

Childbirth practice and Feminist Theory.  
Re-imagining birth in an Australian public hospital

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree at any other University or Institution.

(Signed) Albert Taylor

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## CHILDBIRTH PRACTICE AND FEMINIST THEORY: RE-IMAGINING BIRTH IN AN AUSTRALIAN PUBLIC HOSPITAL

### *Abstract*

The thesis involves a re-examination of feminist views of the childbearing body from a post-structuralist perspective and applies these theoretical ideas to an empirical investigation into contemporary childbirth and midwifery. Critiques of medicalised childbirth developed in Australia, Britain and the USA in the 1970s are related to debates within feminism about appropriate ways to theorise motherhood and the female body as well as to understand the role played by midwives and doctors in childbirth. It is argued these critiques were the product of three strands of feminism that differed in their analysis of gender politics, their philosophy of knowledge and their understanding of power. The three critiques are also related to differences between the USA, Britain and Australia in respect of their medical system, ways in which the history of childbirth practices are viewed and differences between the professional roles of midwives. It is argued that these critiques need to be modified by more recent post-structuralist feminist approaches, particularly the way in which bodies are shaped by language and power is related to the distribution of knowledge

The empirical study concentrates on a maternity unit in a regional town in New South Wales. The unit was studied through repeat interviews with mothers attending the hospital for the birth of their second or a later child, interviews with the midwives and doctors working in the unit and observations over several months. Childbirth is re-imagined as a drama and found to be an intense embodied experience shaped in turn by the practices of the hospital and the changing boundaries between medicine and midwifery, relationships of the women with the staff and the women's own diversity. This approach to the analysis of the interview data demonstrates the limitations of the liberal feminist critique that there is insufficient rational and 'scientific' evaluation of childbirth practices, the radical feminist critique that the key issue is men's domination of women's bodies and the materialist feminist critique of the lack of fairness and support given to childbearing women, while showing how these discourses continue to circulate in debates over the management of childbirth.



## INTRODUCTION.

### *Childbirth and the social body.*

A quarter of a million births take place in Australia every year, the overwhelming majority of them in hospitals (Nassar, Sullivan, Lancaster, & Day, 2000). Birth is both a powerful personal event and a fundamental and significant social event. Because childbirth and reproduction are essential to the continuation of any society, it is in many ways surprising that they are not more central to social theory. The explanation for this lack of attention seems to be because they have been assumed to be part of the natural, rather than the social world. Seccombe (1992:9) points out that even though Marx was critical of the naturalism of nineteenth century Malthusian theory, he nonetheless appears to have assumed that reproduction was part of the natural sphere and could be left to “the worker’s drives for self-preservation and propagation” (Seccombe, 1992:256). van Kreiken (1997) similarly notes that men and women in contemporary sociology are rarely understood as ‘reproductive beings’.

In an immediate sense the way in which birthing occurs shapes the population and age structure, which in turn affect the economic life of the community. These issues have been the focus of demography and the study of family formation (Seccombe, 1992:10), while the rates of maternal and infant mortality which have been within the domains of medicine and public health, are used as indicators of the prosperity and health of a society (Black, Townsend, Davidson, & Great Britain Working Group on Inequalities in Health., 1982). However, demography and public health approach birth as a biological event with cultural consequences, rather than seeing birth itself as culturally shaped.

This study of childbirth is focussed on the cultural and approaches it through three different types of understanding of the birth process. First the broad approach to a range of issues based on a scholarly understanding of childbirth in its social setting. Second, the understanding of those taking an active political role in fighting for policy changes in the childbirth field. And third, the understanding of the women who give birth and the staff who take care of them. This latter strand is based on my own empirical study of a regional hospital, focusing on routine practices in a mainstream institution. Hospital practices have often been set up as the despised “other” form of practice, which always falls short of the ideal childbirth, yet rarely is there a detailed examination of what actually happens.

### *Main issues*

In the extensive debates about childbirth practices over the last thirty years, three main issues have been at stake. The first involves the individual subject and the significance of birth as a physical, psychological and cultural phenomenon. This involves theoretical questions about the understanding of the relationship between the mind and the body, the individual subject and the culture. Childbirth is both common

and exceptional as a physical experience and should be a fruitful site for theorising these issues, if it is not relegated to the realm of the 'natural'.

A second issue involves the significance of birth within feminist literature. Despite rumours of technological experimentation which would dispense with bodily birth or extend it to men, at present only women give birth, and so the significance of birth to female subjectivity and hence to feminism has been widely debated (Ruzek, 1978) (Oakley, 1981b) (Mortimer, 1985) (Adams, 1994) (Umansky, 1996). At the beginning of the 1970s there was a diversity of views about childbirth and feminism, though the issue was taken up most strongly by radical/cultural feminists in the USA. Since then a particular view of the 'natural body' has become associated with 'feminism', something that obscures the diversity of views amongst feminists and the wider community of women and elides the theoretical complexity of the issue into an opposition between male and female dominated childbirth (Annandale & Clark, 1996).

The third much debated issue relating to childbirth involves the context in which it occurs, the kind of assistance practitioners should provide and issues relating to their training, remuneration and the philosophical framework within which they should operate. Practices vary between countries and between different systems within countries (De Vries, Benoit, van Teijlingen, & Wrede, 2001; Oakley & Houd, 1990). But something observable in most countries is that the majority of obstetricians have been men and midwifery has been practiced almost exclusively by women. This raises the issue of the boundaries and power imbalances between different kinds of practice and professions in strongly gendered occupational structures (Ruzek, 1978) (Benoit, 1989; De Vries, 1985; Gross, 1984) (Butter, Carpenter, Kay, & Simmons, 1987; Schofield, 1995). The identification of midwifery as a feminist practice (Rothman, 1990) and with 'natural childbirth' should not divert attention from social and political differences in the practice of midwifery and the cultural shaping of childbirth (De Vries, Benoit, van Teijlingen et al., 2001).

### ***The reason for my involvement in childbirth theory and practice.***

My interest in these issues and my desire to understand them more fully are the result of my own experiences over the last thirty years during which I have been a witness to these developments and a participant in many of these debates. In the 1970s, I was interviewing women in the UK about antenatal care when I had my first experience of midwifery-managed childbirth. I was accompanying a community midwife who worked on a 'Domino' (Domiciliary in and out) scheme, meaning that she looked after her own patients at home before and after the birth. She did take advantage of the hospital facilities for the delivery, but behaved at the hospital exactly as she would have done if she had been in the woman's own home. This demonstrated to me that it is possible to have very personal individualised care in a public health system and that there is no contradiction between having high technology available and delivering safe low-tech care.

Later when I was living in the USA, the professional women I knew accepted without question the system of expensive private medicine. I observed that it seemed to be normal practise to have a Caesarean section, so that work schedules, leave and

childcare arrangements could be predictable. Working class women, on the other hand, especially African American women, had little access even to ante-natal care and there appeared to be very little public concern about the fact that a wealthy city like Boston was reported as having a rising perinatal mortality rate.

When I migrated to Australia, I maintained an interest in birthing issues and became involved with groups campaigning for increased recognition for alternative birth practices. After some time, I recognised that the campaigners had two different objectives. Some wanted mainstream policies to incorporate natural childbirth, including low risk homebirth, rather as midwifery was practiced in Britain. Others rejected mainstream practices and relied on a separate identity for midwives rather as alternative midwifery has developed in the USA. They were much more sceptical about medical concepts of risk and particularly emphasised the importance of all women having the choice to birth at home with any attendant they wanted.

As well as being immersed in the debates of the alternative birth movement, I was visiting mainstream hospital maternity units as a volunteer 'labour supporter'. Being present during several women's labours and births allowed me to observe the way institutions were or were not flexible in response to alternative demands. At the same time, I had many conversations with Australian women outside the alternative birth movement whose expectation was to have a private obstetrician if they could afford one, even for routine births. These quite extensive earlier experiences stimulated my interest to undertake this study and also sparked many of the questions that I have attempted to grapple with through the research.

## ***Background***

Childbirth issues were evident in academic and popular debates in the 1960s and 1970s because the medical profession was being heavily criticised for the excessive use of medical technology (Wajcman, 1991). It should be remembered that, although this development occurred widely across the English speaking world, the actual treatments and hospital systems were very different and this issue will be addressed in Chapter 2. It is the case that many women were dissatisfied with the experience of hospital care and felt that they had no choice over their childbirth nor control over their own body (Arms, 1975; Oakley, 1976, 1979) (Shaw, 1974). The ideas of 'choice' and 'control' suggested that hospital childbirth practices should be examined in terms of consumer satisfaction or lack of it, like other consumer issues such as more liberal visiting hours or access to elective surgery. The investigation of consumer satisfaction with medical care is fraught with difficulty. Most surveys do find that patients express satisfaction with medical care but this is often because they do not have a clear understanding of the alternatives to it or are deferential to the superior knowledge of the medical profession (Oakley, 1992a; Porter & MacIntyre, 1984). The issue of what women want in childbirth is extremely complex and the last thirty years have seen a proliferation of surveys and reports on the issue (Bramadat & Driedger, 1993; Brown, Lumley, Small, & Astbury, 1994; Cunningham, 1993; Gosden, 1990; Martin, 1990). The response from medical organisations involved pointing to surveys of satisfied patients in order to refute these criticisms. However, the issue was far more significant than simply one of consumer satisfaction, though as Crouch and Manderson (Crouch & Manderson, 1993b) argue, these changes in

childbirth practice were consonant with the change to an affluent consumer society in the post-war period.

Childbirth is not just a consumer issue, but touches on women's autonomy and control of their own bodies, issues which were central to second wave feminism. Although in some sections of the women's movement, issues of 'body politics' were controversial, the women's health movement argued strongly that they were an important aspect of the feminist agenda and not just a matter of middle class reformism (Ruzek, 1978). Childbirth appeared as a topic at feminist conferences in both Britain and the USA (Allen, Sanders, & Wallis, 1974) and women in the academy took up the subject. By 1977 there was sufficient literature for a review (MacIntyre, 1977) which categorised childbirth studies as "historical/professional, describing changes in the professional and lay management of childbirth; anthropological focussing on the relation between the management of childbirth and cultural beliefs; patient-oriented studies which examine the perspective of those using the maternity services and patient/service interaction which look at communication between users and providers".

MacIntyre cautioned against accepting 'natural childbirth' ideas uncritically and it does appear that one particular view of childbirth practices tended to be identified with the feminist movement. This suggested that hospital childbirth was a form of technological, patriarchal or capitalist domination which women should resist, "many feminists view obstetrics as forms of sexual politics, putting men's interests ahead of women's health" (Ruzek, 1978:12). Resistance to medicalised childbirth took various forms including the promotion of homebirth, midwifery care and 'natural childbirth'. Ruzek (1978:112) divided birth options into 'conventional feminist' care with registered practitioners and 'radical feminist care' which took place entirely outside the health care system. There is no reason to doubt that for many women the realisation that they could give birth without medical assistance was empowering (Gosden, 1990; Noble, 1997). However, as MacIntyre (1977) had suggested there was a tendency to idealise 'natural' birth and alternative midwifery.

In particular, the predominant theoretical position of the campaign to reform childbirth was to make a firm opposition between a 'medical model' of care by male doctors to an alternative 'woman centred' model practiced by female midwives (Lumley & Astbury, 1980). Hospital birth practice was seen as demeaning to women as mothers and as autonomous individuals. On the other hand, the midwifery model was seen as sensitive to women's concerns and based on a holistic understanding of the person leading to women's empowerment and to birth without intervention or pain relief (Cosminsky, 1976; Ehrenreich & English, 1973; Oakley, 1976). Setting these models up in opposition diminishes the differences which are found between countries or within occupational groups (Oakley & Houd, 1990). It also means that hospitals, where the vast majority of women have their children, are often compared unfavourably with the very small number of homebirths, instead of being understood on their own terms. This is, as Annandale and Clark (1996:30) point out, one of the disadvantages of a theory which assumes an opposition between male and female, technological and natural.

Similarly, the use of historical and cross cultural models led to a modern myth about a pre-industrial utopia in which women were at one with their bodies, gave birth naturally, controlled their sexuality with herbs, ate natural foods and gave birth

without any problems (Purkiss, 1996). Subscribing to this view implies both technophobia, which sees any interference with the body as a threat and a particular psychological understanding of a pre-existing natural body. If the 'oppressive' conditioning is removed the natural, healthy, non-violent, sexually liberated body will emerge.

This utopian view needs to be problematised for several reasons. First, it does not do justice to the theoretical complexity of the relationship between the mind and the body. Birth experiences are widely variable, with some people experiencing great pain and a high level of medical intervention. Others do not complain of pain and give birth with very little intervention (Arney & Neill, 1982; Green, Coupland, & Kitinger, 1990) (Sakala, 1988) (Sandelowski, 1984). Cultural constructions of the female body and social arrangements for pregnant and birthing women, as well as the practices of their carers play a major role in creating these differences. However, such beliefs and practices are more deeply rooted in both social life and the psyche of the individual than the 'myth' suggests. Such accounts abstract from idealised versions of history and from accounts of other cultures a literal understanding of how alternative birth practices can be introduced, rather than understanding them as saturated with complex relationships of knowledge and power. Studies based on actual examples of pre-industrial midwifery find that they are much less ideal than the myth suggests (Benoit, 1989; Leap & Hunter, 1993)

Second, this view associates 'feminism' with one particular kind of analysis of birth and the female body (Pringle, 1998:47). All strands of feminism aim to increase women's individual well being and social power, but many have reservations about promoting this on the basis of the ability to give birth and the qualities associated with motherhood, such as self-less commitment and non-aggression (Snitow, 1990). Many branches of feminism have reservations about the conservative political implications of promoting childbirth as empowering for women (Doyal, 1995) (Lupton, 1994).

Third, 'Natural childbirth' as a self-conscious entity (rather than as childbirth before the possibility of medical intervention) is far more problematic than was often recognised in the 1970s. The history of this self-conscious concept goes back to the 1930s in Britain and the USA and it was 'invented' by a male doctor (Sandelowski, 1984). Even in the 1970s natural childbirth practitioners were not necessarily feminists but also women whose political views and sexual politics were conservative, for example from the Mormon community (Sakala, 1988). It is mistaken therefore to suggest that there is something inherent in the nature of childbirth without medical intervention or midwifery care which is intrinsically feminist or liberating.

The question of whether women want natural childbirth is not a simple one. Margaret Nelson (1983) argued that fashionable ideas of natural childbirth which she had expected to elicit in her interviews with women were a middle class phenomenon and were not shared by her working class subjects who wanted to 'get the birth over with'. Emily Martin's (1987) research reached the opposite conclusion, that middle class women were more likely to adopt a "medicalised" vocabulary and frame of reference, while black and lower class women were not drawn in to the language of medicine and were at least as likely as middle class women to resist medicalisation (Martin, 1987:190,196). More recently, Ellen Lazarus (1994) has argued that there is a class dimension to women's desires but that it does not fall on a natural/technological

divide. She found that middle class lay women expect the doctor to be their advocate in the system to give them a sense of control, middle class health professionals use their knowledge of the system to get what they want, whether that is technology or not but poor women do not expect any control, but are more concerned with continuity of care.

Research in Britain, where midwifery care is more routinely available, does not appear to show a strongly marked pattern of class differences, but a wider acceptance of low intervention birth than reported in the USA (Green, Coupland, & Kitzinger, 1990; Martin, 1990). This variation in the research findings suggests that women's birth choices and hospital birth practices are highly conditioned by the cultural context. It is clear that there is a very complex relationship between women's desires and the organisation of maternity care (De Vries, Salveson, Wiegers, & Williams, 2001).

Activists who are immersed in the struggle to achieve choices for women, such as access to birth centre and homebirth options and increased recognition for midwives do not necessarily dwell on theory and continue to depend on a range of assumptions which mirror those of the '(cultural) feminist' position developed in the 1970s and 80s. Childbirth as 'natural', midwifery knowledge as 'innate' and women as essentially gentler are all commonplace concepts within campaigns for natural childbirth, as seen for example, the title of an Australian midwifery article, *Women have the innate knowledge and wisdom to birth* (Markus, 1997). Even mainstream sociology of health and illness often does not address the issue in terms of complexity but relies on a simplified version of the feminist critique of childbirth (Annandale & Clark, 1996:28).

On the other hand, contemporary feminist theorists tend to ignore childbirth in favour of more exotic terrain. Even though 'the body' is a central preoccupation in post-modern feminist theory, 'childbirth' almost never appears in the index of these works. Extreme bodily situations, such as torture, eating disorders and artificial reproduction seem more fruitful for theorising (Caddick, 1995; Komesaroff, 1995; Rothfield, 1995; Scarry, 1985). Some feminist writings on the body (see for instance Grosz, 1994) suggest that culture and language are not an overlay of the 'natural', but deeply intertwined in the construction and experience of the self. But birth appears to be abandoned as a topic to the advocacy of the natural, the authentic and the caring by childbirth advocates while other post structuralist feminist writers are concerned to work outside the 'reproductive metaphor' altogether (Butler, 1990; Haraway & Randolph, 1997). On the other hand, when post-structuralist concepts are suggested as useful for the study of reproduction within the sociology of health and illness (Annandale & Clark, 1996), they are met with vehement rejection (Campbell, 1997).

If the same theoretical concepts cannot be addressed to all areas of embodied experience, this reinforces the disjunction between maternity and sexuality as if, as Mortimer (1985) suggests, women were divided into 'reproductive and non-reproductive castes'. It is true that if present trends continue, almost 24% of women will remain childless in Australia (Australian Bureau of Statistics, 2001). However 76% of women will be expected to have children, so feminist thinking needs to address the issue rather than allowing a theoretical division of labour in which childbearing women are only mentioned by cultural feminist writing. It would be

strange if feminist theory split into different realms for women who give birth and women who do not. This is why it is important to question the taken for granted position, even if it still has currency in activist circles.

The absence of childbirth as a subject across the whole of feminist theory, as well as the issue of whether childbirth has or has not changed for the better in the past thirty years indicate that the taken for granted position is due for review. Good theory ought to allow the assessment of practice in the light of new theoretical models as well as to see how the theory performs in the realm of practical action (Fraser, 1989:2).

***Childbirth and feminism in the twentieth century.***

Lumley and Astbury (1980) trace two different understandings of the experience of childbirth – one that it should be pain free, the other that it is necessarily painful but that this may be a positive experience. Debates over this issue go back to nineteenth century controversies over women's education and political participation known as 'first wave feminism'. Laqueur's (1990) history of the scientific understanding of sex points out that the place of women in the public sphere and the claims of feminists and their opponents were highly contested and "the battleground of gender roles shifted to nature, to biological sex" (Laqueur, 1990:152). There was a rapid increase in writing about "the nature of women" and of scientific research about anatomy and physiology of reproduction and, in the early twentieth century, the role of hormones. But, Laqueur points out, claims made about sex were part of the political argument, "not susceptible to empirical testing" because the language and presuppositions of scientific enquiry were already saturated by gender (Laqueur, 1990:153). This nineteenth century scientific sexism underpins the idea that childbirth is women's destiny and that it is also a cause of her inferiority.

The question of whether middle class white women would want to continue having children was of great concern at the beginning of the twentieth century because of increasing education for women, the falling birth rate and the use of contraception (Davin, 1974; Reed, 1978; Willis, 1983:112). Many first wave feminists in the USA had experienced 'painless childbirth' developed at specialist clinics in Germany and they demanded anaesthesia in childbirth for all women as a feminist issue (Leavitt, 1980). Many doctors were reluctant to carry out this type of anaesthesia, because of side effects and because they did not like patients demanding particular treatments. The necessity for supervision of women who were heavily sedated expedited the move from home to hospital birth in the USA (Wertz & Wertz, 1977). However, even as changes were being made in childbirth practice, there was considerable debate about the meaning of birth and the best way to understand it. Psychoanalysis was one of the pervasive forms of cultural explanation in the twentieth century, both clinically, in popular culture and in the evolution of gender theory (Kaplan, 1992: chapter 2) and one of its best known formulations was Freud's argument that childbirth was the culmination of 'normal femininity', because, only by bearing a child, preferably a male child, could a woman be compensated for her 'penis envy'. This theoretical development was part of a heated debate over femininity within psychoanalysis in the 1920s and 1930s (Chodorow, 1989). Many women analysts argued against the idea of penis envy by asserting that little girls were equally proud of their ability to reproduce and had an intuitive knowledge of the value of their reproductive anatomy. This was "a model of women with positive primary feminine

qualities and self-valuation, against Freud's model of woman as defective and forever limited, and ... (a) recognition of a male-dominant society and culture" (Chodorow, 1989:3). Such an innate level of gender awareness places at least as much stress on biological destiny as the strictly Freudian view, but the debate lays the foundation for a division over the understanding of female subjectivity, one which promotes motherhood as a strength, the other as a source of weakness.

The idea that childbirth pain is productive became widely known through the work of Helene Deutsche (1945), a German trained psychoanalyst who moved to the USA to escape Nazism. Like Freud she argued that normal women are necessarily 'masochistic', in the technical psychoanalytic sense of deriving pleasure from pain, because otherwise they would not willingly submit themselves to the demands of reproduction. Even with this theoretical justification for the necessity of pain, Deutsche concluded that childbirth without anaesthesia was bound to disappear, not because the medical profession imposed it, but because the "new woman" of the 1930s and 1940s would not tolerate it.

A modern woman, asked to endure labor pains without recourse to the modern devices for easing childbirth, and thus to abide by the Bible's commandment, "In sorrow shalt thou bring forth children," would certainly reject the proposal with indignation. Obstetricians tell us that pregnant women often make them promise at the very first consultation that everything possible will be done to alleviate their labor pains... (Deutsche, 1945:241).

Margaret Mead and Simone de Beauvoir were writers of the generation before second wave feminism who became influential both as personalities and as theorists in the 1970s. These two writers can be taken to exemplify the gulf between two historical strands of feminism. de Beauvoir (1972) stressed the intellectual and social equality between men and women and Mead (Mead, 1962) emphasised the cultural differences between male and female emotions and embodied experience. In other words they represent the 'sameness' and 'difference' traditions referred to by Bacchi (Bacchi, 1990).

While Mead (1972) was known as an advocate of 'natural childbirth', de Beauvoir was a well known critic of motherhood because it confined women to the domestic and mundane (Appignanesi, 1988:3; de Beauvoir, 1972). Mead belonged to the Culture and Personality school of social anthropologists who assumed that psychoanalysis describes universals on which cultural differences, for instance birth customs and mothering practices, are overlaid (see for instance Mead, 1962). Her personal experience of other cultures served to relativise the practices of her own society and she saw no contradiction between motherhood and the professional career in anthropology that she herself enjoyed (Mead, 1972). de Beauvoir (1972) on the other hand portrays motherhood as one of the principle inhibiting factors in women attaining independent self-hood and cultural creativity. As an existentialist she saw psychoanalysis as biologically determinist and unhelpful to women. Her reading of anthropology showed women's lives enmeshed in the 'contingent' rather than the 'transcendent'.

