval set back the research timeline significantly. This difficulty, the time consuming nature of explaining the finer points of qualitative research methods to hospital RECs whose proposal formats are geared towards biomedical research, has been described by others (see Parnis, Du Mont & Gombay, 2005) and presents a significant temporal obstacle to qualitative researchers in the health care field. In fact, Bledsoe et al. (2007, p. 614), describing changes in IRB structure at their university since the 1990s, comment that the time frame for review increased: ‘from usually around forty-eight hours for social science reviews to what could be months for even the most routine projects’. In this instance, it added pressure to the already challenging process of undertaking graduate research (Nutov & Hazzan, 2011; Spaulding & Rockinson-Szapkiw, 2012).

Ethics in research is vital in the safeguarding of human rights. The need for ethics committees and ethical requirements for research involving human beings evolved out the Nuremberg trials after WW2 (Haggerty, 2004; Murphy & Dingwall, 2007; Librett & Perrone, 2010). Given the exploitative nature of the experimental medical research carried out, it is not surprising that ethics committees place heavy emphasis on the consent process. However, the more recent inclusion of sociological research under the ethics committee umbrella does present as a potential predicament (Guillemin & Gillam, 2004; Fitzgerald, 2004) and social research in health care institutions is often subject to further scrutiny by its own HREC that is even less accustomed to qualitative research methodologies (Parnis et al., 2005). This is also noted by Hewitt (2007), who states “there

is evidence to suggest that local medical research ethics committees have difficulty assessing ethical issues arising in relation to qualitative studies ” (p. 1151). Sociological and ethnographic research is not exempt from needing ethical parameters and control, by any means. Nonetheless, as outlined below, ethical considerations are vastly different in qualitative research than in quantitative. In particular, the issue of consent is rather more blurred than in medical or scientific trials, and this has caused some confusion, as well as considerable time, in our ongoing dialogue with the hospital HREC. The focus of the RECs with regards to this research proposal has been predominantly the problem of consent, but the hospital HREC also focused on power relationships and the vulnerability of doctors. Both committees had questions about proposed informed consent and exclusion, and we addressed these concerns in detail.

Consent

The initial idea that we presented to the hospital HREC with regard to consent was an access agreement between the researcher and the hospital managers/unit leaders. This document outlined Newnham’s responsibilities as a researcher, and identified means for staff members to equitably and anonymously air any grievances regarding the research process. It outlined a continuing “contract” of ongoing consent and negotiation, on which Newnham’s presence as a researcher hinged. This seemed to be the most ethical way of approaching the research, as it allowed for staff involvement, and the capacity to address any issues as they occurred; however, it was rejected in favour of more traditional individual informed consent forms. The requirement to use individual consent forms appeared to be a priority for the HREC. However, the use of consent forms does not necessarily fit well into a qualitative research design, particularly ethnography, with its tendency towards more informal means of data collection (Haggerty, 2004).

On rejecting the access agreement, the HREC then asked for full written consent from all staff that Newnham might engage with, before even entering the field. Large institutions with a high turnover of staff and shift changes make the process of individual consent in ethnography almost unachievable (Green & Thorogood, 2009; Haggerty, 2004), let alone prior to entry to the field. At minimum, medical and midwifery students, anaesthetic and obstetric RMOs, registrars and consultants, casual staff, as well as large numbers of permanent staff would be encountered. In response, rather than attempt the impossible, we suggested that written consent from individual participants would be gained once in the field, and that this could only be done with participants present on the day of observation. The following matters were outlined several times: that ethnography is a study of culture/groups/organisations, not individual practice; that consent can only occur in the field; and that it is contractual, that is, dependent on an ongoing relationship between the ethnographer and the participant.