The idea developed in the 1970s that medicine was oppressive to women did not feature in these earlier writers. Sandelowski's (1984) survey of medical, nursing and popular literature of the 1950s concludes that the Natural Childbirth movement of the



time was not marked by a political opposition between women and their doctors. When Margaret Mead, the third generation of a family of university educated women, argued for a 'natural birth' based on her experience of other cultures, she shared with her paediatrician and obstetrician an interest in psychoanalysis and cross-cultural medical and child-rearing practices. It was the nurses who were "too busy to manage any further alterations of the customary routine" (Mead, 1972:254). *Male and Female* (Mead, 1962:220-2) draws on the fieldwork Mead had done before her daughter's birth. She argues that the wide range of attitudes towards childbirth indicates that childbirth behaviour is learned rather than innate and suggests that it is men who are excluded from the event who elaborate fantasies about its fearsome and polluting nature. Anthropological views like Mead's were to become an important resource for childbirth theorists in the 1970s when they were looking for alternatives to medicalised childbirth (Jordan, 1980).

Simone de Beauvoir's monumental work on women, *The Second Sex* was published in 1949 and translated into English in 1953 (de Beauvoir, 1972). It was considered to be scandalous, especially in France because of its rejection of motherhood as a source of fulfilment for women (Okely, 1986:68). de Beauvoir is widely cited in the feminist literature as describing pregnancy as abhorrent. From an existentialist perspective "giving birth and lactating are not activities they are natural functions" (de Beauvoir, 1972:94). As such they have the quality of "immanence". They belong to the ceaseless round of material activities that endlessly repeat themselves in daily, annual and generational cycles and never progress. de Beauvoir wishes women to partake in activities that are transcendent, to adopt projects that will change human life by technical, political or intellectual means as men have always done, even if these are violent and destructive (de Beauvoir, 1972:29 and 95).

For it is not in giving life but in risking life that man is raised above the animal; that is why superiority is accorded in humanity not to the sex that brings forth but to that which kills (de Beauvoir, 1972:96).

Her reading of her anthropological sources is pessimistic and does not acknowledge cultural frameworks for ensuring that children would be appropriately spaced and nourished.

Pregnancy and childbirth and menstruation reduced (women's) capacity for work and made them at times wholly dependent upon the men for protection and food. As there was obviously no birth control, and as nature failed to provide women with sterile periods like other mammalian females, closely spaced maternities must have absorbed most of their strength and their time, so that they were incapable of providing for the children they brought into the world (de Beauvoir, 1972:94).

Unlike Mead who had first hand experience of non-medicalised birth and who sees it as an everyday matter, de Beauvoir finds that the practices of 'primitive peoples' confirm the dangerous uncleanness of birth, which is regarded with horror and she commends medical intervention as saving the lives of women and children (de Beauvoir, 1972:179). She comments that the role of anaesthesia is growing but its significance for women is not determined since their experience of childbirth is so varied:

There are some women who say that childbirth gives them a sense of creative power; they have really accomplished a voluntary and productive task. Many at the other

extreme have felt themselves passive, suffering and tortured instruments (de Beauvoir, 1972:521 2).

Mead on the other hand sees medical practice as 'male' even though increasing numbers of women become doctors. In her view they have to force themselves into a masculine model to compete in the field. She comments on the incongruity of men's determination to:

...indoctrinate women in 'natural childbirth', in fact to return to them the simple power of bearing their own children, which in the course of a most devoted but one-sided development of medicine has practically been taken away from them (Mead, 1962:338).

Mead's comments lay the groundwork for the idea to be taken up in the 1970s that medicine is inherently masculine and childbirth 'women's business', which is relatively straightforward if left without interference.

de Beauvoir's theoretical writing is less positive about motherhood, but her observations about women's experience is quite sensitive to their variety. Although she opposes psychoanalytic theories about women, she used many of Deutscher's (1945) case histories in the *Second Sex*. She describes childbirth as an area in which the conflicts of a woman's psychological history come to the fore, anything but a biologically ordained event. Birth is a unique combination of a bodily event which is automatic and without conscious control but in which the bodily process can be interrupted by unconscious emotional factors "...because of them a well initiated labor stops, contractions become too strong or too weak or they function in a paradoxical way" (Deutsche 1945:229). She argues that without medical intervention, childbirth has to be experienced as a combination of passivity, letting the process carry on and embodied activity, whilst it cannot be controlled, it can be actively participated in.

Direct observation of women in labour leaves no doubt that childbirth is experienced as a strenuous act of accomplishment and that it requires tremendous mastery over fear and suffering...Her activity is fully taxed, her accomplishment is connected with a tense "listening" to the innervation processes and everything else present, past and future seems to vanish (Deutsche 1944:228).

With active participation, the birth process produces a joyful catharsis (Deutsche 1944:244) which is lessened with anaesthesia or active management of childbirth because it reduces the woman's level of participation. Deutsche's description of an activity which is on the borders of the conscious and the unconscious, the social and the physical makes her observations relevant to contemporary considerations of embodiment, even though her psychoanalytic theories became the target for intense feminist criticism.

This was because psychoanalysis in the USA in the 1950s was a very medicalised therapy which prescribed a conventional understanding of femininity and women's roles as mothers. The medical monopoly on analysis in the USA led to the clinical practice of ego-psychology, which aimed to achieve 'adjustment' to the masculine or feminine role and the command of the rational ego over unruly impulses. It was thought normal that all women should become mothers. If they did not they risked

neurosis or a lack of fulfilment, which expressed itself as “masculine protest”, unfeminine behaviour such as lesbianism or seeking paid employment. This dovetailed nicely with the ideology of the housewife in the 1950s and underpinned the functionalist account of gender roles, with a psychic penalty of neurosis if they were not adhered to. The perception that psychoanalysis saw biology and motherhood as inescapable destiny explains the furious opposition of feminists like Millett (1972), and an aversion to the very idea of including the body and motherhood within feminist theory.

The medicalised psychoanalytic understanding of birth led to the practice of ‘psycho-obstetrics’ in which physical symptoms, like morning sickness and birth difficulties were attributed to a lack of adjustment to femininity and female role. Ann Oakley (1980) criticised this practice as oppressive because it enforced femininity and blamed women for psychological problems rather than seeing mothering work as necessary social labour which is insufficiently supported.

### ***Overview of the thesis.***

While birth is a cultural phenomenon, in contemporary western industrial society it is largely seen as a biological event to be handled by the medical profession. Even so, over the last thirty years there has been a ferment of debate about how birth should be arranged and managed, yet births in countries like Australia continue to take place in hospital, the level of technological intervention remains high and the place of midwives in health systems is equivocal. Three key areas of interest in explaining contemporary childbirth practice are; the significance of birth as a cultural phenomenon, its significance to women themselves and within feminist theories of gender and subjectivity, and the role of female practitioners associated with birth, especially midwives.

The starting point for the thesis is the complex way in which second wave feminists theorised childbirth and envisaged alternative practices, starting with debates about the significance of birth in the 1970s. The first chapter reviews liberal, radical and materialist feminist theory and examines their different positions on the significance of birth to women, their theoretical understanding of gender, the role of midwives as female practitioners and the politics of the organisation of childbirth services. Each position advocates a particular vision, a feminist utopia, of what a reformed childbirth practice would be like but these are not all compatible with each other.

The second chapter looks at the diversity of childbirth practice and provision in the UK, USA and Australia which accounts for some of the different prescriptions for change produced by the different kinds of feminism. Particular attention is given to the differences in the way female practitioners have been included or marginalized and the consequences for the kinds of alternative services which have been envisaged.

The third chapter examines the implications of theoretical changes in the 1980s and 1990s, which questioned the premises of the 1970s positions on childbirth in favour of a focus on language and the body. The chapter is concerned with a change from seeing power as domination to identifying it as surveillance and focussing on forms of power and knowledge. It considers post-structural feminist writing which questions

the idea of a 'natural body' in favour of a body and subjectivity formed and inscribed by language.

Chapter four describes the methods used in a study of a maternity hospital which is the source of the empirical material discussed in the second part of the thesis. Chapter five sets the scene for the study, describing the place and the circumstances of the women, doctors and midwives whose words appear in the following chapters. The hospital is described as a place which is intensely inscribed with emotion and meaning for the people who use it and work there. The ways processes of labour and work are structured by the building and the difficulties of accommodating difference and the possibilities of surveillance are shown to be significant issues.

Chapter six contains an account of the drama of birth as the women told it in the interviews, structured by the embodied experience of labour, birth and breastfeeding. The difficulty of speaking about issues on the boundary of the body and emotions and ways in which experiences of birth and relationships with carers are difficult and emotional are discussed. 'Natural' birth is shown to be itself a complex cultural phenomenon involving 'benign' technologies and intervention is found to be a desired choice for some women.

Chapter seven examines the hospital through the lenses of 'feminist utopias' discussed in Chapter one. In terms of the liberal critique, the hospital and its services are shown to be not as rational as they claim to be, choices are haphazardly made and heavily influenced by the emotional quality of relationships. In terms of the radical feminist critique, the accounts finds that 'natural' childbirth is an identity which is partially adopted by some people, but which is problematic to the staff because it interferes with the regime of surveillance of risk. However, most women do not adopt the identity consistently but only some elements of it. In terms of the materialist feminist critique, everyone at this hospital has access to 'good quality' free care, but there are distinctions made between those who have private insurance and those who are public patients, which contradict the assumptions of a universal health system.

Chapter Eight examines the boundaries between the medical profession and midwives. This is not only in terms of formal power but includes the culture of the professions, the use of language, the presentation of self and the emotional quality of work and relationships. The conclusion draws together reflections on the concerns of the feminists of the 1970s and the way they underpin this account of the maternity hospital in the 1990s. Given that none of the utopias has come to pass, the question of the future of maternity services in the post-modern era is raised.

## CHAPTER 1 SECOND WAVE FEMINISM, CHILDBIRTH AND MIDWIFERY: POLITICAL DIFFERENCES AND THEORETICAL COMPLEXITY

The second wave feminist movement appeared to its participants to be a new era of feminist politics, quite unlike the campaigns of the suffragettes or the 'motherist' politics of the inter-war generations (Curthoys, 1992:428). There are competing accounts of the relationship of feminist theory in the 1970s to issues of childbirth and motherhood. Some people argue that motherhood was ignored until the late 1970s and early 1980s when there was a shift towards a feminism of 'difference', others believe that feminism is intrinsically hostile to motherhood and childbirth.

One of the reasons for these contradictory accounts is that feminist theory in the 1970s was in a state of flux and internal differentiation. Rather than a neglect or exclusion, there were numerous strands to the explosion of theoretical and substantive writing about all aspects of women's lives. A considerable amount of work aimed at exploring the issue of childbirth and analysing the provision of childbirth care and its meaning for women. In writing of childbirth, it is often assumed that feminism is an undifferentiated entity (Annandale & Clark, 1996:17). This chapter seeks to bring to light the political and theoretical writings relevant to childbirth, with specific attention to their usually unrecognised diversity. Rather than simple oppositions between pro and anti-natalism or between natural and technological birth, we find different understandings of the oppression of women, each with its own critique of the role of medicine in childbirth and its own vision of the political future which would improve women's situation.

### *Feminism and motherhood*

It has become conventional wisdom to say that second wave feminism rejected motherhood as a political topic until the late 1970s or early 1980s, when it was rediscovered as part of 'difference feminism' (Eisenstein, 1984). Franzway, Court and Connell (1989) argue that this was largely true in Australia, though they acknowledge this is contested, especially by British feminists, like Segal who is quoted as saying that 'it is not true that feminists then were unconcerned about mothers and their children' (cited in Franzway, Court, & Connell, 1989:61). It is true that the 1970s feminist agenda advocated for women the right to choose sex without reproduction and voluntary motherhood by the use of contraception and the right to abortion where necessary (Mitchell, 1971: 145). Like Simone de Beauvoir (de Beauvoir, 1972), feminists of this era asserted that motherhood was not a necessary and inevitable part of being a woman. In particular, they criticised the male dominated medical profession, partners and the patriarchal state for interfering with women's reproductive decisions. They argued that choices about contraception, abortion and childbearing affecting a woman's body and her life experience should be made by her alone (Ruzek, 1978).

However, in many ways motherhood as an issue was embedded in the women's movement from the beginning, even though at first the radical proposition that women

might build their identities around something other than motherhood appeared to involve an outright rejection of it. It can be argued that 'motherhood' had to be questioned so that it could be re-envisioned (Zerilli, 1992)

Given that positions on motherhood were fluid, it is not surprising that views about childbirth were also diverse. There was not at first a division between 'natural' and 'technological' childbirth or an assumption that the desire for a natural birth is intrinsically a feminist position. For instance, when Ann Summers (1975) wrote *Damned Whores and God's Police*, an Australian compendium of feminist thinking, she argued that doctors were withholding Caesareans from women because of a repressive belief in a natural birth and a puritanical disregard of women's sexual needs. In her view, women were entitled to sexual pleasure and this would be enhanced by avoiding the trauma of a vaginal birth.

Other well known feminists argued that women should seek to escape from childbirth completely because their childbearing role was excluding them from full participation in human life. Shulamith Firestone (Firestone, 1973) is remembered principally for her advocacy of technological birth. In fact, she wanted every aspect of the gendered division of labour and gendered psychology dissolved and childbirth was just the most obvious element in the prevailing division. It is not so well known that she did not foresee the end of biological birth, but suggested that in future a few women might choose it as a personal eccentricity, like wearing a white wedding dress (Firestone, 1973: introduction page xx) This irreverence deflates the heavy significance placed on birth by natural birth movements. Her most famous remark, that giving birth is like 'shitting a pumpkin' (Firestone, 1973: 199) can be seen as a protest at the sentimentalising of the birth process Firestone might find it surprising that, just as white weddings have remained common, if not even more fetishised, so 'natural' birth has achieved an apparent association with feminism (Wajcman, 1991: Chapter 3)

Firestone is seen as the prototypical 'radical feminist' because gender is the primary form of oppression in her analysis, but actually she differs from other radical and cultural feminists because she does not see technology as inherently masculine and oppressive. Like Simone de Beauvoir and Ann Summers, she thought that some forms of technology, such as analgesia, Caesarean sections and artificial reproduction could be used to give women increased freedom. Radical and cultural feminists distinguish themselves from liberal feminists who are reformists within patriarchal societies and from materialist feminists who are concerned about class and social justice as well as gender, but the pro-technology stance of these early radical feminists was overtaken by a more 'cultural' form of feminism which saw women's culture as the antidote to an over-technological society (Tong, 1998: 54).

The confusion about the place of birth within feminism may be a product of internal tensions and political differences within and between national feminist movements. Feminists aspired to sisterhood between women but Firestone's remarks about childbirth betray an underlying tension between them. Second wave feminists broadly tended to diverge over approaches to 'sameness and difference' (Bacchi, 1990). Birth of course is central to the idea of 'difference' which may account its location within feminist politics, central to some writers and marginal to others.

Especially in the USA, liberal feminists were sceptical of what they called ‘motherist politics’ and suspected that they concealed an allegiance to conventional gender arrangements (Snitow, 1990). In Britain, Juliet Mitchell (Mitchell, 1971) dismissed women’s writing about the pleasures of breastfeeding as nothing but the ideology of conventional motherhood. However the ‘sameness/difference’ axis itself is related to political and social issues. While most US feminists favoured the liberal, equal rights approach to women’s issues, British second wave feminism was very firmly grounded in the new left and in trade union politics and tended to envisage a socialist future. Bacchi points out that,

because of America’s solidly liberal political culture, American feminists have had some success in entrenching equality “equal rights” legislation there. Britain has a strong Labour tradition and its reforms have been weighted in favour of a welfare approach, based on recognition of woman’s maternal role. Australia has both traditions (Bacchi, 1990:261).

Political conditions varied between Britain, the USA and Australia. Neither British nor United States feminists were as comfortable working with the State as Australian feminists who were organised into a liberationist wing and, through the Women’s Electoral Lobby, gained a route into government which was taken up by the ‘femocrats’ of the Whitlam era (Franzway, Court, & Connell, 1989:133). These political differences can be related to the theoretical location of childbirth writing and the kinds of midwifery politics engendered in each country.

The USA was not only the home of liberal feminism, but also a major source of radical/cultural feminism and counter cultural thinking. Bacchi suggests that cultural feminism in the USA stresses the political importance of mothering because the alternative is competitive liberalism. “Since the possibility of arguing for a more general social justice agenda is not open, those who commit themselves to a maternal ethic often do so as a symbolic protest against an uncaring society”(Bacchi, 1990:260).

America experiences the sharpest divisions [*between different models of feminist theory*] because feminists there have had less success in getting the government to accept even a modicum of social responsibility for a range of human needs, including reproduction. It therefore becomes necessary to argue ‘difference’ to try to have women’s needs addressed or ‘sameness’ because of the fear that any admission of vulnerability will be interpreted as weakness and punished (Bacchi, 1990:260).

Given the difficulty of engaging government action, and the scepticism about governments during the 1970s in the USA, the alternative to liberal feminism was not a campaign for social provision of health services like midwifery care, but the creation of alternatives to the mainstream. Although cultural feminism and the counter culture were somewhat influential in Britain and Australia, they were modified by the local political climate. Feminists in Britain and Australia were debating childbirth issues against a background of state provision of health services under the National Health Service (NHS) and Medibank/Medicare (Australia’s public health scheme) and so this necessarily changed the emphasis of the debates. This is taken up in the next chapter where medicine and midwifery politics are examined. The importance of cultural feminism for the present discussion is the way in which childbirth was theorised.

Cultural feminism has its origins in a libertarian variety of feminism which arose from the sixties counter-culture and the protests against the Vietnam War. This differed from liberal feminism in its stress on the female body and motherhood. In her thorough review of the North American women's movement's attitude to motherhood, Umansky (1996) maintains that second wave feminism in general was not hostile to motherhood, on the contrary she argues that ideas about motherhood were emphasised where feminism intersected with the counterculture, in particular where theorists such as Wilhelm Reich and Herbert Marcuse were influential (Umansky, 1996:53). These psychoanalytically influenced theorists were the inspiration for the founders of 'The Farm' a counter cultural community famous for its lay midwifery (Gaskin, 1977). Umansky (Umansky, 1996) sees the counter-culture as marked by "deeply restructured views of the body, nature and human community", and producing a vision which was "profoundly optimistic and a true utopianism". It appealed to the potentialities of the human, especially female, body for pleasure and fulfilment through sex, birth and breastfeeding in a remade social community (Umansky, 1996: Chapter 2). The circulation of such ideas about the positive value of the 'natural body' effectively marginalised the pro-technology version of radical feminism.

The predominant 'cultural' strand of feminist writing about birth and motherhood which flowered in the 1980s, was not only a reaction to 'anti-motherhood' feminism, but had had roots in work published in the 1970s. Two well known accounts of the history of childbirth, with a feminist agenda emphasising 'female controlled childbirth', that is the autonomy of the woman giving birth as well as female, usually midwifery, care were, in Britain, Ann Oakley's *Wisewoman and Medicine Man* (1976) and in the USA, *Witches, Midwives and Nurses* (Ehrenreich & English, 1973). The fact that these widely noticed works were published early in the 1970s, shortly followed by Adrienne Rich's *Of Woman Born* (Rich, 1977) shows that thinking about motherhood and indeed midwifery started relatively early in second wave feminism.

The next section of this chapter seeks to differentiate the positions developed by second wave feminism theoretically and in terms of their politics of childbirth. The distinctions to be drawn are rather more complex than pro or anti motherhood or technology and underpin problems with understanding childbirth and organising midwifery care up to the present. The critique of medicalised birth was not undifferentiated but contains three different underlying strands. These are: that medical management of birth is harmful and untested even within bio-medical terms (Haire, 1972; Oakley, 1984), that unnatural practices impose 'masculine' technological practices on a female body and deprive women of the experience of their own 'natural' female power (Arms, 1975; Daly, 1978; Rich, 1977) and that unfair practices exclude poor women, denying them proper medical attention, whilst allowing elite groups of practitioners to make a handsome income (Ehrenreich & English, 1973; Shaw, 1974).



## UNTESTED, UNNATURAL, UNFAIR: THREE CRITIQUES OF MEDICALISED CHILDBIRTH.

Feminism in the 1970s was a diverse enterprise. Tables 1.1 and 1.2 set out the three strands of feminist thought addressed in this chapter, liberal, radical, and materialist. The tables also have a column for post-structural feminism which will be addressed in Chapter Three. The next three sections address the first three types of feminism, and argue that each critique of childbirth involves a distinctive politics and construction of the history of childbirth (Table 1.1) as well as a philosophical position with reference to science (Table 1.2).

Table 1.1 shows that criticising medicalised childbirth for being untested and ineffective is a liberal feminist position which does not express a view about the gender of the practitioners and sees history leading to the elimination of ignorance. Radical feminism criticises medicalised childbirth because it is unnatural, and consonant with a technological society which is unsympathetic to women's needs. It tells a history of women healers being marginalized by male practitioners. Materialist feminists are more likely to concentrate on the oppressiveness of an unequal society and to see the history of childbirth connected to the development of capitalism and professionalisation.

Table 1.1 Feminist tradition, critique of medicalised childbirth and construction of history.

Tradition of feminist thought:	Liberal	Radical	Materialist	Post-structural
Critique of childbirth practices	Untested and ineffective  Lack of information for autonomous choice	Unnatural in a technological society	Unfair and oppressive in an unequal society	Diversity, consumerism, surveillance
Historical account of the development of childbirth	Progress and development, elimination of ignorance	Patriarchal suppression of women healers	Separation of the public and the private. Class and gender basis of professionalism	Competing representations and definitions

Table 1.2 places the three critiques in relation to their epistemological positions, belonging to what Guba and Lincoln (Guba & Lincoln, 1994) have called post-positivist, critical and constructivist paradigms and particular traditions of writing in the feminist sociology of science (Harding, 1991).

Table 1.2 Feminist tradition, paradigm and position in the feminist sociology of science.

Tradition of feminist thought:	Liberal	Radical	Materialist	Post-structural
Paradigm: (Guba & Lincoln, 1994)	Post-positivist	Critical	Critical	Constructivist
Feminist sociology of science adapted from (Harding, 1991)	Feminist empiricism	Women's Standpoint epistemology	Gender, race and class Standpoint epistemology	Post-structural epistemology, feminist techno-science
Epistemology:	Scientific method – objectivity, effectiveness and efficiency	Women's standpoint privileged, Narratives of childbirth experience	Standpoint of those excluded by class, race and gender. Consciousness raising	Analysis of discursive formations- no foundations for certainty

***Liberal feminist thinking – untested birth practices – an internal critique of medicine.***

Liberal feminism shares the enlightenment assumption that society is becoming increasingly rational and that liberty to make autonomous choices is an important attribute of adults (Tong, 1998: 39). In the enlightenment view the history of medicine as a story of continuous progress and development by the elimination of ignorance (Singer & Ashworth Underwood, 1962). In this view childbirth practices have improved because scientific medicine has cleared away superstition, contamination and incompetence (Shorter, 1982). This is summarised in the stereotype of *The aseptic male obstetrician and the filthy peasant crone* (Cosslett, 1994). Briefly, the first half of the twentieth century saw the start of the modernizing process in childbirth, in which the health of mothers and babies became the object of interest to the state, and state intervention increased the availability of professional medical care to women (Reiger, 1985). Medicine successfully associated itself with science and scientific management of childbirth was believed to be beneficial. However, the critique of medicalised childbirth argues that medicine does not stand up to its own standards of scientific evidence and evaluation.

***Twentieth Century childbirth practices and scientific medicine***

Medical intervention in the nineteenth and twentieth centuries was not immediately beneficial to women. The transfer of control to doctors in this period did not lower and may have raised the maternal and infant mortality, due to puerperal fever in hospitals and incompetent interventions (MacFarlane & Mugford, 1984; Willis, 1983:112-3). Oakley's (1984 (1979)) history of the medical care of pregnant women gives numerous examples of the application of novel techniques such as radiation treatment, x-rays and drug treatments to pregnant women. These are 'scientific' in the sense that they apply recent scientific discoveries to the female body, but are not 'scientific' in the sense that they have been tested and found to be useful and without side effects. She concludes that pregnant women have frequently been used as guinea pigs without their knowledge or fully informed consent. This is not to say that women

at the beginning of the twentieth century did not share an optimistic view of science – those who demanded obstetric anaesthesia clearly demonstrate that some women did (Leavitt, 1980).

In Willis' (1983) view the higher status of medicine came before any real advances in the safety of childbirth and so the rise in influence of medical care was social and political, not technologically determined. The ideology of medical control had nothing to do with the facts about safety in childbirth. At first, medical control led to the overuse of technology and speeding up labours for financial or social reasons. The poor outcomes were partly because of poor medical student training and the absence of anti-biotics until after the Second World War (Leavitt, 1986).

Mason (1988) similarly argues that the change from midwifery to medicine was influenced more by an aura of scientific professionalism than by evidence of effectiveness. Even where evidence was collected, it was not necessarily acted upon, so in the 1920s in Canada, a report on the birth outcomes of remote populations served by unqualified midwives found them to be better than contemporary city hospitals. This contradicted the contemporary medical ideology to such an extent that the medical profession demanded the suppression of the results.

Although some strands of feminism associate science with male dominance and masculine thinking, science has also been used in critiques of medicalised childbirth (Rushing, 1993). In feminist sociology of science, the use of scientific method for feminist purposes has been called feminist empiricism by Harding (1991) who describes it as 'science as usual'. Feminist empiricists, she argues, do not find any inherent problem with scientific method but criticise the gender bias in its personnel and choice of research problems. Equal participation in science by women and a consequent broadening of the area of interest of science will correct its androcentrism. "Sexism and androcentrism could be eliminated from the results of research if scientists would just follow more rigorously and carefully the existing methods and norms of research" (Harding, 1992:51).

#### *Doris Haire and the critique of harmful and unevaluated medicalisation*

As an influential example of this strand of childbirth critique I take the work of the North American consumer advocate, Doris Haire (1972), a childbirth educator and consumer representative on Food and Drug Administration Committees in the USA. Haire's arguments exemplify a recurring strand in the debate over natural childbirth, one which appeals to scientific research rather than the analysis of power relations or appeals to the natural. As Rushing (1993) points out, science and feminism are the twin ideologies invoked to support the rise of midwifery in North America. This is somewhat paradoxical because science is heavily criticised by some varieties of feminism as a 'masculine' way of knowing,

Haire (1972) argues that the principal problem with modern medicine is the 'unphysiological' nature of modern childbirth practice and its effect on the baby. Examples of this are the over use of analgesics and making women stay in bed and lie on their backs for delivery. Rather than appealing to historical or cross-cultural evidence, she appeals to superior scientific knowledge of the mechanisms of labour and birth. Haire (1972: 3-5) blames the unphysiological practices of American

obstetrics for high rates of perinatal death and of brain damage, thus radically undermining the rationale for interventionist obstetrics, which had from the beginning of the profession, based its claims for on the ability to reduce perinatal mortality and preserve the foetal head from damage during birth (De Lee, 1986). Like Mead, she does not set up an opposition between women and the medical profession but excuses medical professionals from responsibility for these 'cultural practices' which have developed in the twentieth century. From a theoretical viewpoint, she is accusing medicine of allowing scientific knowledge to become contaminated with cultural practices, both the habits of doctors handed down from the past without sufficient scientific scrutiny, but also the cultural demands of women for 'painless' childbirth. It is not only medical practices that need to be changed but also the mothers' tolerance of pain. For Haire nurse midwives are preferable because they are the only practitioners have avoided the 'cultural warping' of childbirth and allow the underlying physiology to operate unimpeded (Haire, 1972:2).

I have characterised the liberal, scientific paradigm as being one which promotes choice (Smeenk & ten Have, 2003). However, for Haire the only rational decision is to avoid medication during birth. For her any medication is a potential hazard to the foetus. Even though the mother's comfort (i.e. through the use of analgesia) may not be compatible with the best interests of the baby, as a rational person, she must be prepared to endure a "stressful, unmedicated labour" to ensure that her child reaches its full potential (Haire, 1972:15).

Apart from Haire's consumerist critique of obstetrics, there are other rational traditions which criticise the present regime of childbirth practices and recommend eliminating irrational practices in favour of more rational ones. One of the most influential of these is Evidence Based Medicine (EBM), which continues to argue that all medical practices, including childbirth practices should be evaluated by the best possible evidence, not chosen because of tradition, culture, personal desire or clinical judgement (Chalmers, 1989; Chard & Richards, 1977; Sackett, Richardson, Rosenberg, & Haynes, 1997).

### *Evidence Based Medicine*

Evidence Based Medicine operates within the positivist paradigm; the body is conceptualised as a natural object, which operates similarly whatever the cultural context. The cultural and the natural are strictly separated (Latour, 1991). Rates of intervention in childbirth are compared and when international or inter-regional differences are found they are said to show that social factors are contaminating the 'real' need for intervention into the biological. The body is believed to be a biological universal and so any variation in intervention rates is 'cultural' and therefore incorrect. For example, Marc Keirse (Keirse, 1993), one of the founders of EBM, writes that it is impossible that the uterus should behave differently on one side of the English Channel, where doctors have a tendency to induce births than on the other where they prescribe large numbers of drugs to prevent labour starting early (Keirse, 1993). This is a useful tool for critiquing medical practice but it carries the implication that if there are differences one or other pattern of treatment must be wrong, rather than seeing birth as so thoroughly culturally shaped that differences might be expected.

Evidence Based Medicine does not adopt a principled opposition to intervention as such, only to unevaluated intervention. Unlike Haire's notion of physiological childbirth or the radical feminist idea of the 'natural' body, EBM sees 'alternative' practices as much in need of evaluation as mainstream ones (Chalmers, 1992). The movement towards reforming childbirth based on EBM is not intrinsically feminist, though its 'anti-authoritarian' stand (Chalmers, 1989:31) is a useful tool against paternalist medical authority and its philosophical commitment to scientific method, increased choice and autonomy have much in common with liberal feminism (Campbell, 1997). Apart from the cultural shaping of the objects of medicine, Evidence Based Medicine is also itself a cultural production, with its own beliefs, practices and prophets (for example Sackett, Richardson, Rosenberg et al., 1997; see also Warren & Mostellar, 1993 for an example of EBM being preached to unbelievers). The role of EBM in the development of maternity care in post-war Britain is described further in Chapter 2.

The strong claims to truth and the cultural authority of scientific method mean that it is an attractive option for feminists working within the fields of public policy and medicine (Campbell, 1997). Ann Oakley (1992b) and parts of the consumer lobby in the UK subscribe to the scientific philosophy of EBM (Campbell, 1997). Other feminists find it incompatible with other aspects of feminist research ethics and philosophy, for example, because randomisation takes away autonomous choice and because the approach is seen as objectifying (This position is criticised by Oakley, 1990).

The scientific critique of medicalisation as ineffective and harmful, echoes liberal feminism in that it appeals to rationality and women's autonomous judgement, rather than emotion. The idea that gender should not impede women's equal access to professional training as obstetricians and to equal recognition as professional midwives fit well with a liberal feminist agenda as does the idea that women as consumers and practitioners are capable of evaluating statistics and making properly informed choices. Unlike other strands of feminism, it does not assert that the emotional qualities or the gender of the practitioners is relevant to the type of childbirth practice. Table 1.2 lists this critique as post-positivist in its methodology, while the next two strands of feminist thought, radical and materialist feminism both appear under the critical paradigm.

### *Critical epistemology*

The idea that the most objective source of knowledge is from the standpoint of the oppressed relates to the feminist tradition of 'speaking out' of your experience in consciousness raising groups by second wave feminists in the 1970s (Coote & Campbell, 1982). Women speaking of their lives together became aware of the similarities in what they had thought were individual problems, such as family violence, sexual harassment, dissatisfaction with the ideology of motherhood. These shared understanding are encapsulated in the slogan 'the personal is political'. Concepts such as 'oppression' and liberation movement were borrowed from the civil rights tradition and consciousness raising practice was similar to emancipatory traditions such as Freire's 'education for liberation' (Freire & Ramos, 1972).

A critical epistemology relies on the views of those with the least power for an explanation of social life (Guba & Lincoln, 1994). For instance, the feminist sociologist, Dorothy Smith (Smith, 1990) argues that women's practical knowledge in housekeeping, childrearing and office management is the unacknowledged labour which allows scientific research to exist. She argues that feminist methodology should start at the level of the everyday experience of ordinary people and avoid abstractions which alienate the knowers and their forms of knowledge from the objects of their research.

This personal and engaged mode of research rests on what Harding calls 'standpoint epistemology' leading to 'strong objectivity' rather than value neutral, scientific objectivity which conceals power relations. (Harding, 1991). Freire, Harding and Smith all draw heavily on a Marxist epistemology, which concentrates on looking at the exploitation of labour and the uncovering the ideology of power relations (Harding, 1992; Harding, 1986, 1991; Smith, 1988, 1990). In this framework scientific knowledge is not objective but 'objectifying', it is not a critical tool for emancipation but one which contributes to the 'relations of ruling' (Smith, 1990), whereas a critical, feminist method allows women to speak out and is liberating in itself.

Such feminist method encourages attention to the relationships between researcher and research subjects. Ann Oakley (1981a) recommends that feminist researchers should not resist the temptation to answer questions about themselves, the research or the interviewees' anxieties. Oakley's interviewer has to get involved, becoming friends with her interview subjects and attending their births when invited. For her the aim of producing standardised unbiased (reliable) interview data extracted by a faceless interviewer from an objectified subject is 'a contradiction in terms' since the aims of feminist research are to revalue women's lives and allow their voices to be heard (Oakley, 1981a).

This epistemological viewpoint informs Graham and Oakley's (1981) insistence that women have significant knowledge of their own bodies and lives during pregnancy, different from the biomedical framework. Similarly, Emily Martin finds a separate and pre-scientific system of knowledge in the way in which black and working class women explain the processes of menstruation, birth and menopause (Martin, 1987). Some writers find that the system of everyday practical midwifery knowledge is preferable to objectifying scientific knowledge (Dalmiya & Alcoff, 1993). Nancy Stoller Shaw (1974) and Barbara Katz Rothman call upon 'grounded theory' to underpin their sociology of childbirth and midwifery and the ethnographic traditions of anthropology are applied to childbirth in contemporary society by Jordan (Jordan, 1980), Martin (Martin, 1987) and Davis Floyd (Davis-Floyd, 1992). Using such qualitative methodologies, critical feminists reject scientific positivism in favour of 'interpretive reason', that is understanding the meanings and hearing the voices of the 'other' (Bauman, 1992:144).

The remaining two critiques of medicalised childbirth to be addressed in this chapter share this critical paradigm and its tendency to search for explanations in terms of the origin and historical development of oppression, but they differ as to their theoretical and political analyses.

***Un-natural birth: Radical/cultural feminism and the lay midwife alternative***

The second critique of medicalised birth is that it is 'un-natural'. For Radical/cultural feminists the oppressor is the male sex in the patriarchal order, these are 'categorical' gender categories resting on the assumption that men and women have distinct psychological natures and belong to groups whose interests are always opposed (Connell, 1987). Cultural feminists praise women as inherently more caring and politically opposed to a technologically dominated society (Tong, 1998: 36). The radical/cultural feminist version of a critical discourse appeals to women's superior knowledge and practice which is seen as distorted by male domination. Medicalised childbirth is 'unnatural', because it imposes an oppressive male medical system on a female body, which would function optimally if allowed to be 'natural'. De-professionalised childbirth services outside the mainstream or a midwifery practice which conforms as little as possible to the medical model are the best options for avoiding this form of domination.

Radical feminist analysis is distinguished from other critical theories because of the primacy it gives to gender especially a supposed gender psychology in explaining the oppression of women. Radical feminist writers explain historical and contemporary manifestations of oppression by emphasising the fear and hostility that male priests, doctors and the state expressed towards women, especially midwives, by trying to eliminate them in the witch-hunts of the sixteenth and seventeenth centuries (Daly, 1978; Ehrenreich & English, 1973; Rich, 1977). They suggest that past patriarchal practices are continuous with those of the present because they arise from a masculinity which is in its essence controlling and dominating. In the past, the predominant form of domination was religion, the present form is capitalism and technology, but these are all essentially masculine formations. Knowledge from the standpoint of women can unmask this oppressive masculine reality, returning women to natural birth and de-professionalised midwifery practice, in a world that is separate from male domination. Contemporary childbirth care is said to be 'unnatural', meaning that in historical time and in contemporary village cultures women give birth in simpler ways which were gentler and required less intervention than contemporary technological childbirth.

The classic expression of this view is that of Adrienne Rich, a poet and writer, who was active in the radical Women's Liberation Movement (WLM). In *Of Woman Born* (1977), Rich argues that motherhood is oppressive for women, not by its nature but because it is lived under patriarchal domination. Her account of the history of the medical management of childbirth emphasises cruelty and exploitation by men against women. She concedes that capitalism may have exacerbated women's oppression by separating public, productive life from the realm of the private but since this does not account for women's subordination in all previous known societies, it is necessary to be a 'radical feminist' and retain the emphasis on gender, not class as the primary oppression. "The woman's body is the terrain on which patriarchy is erected" (Rich, 1977: 55).

Another influential radical feminist, the theologian Mary Daly, also sees the history of childbirth as part of male domination of women. Daly (1978) characterises medicine as the paradigmatic modern mechanism of oppression, equating it with other physical

manifestations of men's control of women such as foot binding, widow burning and genital mutilation. Like Rich, she argues that patriarchal oppression is not related to a particular form of society, but is an unchanging reality, appearing in different forms throughout history.

The radical feminist Mary O'Brien (1981) argues that reproduction is fundamental to the understanding of women's oppression because western political and philosophical thought from Aristotle to Marx as the philosophy of patriarchy, grounded on a rejection of birth and the body. She attempted a feminist dialectics of reproduction analogous to Marx's analysis of production involving 'modes of reproduction' that parallel modes of production in the economic sphere. In her schema, women's oppression is the result of their loss of sole power over reproduction when men discovered paternity (O'Brien, 1981).

The radical feminist explanation for the male treatment of women is trans-historical and assumes deep psychological sources. Bodily mistreatment of women is seen as the major symptom of male hatred and fear of women. In *Gyn(ecology)* Daly (1978) denounces both physical treatments such as the pill and hysterectomy and psychological ones such as tranquillisers and psychotherapy as mechanisms to deprive women of their power. Radical/cultural feminists like Rich, Daly and O'Brien may acknowledge an economic motivation for displacing women as healers and midwives, but they suggest that masculine jealousy of women's reproductive functions and a desire to deprive them of this power are more significant and underlie the advance of the male medical profession.

Rich and Daly criticise medicalised childbirth but they do not praise birth and mothering as signs of an essentially caring female nature as in later forms of cultural feminism (Gilligan, 1982; Ruddick, 1990). Rich, like Mitchell (Mitchell & Oakley, 1976) and other feminists in the 1970s, addresses motherhood for women as a frustrating rather than a fulfilling experience. She rehabilitates the idea of motherhood and the centrality of the bodily experiences of bearing and nurturing children, by attributing its oppressive features to male domination of women's lives. In later work, she suggests that women's physical experience of pregnancy, childcare and friendship are part of a 'lesbian continuum' of emotional and embodied intimacy in which they are far more comfortable than they are in heterosexual relationships (Rich, 1980). Daly (1978) is looking forward to a type of female existence unlike any previously known, in which women are empowered selves, rather than the servants of others. Rich and Daly are suggesting the creation of a separate 'women's sphere' which would be a non-violent society better suited to meeting women's needs than contemporary heterosexual society.

The appeal of alternative childbirth, with female attendants drawn from the woman's own social circle arises from the desire for women to 'reclaim their power' in the way Rich and Daly suggest. Midwifery care is preferred to obstetric care, but lay midwives are preferable because the practice of nurse midwives is seen as closer to the 'masculine' medical model. Because lay midwives have not been professionally socialised within the medical care system, they are seen as closest to women and uninfluenced by masculine scientific knowledge (Arms, 1975; Weitz & Sullivan, 1985).



Homebirth is the most effective method of escaping from masculine oppression, because it takes place on the woman's own territory outside professional control (O'Connor, 1993) and midwives only use technology as a last resort (Peterson, 1983). The kinds of evidence which are used to support this contention vary from the experiential to the scientific. Narratives of successful birth at home, even against medical advice are told to reinforce the belief that medical knowledge and the risk categories, which impose medical control, are flawed (Ruzek, 1978). These birth narratives appear frequently in alternative birth literature and constitute a genre of their own. In one of the more systematic studies of alternative childbirth practices Rothman (1983) describes how hospital trained midwives learn to set aside hospital protocols and trust their intuition and the woman's own assessment of her condition and Sakala (Sakala, 1988) documents the intensive relationship and herbal remedies used by lay midwives in the Mormon community of Utah.

As well as the narratives and insider accounts of alternative birth, some appeal is made to scientific research, especially because it has so much power in the 'outside' community (Rushing, 1993). As Ruzek says lay accounts are only really authoritative within the lay community (Ruzek, 1978:132). Some studies have findings support the idea that homebirth is safe and these are frequently cited (Mehl, 1978; Tew, 1978). Nevertheless, faith in the power of natural birth is such that research can be rejected if it does not confirm the narrative of women's experience. Scientific research which questions the standing of 'experience' is seen as masculine, value laden and serving the interests of the dominant power. For example one of the authors who produced the much cited 'safety of homebirth' research later suggested that twins, breeches and post-dates pregnancies are at higher risk at home and was denounced by the homebirth supporters who had previously relied upon his work (Mehl-Madrona & Mehl-Madrona, 1997).

The radical feminist critique of 'unnatural' childbirth is not only anti-technological, it is also nostalgic for village communities and simpler ways of life. It appeals particularly to the culture of 'lay-midwifery' and a critique of highly developed divisions of labour and the professional monopoly of knowledge and practice. (Ehrenreich & English, 1973; Oakley, 1976; Rich, 1977). Sally MacIntyre identified this in the 1970s as the 'golden age' view of midwifery and suggested that sociologists should be sceptical of it (MacIntyre, 1977).

The radical feminists analysis of professionalism is that it is an inherently masculine activity because it involves power and exclusion, so the answer is to appeal to de-professionalised practice; what Ruzek calls the 'radical health care world' (Ruzek, 1978). It is particularly evident in the lay midwife tradition in the USA, which I discuss further in Chapter 2.

### *The history of a gendered struggle over childbirth.*

In the radical feminist account of the history of childbirth, gender relations are invoked as the principal explanation for social change. The origin of male dominated childbirth practices is said to be that men opposed and tried to eradicate the women healers because they were a threat to their own authority. In this account, the burning of witches in the 16<sup>th</sup> and 17<sup>th</sup> centuries was both a practical measure, which disposed of the professional competition, and a powerful symbol of men's hatred of women;

the opposition men and women is the underlying reality to be brought to light by radical feminist theory (Daly, 1978; Ehrenreich & English, 1973). Rich (Rich, 1977) also attributes the medical take-over of midwifery to male fear of women's reproductive power and the desire for control rather than to the technical superiority of the forceps in the eighteenth century or safer childbirth in the early twentieth.

The idea that men engaged in a deliberate campaign to displace women as practitioners is found in many histories of midwifery, (Donnison, 1977; Tew, 1995) and has achieved the status of an orthodoxy, but its factual accuracy has been challenged by historians. The number of midwives who were literally burned as witches seems to have been very small, hardly exceeding their proportion in the population (Harley, 1990). There is also evidence that rather than being subversive figures, as suggested in the feminist account, midwives testified as expert witnesses in witchcraft trials and paternity suits (Harley, 1993). As respectable women licensed by the Church authorities, they seem to have been allied with authority rather than subversive of it. Nevertheless the equation of midwife and witch has great emotional and political appeal as a rhetorical move reclaim the domain of healing for women and to reassert ownership of knowledge of the body and its reproductive functions.

*Utopian visions of the natural: Suzanne Arms.*

A good example of this type of utopian vision is found in Suzanne Arms (1975) *Immaculate Deception*. The title refers to the success of the medical profession in convincing women that childbirth is painful and dangerous, that modern obstetrics is essential and its self-fulfilling prophecy of interference and dependence on pharmaceutical analgesia which produces iatrogenic disorders. Contemporary women, Arms believes, should take more exercise and eat simply so that although childbirth is strenuous, it should not be anymore dangerous than it was for 'primitive woman' and the need for complex obstetric interventions could be avoided. Unlike modern North American women, "primitive woman was accustomed to seeing all of life's processes - birth, death, reproduction- take place immediately around her. Childbirth was part of the natural order of things - a commonplace occurrence and she dealt with it in a matter of fact fashion and without fear" (Arms, 1975:8). Her work is based on personal experience informed by the California counter-culture where she interviewed lay midwives who carried out births for their friends and neighbours and learned from each other rather than being formally qualified in midwifery (Arms, 1975). She draws an idealised picture of the practice of midwives in fictionalised accounts of a mythological past and of ideal typical situations in the present. Her book is full of 'origin stories' which justify the present practices of the counter culture by depicting similar events in the 'golden age of midwifery'.

Her opening chapter is a fantasy set in an agricultural community in the distant past. A young woman goes into labour but she is not afraid because birth is part of everyday life and she has seen many births before. She carries on with her everyday activities, supported by female relatives. They call the village wise-woman to assist with the delivery and give her gifts rather than payment. The division of labour in this scenario is much less specialised than a modern one - a model that many counter cultural groups saw as desirable (Reich, 1970: 252).