The final piece of correspondence from the hospital ethics committee requested for the consent of all relevant heads of department rather than just the obstetric and labour ward heads. In real terms, this meant gaining approval also from the heads of the anaesthetic and neonatal departments. Once this was achieved, it was then deemed more suitable to offer those staff who wanted to decline the opportunity to opt out of the study, rather than asking all staff to opt in, by way of a signed opt-out form. In part, this was because of the fact that if an anaesthetist or other staff member came into the room with a labouring woman where Newnham was also present, then explaining the study, and signing a written consent form could be disruptive. The final process has been to disseminate to as many staff as possible – through presentations, information sheets, and the presence of Newnham in the hospital – the aims and methods of the research, and inform these staff of the opportunity to opt out of the study. During the period of observation, no-one signed an opt-out form.

The process described above only relates to the consent of hospital staff members during the participant observation phase of the study. The pregnant women in the study who were recruited for

interview all had individual consent forms. They later also decided whether or not they would consent to Newnham's presence at their labour and birth. We set up the study in this way, as we did not want to intrude on women in the labour ward who were already in labour, to ask if a stranger could be present during the labour and birth. Therefore, the observation period on the labour ward took place outside of the birth rooms, unless one of the women already in the study, who had previously consented to Newnham's presence, was in labour. Newnham was on call for these births.

Bias

A further issue raised by the hospital committee was that junior medical staff are considered a vulnerable population and might change their practice if observed, to the point where "the risk for bias and consequent risk of adverse and/or biased outcomes (particularly in a labour ward setting) appears to be high" (HREC, personal communication, 2011). Although there are issues around power in the field, and they need due consideration, we found this comment somewhat surprising. Given the historical power base of the medical profession, the years of training and subsequent enculturation of doctors, and the fact that they are working within a clear professional model, with guidelines, policies and procedures, we did question how the presence of a midwife-researcher (qualitative at that) would impact on the practice of any medical professional. The need for Newnham's presence in the labour room was questioned, not because of the vulnerable situation of the birthing women, but because it might influence the practice of the doctors, particularly if they knew the true nature of the study.

Concern over focusing on epidural administration specifically as a pain relief option was also raised as a source of potential bias. In an attempt to give background to the study, in the opening paragraph for the participant information sheet, we wrote a brief sentence about the pros and cons of epidural analgesia. We also explained that the research would focus on discovering women's perspectives on seeking epidural pain relief. This background information was identified by the HREC as introducing bias (although the information in question could be accessed by women from any pregnancy website). It was considered a means of predisposing women to "researcher ideology" (HREC, personal communication, 2011). The hospital HREC required that the specific focus of epidural analgesia not be revealed. We were not entirely comfortable with this request, regarding it to be ethically questionable, as concealing the specific nature of study introduces an element of covert data collection. Equally, we disagreed with the premise that knowing the specific type of analgesia would actually introduce bias. Indeed, in qualitative research, the predisposing views of the researcher form part of the research process and, provided they are transparent, reflexively analysed, and do not unduly influence data collection, do not require eradicating in the name of objectivity (Hewitt, 2007). However, the information sheet was revised, informing participants that the study was focused on analgesia in general, to meet the HREC requirements. We did this despite our misgivings, because of time frame considerations and the concern that the proposal would not otherwise be approved.

The emphasis on bias by the HREC appeared grounded in quantitative epistemology and, as outlined, continued throughout the review process, despite our responses to their concerns, including the clear delineation of the tenets of rigorous qualitative research: the importance of recognising bias (or researcher stance) and writing this into the research process; of being clear and transparent in the collection and analysis of data; and the use of reflexivity (Karnieli-Miller, et al., 2009; Hewitt, 2007; Liamputtong & Ezzy, 2005; Thomas, 1993). In the ongoing correspondence with the HREC, it became apparent that the qualitative methodology was unfamiliar, and their main concerns lay primarily with the well-being of junior medical staff during the study. Bledsoe et al. (2007, p. 631) point out that the privileging of consent forms by IRBs over other ethical factors indicates a legalistic emphasis, rather than an ethical concern over the whole research project.