Arms gives details of the supposed practices of this idealised past midwife or wise woman, for instance, hygienically using moss and leaves to absorb faeces and amniotic fluid. The young woman takes off her clothes when the labour makes her hot and drinks strawberry leaf tea. The childbirth practices are portrayed as both superior to modern ones as well as conforming to modern notions of hygiene (compared to Mead's (Mead, 1972:249) account of birth in the "'evil place' reserved for pigs and defecation"). Whilst the appeal is to the distant past, the practices described are those of Arms' contemporary 'lay' midwives in California and Tennessee (Arms, 1975: Chapters 11-15). Ethnographic studies of childbirth in contemporary agricultural communities suggest that women prefer traditional midwives because they preserve their modesty during labour (Jordan, 1980), rather than revelling in nakedness and the sensuality of birth. Arms is not writing a historical ethnography but a speculative account meant as an implicit critique of the repressive hygiene and dietary practices of contemporary USA obstetrics, gowning, shaving, enemas, and the restriction of movement and nourishment. In the alternative utopia the baby is delivered without fuss and put naked to the mother's breasts and covered with a special skin, this is a criticism of hospital practice of separating mothers and babies and delaying breastfeeding, but written with an eye to the modern concern that the baby should not get cold. Arms' new mother returns to work with the baby in a sling and feeds on demand (Arms, 1975: 1-6). This invites comparison with the extended separation from everyday life and the rigid scheduling of infant feeding which were traditional aspects of hospital childbirth practice.

### *Critique of radical feminist arguments*

Arms' account idealises pre-industrial society as a utopia before the oppression of women. This is in very strong contrast to Simone de Beauvoir's (1972) description of women's lives in pre-industrial society as bound to the boring drudgery of food production and childbearing while the men bravely protect them and engage in extending human culture. Whilst it is an appealing myth, the radical feminist 'herstory' is too simple. As Triechler (1990) points out, this construction of midwifery tends to place 'women' as a group outside culture and power relations and imply that they are always 'innocent'. The idea that women have 'innate' knowledge of birth or midwifery skills, that they are essentially gentle and that power relationships between women are always benign are all theoretically problematic and empirically refutable. Disputes within the alternative movement in both the USA and Australia have been extremely bitterly fought (Gosden, 1996; Mehl-Madrona & Mehl-Madrona, 1997). Cecilia Benoit documents the work of granny midwives in Newfoundland and Labrador and finds that the actual conditions of work were physically demanding and poorly rewarded. The traditional midwife's range of natural remedies and practical skills did not avert some tragedies and none of her interviewees recommended a return to homebirth practice (Benoit, 1989:643). Nicky Leap (1993) interviewed many British traditional midwives and their clients and similarly found that conditions of work were often grim and the 'lay midwives' were not such saintly characters as the mythology suggests. As Annandale (1996) argues, the division of childbirth into natural and technological encourages thinking in dichotomies and the recommendation of alternatives which are not always completely elaborated.

There is an evangelical aspect to alternative midwifery. The superiority of homebirth is believed to be evident to anyone who is not blinded by fear or self-interest. In time

they believe, right will surely prevail. Diane Gosden's (1996) nuanced and sympathetic account of struggles within the homebirth community in Australia acknowledges many of these problems and argues that, nevertheless, the alternative birth culture should be granted tolerance within a post-modern polity as a form of 'difference'. This is an appealing view, but the radical feminist view of childbirth is not one of difference but of moral and physiological superiority, an alternative way of seeing the clash between scientific medicine and radical feminist views of childbirth is to cast them as two modernist projects, which are vying for supremacy.

Although it appeals to sisterhood, the vision of alternative childbirth, which Arms exemplifies, contains a heavy moral prescription in favour of a type of birth that all women 'want', or at least ought to want. The idea that natural birth is the 'truth' of the female body, hidden by the deception of the medical profession implies that women who think they want anaesthesia or other intervention are suffering from false consciousness. This denies women autonomy and their right to different desires and it ignores women's differential access to resources. Because the radical feminist position is separatist in theory and in practice, institutions and technologies are identified with patriarchal power and placed 'off limits' to women.

The issue of the cultural construction of women's choices is a complex one and encompasses their unconscious relationship to their bodies and their emotional reliance on their practitioners. There is no doubt that some women have experienced great joy from the practices of the alternative birth movement, even to the extent of describing it as 'ecstatic' (Gosden, 1990; Lane, 1996; Noble, 1998), but the extension of this to the wider society is not straightforward, simply because it is a cultural construction, not a 'natural' bedrock. For De Beauvoir, the love of nature so characteristic of is explained by women's exclusion from the realm of free action:

Any woman who has preserved her independence through all her servitudes will ardently love her own freedom in Nature... She endeavours to combine life and transcendence...(and is) at home in a naturalism like that of the Stoics or the Neoplatonists of the sixteenth century...woman has a profound need to be ontologically optimistic - she must believe that the nature of things tends on the whole to be good (de Beauvoir, 1972:631).

The idealisation of the natural is not necessarily empowering but a symptom of women's subjection and inability under present social arrangements to take action.

### ***Inequitable birth: materialist feminist critiques of childbirth practices***

The third critique, materialist feminism is also a form of critical discourse based on the point of view of the oppressed. Materialist feminists look to social and economic structures rather than to categorical gender divisions to explain the present circumstances and the history of changes in childbirth. The reform of childbirth and the advocacy of midwifery are part of a social justice agenda, necessary because women are treated unequally with men in the burden of reproducing the species and the society. Women without material resources are given poorer access to individualised care, and professionals use their monopolies on knowledge to subordinate both women and other workers. While Radical feminists have a utopian

idea of abolishing the division of labour and de-professionalising midwifery, materialist feminists are more interested in women's access to the labour market in general, including their access to professional power in their own right; this corresponds to Ruzek's category of 'traditional feminist' (as opposed to traditional authoritarian or traditional egalitarian) health care worlds (Ruzek, 1978:112).

In *Medical Dominance*, Willis (1983:92) argues that as only women were allowed to be midwives until recently, the issue is gender specific. It also is of interest to the state because of the relationship between infant mortality and the reproduction of labour power, which is important for the economy (Willis, 1983:93). The historic changes in childbirth involved both gender and class because they shifted the work of delivering babies "from working class women to middle class men" at the same time as they moved them from home to hospital birth (Willis, 1983). He suggests that the rise in the professional status of the medical profession meant that they displaced all kinds of working class practitioners but that midwives were easier to subordinate because they were women.

The shift from home to hospital childbirth and the perceived need to involve medical practitioners can be seen as a consequence of industrial capitalism. In societies like Britain, a century of urban living, combined with poverty and inadequate nutrition led to high perinatal mortality and birth complications at the beginning of the twentieth century. *Letters from Working Women* collected at this time by the Women's co-operative guild, report a stillbirth and miscarriage rate of 215/1000 (Davies, 1978). With incomes less than 30 shillings a week, women had extreme difficulty in saving 30 shillings for a doctor or midwife and went short of food to feed their families. Intergenerational poverty may have led to a high incidence of rickets and pelvic deformation leading to difficulties in childbirth. Reiger reports that Australian obstetricians working in the 1950s had experienced considerable pelvic deformity in their careers (Reiger, 2001a:26). At the same time, an ideology of female purity left women ignorant of the functioning of their own bodies, never having been instructed in "the duties of marriage" (Davies, 1978; Leavitt, 1986: Chapter 3). Early twentieth century midwives report that they attended women who were unaware of the facts of childbirth (Leap & Hunter, 1993). Barker (1998) describes the way in which early 20<sup>th</sup> century maternity advice dismissed the ability of women to take care of themselves in pregnancy and stressed the necessity for medical intervention. This had a class dimension to it, since the medical fees and the enforced leisure which was recommended was obviously directed to middle class, rather than working class women. It was therefore the material circumstances of women's lives together with a particular ideology of womanhood, which made the use of obstetric intervention appear vital at the same time creating inequality in access to care.

#### *Materialist explanations of childbirth and the division of labour*

The kind of utopian thinking about childbirth which appears in the American counter culture and the radical feminist health movement is somewhat at odds with the concerns of socialist feminists who were trying to develop a feminist theory and politics consonant with left wing thinking generally and in particular, Marxist theory. It is often pointed out how the new left in the 1960s alienated women by its dismissive attitude to women's issues and its oppressively sexist practice, but the old left had also been problematic for women. Sheila Rowbotham (1978: Section 2)

describes how the left was suspicious of women's issues generally because they distracted from the class struggle. In particular, it was hostile to campaigns for contraception and abortion. For socialist feminists, the issue was how to bring 'women's issues' into the forefront of political thinking.

There had been a long debate about the association of radical politics and the 'sexual question' since the Utopian socialists of the nineteenth century. According to Rowbotham (1978) issues such as the availability of contraception and abortion had been controversial because many socialists saw 'voluntary motherhood' as a reminder of Malthusian population policies, an imposition on the working class or an attempt to ameliorate the system rather than overturn it. Many Marxists argued that all such questions would be settled after the revolution and that socialist women had to have large families to contribute towards the struggle. Many suffragists had looked disapprovingly on libertarian sexual reform, and contraception and abortion were suspect because they were associated with right wing eugenics programmes.

Both right and left wing politics, dominated by men, tended to fall back on pro-natalist politics, as the Soviet Union did in the 1930s. Nevertheless, radical women such as Margaret Sanger in the USA and Stella Browne in the UK continued to argue for women's control over their own bodies, enjoyment of sexuality and access to freely chosen motherhood (Rowbotham, 1978). For socialist feminists, the kinds of arguments made by radical cultural feminists such as Arnsperger (Arnsperger, 1975) including the rejection of medical services and the idealisation of motherhood contradicts these long held aims.

Against the background of such debates on the left, British feminist theorist Juliet Mitchell (Mitchell, 1971; Mitchell & Oakley, 1976:107-108). included birth in one of the four key areas of women's oppression, production, reproduction, sexuality and socialisation. She argued that the widespread use of contraception made it possible for birth to be separated analytically from sexuality and the socialization of children. Instead of an 'unmodified biological fact' real choice changes the significance of birth and by introducing technological control, allows it to become 'humanized' rather than 'natural' (Mitchell & Oakley, 1976:107-108). She argued, against the radical/cultural feminist ideal of women's liberation based on the female capacity to give birth and to nurture, that "the reign of nurturing, emotionality and non-repression ... (does not) have much to do with the reality of the past or of the future... It is not a question of changing (or ending) who has or how one has babies. It is a question of overthrowing patriarchy" (Mitchell, 1975:416).

There are tensions between the 'natural childbirth' movement and socialist/materialist feminism that are sometimes submerged by an acceptance of 'natural' as the feminist position on childbirth. Leslie Doyal (1995) argues that there are still areas of inequality in maternal and perinatal mortality rates, both nationally and globally, and that the social causes of these are more important to address than the finer details of how births are accomplished. Therefore, for socialist/materialist feminists, the material conditions in which women give birth and become mothers are as important as the kind of medical attention they receive. This does not mean that the arrangements for the care of birthing women are irrelevant to socialist feminists, but they see these as based more on social class and power, than on categorical understandings of gender.

The power of professionals are of interest to socialist feminists and in particular the relative power of occupational groups dominated by men, as medicine has been until recently and obstetrics still tends to be. The ambiguity of the status of intervention in childbirth means that there is a paradoxical excess of some kinds of intervention in lower income or marginalized groups but at the same time they do not have the same access to low intervention care or to elective pain relief or interventions which private patients enjoy. Staff make assumptions about women's desires on the basis of social class or racial origin, one study in the USA found that it was as hard for middle class white women to ask for intervention as it was for black women to refuse it (McClain, 1990). While increased medical attention is not an undiluted benefit, individual attention is something that might be of benefit to all women, not just those who are affluent enough to pay for it. Therefore, inequality and professional power are issues for writers in the materialist tradition in the USA as well as in Britain and Australia.

### *Materialist feminism and the history of midwifery professionalisation*

Materialist feminist histories relate changes in childbirth practice to changes in women's lives with the advent of capitalism. In the course of the seventeenth and eighteenth centuries the public and private spheres were separated because of the increase in waged work, rather than village agricultural production. Changes in the management of childbirth were part of the wider transformation of a rural feudal system with relatively settled village life into industrial and capitalist societies based on wage labour and city dwelling for the majority. Along with these transformations is the development of a market for medical services. This entailed the gradual reorganisation of occupational groups, such as physicians, barber surgeons and apothecaries into the medical profession until the Medical Act of 1858 gave them a common register, although it was some time before they could really be said to be a unified profession (Willis, 1983: 37). Materialist feminist accounts stress the exclusion of women from education and the professions in the development of capitalism (Oakley, 1976), rather than a struggle by men to displace women on account of their gender.

Feminist scholarship since the 1970s has paid a great deal of attention to the history of women's work which sets them in the economic context of their time (Marland, 1997). Detailed historical research serves to de-mythologise the idealised portrait of women healers as 'the poor people's physicians', as portrayed in the radical feminist account and in Ehrenreich and English's pamphlet (Ehrenreich & English, 1973). They rediscovered histories of women's work from the first wave of the feminist movement and rediscovered Clark (1919) and Hurd Mead's (1938) accounts of female practitioners in the seventeenth and early eighteenth centuries. This extensive material on the role of women in both midwifery and medicine in the seventeenth and eighteenth centuries obviously refutes the polemical radical/cultural feminist idea that men successfully eliminated female practitioners by hunting them down as witches between the fifteenth and seventeenth centuries.

Ann Witz (1994) argues that midwifery in the seventeenth and eighteenth century was in transition from the domestic sphere to the marketplace. This means that there were several categories of midwife practicing at all levels of society. Some women were

participating in the market but midwifery, cookery and herbal medicine were skills developed by women of all classes, especially those who were the mistress of large households. The diaries of many noble women show that they often helped their tenants and neighbours in childbirth (Fraser, 1984:445). Nevertheless, women were joining a move towards selling services on the market until, in the nineteenth century a combination of class and gender structures led to women's exclusion from the centres of power in civil institutions, such as the Royal Colleges of Medicine and Surgery and the universities and from direct access to state power through the Parliament (Witz, 1994).

Witz (1994) therefore questions the radical feminist account of a patriarchal takeover of women's sphere of knowledge. She terms this version of the history of female medical practice, the 'strong thesis' and criticises it on several grounds; it attributes too much continuity between the early modern period and nineteenth and twentieth centuries, with insufficient attention to social change and historical detail. Rather, Witz argues that capitalism and patriarchy are interrelated structures for explaining class and gender oppression and it is not possible to argue that gender is more or less important than social class.

#### *Hospital birth, class and race: Nancy Shaw*

Nancy Stoller Shaw's (1974) study of obstetrics is a materialist feminist study of childbirth practices, carried out in the USA in the 1960s and published in 1974. She criticises the production line organisation of personal care and combines with it an awareness of the ways in which class, race and gender interact to deprive women of choices. Shaw's (1974:71) description of routine deliveries at the main research site illustrates both the differences and the similarities between public and private patients. All public patients and those private patients who had been given scopolamine (an amnesiac drug which meant that they would not recall labouring in the public ward) were taken to a common labour area. Here they were often restrained in canvas sided cots or tied to the bed because the disinhibiting effect of the drug might lead them to thrash about and hurt themselves. Private patients who were conscious had their own room until they were ready to deliver when all patients were transferred to an operating theatre-like delivery room. There was little difference between treatment for public patients and private ones except that a private patient would have her own doctor if she were conscious.

Shaw (1974) highlights the brutal and contemptuous treatment given to Black and Hispanic women at the city hospital because they could not pay for their treatment. These women were considered incapable of being educated and suspected of being unfit mothers. For example, women on the postnatal ward were lined up to have their genitalia washed by a nurse rather than being told how to do it themselves and allowed to wash in private. This treatment could not be justified by any difference in funding or staffing levels but was the result of a long standing racist culture. Her major concern is the lack of dignity in the way that women were physically treated especially being left alone and lined up with their genitals exposed in a common labour ward. She is not entirely opposed to technology in itself - for instance she suggested that for women who would like anaesthesia, epidural anaesthesia is superior in that it would relieve pain whilst leaving a woman conscious of her treatment and able to participate in the delivery of her baby. However she noted that this form of



anaesthesia was more readily available to private than to public patients (Shaw, 1974: 95).

The focus of Shaw's critique in this work is not the level of intervention in itself but the prevailing lack of respect for women on several levels - one of them being lack of informed consent. She is critical of the economic organisation and class discrimination in the two tier system of care, both the humiliation for poorer women attending a 'charity' clinic and the large fees which the private patients paid for care which was highly routinised. It is significant that her contemporary observation of the introduction of Medicaid illustrates how its operation made women's situation worse rather than better, women asking for 'reduced fee' care were pressured by the hospital to become welfare recipients in order to have their fees paid in full. She points out that a health maintenance organisation would have charged lower income women far less for their care and that they would have had ante-natal care in an office setting which was far more humane than the clinic (Shaw, 1974:56).

Unlike radical feminist writers on childbirth, Shaw does not use the gender of the practitioners to explain problems with childbirth practices, though she notes that relatively few doctors were women (Shaw, 1974:24). The nurses, who were all women, were said to be more understanding in face to face contact with women patients but to express frequently vehement negative opinions about patients in private. Shaw's solutions to these problems fall within Ruzek's category of 'traditional feminist solutions' rather than the radical, deprofessionalised type of midwifery (Ruzek, 1978:112). For instance, she advocates socialised care by either a doctor in a health maintenance organisation or a midwife in a federally funded programme (Shaw, 1974 56-57). She argues that women should be allowed to practise prepared childbirth or choose a method of anaesthesia, such as an epidural, which would allow dignified participation in the birth. She envisages the power imbalance involved in doctor patient relationships being redressed by large scale consumer movements which give patients the right to license doctors, an increase in professional midwifery and the socialisation of medical care such that childbirth expenses would be covered for all women. Shaw is not concentrating so much on the content of the technology as on the social relations in which it is embedded. Her ideal for childbirth services is that they should be socially provided with universal access and that all women receive respect and are given choices, whatever their racial or class background.

#### *Equal treatment of women as mothers and workers.*

In materialist feminist terms, the impact of professional domination falls more heavily on those who also lack material resources because of their class or race. The political solutions proposed are less utopian and separatist than the radical feminist ones and include the role of the state in providing equitable, socialised care utilising the skills of professional midwifery. Hospital childbirth management is seen as oppressive. This overlaps with the concerns of the 'unnatural' critique, but is more focussed on social inequality and discrimination on the basis of class and gender. It is less techno-phobic than the first critique and concerns itself more with the distribution of power than the content of the technology itself. Professionalisation is of concern insofar as it is socially exclusive and male dominated, but the aim is to modify it by equalising relationships between doctors, midwives and women, rather than to abolish it.

## Conclusion

These differences represent different theoretical understandings of the significance of the medical management of birth. Bryan Turner (1987) suggests that sociologists should “use theory creatively and constructively” rather than compulsively annihilating all previous positions. Similarly, Teresa de Lauretis (1990) argues that we must value what has gone before in feminist theory, rather than dismissing other people’s work as ‘essentialist’ or whatever label is fashionable at the time. Liz Stanley (1990) also argue against an adversarial method of theorising for feminism. She suggests that the bolstering of one’s own claims by the destruction of other’s arguments is a negative inheritance from the past, in which a unitary truth can be established by the demolition of ‘false ideas’. The complexity of the social world demands recognition of multiple perspectives and a degree of reflexivity about one’s own point of view.

Table 1.3 summarises the different political futures envisaged by the three strands of feminism considered in this chapter. It also refers to another perspective, post-structural feminism which will be addressed in Chapter 3. To summarise then, the liberal feminist perspective stresses equality of opportunity for women within the capitalist economic and social system and argues that women are as rational and autonomous as men are. Childbirth is not a central preoccupation of liberal feminist writing because it stresses equality between men and women, rather than focusing on those things which make women different or require different social provisions. It is fair to assume that liberal feminists would expect that women should have equal opportunities to become obstetricians, but there would not necessarily be many changes to the practice of obstetrics just because females were practicing. Similarly, there could be no rational objection to men becoming midwives, because no intrinsic gender differences are accepted which would affect their choice of occupation.

Table 1.3 Feminist theoretical traditions, understanding of political power and preferred future for childbirth services.

Feminist theory:	Liberal	Radical	Material -ist	Post-structural
Conception of power in relation to childbirth	Competing interest groups, technical rationality	Male oppression of women	Class and gender oppression	Multiple sites of capillary power
Preferred mode of political operation	Equality of access to professions and services Right to privacy	Separate /alternative women centred services Rejection of masculine professions	Working with the state Social and gender justice Democratic reform of professions	Intervention into public discourse – changing discursive formations.
Ideal future of childbirth care:	Competing market choices Private practice	Lay midwifery Self- employment	Socially provided, midwifery based service. Salaried practice	Tolerance of difference Surveillance of outcomes Local provision - global regulation

In this liberal framework, the method of childbirth does not have any social significance but rather is seen as a private choice between a properly informed woman and her doctor. One might extrapolate from this liberal view that, as long as a woman has the evidence required to make a rational decision, there is no reason why she should not have whichever mode of birth anaesthesia or natural childbirth she wishes. The market would be expected to provide these choices, so those who wish to pay may rightly expect a better range of choice. Governments might be encouraged to provide stronger consumer choice through a voucher system or similar measure to strengthen the market and through allowing midwives to compete with obstetricians on this basis if they wish.

This liberal position contrasts strongly with the radical feminist view that the conduct of childbirth is a central arena in which women are oppressed by male dominated medicine. The radical view of childbirth asserts that it is a set of unnatural practices appropriate to a technological society. This has resulted from a historical process of the patriarchal suppression of women healers, which in turn is only one aspect of the male oppression of women. The proposed solution is to have separate/alternative women centred services and to reject the masculine model of the professions in favour of lay midwifery (that is midwifery practiced without medical or nursing qualifications), with self-employment in a greatly simplified division of labour.

The socialist/materialist feminist position is that medicalised childbirth is unfair and oppressive in an unequal society. It criticises the class and gender basis of professionalisation within a society characterised by class and gender oppression. However, unlike liberal and radical feminist positions, materialist feminists have a history of working with the state to achieve social and gender justice. Rather than de-professionalisation, they advocate the democratic reform of professions, socially provided midwifery based maternity services and salaried practice because it is more economical and is more likely to result in equality of access. The three critiques which have been discussed in the chapter were developed from theoretical debates in the 1970s. Post-structuralism, the final perspective in the tables began to be influential in the social sciences in the 1980s. The tables show that it is different in its philosophy and assumptions. It will be addressed in Chapter 3, after some consideration of the international differences which affected thinking about childbirth and midwifery.

There is a diversity of arrangements for childbirth and the differences between midwifery in Britain, the USA and Australia are a case in point. Midwifery in Britain is a professionalised practice and with a concern for social justice in the provision of services. Childbirth in the USA is polarised between the doctrine of liberal, privatised choice in which midwifery has a minor role and an alternative lifestyle involving de-professionalised lay midwifery which has had an influence far beyond its actual numbers on ideas of natural childbirth. Australian childbirth services reflect the influence of both Britain and the USA and a complex mixture of mainstream and alternative options which make it very difficult for changes to take hold. This will be the subject of the next Chapter.

## CHAPTER 2: CHILDBIRTH , MIDWIFERY AND PROFESSIONAL POWER IN THE USA, BRITAIN AND AUSTRALIA

The liberal, radical/cultural and materialist feminist views of childbirth described in the last chapter were part of an international social movement and there were certainly currents of influence between them. However, they arose in very different political and social contexts. In particular the idea of rejecting the medicalisation of birth and of turning to midwifery managed childbirth had very different implications, depending on the prevailing childbirth practices, the organisation of the health system and the development of the boundary between medicine and midwifery.

This chapter compares Australia, the country in which my empirical work is based, as the pivotal case and uses two other countries from the English-speaking world, the USA and UK, for primary comparison. The theoretical justification for this is that as in many areas of Australian social life, including the history of the women's movement, the types of provision of medical care and the campaign to reform childbirth, the dual influences of British and North American practices are prominent in Australia. While there are similarities between Australia and each of these countries, key differences and similarities are found in the degree to which the health system is dominated by high technology medicine and specialty practice, the politics of professionalisation, especially the boundaries between medicine and midwifery and the development of childbirth alternatives. Disentangling the interaction of these influences casts light on the uniqueness of Australian experiences in comparison with the British and American systems and in the light of the significant differences between them.

### *Childbirth in the USA, British and Australian systems.*

#### *Private obstetrics and childbirth as a surgical procedure in the USA*

The previous chapter distinguished three different critiques of medicalised childbirth. The fact that such strident and varied criticism has arisen in the USA, along with the proliferation of alternative practices including lay midwifery, may be because the medical system developed high technology, private medicine to a far greater extent than any other country. As a consequence the system is dominated by specialist practices and primary care is relatively under-developed, there is a wide use of expensive resources combined with a lack of access for those who are not securely employed, and the use of technology is routine especially in childbirth. The USA has a "laissez faire, commodified" (Freund & McGuire, 1999:250) health system, which is expensive in terms of its gross national product, and has very little government input into the services it provides. The most powerful groups in the US health system are corporations which provide services, insurance and technology, although, as Friedson pointed out, the medical profession continues to have substantial autonomy (Freund & McGuire, 1999:250; Friedson, 1986). In the medical field, as in other, areas of society, there is a high degree of commitment to a free market but many people

are dissatisfied with the expense of health insurance and the lack of access to health care, which impacts particularly on those who are unemployed or insecurely employed (Lazarus, 1994:26). Childbirth care is expensive, as it is provided almost exclusively by private specialist obstetricians rather than general practitioners or midwives. The very poor have access to Medicaid, but public hospitals are underfunded (Matcha, 2003:37). The working poor are forced into debt to access mainstream services and this creates a market for alternative services, some of which, like lay midwifery services are radically different to mainstream care. Nevertheless, these alternatives are only used by a very small minority of women; in 1990, 99.9% of births in the USA took place in hospital and 95.3 of the deliveries were attended by physicians (Lazarus, 1994:29).

The United States was at the forefront of the modernisation and medicalisation of childbirth and childbirth there is still predominantly a medical event (Lazarus, 1994). At the beginning of the twentieth century, pregnancy became defined as a medical concern (Barker, 1998) and childbirth moved into hospitals under the control of specialists, largely because of the extensive use of anaesthesia. In the USA the proportion of births in hospital in the USA had reached 88% by the 1940s (Leavitt, 1986:170), and was the accepted norm except for remote and impoverished populations who continued to be cared for either by granny midwives or by the small number of nurse midwives such as those associated with the Maternity Centres Association and the Frontier Nursing Service (Shaw, 1974). The vast majority of women had babies in hospitals cared for by obstetric specialists who practiced on a fee-for-service basis, assisted by obstetric nurses who did not take independent responsibility for births (Wertz & Wertz, 1977). The extent of medicalisation described by Shaw (1974) and criticised by Arms (1975) and Haire (1972) was distinctive to the USA.

The major feature which led to a great number of other interventions was the widespread use of total obstetric anaesthesia, using a mixture of a pain relieving drug and an amnesiac. This 'twilight sleep' made women virtually unconscious during childbirth and encouraged quasi surgical birth practices, such as strapping to the delivery table, putting legs in stirrups, using spinal block for delivery, routine episiotomy (surgical incision in the perineum) and assisting the birth with forceps. This particular regime was not practiced in Britain nor in most hospitals in Australia.

Shaw's (1974) study detailed in Chapter 1, vividly exemplifies the high degree of medical involvement in USA childbirth in the late 1960s. She described the routine of delivery as emulating a surgical operation - the patient was gowned and her legs placed in stirrups ready for the surgeon. Because it was treated as a surgical procedure, the doctor was displeased with the nurses if the patient was not ready. If the doctor was not ready though, labour might be delayed either physically or with drugs. Operating theatre procedures were followed so the woman was draped with sterile cloths, given a caudal block for anaesthesia and, in most cases, scopolamine (an amnesiac drug) so that she would not remember the delivery. Episiotomies were routine (similar to an incision for an abdominal operation), the delivery was carried out by forceps, the episiotomy repaired and the nurses left to clean up. If the delivery happened quickly so that this procedure couldn't be followed, this displeased the doctors who wanted to follow this sequence of events whether it was necessary or not (Shaw, 1974:79-80). An unconscious or amnesiac patient accommodated the operating theatre model much better than one who was awake (Sandelowski, 1984; Wertz & Wertz, 1977)..

Doctors trained in this system considered any conscious childbirth to be 'natural' however much intervention had taken place as long as forceps were not used in the delivery (Lazarus, 1994:27). Shaw (1974:75) found that alternative practices were very difficult to insert into this 'production line' organisation of delivery. Women found it difficult to resist the system and practice the locally publicised Lamaze or Bradley methods of prepared childbirth because they were not allowed to bring a partner or a companion to act as a labour coach (Shaw, 1974:75). Women were induced to consent to anaesthesia at the first booking visit so that six months or so later they could be given drugs without the necessity of obtaining consent.

Shaw documents the type of practices which were common in the USA in the 1970s, and as discussed in the last Chapter, her solution was for more consumer control of professions and more community based care. It was the heavy use of anaesthetics, the medical specialisation, the concentration of birth in hospitals and the criminalisation of domiciliary services together with expensive, fee for service medical practice, which created a demand for childbirth alternatives in the USA (Arms, 1975). The extreme development of the medical system of childbirth in the USA makes it understandable that some people took matters into their own hands and worked 'outside' the system in providing the kind of childbirth alternatives described by Arms. The situation was very different in Britain, and this accounts for the different character of the campaigns for childbirth reform.

#### *National Health Service maternity care in Britain*

Maternity services in Britain are not dominated by private practice because maternity care has been provided by the National Health Service since 1948, universally available, free at the point of service and paid for by taxation revenue (Webster, 1998:38). The most common practitioners are salaried midwives working in hospitals or employed by local authorities. In hospital they work with obstetricians employed by the National Health Service, and in the community with General Practitioners who are paid capitation fees by the government, not fees for service by the patient. Antenatal care is shared between midwives and doctors and normal deliveries are handled by midwives unless there is a reason for a doctor to be called. The National Health Service was used by all sections of the population. Although there has been an increase in private practice since the 1980s it has not displaced the NHS (Webster, 1998:155). The competition for patient fees, which influences the policing of professional boundaries and the competition for clients in the USA and Australia has not been so salient in Britain.

#### Evidence Based Critique

Two developments in post-war Britain are significant in the discussion of childbirth policies and care; these are Evidence Based Medicine (EBM) and Active Management of Labour. Evidence-Based Medicine involves the rigorous evaluation of all medical interventions, ideally by the use of a prospective trial with the use of randomised controls (RCT) to eliminate as many known and unknown sources of bias as possible (Chalmers, 1989). This model was developed to test the efficacy of pharmaceutical agents after the Second World War. The extension of this approach to

all medical care, especially to obstetrics, arises from the work of Archie Cochrane, an epidemiologist who believed that the National Health Service (NHS) could and should provide free medical services but only on condition that they had been shown to be effective. He believed that testing the efficacy of all aspects of medical care would prevent waste and limit the great increase in demand for medical services arising from the NHS (Cochrane, 1972). The style of practice which relies on reviewing such RCT evidence has been developed and advocated as a progressive strategy for doctors and patients, particularly by David Sackett and his colleagues (Sackett, Richardson, Rosenberg et al., 1997).

Cochrane (1971) was particularly critical of obstetrics, which he felt had introduced numerous interventions into childbirth practice without any form of evaluation. In particular, he shows that there is no correlation between the change to hospital birth and the drop in the perinatal mortality rate; so the two are not causally connected (Cochrane, 1972). In this he agrees with the feminist history of childbirth, its critique of indiscriminate experimentation with women's bodies. In particular this accords with Ann Oakley's (1984) claim that the regime of ante-natal care has never been evaluated and Marjorie Tew's (1995) argument that homebirth was abandoned in Britain without good evidence.

In the post-war Britain, however, changes in obstetric care resulted from different intellectual understandings of the underpinning of birth (De Vries, Salveson, Wiegers et al., 2001). An important element was an attempt by obstetricians in Aberdeen, Scotland to reduce the very large social class differential in perinatal mortality (Tew, 1995). A greater level of statistical surveillance in the welfare state, resulted in the idea that pregnancies longer than 40 weeks were at risk. More births were induced at this time, with a resulting drop in the perinatal mortality rate. This trend spread throughout Britain, resulting in what Shorter (Shorter, 1982) sees as an inexplicably higher level of inductions than in the USA at the time. The USA was continuing with its high level of anaesthesia and operative birth, and being a decentralised system, would not have had the population based statistics on which to base social class correlations and trace outcomes. In Britain, the belief that this would decrease perinatal mortality helped the pressure towards hospital delivery and away from homebirth. Some homebirth advocates depict this as a masculine obstetric conspiracy, but it was based on a social justice agenda of trying to reduce the differentials in social class mortality (Black, Townsend, Davidson et al., 1982; De Vries, Salveson, Wiegers et al., 2001:257).

While the critique of childbirth in the USA was provoked by the regime of 'twilight sleep', the major controversy in British childbirth was caused by the introduction of Active Management of Labour, which had been developed by O'Driscoll in Dublin (O'Driscoll, Jackson, & Gallagher, 1970). This involved guaranteeing women that they would be in labour for only twelve hours for a first and nine hours for a subsequent birth and was accomplished by giving women one to one support by a midwife and by accelerating labour with oxytocic drugs if it deviated from a statistically average rate of progress known as a Friedman curve (Friedman, 1978).

This was the result of a change in understanding of problems in labour, from a mechanical view that the pelvis was too small to the physiological idea that the strength of the contractions was ineffective to expel the foetus. The mechanical

explanation may have been more plausible in the early twentieth century, when as we have seen, working class women had poor nutrition and may have been suffering from rickets and a deformed pelvis. In the prosperous 1950s with welfare state providing school meals and milk and vitamins for pregnant women, problems in labour were visualised very differently. If there was a long labour, the mother's physiology was identified as being at fault. This programme was justified as reassuring to women and giving them confidence, though it is not clear whether it was the medical intervention, the support of a nurse or the assurance of a short labour which produced the good results. It was developed in Dublin, where women would have been used to long labours, rather than the medicalised regime of the USA. When the programme was imported into the British National Health Service, it rapidly lost the element of social support and became a regime of 'daylight obstetrics' which attempted to 'optimise resources' by delivering all babies while the hospital was fully staffed and avoiding deliveries on night-shifts.

From Shaw's (1974:73) observations of the USA, it seems that because women were unconscious and being treated as surgical patients routinely, the acceleration of labour did not emerge as a controversial issue. But Britain had not experienced such a high level of medicalisation, so the very rapid increase in induction and acceleration of labour with drugs, reaching 75% of births in some hospitals, (Oakley, 1979) caused a great consumer outcry (Oakley, 1981b). The rate of intervention declined rapidly in response to media attention, women's complaints and academic critique (Chard & Richards, 1977). This was very different from the experience in the USA where the positions of mainstream and alternative childbirth policies were more polarised (De Vries, Salveson, Wieggers et al., 2001:245).

### Homebirth in Britain

Another reason why the reaction to medicalised childbirth was different in Britain was that the move to majority hospitalisation of births took place in the 1950s and 1960s rather than in the 1930s. Up to the 1960s, homebirth was very common for low risk births in Britain (De Vries, Salveson, Wieggers et al., 2001). Only high-risk pregnancies and those with a social class advantage or professional connections were guaranteed a hospital bed, the rest took place at home under the care of domiciliary midwives and General Practitioners (Torres & Reich, 1989). Homebirth in Britain was a routine part of the health care system and did not imply alternative birth practices.

In general, the level of technology used both at home and in hospital was less than that used in the USA. British district midwives used analgesia at home and delivered twins and breech babies as a matter of course not as in defiance of medical authority. More analgesia was used at home in the 1950s than would be used in alternative practice today, primarily gas and air and pethidine, a morphine derivative which is not used by alternative homebirth midwives because it depresses respiration and makes it more likely that the baby will need resuscitation. But similar analgesia was used in hospital. Traditionally, the local authority midwife rode a bicycle and wore a distinctive navy blue uniform. It is difficult to associate the feminist or counter-culture figure from literature in the USA with the efficient, kindly, practical and often somewhat authoritarian British domiciliary midwife (Leap & Hunter, 1993).



Between 1950 and 1970, there were several government enquiries which resulted in a policy change to move all births to hospitals and the homebirth rate reduced rapidly to 1% (De Vries, Salveson, Wiegers et al., 2001:255-257). This was to a large extent approved by childbirth consumer groups who at that time were lobbying for choice between home and hospital for all women, for humane childbirth care and to have fathers present at birth (Williamson, 1992:31). The loss of homebirth as a choice happened at a rate that exceeded even the expectation of the policy makers, virtually 100% of deliveries were in hospital by 1970. It has been suggested that the centralised organisation of the National Health Service accounts for the speed of this change (Torres & Reich, 1989). There was also a move towards concentrating births in large hospitals. This arose from increased surveillance of perinatal mortality rates, culminating in the 1958 survey of all births in Britain in one week and was an attempt to diminish class differences in perinatal mortality rates. The data from this survey were said to indicate that small units such as nursing homes and GP run cottage hospitals had higher perinatal mortality rates than large units and so justified the concentration of births into larger hospitals with consultant care though Tew (1995:319) strongly contests this view and the recommendation has been revisited by more recent policy makers (Department of Health (UK), 1993). The previous domiciliary midwifery service continued providing antenatal and post-natal care. Unlike women in Australia and the USA, women in Britain were entitled to ten days midwifery care after each birth, either in hospital or at home (Tew, 1995) (Torres & Reich, 1989) and the extent of routine domiciliary midwifery care is still greater than in Australia.

An insight into the safety, acceptability and mainstream character of homebirth in Britain is provided by a study done in the 1970s (Goldthorpe & Richman, 1974). A strike by NHS consultant obstetricians meant that women who were expecting to go into hospital were delivered at home by domiciliary midwives. Fortunately at that time there were still sufficient midwives who had been trained 'on the district' who were confident to do homebirths. This fortuitous experiment found that the homebirths were as safe as hospital care and that the women preferred them, even though they had previously wanted to go into hospital (Goldthorpe & Richman, 1974). It is very difficult to compare regimes of childbirth care because of the motivations of women who make particular choices and the need for trust and confidence in the system. The intense emotion involved makes it difficult to obtain the kind of randomised controlled trial evidence required by Evidence Based Medicine. The Goldthorpe and Richman (Goldthorpe & Richman, 1974) study relied on a fortuitous combination of trained homebirth practitioners and clients who had homebirths as part of a mainstream service, not because of an ideological commitment and so the satisfaction and good outcomes are particularly significant.

There is no doubt that when British and American writers in the 1970s were writing about the over-medicalisation of childbirth, they were reflecting a considerable level of discontent by women in those countries. However, the situations were very different. In the USA there was a dominance of specialist practice, which treated women as patients undergoing a surgical operation. Hospital medicine in the US was expensive, and for reasons that will be discussed in the next section, midwifery was not a viable alternative for most women. In contrast, in Britain, there was a highly centralised, publicly funded service which changed rapidly between the 1950s and the 1970s from a system of domiciliary midwifery with hospital care for special cases to

virtually 100% hospitalisation, and from relatively low intervention practice to rates of induction and epidural anaesthesia as high as 75%. However, British women had always had levels of care from skilled female midwifery practitioners and never experienced the regime of unconscious birth so prevalent in the USA. This accounts for the different nature of childbirth and midwifery politics in that country.

### *Complex development of private practice and public funding in Australia*

Whilst in the USA health care, including obstetric care, is predominantly in the private sector and in Britain, there is universally accessible publicly funded health care, the picture in Australia is more complex. There is a mixture of public and private provision, in which the governments of the various states provide hospital care and the Commonwealth subsidises access to health care through reimbursing medical fees in whole or in part. As Judy Lumby (2001:68) points out, the Australian health care system has never been designed as a whole. Rather it is the outcome of a series of historical compromises, most of which have been driven by a tension between the government's funding of and the desire to control the health system and the medical profession's desire to retain independence, even though it is heavily subsidised by the state.

To a lesser extent than in the USA, Australian women use private obstetricians for the principal source of care in childbirth. The ability to choose a private obstetrician is a strongly entrenched ideology, and public hospital care and independent midwifery care are less salient in the public mind. All women have access to ante-natal and obstetric care under the government funding scheme known as 'Medicare'. This is paid for by a taxation levy and from general revenue. Many women have private health insurance also and the Commonwealth Government also gives a 30% rebate on private health insurance premiums. Even though a standard medical fee is reimbursed by Medicare (the government health scheme), the idea of a private contract between the woman and her doctor has a long history and private obstetricians commonly charge in excess of the standard fee, so that the patient has to pay the 'gap'. The cardinal principles of the Australian medical profession have long been that patients must be free to choose their doctor and doctors their patients and that remuneration should be fee for service and uncapped by the government (Sax, 1984:58).

The prestige of specialist obstetric care for normal women and the primacy of private, fee for service contracts has a long history. Throughout the twentieth century there were struggles over health schemes including doctors strongly resisting 'panel medicine' in which the moderately well off could band together to buy cheaper medical care which was free at the point of service (Sax, 1984:Chapter 2). There were several unsuccessful attempts to introduce health insurance schemes but when Britain introduced a National Health Service after World War 2, there was a vigorous campaign against any such scheme by Australian doctors, who took the scheme to court on the basis that having the medical profession directly employed by a government health scheme was a form of 'civil conscription', forbidden by the Australian Constitution (Sax, 1984:58).

The availability of private obstetricians for all women, even for those with low risk pregnancies took place between World War 2 and the 1970s. At that time, Australia had a two-tier health system in which 60% of people held private health insurance,

with the premiums subsidised by government, via tax rebate (Sax, 1984:Chapter 3). Insured women had babies at private hospitals or as private patients in a public hospital, cared for by their obstetrician who saw them for ante-natal care at 'his' (there were very few, if any female obstetricians) private rooms and came to the hospital for the delivery of the baby. The 40% of people without insurance received free care as public patients from the private specialists who acted as 'honorary consultants', in return for the use of the hospital facilities for their private patients.

In present day Australia, hospital care in public hospitals is free, including for obstetrics, but there is no guarantee that patients will be cared for by a particular specialist. Private health insurance covers private hospitals and the choice of one's own doctor, thus providing continuity of care, at least during pregnancy, whereas the public system does not allow a woman to get to know the practitioners unless there is a special 'know your midwife' scheme in place.

The contested origins of the system combined with budgetary and interest group pressures mean that the Australian health system is a complex hybrid. Rather than having separate public and private systems, they are heavily interdependent. Private medicine (and health insurance premiums) are subsidised by the state through Medicare rebates. Where private patients are treated in public hospitals, their fees help to keep public hospital budgets in balance. The same specialists work in the public and private systems which means that public patients have access to high levels of expertise but the specialists have no incentive to reduce public hospital waiting lists as this would make private care less attractive. Although it is widely believed that the private system is independent and 'takes the strain' off the public system, in fact, the vast majority of health spending is from the public purse or from individuals and only 10% from private health insurance (Leeder, 1999). It is very difficult to keep a universal system in balance with a private one based on community rated insurance. The introduction of the Medibank/Medicare government funded provision meant that more people relied upon public care and the rate of private health insurance membership declined from 65% in the 1970s to 32% in 1998, when the government introduced a 30% premium rebate to halt the decline.

The division of labour in childbirth exists against the background of specialists who are committed to private obstetrics and a public view that specialist care is necessary for all childbirth. Midwives in public and private hospitals are essential supports to obstetric practice as specialists cannot manage a caseload of several hundred deliveries a year without them. Australian midwives have a tradition of taking a good deal of responsibility for women in labour, especially those who are public patients and they are not so de-skilled as obstetric nurses in the US. However, they have not traditionally been solely responsible for deliveries like British midwives, unless they were practicing in rural areas. Their training reflects this, midwifery training was a common nursing specialty but did not train midwives to the same level of independent practice as British midwifery training.

In the 1970s the consumer movement against technological birth created opportunities for some midwives to practise independently. There was a rise in patient activism and in homebirth, both conventional and in some rural areas of a more radical counter cultural type. Schofield (1995) argues that the Hawke Labor government's combination of economic rationalism and social democracy challenged the fee-for-

service dominance of obstetric practitioners. The 1980 and 1990s were decades of intense policy activity in the area of women's health and childbirth. The federal government ran an extensive consultation for the National Women's Health Policy which included reproductive health and sexuality as one of the six priority areas (Commonwealth of Australia, 1989). Victoria and New South Wales all undertook reviews of their obstetric services which reported in the late 1980s (NSW Health Department, 1989) (Health Department of Victoria, 1990). Schofield (1995) concludes that there had been a shift in public policy discourse in the 1980s to one in which not all women were deemed to require specialist obstetric services - and a subtle shift in the language of policy documents towards 'family centred' (as opposed to specialist dominated) maternity care. Schofield found that the barrier to real change was the continued reliance on private medical practitioners by middle class women and the expectation that the professional monopoly of obstetricians could be challenged by private midwives who were not eligible to receive rebates under the Medicare scheme (Schofield, 1995).

Issues of co-operative care by all practitioners were also raised in these debates. General Practitioners sided with specialists instead of forming teams with the midwives, which they might easily have done (Schofield, 1995). In this they followed their colleagues in Great Britain a century ago (Witz, 1994:105). In a fee-for-service climate where there is a competition about who should deliver primary care, it is not surprising that General Practitioners should be concerned to lessen competition rather than promote cooperation to reduce workloads and deliver better care.