However, finally, after clearly outlining the purposes and methods of ethnography, it was not until we really laid out the bare bones of the study in this way – that the research is primarily focused on social and cultural influences on women in their choice to use pain relief, and that the doctor entering the labour room to perform a procedure is of least interest to the study – that consent was finally granted. In reality, while Newnham spoke to doctors about their thoughts regarding analgesia, she was only present in the room twice while epidurals were actually being inserted. In her observation, there was no question of the anaesthetist being influenced or vulnerable to her presence, although it was not always clear at the time that they knew Newnham was there in a research capacity (which presents another ethical conundrum altogether, and needs to be addressed more fully elsewhere). However, even though Newnham did document these encounters in her field notes, the presence of the doctor did not represent a major aspect of the study, as we suspected. This illustrates Haggerty’s (2004) point that it is difficult to transfer the notion of risk as a quantifiable measure, as it is used in biomedical research, to qualitative research scenarios; scenarios involving harm cannot be projected in a tangible, empirical way, and are consequently subject to the imaginations of the REC members, and therefore essentially both limitless and subjective.

Discussion

Qualitative research in health care settings is necessary for increasing knowledge and understanding of meaning and experience, and, in critical frameworks, researchers also attempt to unravel the influences of power in the construction of these meanings (Hewitt, 2007; Thomas, 1993). Qualitative research addresses aspects of people’s lives that cannot be understood through positivist research methods, as important as those methods also are. Ethnography in particular is able to scrutinise culturally reproduced normative behaviours and identify beliefs that are represented as truth. Ethnography has been described as “the gold standard for the study of processes” (Murphy & Dingwall, 2007, p. 2230) and as such, it is important that future ethnographic research is not abandoned, or subject to so many restrictions that it becomes meaningless.

Our experience with the hospital HREC illustrates their emphasis on principle-based ethics, and the attempt to define this by the use of individualised written consent forms (albeit opt-out, rather than opt-in). It appears that RECs, by virtue of their foundation in biomedical research, use quantitative standards and methods leading to a paradigm bias against qualitative design, and concerned researchers have remarked on this over the last decade (Bledsoe, et al., 2007; Cutcliffe & Ramcharan, 2002; Haggerty, 2004; Librett & Perrone, 2010; Murphy & Dingwall, 2007; Ramcharan & Cutcliffe, 2001). In considering this matter, Parnis et al. (2005) recognised the adherence of the health care institution REC to a dominant (biomedical) framework as a significant impediment to carrying out their research. The lack of knowledge about qualitative methodology led to requirements that these authors deemed as inappropriate, and they remarked that “the many strategies we established to respect the women who participated in our research were as or more valuable than the formulaic expectations laid out on the ethics application forms, which were, arguably, better suited to biomedical research” (Parnis et al., 2005, p. 694). Parnis et al. (2005) admitted that their final research proposal differed fundamentally from their initial one, in part because of a concern that the ethics committee simply would not approve their original proposal. This was not because it was unethical, but because their use of feminist methodology would be misjudged, largely because of the committee’s emphasis on risk and paternalism (Parnis et al., 2005). In a similar vein, we also found ourselves complying with a consent process that appeared less ethical than our initial proposed access agreement, and with a changed study outline, in that the disclosing of the study’s particular focus was veiled to participants.

The situation of having to change a research methodology or design because of ethics committee input has also been described by Librett and Perrone (2010), and they suggest that the “mission,

purpose and objective of IRBs ... can hinder the researcher's ability to conduct ethical research" (p. 742). In addition to potentially decreasing the ethics of studies, this situation is problematic because it can lead to circumstances where ethics committees have power over knowledge production (Haggerty, 2004; Librett & Perrone, 2010). Reasons for this are multifactorial, but include: misunderstanding of qualitative research methodologies; emphasis on medically determined risk prevention; paternalism; and narrow definitions of informed consent. There are examples of qualitative research proposals being rejected outright by ethics committees because they are not "science" (Librett & Perrone, 2010, pp. 734-736), and of research topics discarded before they commence just at the thought of the ethics review process (Bledsoe et al., 2007). Ironically, this circumstance, where ethics committee regulation can act as a barrier for otherwise ethical research, has itself been described as unethical (Nicholl, 2000, as cited in Murphy & Dingwall 2007, p. 2228), and is effectively limiting research directions by academics and their students (Bledsoe et al., 2007). By emphasising the ethical principle of "autonomy" (on which informed consent is based), it may be that principles of respect, justice and beneficence are impeded (Murphy & Dingwall, 2007), particularly if ethnographic research proposals are being changed or refused purely because of a lack of "fit" between the messy qualitative reality and the neat quantitative ideal of informed consent.

Addressing Ethics in Ethnography

In an attempt to address the above concerns, it has been suggested that ethics committees specifically designed for ethnography be arranged. Failing that, that traditional ethics committees be mandated to include an ethnographer, and/or that ethics committee members are trained in qualitative research methods (Librett & Perrone, 2010). Ethics training and accreditation for academics as a way of bypassing the need for ethics review, freeing RECs to monitor continuing research has also been suggested (Murphy & Dingwall, 2007). In addition, the lack of transparency of REC review processes has been acknowledged (Haggerty, 2004), and it has been suggested that public dissemination of review board decisions could assist scholars by utilising a system similar to that of legal precedence (Katz, 2006).

However, in an insightful paper, Guta, Nixon and Wilson (2012) have framed the apprehension of academics over the "ethics creep" of RECs (Guta et al., 2012; Haggerty, 2004) within the broader neoliberal 'apparatus' that impacts the wider research community (including academics, researchers, members of RECs and research institutions) as funding, knowledge commodification and bureaucratic demands are changing research culture as a whole.

While we are troubled about the notion of ethics creep and the potential for advancing a specific knowledge agenda, the concern raised by Guta et al. (2012) – that the current academic disparagement of RECs specifically may detract from a wider critique of macro influences – is of note. Therefore, suggestions that address the issue at an REC level, although potentially useful, do not necessarily confront the wider issue of "profitable academia" or the idea that academics are increasingly frustrated with this process, in part, because of the increasing pressure to access funding, to publish, and to compete in this environment (Guta et al., 2012, p. 8). These complexities, including the various external influences on RECs, and the fact that participating members of RECs are often themselves researchers and academics, have also been noted by Bledsoe et al. (2007), who nevertheless conclude that the current status quo serves to limit research and knowledge production.

A way through the research ethics quagmire may lie in proposed models of ethics that move the debate forward by stretching the ethical imagination. In an attempt to bridge biomedical and social research ethics, Ramcharan and Cutcliffe (2001) have identified what they term an *ethics as process* model that focuses specifically on the intricate ethical dilemmas encountered in qualitative research, and which addresses areas of risk to participants that might not have been consid-

ered by a REC. To this end, the authors recommend a monitoring process, whereby emerging ethical issues can be addressed as they occur, and the risk:benefit ratio of the research is balanced contemporaneously, initially inclining towards benefit rather than risk (Cutcliffe & Ramcharan, 2002; Ramcharan & Cutcliffe, 2001). The advantage of this model is that ethical concerns stay at the forefront of the research process, whereas “[p]erhaps traditional a priori approaches to ethical consideration would have indicated that once formal approval had been granted by the ethics committee, providing the research team adhere to the plan of study, they need pay no further attention to subtle ethical concerns” (Cutcliffe & Ramcharan 2002, p.1006).