Understanding these professional boundaries which have such an effect on the kinds of choices women can make about childbirth requires an understanding of power relationships involved in professionalisation and the different historical context in the USA, Britain and Australia and this is the topic of the next section, which employs the three strategies described by Willis (1983) as maintaining medical dominance over allied health occupations. It is helpful to apply these categories to the way in which midwifery is related to medicine in different English speaking countries. They are *limitation* to a particular part of the body, like dentistry or optometry, *subordination* to medical authority like nursing and *exclusion* from the realm of legitimate practice, like many 'alternative' therapies, such as chiropractic <sup>1</sup>(Willis, 1983: Chapters 6 and 7). In Australia, Willis (1983: Chapter 5). argues that midwifery was subordinated by virtue of its incorporation into nursing, which was already under medical control because nurses could only carry out doctors' orders and neither diagnose nor prescribe. By contrast, in Britain midwifery was limited to normal births, whilst in the USA, midwifery was excluded in the same way that homeopathy was excluded in Australian medical practice. The next section of this chapter traces the evolution of professional boundaries between midwifery and medicine in the three countries.

### ***Professionalisation and Professional boundaries***

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<sup>1</sup> Willis uses this example because in the 1980s the medical profession was hostile to chiropractors and did not refer patients to them. The situation is somewhat different now, but the principle of exclusion still applies to many alternative practitioners, including lay midwives.

As the first part of this chapter shows, the way in which childbirth is arranged differs greatly between countries depending on the balance of power relationships between participants in the health system. These have been characterised as corporate rationalisers (government and health insurance companies), professional monopolists (doctors and other health care workers, including midwives) and the least organised and powerful group, the consumers (Williamson, 1992:3 and 134). There is a considerable literature on the sociology of the professions, which helps to establish some working concepts for the comparison of the situation of midwives in Britain, the USA and Australia.

Although gender was not the focus of most theories of professions, more recent analyses have shown that it has played a large part in the differential access to privileged resources by different groups working in health care (Willis, 1983:18; Witz, 1994). Ann Oakley's (1976) *Wisewoman and Medicine Man* published in 1976 drew upon Friedson's concept of autonomy to explain women's loss of control over childbirth. This type of feminist critique sees professionalism as a masculine project and recommends less hierarchical 'de-professionalised' relationships for women's professions. But Ann Witz (1994), writing in the 1990s, describes nineteenth century 'women's professionalising projects' and disputes that women were or are uninterested in professional power. She examines the use of gender as a resource to exclude women from medicine and to limit the power of nursing and midwifery to attain professional status in a similar manner to medicine.

The medical profession was reorganised in the nineteenth century to incorporate, university educated physicians as well as surgeons and apothecaries who had previously been apprentice educated and of lower status (Willis, 1983). The pre-industrial occupations of law, medicine and the Church had been called 'professions', from feudal times, but in the nineteenth century, the title of 'professional' was prized because it distinguished a 'gentlemanly occupation' from socially inferior trades (Friedson, 1986). 'Professions' required University education, carried a comparatively high measure of social esteem together with a higher income than other occupations and the power of independent action within the law. Industrial society produced new occupational groups which aspired to similar status, including some, like pharmacy and accountancy which had previously been trades and others like nursing and midwifery which had been practiced in the domestic realm or had not been organised at all (Larson, 1977; Witz, 1994).

In sociology, there have been two broad approaches to the professions in general and medicine in particular (Turner, 1987:130; Willis, 1983:9). The first view is traced back to Durkheim who considered the bonds of professional association to provide the social solidarity necessary for the 'organic' division of labour characteristic of industrial society. He envisaged the growth of professional associations which would encourage social cohesion rather than conflict arising from class divisions. Following Durkheim's positive view, Talcott Parsons (1951) defined the medical profession as 'functional' for society because it controlled deviant sickness behaviour. He characterised medical professionals as altruistic and devoted to the service of the public, and saw the profession's prestige to be grounded in the mastery of complex technical knowledge. In this era, women were not thought to be capable of professional organisation and the occupations of nursing and teaching were only

thought to be ‘semi-professions’ because they could not assemble the correct ‘traits’ to conform to the professional paradigm.

A second view, more critical of professions has grown up since the 1970s (Johnson, 1972). This sees professions as organised not so much for the benefit of the public, but to promote the interests of their members within capitalist society. As well as controlling a body of complex knowledge, they create a market for their services, and negotiate with the state for a monopoly on the supply of these (Friedson, 1986:58; Larson, 1977). Friedson argues that professions remain distinctive types of occupation even when doctors work in bureaucratic organisations. because they retain autonomy in the way they carry out their work They do this because their professional organisations include not only practitioners, but also ‘teacher-researchers’ who produce knowledge and authorise credentials and professional elites who manage institutions like hospitals and advise on social policy (Friedson, 1986:211). Friedson points out that nursing and allied health ‘professions’, like midwifery, although they use the name and aspire to self-regulation and social respect, do not in fact have so much autonomy in making decisions and thus are not ‘professions’ in the sociological sense of the word (Friedson, 1970). Following from this analysis it is important to observe whether midwifery research defines the field and whether midwifery organisations have the same power to influence government policy as the medical profession.

This critical approach to professions argues that, although learned professions rely on their ancient forebears and their abstract knowledge, they have actually attained their privileged position in the labour market at a historically specific time and in a particular political context. Evan Willis (1983: Chapter 2) analysed the attainment of medical dominance by the Australian medical profession in the nineteenth century. He points out that medical power includes not only autonomy to govern its own work, but also authority over the work of others, including midwives, in the health division of labour and a measure of sovereignty over health issues in society. Professionalisation is better understood as a form of social closure, as demonstrated by Willis’ analysis of the rise of the Australian medical profession as a movement of collective social mobility undertaken with the backing of the state based on class and gendered power (Willis, 1983).

Willis (1983) argues strongly against ‘technological determinist’ arguments that professional power reflects and rewards the effectiveness of the knowledge base of that profession: Rather he argues that historically the scientific and technical advantages of medical care were achieved *after* professionalisation and were not the cause of it. In other words, the distribution of the work done by particular professional groups reflects their power, and does not cause it. Nurses and midwives are often delegated tasks which used to be a medical monopoly when more complex tasks become available, but this does not in itself ensure them any more power as a group. The history of the professional boundary between medical and midwifery groups demonstrates that the technical division of labour could have been very different if the power relations of class and gender had favoured the midwives and not the doctors.

### *Late boundary setting and the exclusion of midwifery in the USA*

The tightening of professional boundaries by registration and state sponsored monopoly was achieved at different times in different countries. Attempts at medical registration and state regulation in the nineteenth century failed because of popular health movements but in the early twentieth century the Flexner report imposed a higher standard of scientific medical education and closed many private medical schools, confining medical education to wealthy elite males (Ehrenreich & English, 1973).

The American obstetric profession is therefore said to have had weaker boundaries than its British and European equivalents at the beginning of the twentieth century (Arney, 1982). Arney argues that this later start in boundary setting meant that the North American medical profession drew the limits more tightly than in Europe, attempting to eliminate competition from the midwife and non-specialist medical practitioners. All births were defined as potentially pathological and in need of specialist obstetric attention and midwifery was criminalised, subject to prosecution as practicing medicine without a licence (Arney, 1982; De Lee, 1986 originally 1915).

### *Childbirth alternatives in the USA*

In the USA the feminist critique and other consumer movements in the 1970s created a demand for 'out of hospital' birth, either at home or in a birth centre. This was met both by the expansion of nurse midwifery and by the practice of lay midwifery (Adams, 1989). Also, in the USA, private obstetric care is expensive for people who have little or no health insurance (Annandale, 1988) and efforts to introduce universal health insurance have not been successful to date (Freund & McGuire, 1999:253). This has left room in the market for cheaper nurse-midwifery care and birth centres. This means that in the USA there are many different alternatives to mainstream obstetric practice.

These birth alternatives correspond roughly to the two feminist "health care worlds" of the 1970s, identified by Ruzek in her history of the women's health movement, "traditional feminist" and "radical feminist". "Traditional feminist" care offered conventional standards of care by sympathetic doctors and nurse midwives either at home or in a birth centre (Ruzek, 1978:138). As well as this more mainstream response to the critique of obstetrics, alternative lifestyle movements and racial and religious minority cultures have also created markets for de-professionalised lay-midwifery (Rushing, 1993; Sakala, 1988). This latter form is what Ruzek calls "the radical feminist health care world".

The traditional feminist world in the USA is one of birth centre care, homelike settings near or within a hospital run by professionally qualified midwives (Foley, 2003:167). Its existence challenges the monopoly of obstetrics over the provision of childbirth services and is often fiercely opposed, by obstetricians who make accusations of malpractice and lack of safety. Treichler (Treichler, 1990) describes how medical organisations attempted to close a midwife run birth centre in New York city by any means – appealing to the health department, demanding a randomised controlled trial to prove the safety of its practices and lobbying the insurance industry

to refuse it reimbursement. Such accusations function as a form of professional boundary maintenance.

The existence of the birth centre is often dependent on the goodwill of obstetricians and involves difficult compromises over birth practices by midwives. In a detailed study of an American birth centre, Annandale (1988) describes nurse-midwives in birth centres as mediating between the demands of their clients and the expectations of the obstetricians. The birth centre's survival depended on the midwives satisfying the obstetric managers that their practices were appropriate and safe. Some of the issues around which conflict was centred were how long a pregnancy should be allowed to continue after the due date before induction, how long labour should last without acceleration and the identification of complications. Foley and Faircloth (2003) describe the boundary work which is necessary between medicine and midwifery which they observed amongst Florida midwives.

As well as the boundary with the obstetricians, the midwives in Annandale's (1988) study also had to satisfy the expectations of the women and these were often contradictory. Women committed to a natural birth resisted transfer to obstetric care even when the midwives would have felt safer to hand over responsibility. These clients were likely to resort to homebirth or unattended birth if they felt their desires for a birth without intervention were likely to be frustrated. Alternatively, women attracted to the Birth Centre because it was cheaper than obstetric care were not committed to birth without intervention and were likely to demand transfer *out* of the birth centre if they felt that giving birth without anaesthesia was too difficult for them (Annandale, 1988). The traditional health care world demanded complex negotiation of professional boundaries.

The more alternative 'radical health care world' in contrast involved de-professionalisation of health care services, especially those which are really 'well care' like contraception and childbirth and a radically different philosophy. The North American homebirth movement is distinctive in its development of a tradition of apprentice-trained lay midwives (Peterson, 1983; Sakala, 1988; Weitz & Sullivan, 1985, 1986). Because lay midwifery was originally part of the counter culture, the midwives did not see themselves as full time professionals, wanted little if any money and were rewarded for the ample time they spent with birthing women by the natural high they got from 'birth energy'. There is a blurring of the boundary between birthing women and women who care for them. Lay attendance at childbirth or even parent only birth fitted into this self-help model (Ruzek, 1978:112).

In this world, childbirth knowledge is seen as cultural rather than medical, the idea of 'risk' is something psychological and subjective rather than objective and scientifically measurable (Ruzek, 1978:110). This is a very different culture which as Katz Rothman (1983) describes, leads even midwives who are registered nurses to practice differently. The issues that were particularly the focus of professional boundary maintenance in the birth centre, such as length of pregnancy and length of labour are allowed much more variation at home as long as the midwife feels that the mother and baby are doing well. In the home setting, registered nurse homebirth midwives practice very similarly to lay midwives.



There is a tension between the commitment to a radical alternative philosophy and desire to increase legitimacy by professionalisation. Until the 1980s some of the States actually prohibited midwifery, while others permitted lay midwifery practice and others were unclear in their policy or did not enforce the statutes that were on the books (Butter & Kay, 1988:1161). Some lay midwives in North America have taken steps to professionalise their practices by registration or licence (Butter & Kay, 1990). This is not uniform however, as some midwives prefer the original anti-professional approach (De Vries, 1985; Weitz & Sullivan, 1985). Lay midwifery is valued for its opposition to the 'medical model' so there is a fear that legalisation and registration will co-opt and bring lay midwife practices closer to medical ones (Foley, 2003:172). Weitz and Sullivan (Weitz & Sullivan, 1985). found that licensed lay midwives in Arizona tended towards what they saw as a medical definition of care and a more hierarchical style of practice De Vries (De Vries, 1985). concluded that midwives in California would be better able to preserve the distinctive character of their relationships with clients if they remained unlicensed even though this meant suffering under threat of prosecution. Even where licensure is available a few women will continue to use unlicensed practitioners because they share religious beliefs or because no other home birth providers are available (Myers, St. Clair, Gloyd, Salzburg, & Myers-Ciecko, 1990).

The exclusion of midwifery services from mainstream care in the USA has had the effect of generating passionate commitment to radical alternatives which operate outside the health care system and which see accommodation with it as an undesirable compromise. The 'radical health care' world of the USA has a high profile compared to more mainstream feminist alternatives considering the small number of participants (Foley, 2003:167). Their scepticism about risk and the close relationship between women and midwives have influenced many homebirth groups in Australia. It is notable that the private practice climate in the USA encourages a wide range of alternatives while creating intense boundary problems and difficulties for midwives and women who are choosing services on a mixture of financial and ideological grounds. The fact that both the counter culture and the women's health movement originated in the USA may mean that its example has been taken as axiomatic of feminist alternatives, even though as Annandale and Clark (1996:29) believe the dichotomies are too heavily distinguished and the alternatives not completely coherent.

### *Demarcation and the limitation of Midwifery in Britain*

The historical development of British midwifery accounts for the midwife's role in the maternity care division of labour. In Willis' (1983) terms, British midwifery was *limited* by medical dominance, not *excluded* as American midwives have been. This was largely because the British medical profession had achieved registration and state monopoly early, in 1857, and came to terms with midwifery registration in 1902 (Witz, 1994).

According to Arney (1982), the British obstetric profession had enjoyed much more secure boundaries than the American profession and was prepared to countenance the division of childbirth into discrete normal and abnormal cases - the normal ones being delegated to the midwives Witz (1994: Chapter 4) argues that this process of demarcation took place after a struggle between midwives who wanted complete

professional autonomy by a *revolutionary* strategy to usurp professional territory from medicine and those who were prepared to *accommodate* the demands of the medical profession.

The outcome of this struggle illustrates Willis' (1983) thesis that it is social power which determines the technological division of labour, not the other way round. If the revolutionary strategy had succeeded, midwifery would have been a self-contained separate female specialty with status equivalent to medicine. The Female Medical Society set up an Obstetrical College in 1864. Witz (1994) calls this a credentialising tactic, that is it provided separate medical education rather than changing legislation. Midwives would have been trained in midwifery and obstetric surgery, making them independent of doctors. The energy behind this reform was dissipated when women gained access to full medical training, but the fact that it was suggested and supported in the second half of the nineteenth century illustrates that the familiar division of labour between medicine and midwifery was not inevitable, there could have been a very different 'female medical profession' in which a combined midwifery/obstetrics would have been dominated by women.

The struggle over midwifery registration in Britain at the end of the nineteenth century raises issues of midwifery competence and the shared or competing interests of obstetricians, midwives and General Practitioners which are not resolved in Australia to this day. According to Witz (1994), the British medical profession in the late nineteenth century was divided on midwifery registration. The obstetric specialists favoured what she calls *de-skilling*, (Willis' limitation) which means that midwives were restricted to normal birth under a certain amount of medical supervision to ensure that they called a doctor for complications. Advocates of this strategy believed that it was possible to divide births into 'normal' and 'abnormal' and that midwives could be limited to the normal. They supported midwives in their quest for registration because it made no material difference whether midwives or GPs took care of uncomplicated births and it was, "a means of controlling both the knowledge base and the sphere of competence of midwifery" (Witz, 1994:105). In order to do this, they wanted medical control of the midwives' training and registration. They argued that midwives' education should be sufficient for them to "know their own ignorance" (Witz, 1994:113) and therefore to call in specialist attention when necessary.

In Britain at the time of the debate over midwifery registration, general practitioners opposed midwifery registration because they were in competition with the midwives for family practice cases, what would now be called primary care. They favoured the strategy Witz (1994:105) calls *incorporation* (Willis' exclusion) in which the general practitioner took on "virtually the whole gamut of tasks associated with the occupation role of midwife". They would have argued, as doctors did in the USA, that natural and unnatural labour could not be distinguished and so midwifery as a separate sphere of practice should be abolished. However, this view did not prevail in Britain, because of the power and confidence of the specialist lobby which supported midwifery registration and because the leaders of the midwifery organizations accepted 'limitation' in order to gain a degree of autonomy in the practice of normal birth (Arney, 1982; Witz, 1994:121). Midwifery registration was achieved also because doctors did not want to take on the time consuming business of midwifery, especially for the large number of births in rural areas and to working class women, as

this was seen as “tiresome and unremunerative work” (Witz, 1994:115). British midwives thus achieved registration and limited autonomy in “the daily practical accomplishment of midwives tasks” (Witz, 1994:121). Professional autonomy in Friedson’s terms was, however, elusive as the central midwives board which oversaw the examining and registration of midwives was under the control of the medical profession (Witz, 1994:123). The Act established a registration process for midwives, which was separate from that of nurses. It provided for sunset clauses for practicing lay midwives and a continuing option of direct entry training (that is without nursing training) for midwifery – although the direct entry route had lower status than the nurse midwifery qualification and attracted a diminishing number of candidates (Robinson & Thomson, 1994:263).

As government welfare provision for families grew between the wars and especially after the second war, midwives became salaried local authority employees rather than private practitioners. After 1948, the NHS ensured that there was no financial incentive for either Obstetricians or General Practitioners to exclude midwives. General Practitioners were not paid on a fee-for-service basis, so it relieved their workload to work in teams with midwives who were employed by local health authorities. Although this sounds very progressive by Australian standards, Robinson (1989:176) suggests that having two different practitioners trained in the area of primary care of pregnant women was a duplication of effort and the midwives ability and independent expertise was not always acknowledged. The British Association of Radical Midwives has suggested that midwifery primary care should displace general practitioner primary care altogether (Flint, 1988).

### Childbirth alternatives in Britain

The situation in Britain has been less organised around alternatives to mainstream care. Rather it has consisted of consumers criticising the quality of care and midwives defending their professional status. The social and political arrangement of childbirth services has not encouraged the development of radical alternatives, but it has encouraged debate about alternative practices and evaluation in which midwives have taken part.

Whilst homebirth (domiciliary delivery) was increasingly discouraged by General Practitioners and became very uncommon between 1970 and 1985, it was never criminalized as it had been in the USA. Midwifery regulations in Britain stemming back to the 1902 Act mean that the local authority is legally obliged to provide a midwife for any woman who wants one so homebirth has more of a place in mainstream care than in the USA or Australia. Consequently, there was very little opportunity for the growth of deprofessionalised lay midwifery.

In Britain, childbirth alternatives have been fashioned through consumer campaigns and childbirth education groups (Williamson, 1992). These have concentrated on changing birth practices within hospitals rather than developing deprofessionalised alternatives (Balaskas, 1983). Whilst the medical profession has disapproved of homebirth and promoted technological interventions in hospital, the debate has been over effectiveness and efficiency within National Health Service hospitals run by salaried obstetricians and midwives (Chalmers, 1989, 1992; Chard & Richards, 1977, 1992). Unlike women in the USA and Australia, consumer movements have not had

to deal with the opposition of a body of specialists who depend on normal childbirth for their income. In fact in one of the most famous cases, it was Wendy Savage, an NHS obstetrician who was attacked for not performing enough interventions and whose defence was organised by consumer movements (Savage, 1986).

In contrast to the USA and its alternative lay midwife tradition, mainstream midwifery in Britain has always included some midwives who did not have nursing training (direct entry midwives). The intention of direct entry training in the 1902 Act was to cater for countrywomen and granny midwives who could not afford nursing training but who took care of the rural and urban working class. Until the 1980s, direct entry midwives were a lower status group and were not eligible for promotion. The consumer and feminist critique reawakened interest in midwifery and more educated and ambitious women used 'direct entry' midwifery training as a route to a career in natural childbirth. These midwives do not see themselves as inferior practitioners because they are not nurses, some of them are tertiary educated in other disciplines and act as pioneers, theorists and historians. The prohibition on their promotion has since been removed (Leap & Hunter, 1993; Robinson & Thomson, 1994). The rise in direct entry training bolsters the separate identity of midwifery and counters moves to integrate nurse and midwifery training.

British midwives have a limited degree of independence and a claim to state backing in the interests of saving money and responding to consumer pressure against hospital births. They are a more unified group than Australian midwives, as their response to attempts to incorporate their registration into nursing shows. In this context, there has never been a climate for the development of deprofessionalised lay midwifery in Britain. Even at its nadir in the 1970s, it was possible to arrange for a homebirth with registered practitioners and for women without nursing qualifications to become midwives, though very few did. In comparison to Australia, British midwives have strong separate midwifery representation that has resisted the absorption of midwifery education into the field of general nursing (Robinson & Thomson, 1994).

In Britain, there are some tensions over the professional role of midwifery and the extent to which midwives can be independent practitioners of low intervention birth, especially at home. The 1993 Winterton report, from a government enquiry chaired by lay people recommended against the policy of 100% hospitalisation for birth and argued for renewed choice (Department of Health (UK), 1993). This led to opportunities for a resurgence of domiciliary midwifery under the NHS despite opposition from some specialists, non-cooperation by some general practitioners and reluctance from some midwives (Tew, 1995). The recent intervention of the central government in opposing 100% hospital childbirth policies may serve to promote midwifery services even against the opposition of the obstetricians but the outcome of this policy change remains to be seen (Tew, 1995). Although the change is not as rapid as some proponents hoped, the opportunities for state funded alternative childbirth are more extensive than in the USA, where alternatives are in the private sphere, or Australia where there is a medical monopoly on Medicare rebates for childbirth services.

In the context of feminist and consumer debates about childbirth, the Association of Radical Midwives proposed an extended role for direct entry training to establish a more independent and less doctor oriented midwife (Robinson & Thomson,

1994:271). Leaders of the midwifery 'renaissance' such as Caroline Flint in Britain have had an international influence including on nurse midwives in Australia (Brodie, 1994). However, the radical alternative in Britain fosters increased professional status rather than leading to separatist, apprentice training and alternative medicine. Rather than rejecting 'scientific knowledge' as alternative midwives in the USA tend to do, radical midwives such as Caroline Flint employ its techniques to gain professional status. She has an international reputation for her randomised controlled trial of a 'team midwifery' scheme called 'Know your Midwife' (Flint & Poulangeris, 1987). Many British midwives have been involved in the Evidence-Based Medicine (EBM) movement and have undertaken trials of many aspects of maternity care (Chalmers, 1992). British midwives are therefore staking a claim to be more rational and effective than obstetrics rather than resting their arguments on an ideology of the natural body.

### *Midwifery, nursing and subordination in Australia*

In Australia, midwifery regulation followed a similar path to that in Britain at the beginning of the twentieth century. Willis (1983:94) points out that the newly organised medical profession was divided over the issue. Just as Witz described for the UK, elite practitioners had nothing to do with midwifery but GPs needed it to build up a practice. He argues the status of midwifery had declined in the nineteenth century because in the prevailing cultural climate it had an indecent association with sexuality and the body (Willis, 1983:94). Midwifery also had a professional boundary with nursing, which aimed to incorporate midwifery into its own body of knowledge and sphere of practice.

Willis (Willis, 1983:94) further points out that the beginning of the twentieth century, when British midwives were being registered and obstetricians in the USA were arguing for their professional monopoly, was a period of state concern for mother and infant welfare, an era of increasing belief that the government was responsible for the health of the population and a time of publicly expressed fears of 'race suicide' if the white population's fertility declined. All of these issues were apparent in Australia and led to a government baby bonus of five pounds for white mothers (not Asian or Aboriginal women), to allow skilled attendance at births. The medical profession opposed this measure, fearing that the money would go to midwives, but actually more women paid for medical attention (Willis, 1983:112).

Willis (Willis, 1983:114-5) traces the history of the 1915 Midwives Act which set up a midwives board and State Registration. He points out that midwives had to be at least twenty-three years old, of good character, trained or in practice for two years. At this time, nurses could only be midwives in country areas. However after the 1828 Nursing act all midwives had to be nurses first. This effectively subordinated midwifery to nursing even though local midwives were still valued and untrained midwives still practiced in country and working class areas

Unlike midwifery in Britain and some other countries, notably the Netherlands (Kloosterman, 1978), Australian midwifery does not at present have a separate identity from nursing, although proposals for a Midwives Act are under consideration. Without a separate midwifery register, registered midwives are considered by the nursing registration authorities to be a sub-speciality of general nursing. This was the effect of formalising the subordination of midwifery in the 1920s (Willis, 1983:116:).

The move towards an increase in professionalisation of nursing since the 1980s means that contemporary nursing identifies midwifery, which has good claims to independent identity, as a crucial part of its professionalisation project. Midwifery is significant to nursing in its quest for more professional autonomy because some midwives have already pioneered independent practice (NSW Nurse Practitioner Review. Stage II. 1993) and midwifery was included in research on Nurse Practitioners by the New South Wales Health Department (NSW Health Department, 1993). The New South Wales Nurse Practitioner Act (1998) holds out at least the possibility that midwives working in remote locations or areas of need will have greater autonomy and limited prescribing rights. Some midwifery leaders have proposed a separate midwifery register and direct entry midwifery training, similar to the UK but the nursing profession has been reluctant to countenance these measures.

In Australia then, a midwife is very often a qualified nurse with a midwifery certificate, rather than someone who has deliberately chosen midwifery as a profession. There is a wide range of variation in the way nurses use midwifery qualifications, which reduces the level of closure obtained by the occupation. Many gain it as an additional qualification and never practice. Before the move to University training in the 1990s, young nurses very frequently took midwifery as a specialist qualification because extra 'certificates' meant higher pay and in case they needed midwifery qualifications for remote area practice where they might be the only health care practitioner in the area. Those who do practice usually work in obstetric units under medical supervision. Midwives take care of labouring women but they are not responsible for decisions about their care and the actual delivery has until recently been left to the doctor. Since the 1980s, some midwives have the opportunity to work independently in a birth centre, but as cited above, these births amount to less than 5% of the total, so while the changes in practice are significant, the numbers of midwives able to work in birth centres is very small (Nassar, Sullivan, Lancaster et al., 2000).

Even more minute are the numbers of midwives in private practice. In theory a private practice can be set up on the basis of a midwifery certificate alone. There is an accreditation through the Australian College of Midwives (ACMI), but this system of specialist qualification has no legal status and is not a very powerful form of closure. In Witz's (1994) terms it is a *credentialising* rather than a *legalising* tactic. Not all private midwives are accredited by the ACMI. The accreditation is not sufficient on its own to gain visiting rights at a hospital, so it is less powerful than a medical specialty accreditation (NSW Health Department, 2000). With accreditation and 'visiting rights' an independent midwife can deliver her patients either in a hospital or birth centre or at home. If she does not have them and a homebirth patient needs transfer to hospital they will be out of the midwife's care once they enter the hospital.

The requirements for accreditation are difficult to meet especially because independent midwives often do not have sufficient private patients to fulfil them. In addition, accreditation is done separately by each hospital and the obstetricians have considerable say in their success, which means that the number of accredited midwives remains very low. The Royal College of Obstetricians and Gynaecologists argue for team midwifery rather than independent midwifery on the basis "there is no such thing as a truly independent profession" (NHMRC 1994). However, if accreditation is very hard to obtain, it does not induce midwives to act as part of a

team. The requirement to hand over care of private midwifery patients if they are transferred to hospital is likely to act as a disincentive to cooperative care.

### Alternative birth options in Australia

The situation for birthing alternatives in Australia is complex. The homebirth movement in Australia started in a very similar way to that in the USA, in association with the Vietnam War, the protest movement and the rise of feminism (Noble, 1998; Reiger, 2000-2001). However, birthing alternatives have developed somewhat differently because of the tension between the universal provision of care and the professional dominance of specialist practitioners. Midwives in Australia are firmly within the nursing profession and have less autonomy than midwives in Britain, but there are contradictory influences on birth politics from both the USA and Britain. This means that there is a great variation in the way homebirth midwives practice and their qualifications to do so, including formal midwifery qualifications from Australia and overseas, especially Britain, and apprentice 'lay' midwifery training from Australia or from the USA, which often includes certification.

There is some evidence that more Australian women might choose alternative birthing if it was available to them. Cunningham (Cunningham, 1993) found that women who had homebirths or birth centre births were more likely to want to repeat the experience than women who gave birth in ordinary hospitals. Smith (Smith, 1993) showed women in the Australian Capital Territory were not given a full range of choices when choosing birth services and that it was often professional insiders, like doctors and midwives who had the knowledge to choose homebirth which was not shared with the lay public.

However, one of the constraints on the growth of independent midwifery practice is its situation within the wider medical system, especially in terms of finance. As previously mentioned, in the USA private obstetric services are beyond the means of many uninsured families and this is an incentive to consider alternative forms of care (Annandale, 1988). There is no pool of uninsured or otherwise unprotected Australian women to provide a market for midwifery services so the absence of government funding is a large disincentive to Australian women having home births or hiring independent midwives. All women have the option of free public obstetric care and private obstetric care is also subsidised by Medicare, which means that although families have to have private health insurance and even pay a 'gap' fee for the services of a private hospital and doctor, they are not liable for the whole cost of the birth.

Most independent midwifery is fully private, although some health funds reimburse nurse midwifery services and there have been experimental publicly funded homebirth schemes in Western Australia and Tasmania. Unlike certified lay midwifery in the US or direct entry midwifery in New Zealand, which can be reimbursed by third party providers, there is at present no form of licensing for lay midwives in Australia and so lay midwifery is paid for entirely by the family. Since 1992, when 'midwife' became a legally protected title and providing midwifery services without registration became a criminal offence, lay midwives cannot practice openly and offer only 'birth support'. Some of the fall in 'planned homebirths' and rise in 'born before arrival' births may be a result of lay midwifery, a planned

homebirth is reported as one that happened too quickly to get to hospital (the excess 'born before arrival figures can be seen in Nassar, Sullivan, Lancaster et al., 2000). The crisis in the provision of professional indemnity insurance since the mid-1990s, means that it is very difficult for independent midwives to be insured at all.

It appeared during the 1980s, that the policy activity around birth would yield some positive benefits for alternative childbirth in Australia. In 1987 the National Health and Medical Research Council found that "An extensive review of the literature did not substantiate the expressed concern about the safety of homebirth... women should be able to make their own choice as to place of birth".(NHMRC cited in Norling 1991:69). This report has since been disavowed by the NHMRC, but at the time it was seen as a victory for advocates of homebirth midwifery, both registered and lay midwives.

The Medicare benefits review board (the Layton Commission) found that (registered) midwifery met the committee's criteria for safe effective service, but the campaign for reimbursement under Medicare was refused because the committee was unwilling to recommend extension of Medicare benefits to any more health professionals (Australia. Medicare Benefits Review Committee, 1985, 1986). The government was and remains unwilling to grant Medicare provider numbers to any further categories of practitioner, however deserving, because it has no control over the amount of extra expenditure. Instead, the Layton Commission recommended forms of practice with limited expenditure, such as sessional employment of podiatrists and chiropractors in hospital. Similarly, their approval of midwifery education, standards and access to care led to a recommendation that the government fund an experimental alternative birthing services programme and this became the Commonwealth Alternative Birthing Services (ABS) funding programme.

Unlike the USA, the Australian feminist movement has made great gains with the assistance of the State (Franzway, Court, & Connell, 1989), so state funding was not an entirely unreasonable expectation, although the idea that funding would be extended to unregistered practitioners was probably unrealistic. But the funding did not promote the same kind of fee for service practice as enjoyed by obstetrics and therefore give independent midwives the status and financial assistance they had been looking for. The bulk of the funding did not go to homebirth but to set up birth centres in hospitals. Funding had to be applied for and the bureaucratic requirements of the funding excluded the alternative lay midwives and some homebirth groups who were unfamiliar with writing grant applications and the expectations of grant giving bodies. Some successful pilot homebirth programmes were carried out in Tasmania and Western Australia.

In the late 1980s a philosophical split within the homebirth movement developed over the scope of homebirth practice (Gosden, 1996). One consequence was a divergence in the reactions to guidelines produced by the NHMRC (NHMRC, 1989) for the practice of homebirth. The fact that the guidelines acknowledged women's right to choose homebirth appeared to be positive but this was outweighed for some by the fact that they recommended only registered practitioners for low risk pregnancies. Some registered midwives were happy to adhere to NHMRC guidelines and take only low risk cases, (this would be similar to midwifery practice in Britain). Other registered midwives and lay midwives believed that it was important for them to have the power to decide what cases to take on, especially because they were responding to a demand to



have post-dates, twins or breech babies at home. These wide boundaries of practice are more like the practice of lay midwives in the USA. Birth alternatives in Australia then are diverse, including birth centres in hospitals, a relatively professionalised independent midwifery and a more alternative midwifery which draws its inspiration from the USA.

## *Conclusion*

The most well known feminist critique of the childbirth system relates to the USA, which had the most specialist, privatised and technological system. It is a society with a large, de-centralised health system. Within it there are numerous competing groups providing widely different levels of obstetric care. The US has also been a lively source of alternative visions, alternative lifestyles and several schools of feminist theory. The USA has the most extreme variation between lavish specialist obstetric provision and radical alternative midwifery. This polarised situation appears to underpin much of the discourse of the 'natural alternative' in birth, discussed in the Radical feminism section of Chapter One. In Britain and Australia, the government has provided more social provision for reproductive needs and feminists have had more success working through trade unions and state bureaucracy, which is more consonant with the materialist feminist analysis described in the 'Inequitable birth' section of Chapter 1.

Britain and Australia have more social provision for childbirth care and a more independent role for registered midwives, but the idea of a radical alternative and a sharp dichotomy between medicalised and alternative birth is still in circulation. Literature, conference speakers and internet access mean that alternative visions of midwifery have global influence and have certainly had an impact on both alternative and mainstream childbirth in Australia, but the alternatives they promote need to be tailored to the political and social systems of the societies they are being adapted to. It should not be forgotten that female practitioners also have privatising interests and professional ambitions which are downplayed by the 'natural childbirth' ideology (Annandale & Clark, 1996; Treichler, 1990).

As in the USA and Britain, birth in Australia has been placed squarely within the health system. However, the Australian population is much smaller, there is more generous provision of healthcare and more extensive surveillance of perinatal mortality than in the US. Australian feminism has absorbed influences from radical, cultural and liberal feminism, but it was more successful in influencing the social democratic state and so there has been an expectation of gaining state funding for birthing alternatives, even ones which are quite radical.

Extreme alternatives have not been as important in Britain as in the USA, whereas Australia has developed both mainstream midwifery care and a lay midwifery culture, which interact. The impact of these alternatives on the care of mainstream women may not have been as great as the controversy they create. The Australian alternative practitioners who wanted both government funding of homebirth midwifery and freedom to determine the scope of their practice were appealing to the type of professional autonomy defined by Friedson (1970) and institutionalised in the medical profession. This was intended to preserve a style of 'autonomous' practice so that women seeking alternative childbirth options could find midwives (or very rarely

doctors) who were willing to practice in alternative, personalised styles, preserve older style practices such as vaginal delivery of breech babies and twin at home or 'push the boundaries' of hospital practice, based on their own experience and their relationship with the woman concerned. It may be that the heightened surveillance of Evidence Based Medicine is bringing this style of professionalism to a close. Ann Oakley (Oakley 1982:288) argues that such routine evaluation of practice calls into question the idea of professional authority on the traditional model.

Theorists of the professions have called this issue the 'indeterminacy' of professional knowledge. If there is too close a match between a given condition and its treatment, the application of the treatment becomes a technical matter which can be handled by personnel with less education, skill and hence lower levels of social prestige and material reward (Friedson, 1986; Johnson, 1972). This is of particular relevance for birthing procedures. Practice by guidelines based on RCT evidence could have the effect of making practice more uniform. A uniform style of 'evaluated' practice means that alternatives, whether they are the preservation of old skills or practices based on alternative therapies or worldviews cannot be practised under the umbrella of clinical freedom. On the other hand, as Benoit (Benoit, 1989) points out, the degree of autonomy which was actually enjoyed by the traditional midwives who are idealised by alternative birthing literature was severely circumscribed.

While the surveillance of outcomes and uniformity of practice styles may be problematic for independent midwives who offer alternative styles of care, the evaluation of practice may have the potential to increase the power of midwives who practise as professionals within larger scale systems. As Schofield (Schofield, 1995) has suggested, it is probably too difficult for independent midwives to challenge the power of private obstetricians on the ground of fee for service practice, but hospital practice may be a better basis for increasing the power of midwifery in Australia and for promoting the interests of the majority of childbearing women. Opposing conventional professional autonomy with 'de-skilled' hospital practice is to a large extent the product of a radical/cultural feminist world view in which lay midwifery is the anti-thesis of the technological world. The dichotomy of 'autonomy' and 'de-skilling' may never have been an accurate characterisation of the work traditional midwives actually did (Benoit, 1989). Some midwives in the USA describe their practices as more faithful to the evidence than those of the obstetricians (Foley, 2003:172). Midwives in Holland are also practicing in ways which combine a judicious use of technology and risk assessment with their conventional role of protecting birth as a normal event (Smeenk & ten Have, 2003). If evidence based practice has the potential to promote lower intervention care which is cheaper, less intrusive and can be carried out by midwives rather than doctors, this may be cast as 'de-skilling' of medical work, but this is not necessarily a bad thing if that work had been inappropriately 'over-medicalised' in the first place.

The medical profession is a long way from surrendering its privileged position in the medical division of labour, still less its class and income position (Reiger, 2001b). Nevertheless the trend towards research-based practice has the potential to increase the professional standing of midwives in both Britain and Australia (Ahmed & Silagy, 1995; Chalmers, 1992), and this is acknowledged to some extent by their medical colleagues (Pepperell, 1995:285). In fact both the obstetricians and the midwives may

be practicing within an network of surveillance of risk which makes the older version of professionalism obsolete.

*Post-structuralism, childbirth and midwifery*

Since the early 1980s, the social sciences and feminism have been increasingly subject to the influence of post-structuralist thinking. Theories which explain social change by appealing to an overall mechanism of history, whether it is rationalisation, exploitation or patriarchy are all criticised from a post-structuralist view because they are said to be universalising and insensitive to local difference and individual agency (Annandale & Clark, 1996:21). Even the critical grand narratives which claim to uncover class and gender oppression are thought to contribute to inappropriate intolerance of the diversity of social forms and a mechanistic view of social change. They are themselves discursive constructions which serve the needs of power (Fox, 1999).

Annandale and Clark (1996) argue that it is necessary to apply post-structuralist ideas to the realm of reproduction, so the next chapter examines some ways in which these theoretical ideas can be applied to childbirth and midwifery. Instead of concepts of power and domination, it raises ideas of surveillance and governmentality. All types of knowledge are seen as leading to both objectification and subjectification and multiple sites of power are recognised which are understood to operate in a capillary fashion, (that is through complex and multiple channels) rather than being exerted from above. Post-structural theory implies an awareness and a tolerance of difference within groups rather than analysing them as totalities. Surveillance of outcomes can lead to increases in disciplinary knowledge and heightened levels of normalising expectations, but this is not purely good nor entirely bad. Rather than a 'natural body', post-structuralist theory canvasses the way in which the body is inscribed and formed through language and discourse. Instead of a single 'healthy', normal or natural model for birth, it creates the conditions for diversity, based on competing representations and definitions. It can also provide the preconditions for local provision within global regulation. The next chapter deals with the development of such a post-structural politics of childbirth.

### CHAPTER 3 CHALLENGING THE NATURAL BODY.

The theories discussed in Chapter 1 depended on either an assumption of increasing rationality, by liberal feminists, or a critique of domination by radical and materialist feminists. Since the early 1980s, the social sciences and feminism have been increasingly subject to the influence of post-structuralist thinking, although this has resulted in heated debate. Barrett and Phillips (Barrett, 1992:2) point out the 'paradigm shift' that occurred between 1980s and 1990 which 'destabilised the foundations' of 1970s feminism. All theories, like those discussed under the three 1970s critiques of medicalised childbirth, which trace origins and construct histories showing, for instance, how childbirth has 'come out of the dark ages' or been subject to the systematic takeover of women's knowledge are modernist 'grand narratives'. In other words, from a post-structural point of view they are not privileged versions of 'reality' but rhetorical devices, which command allegiance to a particular viewpoint or 'truth claim'. In the realm of reproduction, post-structuralist thinking challenges many of the key ideas put forward in Chapter 1 such as the 'universalising of women's experiences and the valorisation of gender differences' and the idealisation of the midwifery alternative (Annandale & Clark, 1996). In this chapter, I put forward the relevance of post-structuralist ideas to the theorisation of childbirth, stressing especially its re-conceptualisation of the nature of power and domination and new ways of understanding the constitution of subjectivity, authenticity and the body.

One post-structural critic who has been influential in the social sciences is the philosopher Foucault (1994) who believed that the 'sciences of man' (sic) that developed evolutionary theories of human nature from the nineteenth century onwards, were about to be displaced by a forms of knowledge which did not make 'man' the object of knowledge, but rather analysed how the social and material world were shaped by language. He disputed the idea that all power is 'sovereign power' held and exercised by an oppressor class, whether men or owners of private property. He thought that power pervades all types of knowledge and all relationships. Medical power for Foucault (1973) was not the possession of a group of middle class male chauvinists but the consequence of a particular way of constructing the human body.

The shift to post-structural theorising has taken place against a wide-ranging debate about whether or not contemporary society can be characterised as modern or post-modern – and what kind of new theory is required to interpret it. Foucault is anti-modernist and in favour of post-modernism (Jameson, 1991). He sees society as post-industrial, that modernist attempts to emancipate humanity have proved to be self-defeating and that a radical departure from previous conceptions of power and the subject is required. Foucault (1991:223) questioned the directionality and continuity of history as well as the idea that power is only the model of sovereign or juridical power exercised by a dominant group. Rather he traces power as embedded in techniques of surveillance and discipline developed in the nineteenth century prison, school, work-place and hospital (Burchell, Gordon, & Miller, 1991:222)

This understanding of power intersects with the understanding of the body as culturally produced. In general from a post-structural point of view the body is not oppressed from the outside but produced by and embedded in networks of power.

This changed idea of power and the subject is a major departure from the types of feminist analysis performed in the 1970s, whether they were appealing to science to understand the female body, whether they saw women's natural bodily functioning as oppressed by patriarchy or their physical and emotional work expropriated by capitalism.

These ideas have developed since the mid-1980s with the waning of socialist ideas and the resurgence of political liberalism. The import of Charles Lemert's (1997) title, *Post-structuralism is not what you think* is that this is not just a change in 'theory' but responses to actual changes in the nature of social and political life. The political context of the 1980s and 1990s was very different from the 1960s and 1970s when the three feminist critiques of childbirth were developed. The Radical feminist utopia which rejects the contemporary division of labour and plans a return to an idyllic pre-industrial community has found echoes in far right retreatism, but is not a completely adequate response to globalisation and can easily become co-opted (Purkiss, 1996). In any case, its ability to proceed with alternative healthcare provision has been subverted by the litigation crisis and increased levels of surveillance of perinatal outcomes (Bastian & Lancaster, 1990). As far as the demands of materialist feminists for more social support for reproduction go, the regimes of Reagan and Thatcher espousing neo-classical economics and small government in the USA and Britain, and even the Australian Labor party negotiating with big business, have made many of the revolutionary aspirations of the 1970s seem utopian. Whilst Australian feminists had made successful inroads into government policy, economic changes began to threaten feminist reforms based on the intervention of the state (for instance see Broom, 1991 on the bureaucratisation of the women's health movement). While the adoption of post-structuralist concepts has been controversial with some feminists and commentators on the left, they have also been adopted widely and given a critical edge. However, the study of childbirth seems to have been less influenced by post-structural theory and considerations of feminist childbirth policy retain a commitment to universalising women's desires and dichotomising medical and midwifery models of care (Annandale & Clark, 1996).

### *Post structuralism and language*

A major issue addressed by post-structuralist theories is the role of language in constructing the social and its relationship to the material world, especially the body and sexuality. Foucault (1994) argued that historical epochs were characterised not so much by a mode of production which then gave rise to ideology and consciousness, but that there were, in each era, overarching ways of conceptualising the world which allowed particular kinds of knowledge to flourish, particular things to be perceived and said. Foucault's (1994) *The Order of Things* traced the change in the 'episteme' from the religious world view of the middle ages in which all of nature was linked by resemblance and correspondence, through the classical period in which things were catalogued and classified, to the modern era which is the era of the study of 'man'. The human sciences, including economics, sociology and psychology, are in this view heirs to the nineteenth century episteme which arose after the French Revolution and in which 'anthropology', the study of 'Man', becomes the measure of all things.

In this work, Foucault (1994) formulated the relationship between the individual psyche and the culture by saying that the psychoanalytic and the anthropological are

intersecting planes, “the signifying chain by which the unique experience of the individual is constituted is perpendicular to the formal system on the basis of which the significations of a culture are constituted” (Foucault, 1994:380). So, psychoanalysis shows how language and narrative are embedded in the individual and anthropology how the social impacts on the individual subject shape their understanding of what their physical, emotional and social experience means. Following Foucault’s idea that psychoanalytic and cultural discourses shape our unconscious beliefs, our bodies and our behaviour, it is interesting that psychoanalysis and anthropology pervade the writings about childbirth and the female body that were the foundation of the different feminist critiques. The problem is the way they tend to lapse into ‘disciplinary’ knowledges and revert to fixed oppositions of moral/immoral, natural/technological.