Hammersley (2009) also made the point that the status of ethics approval could lead to a diminishment of the researcher’s sense of ethical responsibility. Rather than the further regulation that Ramcharan and Cutcliffe’s (2001) model might imply, Hammersley (2009) considered that RECs hold no authority to regulate research ethics, and would play a more useful role by providing a place for the discussion and facilitation of ethical issues for researchers. This approach, of a REC having a facilitative, rather than a regulatory, role would appear to support the ethical nuances of qualitative research. Outlining case studies of a REC that utilised a “values-based approach”, Connolly and Reid (2007) have written that included in this approach was the acknowledgement that researchers had expert knowledge of their methodologies, and if peer review were achieved, the REC did not consider methodology part of their remit. Currently, the majority of RECs consider the methodology as part of the overall review process, and this is a bone of contention amongst qualitative researchers (Hammersley, 2009; Ramcharan & Cutcliffe, 2001). This scenario represents a positive step forward in the current debate of the role of RECs in qualitative research. The raft of matters needing to be attended to in qualitative inquiry, including: ongoing consent negotiation; member checking; avoiding putting pressure on participants; avoiding the situation where respondents reveal too much; balancing personal versus social benefit; and leaving the field (Blee & Currier, 2011; Cutcliffe & Ramcharan, 2002; Ellis, 1995; Hewitt, 2007; Ramcharan & Cutcliffe, 2001) that are currently negotiated individually by researchers, and historically neglected by RECs, could be tackled in mutually conducive way.

Three other models that attempt to broaden the concept of ethics are now described. Guillemin and Gillam (2004) sought to differentiate between the “procedural” ethics of RECs, and the “ethics in practice” of everyday fieldwork. In doing so, they have proposed that the notion of reflexivity, usually understood by its role in determining rigour, be used as a means of establishing ethical decision-making. In this sense, reflexivity requires an acknowledgement of the “microethics” of daily encounters in fieldwork, sensitivity to these moments when they arise, and, by virtue of the former two, an ability, or at least an increased potential, to therefore attend to these “ethically important moments” when they occur (Guillemin & Gillam 2004, p. 276). Hewitt (2007) has outlined an argument for an *ethics-of-care* (Gilligan, 1982, as cited in Hewitt, 2007), with feminist underpinnings, whereby an adherence to specific ethical principles is seen as less important than taking a committed stance as a researcher to empathy, responsiveness, and engagement with participants on an equal footing. González-López (2011) introduced a framework of *mindful ethics*. Founded on the Buddhist concept of mindfulness, grounded theory, and Guillemin & Gillam’s (2004) ethics in practice, it has an emphasis on openness, receptivity and flexibility that is rooted in connectivity rather than individualism. These conceptual models represent a shift from an ethical understanding based purely on principles (of autonomy, beneficence, respect and justice) and attempt to enhance the ethical direction of qualitative research by moving beyond the principles-based general to the more nuanced particular.

Just as the REC ethics approval process has been described as taking attention away from daily ethical dilemmas (Bledsoe et al., 2007; Cutcliffe & Ramcharan, 2002; Hammersley, 2009), it follows that a shift towards such models could have a positive influence on transforming the REC role towards that of facilitator rather than regulator, in ways such as those illustrated by Connolly

and Reid (2007). Ideally, continuing robust discussion, theorising and practice that embraces the nuances of qualitative research, that recognises the connectivity between researcher and researched, and the potential for good or harm that this entails could even, eventually, have an impact on Guta et al.'s (2012) "research machine industry" (p. 8).

Conclusion

In detailing our experience, we contribute to the current debate within qualitative research literature about the ethics review process from an Australian perspective. We have highlighted several points of contention by the HREC toward our proposal for undertaking ethnographic fieldwork and, although it was ultimately approved, it required several changes which we were reluctant to make. In addition, the approval process consumed a substantial amount of the second year of PhD candidature, causing significant stress and pushing out the research timeline. We agree with points in the extant literature that an altogether different system of ethics is appropriate for qualitative research methodologies, and that a move towards a more facilitative role for RECs would be useful in furthering the exploration of ethical questions in qualitative inquiry. As research ethics becomes concurrently more institutionalised, yet increasingly complicated, Guta et al. (2012) ask that we "(re)imagine the ethical researcher in today's academic industrial complex" (p. 9). In order to do this, we suggest that ethics models that focus on the particular – the nuanced ethnographic experience – provide a way forward. Although we do not reject outright the usefulness of principle-based ethics, particularly in their context of human rights over bodily interference, there is opportunity for increased ethical responsibility, in conjunction with a revision of the REC role, in continuing a comprehensive and robust dialogue addressing the subtleties and complexities of ethics in qualitative research.

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