### Gender dichotomies

Feminism has drawn several useful concepts from the post-structuralist idea of language and the way in which it constitutes reality. The utopian idea of alternative childbirth drew deeply on nineteenth century images that the world of women was purer and more moral than the world of men, a view that resonates with the American tradition of the country being less corrupt than the city (Kaplan, 1992). This promoted the duality of thinking which separates women, the country, motherhood, emotion and purity from men, the city, reason and sexuality, which in turn has had an impact on our ideas about birth. This dualistic Western thought reflects a ‘masculine’ approach to human life, in which the mind is unsullied by the dirty materiality of the body (Annandale & Clark, 1996:19). The ideal masculine body is ‘clean’ with sharp boundaries, ‘mens sana in corpore sano’ an ideal which the menstruating female body can never emulate, hence the nineteenth century suspicion of female participation in education and politics (Petersen & Lupton, 1996). The childless woman who leaks blood is one type of body who contravenes this standard, but the childbearing body appears even more grotesque within this framework, in that it becomes a different shape, grows an alien being within its boundaries and then leaks blood, shit and milk in the process of expelling and nurturing the dependent creature. The inheritance of dualism makes it difficult to overcome the polarities between male, clean and rational; female, dirty and emotional. They are embedded in our habits of speech and thought. This body of discourse has an adverse impact on thinking about birth which is an intensely embodied experience which confronts the normal boundaries of polite behaviour. It raises issues about the conscious control or otherwise of the birth process, questions women’s ability to be rational and autonomous if they are also giving birth and confuses the bodily, the sexual and the shameful.

Because of these deeply embedded cultural discourses, there is a contradiction between the sexual body and the maternal body and confusing them is deeply disturbing. The front cover image of a naked, heavily pregnant film star is confusing. Is it meant to be sexual, in which case it borders on the pornographic or is it a wholesome celebration of the pregnant body? (Liss, 1994). The representation of a woman as independently sexual, a mother and a rational adult is difficult to accomplish even after second wave feminism; most stories promote one or two of these elements, rarely managing to encompass all three (Kaplan, 1992). The linguistic and conceptual inheritance of mind/body dualism makes it difficult to grasp the profound and non-linear link between the apparently physical and apparently

psychological. Most formulations fall into determinism of the mind or of the body and almost never find a satisfactory way of connecting or describing phenomena while retaining the subtle interconnection of the two (Grosz, 1994:Chapter 1).

The binary oppositions 'male/female' and 'nature/culture' can be overturned rather than one term being privileged over the other, as is found in enlightenment thought (male/culture as the basis of civilisation) or radical feminist thought (female/nature as the salvation of the earth). Marilyn Strathern (1988) argues that the association of women with private/nature and men with public/culture is not universal. In New Guinea, for instance, gender is differently conceptualised. If these are not universals, as suggested by structuralist linguistics and anthropology, then it is open to post structural feminism to write them differently. This is an alternative way out of the 'sameness/difference' dichotomy. Tess Cosslett (1994) uses a post-structural approach when she analyses the representation of childbirth in literature to highlight the demonisation of the dirty, peasant midwife and the diversity of women's own accounts of their birth experience. However, the implications for the acceptance of differences and the undermining of dichotomies have not been fully explicated when it comes to childbirth (Annandale & Clark, 1996).

### *Feminist critiques of post structuralism*

Post-structuralist theoretical developments have been and still are controversial for many feminists. The idea that the category 'woman' is not 'fixed' but can be dissolved is alarming to many who see it as undermining the political thrust of feminism (Soper, 1990). The theories tend to be very abstract and Ann Oakley asks whether post-structural theory has any practical application in the study of women's lives including childbirth (Oakley, 1992b). Although she agrees that the dichotomy between 'midwife/obstetrician, male/female, science/emotion' is unhelpful, she is sceptical about some of the other elements of post-structural thinking, such as the way in which gender is conceptualised, the place of the body in social theory and the relationship between the body and culture, especially the body and language. The challenge of a post-structural theory displacing both the progressive notions of the enlightenment and the critical arguments of Marxism and feminism was and is a subject of impassioned intellectual and political debate from feminists who have a socialist materialist perspective because of its political implications (Morris, 1988; Soper, 1990).

Other opponents of post-structural feminism include Alcoff who sees in post-structuralism "no possibility of emancipation, only micro-politics, no overall structures and no way of knowing which discourses are truly resistant" and Nancy Fraser who fears "normative confusion" (Alcoff and Fraser cited in Sawicki, 1991:95). Nancy Hartsock (cited in Sawicki, 1991:95). fears that post structural theorising in general and Foucauldian feminism is too nihilistic, relativist and pessimistic for feminism and can only interfere with established political and social gains:

Why at the point in history when feminist voices, authorities and identities are being established, do post-structuralist critiques of authority, identity and personal narratives become fashionable? Hartsock (cited in Sawicki, 1991:105)

Post-structural feminists are also accused of betraying the emancipatory origins of feminism and engaging in an intellectually dishonest takeover of the academy, based on incomprehensible theory which leads to an increase in the production of papers and the possibilities of academic careers for its devotees but which is as oppressive and dishonest as Soviet Lamarckianism (Curthoys, 1997). Critics of post-structural theory argue that it is itself an unacknowledged 'meta-narrative' which has the potential to reinforce the status-quo rather than to promote agency and resistance. In particular, suggestions that post-structural theory can be applied to reproduction is rejected on the grounds that it puts at risk the gains midwifery and evidence based medicine have already made (Campbell, 1997).

### *Foucault, Childbirth and feminism*

Advocates of the use of Foucault's work argue that he shares with feminism a politics of the micro-personal together with a macro-politics centred around body concerns, especially power/knowledge, discipline and sexuality (Annandale & Clark, 1996; Sawicki, 1991). Admittedly, his notion of disciplinary power replacing sovereign and judicial power based upon violence challenges the analysis of women's oppression as the result of patriarchal social organisation based upon male violence (such as rape and family violence) and the institutionalised regulation of women (such as the nineteenth century married women's property laws and the absence of rape as an offence against married women). But in Foucault, sexuality and the discourses that surround it, imply a 'capillary' type of power which involves sexuality in the widest possible sense, including physical being, the reproduction of the species and sensuality.

Rosemary Pringle (Pringle, 1998: 43) points out that the 1970s feminist critique of obstetric care implies a top down model of power in which men exert control over women, and obstetric practices are imposed. Annandale and Clark (1996) argue that such a dichotomous model both universalises women's oppression and clings to the idea of women as powerless. The use of a capillary model of power implies more subtlety in assessing the force and operation of all such regimes of technology and its analysis is not undermined when it is found that many such innovations were at women's request, as is the modernist analysis (see Campbell, 1997 for an example of this difficulty). An advantage of the post-structuralist framework is that the political importance of the technology cannot be 'read off' from its characteristics, it may change depending on how it is used (Haraway & Randolph, 1997; Wajcman, 1991). As Riley (1977) pointed out, women's needs, desires and bodies are very diverse. It is not helpful either to prescribe the kinds of birth practices which they must choose or to depict them as powerless in the grip of overwhelming domination. Even the dichotomy between medicine and midwifery is blurred when the actual practices and discourses of midwives are examined (Foley, 2003).

Many feminists have employed Foucauldian concepts to rework feminist theory in a post-structuralist vein. In the USA, the philosopher Gina Sawicki argues that Foucault's attention to the productive nature of power and his emphasis on the body as a target and vehicle of modern disciplinary practices were compatible with already developing feminist insights about the politics of personal life, the ambiguous nature of the sexual revolution, the power of internalised oppression and the seeming intractability of gender as a key to personal identity (Sawicki, 1988:95). The fact that



Foucault's work can be seen as both advocating and as hostile to progressive politics, may depend on the political and intellectual climate in which he is received.

Of course, the impact of Foucault's work was different in the United States, where even liberals are on the defensive, than it was in France where Marxism still represents a viable theoretical alternative among the intelligentsia and where there is a mass based socialist party. There is a danger that Foucault's work could serve to bolster already strong opposition to the idea of radical politics in this country (Sawicki, 1991:122).

Even within the USA, feminists have used Foucauldian ideas in different ways. Sawicki (Sawicki, 1991) stresses the idea of difference in opposition to a radical/cultural feminist assumption of a unity of interest amongst women. Diamond and Quinby, on the other hand, use a Foucauldian analysis of power/knowledge to attack the liberal feminist idea of the individual woman's rational 'control' over her body (Diamond & Quinby, 1988).

Sawicki for instance employs the notion of power as capillary, omni-present and productive. This displaces the necessity for women as a block to oppose men as an opposing force and allows more subtle and nuanced understandings of the ways in which gendered power operates. Sawicki develops this analysis in respect of reproductive technologies generally, arguing for more acceptance of diversity (Sawicki, 1991).

The use of post-structuralist concepts derived from Foucault, from French feminists such as Kristeva (Kristeva, 1982; 1985) and Irigaray (1985a; Irigaray, 1985b) and from the Australian feminist theorists of corporeality (Gatens, 1996; Grosz, 1994) produces a very different analysis of childbirth practices from the modernist feminist theories discussed in Chapter One. Feminist post-structuralists and those who Lemert calls 'strategic post-structuralists' argue that they can retain a critical political edge while adopting theoretical tools appropriate to a 'post-modern' age (Lemert, 1997). The next section addresses the concepts in Foucault's work which question the 'progressive' aspects of twentieth century social policy and the types of politics which are required to counter oppression, in other words the issues of most concern to materialist feminists. The following one examines concepts which counter ideas of authenticity and the natural body, thus making it necessary to rethink the theoretical basis for the radical/cultural feminist view of childbirth.

### *Power/knowledge*

In Foucault's (Foucault, 1990) view, power/knowledge has two connected aspects, anatomo-power which deals with the individual and bio-power which looks at the population. These are linked by the operations of confessionality, surveillance and normalisation. Anatomo-power covers the conduct of individual bodies and their regulation. Foucault suggests a heightened degree of regulation of all bodily conduct during the nineteenth century, based around the discipline of the army and the school, including behaviour such as standing and sitting quietly and in ordered rows, maintaining silence or performing drills, adopting heightened standards of personal hygiene and bodily boundaries, not spitting or urinating in public and using a handkerchiefs. Elias (Elias, 1978) has traced such changes in public manners back beyond the renaissance, so Foucault's periodisation may not be strictly accurate, but

the point remains that increased public education and work in factories together with the development of expert medical, psychological and educational expertise intensifies this form of regulation in the nineteenth and twentieth centuries (Foucault, 1965, 1990, 1991). This was the very time when women's bodies were also subjected to heightened expectations of modesty and shame and medical intervention in birth began to be seen as necessary. Barker (1998) argues that the definition of pregnancy as a medical event was created discursively in the advice literature given to women between 1913 and 1930 which gradually reinforced professional power and created a new form of subjectivity, that of a patient rather than an autonomous actor.

Connected with these new types of power are two mechanisms, panopticism and confessionality. Panopticism is expounded in *Discipline and Punish* (Foucault, 1991). In this work Foucault questions the supposedly benevolent reforms, based on the utilitarian ideas of Jeremy Bentham. Rather than benign substitutes for the 'barbaric' violence of sovereign and judicial power in which pain is visibly and publicly inflicted on the body, he suggests that the Panoptic prison in which individuals are kept in silent solitary confinement under the gaze of a warder, is a form of internal violence. He points out that the deprivation of human speech and company and the constant gaze is not less violent in its effects, though bloodless. On a literal level, panopticism is seen in the nineteenth century hospital Nightingale ward, where a sister can observe all the beds at once and where traditionally, a military style order (beds smooth, lockers tidy etc.) is enforced (Game, Pringle, & Grace, 1983). Nancy Shaw (1974) observed the occurrence of this actual visibility of the body in childbirth in the open labour wards of hospitals in the 1960s. However on a metaphorical level, the panopticon represents modern society in which everyone is constantly subject to different types of surveillance. This subjectification means that health measures to reduce the perinatal mortality rate become the responsibility of the individual woman who is considered derelict or 'risky' if she does not behave responsibly in pregnancy (Barker, 1998; Petersen & Lupton, 1996).

Connected with the individual level of intensification, is the idea of bio-power operating on the population level. Surveillance of the population, as for instance by medical examination for army recruits or construction of weight charts to oversee the development of children in baby health centres, collects information and creates new categories of people (Armstrong, 1983; Davin, 1974). These lead to feedback mechanisms (normalisation) that affect the individual conduct of everyone, leading to increased expectations of individuals, such as particular regimes of diet and exercise in pregnancy, especially the prohibition on drinking alcohol (Crouch & Manderson, 1993a).

Arney's (1982) study of perinatal mortality rates uses Foucauldian concepts to demonstrate how statistical surveillance shows patterns not readily detectable on the level of the individual case narrative. As already discussed in Chapter 2, changes in childbirth management in the 1950s in Britain were due to such large scale data collections which showed an unexpected number of unexplained deaths of full term infants especially those born after 42-week pregnancies. This created a new category, the 'post-dates' pregnancy and led to women being induced at 42 weeks and to premature babies being delivered in large hospitals, rather than at home or in GP units (Tew, 1995). My interpretation of this is radically different from Tew's (1995) which stands squarely within the dichotomising tradition. The force of using Foucauldian

concepts is that it is impossible to dismiss changes in governmentality as purely oppressive or only motivated by special interests which can be unmasked and discredited. While the increased surveillance has undoubtedly increased the medicalisation of childbirth it has also had positive results with the number of babies dying reduced. Perinatal mortality is strongly correlated with measures of social class and material deprivation (Black, Townsend, Davidson et al., 1982), so the reduction in perinatal mortality, while it does not eliminate the social class differential, at least affects those women and babies who are most disadvantaged. This illustrates the idea that the intensification of power can be simultaneously repressive and productive (van Krieken, 1996). This kind of surveillance is what Foucault called 'security'. It involves calculating risks, cost benefit analyses and the calculation of a range of permissible conditions and actions, rather than prescription of right and wrong as with juridical or sovereign power (Gordon, 1991:20). Also, it is 'strategically reversible', the fact that the state develops such standards can become the basis for a counterclaim from groups who are not in a position to meet them (Gordon, 1991:5), for instance the Aboriginal population of Australia (Plunkett, Lancaster, Huang, & National Perinatal Statistics Unit (Australia), 1996). However, a further implication of such changes in governmentality is that there is also a change in subjectivity, which cannot be wished away with proposals of return to a previously desired state.

Many commentators conflate a Foucauldian analysis with a modernist one in which real interests can still be unmasked and dichotomous alternatives still envisaged. Arney (1982) does this when he argues that obstetricians in Britain have accommodated most alternative birthing options, even homebirth, as long as it is included in the network of assessment and surveillance. De Vries (1985) depicts this as a form of post-modern tolerance, which disguises a power relation, the desire to rescue that does not respect women's autonomous choices. This argument shares the North American libertarian tradition and implicitly assumes a pre-discursive body which will come into operation if the state and the medical profession are excluded from the field. It underestimates the extent to which women's embodied experience and subjectivity is produced by the power/knowledge system, so that 'autonomous choice' is also a form of cultural production, which is shaped by discourses and regimes of risk. The subjectivity produced by increased surveillance and normalisation, with its expectation of very low or no perinatal mortality, cannot be lightly done away with.

The idea of the gaze which leads one to normalise one's conduct - and even one's thoughts, is one mechanism which connects the idea of bio-power and anatomo-power together and has been identified in many of the apparently benign social welfare institutions of the twentieth century, for instance Armstrong's (1983) study of the proliferation of child mental health services. Ante-natal care in which women are traditionally weighed at regular intervals and questioned as to their diet by midwives or doctors is an example of a normalising surveillance practice without a proven medical rationale (Oakley, 1984). The very fact that a woman 'fails' to present herself for ante-natal care early enough in pregnancy is now enough to count as a 'risk factor' for her pregnancy.

The significance of such practices is not only in their medical rationale or lack of it, but also that they lead to the collection of statistics (such as charts of normal weight gain and normal child development) against which individuals assess their own

normality, delinquency or lack of it. Through surveillance and pan-opticism then, bio-power and anatomo-power are linked. Foucault (1991) argued in *Discipline and Punish* that description, which was classically the privilege of the powerful, became extended to all as a method of 'objectification and subjectification'. Objectification occurs when individual differences become obvious to the authorities and of interest to government and subjectification is occurs when people's knowledge of the norms involved them in regimes of self-surveillance and self-improvement (Rose, 1990:152).

In so far as feminists have used post-structural ideas in reference to childbirth they have tended to be pessimistic about the effects of power/knowledge. Deborah Lupton (1994:150) employs the Foucauldian critique of contemporary medicine to critique 'natural childbirth practices. In her synthesis of cultural ideas about medicine, she suggests that far from challenging medical domination of women's lives 'natural childbirth' has increased professional surveillance (see also Petersen & Lupton, 1996:77). Surveillance is intensified by the requirement for women to 'confess' their emotional and physical sensations to their caretakers and the increased expectation that they will give birth 'normally, that is without anaesthesia or technical intervention. Crouch and Manderson (1993a) similarly use the concept surveillance in their account of ante-natal care, *Belabouring The Pregnant Body* in which the expectations of the body's performance and the attention to diet and exercise required to elicit the 'natural' performance are criticised as oppressive. The 1970s feminist critique of childbirth as oppression has been criticised for writing of women as if they had no power (Pringle, 1998:45). However, these readings of post-structuralist thinking become very close to rendering women as powerless as the theories they are criticising.

It is a salutary corrective to see that supposedly 'humanist' practices can become dominating, but it is not necessary to conclude that all knowledge is equally oppressive at all times and in all settings. While any particular kind of knowledge, whether it asserts itself as 'scientific' or 'emancipatory' can become 'disciplinary', routinised and oppressive, Foucault's (1994) earlier work on the episteme did leave at least the possibility of non-oppressive knowledge forms. At this time, he did not condemn some (structuralist) types of psychoanalysis and anthropology which leave open the gap between the self and the other, 'our culture' and the other culture, in which fresh emotions and practices can be born. In a Foucauldian view, nothing is evil in itself in the 'government' of the self or social policy but things are inevitably going to go wrong. It is always possible to try to avert this, leading to a stance of pessimistic activism rather than profound and paralysing despair (Gordon, 1991).

### *Confessionality*

Another two edged mechanism through which knowledge and power are linked and made effective is that of confessionality. In Foucault's accounts of the development of human sciences and clinical expertise, the doctor, social worker, psychologist and psychoanalyst (and maybe nurse or midwife) have taken over the priestly function of pastoral responsibility for the individual in which the person is induced to confess their inner life. In psychoanalysis this is seen as a curative process and such discourses are a part of both medical, midwifery and alternative childbirth practices (Peterson, 1984; Raphael-Leff, 1991). As can clearly be seen in the popular media

such as TV talk shows, self-help therapy books and other psychotherapeutic discourse, the idea that 'telling the truth' about oneself is a health giving activity is widely accepted in late twentieth century society.

The idea that humane childbirth care involves a closer relationship between the midwife or doctor and the childbearing woman implies that she will reveal more about her inner life and personal affairs. Foucault clearly argued that this, like any type of knowledge is bound up with power and can be dangerous. Nicholas Rose (1990) similarly argues that such excess of publication of personal details enmeshes the person still further in networks of power and control. Similar scepticism has been applied to the role of confessionality in feminist homeopathy and homebirth midwifery (Gosden & Saul, 1999; Scott, 1998). Just as a sixteenth century woman might discuss her diet, her bodily feelings and her daily practices with her confessor as aspects of her spiritual health, so a contemporary alternative childbirth believer would discuss them with her midwife in order to achieve a 'good birth', or even be involved in more intrusive kinds of therapy such as rebirthing (Peterson, 1984) (Reiger, 2001a:77). Foucauldian sociologists of medicine like Armstrong (Armstrong, 1994) argue that such increase of confessionality does not make medicine more humane but enthralls the patient even more firmly in networks of power. The idea that all midwifery care must involve such an in-depth relationship between one midwife and her patient is part of the dichotomous ideal which Annandale and Clark find unrealistic (Annandale & Clark, 1996).

This does not mean that there is no possibility for a positive relationship between women and their carers. As described in the introduction, the 'talking cure' is inherited from psychoanalysis, which in its origins dealt with the link between the mind and the body, in particular the female body. Foucault did not condemn it completely; he also pointed out some of the positive aspects of psychoanalysis. It challenged the idea that sexuality was just the result of overwhelming repression by finding sexual desire at the heart of the family, framed in terms of the Oedipus myth (Foucault, 1990:81 and 113). Most importantly, unlike other medicalising systems, psychoanalysis challenged the nineteenth century eugenicist theory of biological degeneracy and perversion (Foucault, 1990:118). Although psychoanalysis has always laid claim to scientific status, it is in Foucault's view part of the coming episteme in which 'man' will no longer be seen as an object of study, but as a subject whose biological being is inseparable from culture and language, in other words a type of discourse (Forrester, 1990:3). In this framework then, there is a space for interaction between people in which the discourses applied to the body can be interpreted, with a corresponding impact on the body, just as Deutsche (Deutsche, 1945) had suggested. This is only negative when the power is unacknowledged, the confession expected and the practice medicalised, as her work was in the 1950s.

All the human sciences, including those which attempt liberating or humanising discourses, are implicated in the increase of surveillance and there is no doubt that 'humanised' childbirth has the potential to exert disciplinary force and control on women in the same way as prison reform and psychiatric benevolence were analysed as regimes of panoptic self-surveillance by Foucault. However because the web of power/knowledge is productive and because there is no one pre-existing subjectivity which can guarantee that opposition will be in itself beneficial, there is at least the potential for a different analysis by post-structuralist feminists. Post-structuralist

feminists do not necessarily dismiss these forms of knowledge, though they do not necessarily privilege statistics over art or fiction. In Donna Haraway's (Haraway & Randolph, 1997) volume containing the art of Lynne Randolph as well as science fiction and philosophy, she points out that although statistical surveillance may have oppressive consequences all forms of knowledge can be the 'speculum' with which oppressive systems can be opened up. She remarks in reference to the lack of perinatal data for the most powerless women in Brazil (Scheper-Hughes, 1992), that whilst surveillance can be oppressive, invisibility can also be deathly (Haraway & Randolph, 1997).

Although Foucault was concerned about the combination of individualisation and totalising power, he was not completely pessimistic, because of the way in which this type of governmentality has the potential to be both oppressive and also productive (Gordon, 1991:3). Even though power and knowledge are thoroughly interwoven, there is at least the possibility that, "criticism can be a real power for change, depriving some practices of their self-evidence, extending the bounds of the thinkable to permit the invention of others"(Gordon, 1991: preface page x). Critical awareness of the discourses which compose our social and physical world gives access to an alternative power/knowledge and this is in some ways more optimistic about the possibilities of change than the grand narratives which required total remaking of the social world.

### ***Language and the Natural Body***

Post-structuralism addresses the idea that the body is essential to social theory and philosophy and finds ways to connect the immateriality of language and the materiality of the body. The body is theorised as historical and cultural rather than an unchanging biological reality. This challenges the universalistic assumptions of both Marxist and liberal thought and the feminist theories based on these models (Annandale & Clark, 1996). Gatens (1992) suggests that this new understanding of the body arises from theoretical problems incorporating women's bodily existence into either liberal or Marxist feminist theory and also to the influence of the work of Foucault.

Foucault's project in the *History of Sexuality Volume I* (1990) was to challenge what he calls 'the repressive hypothesis'. He identified the nineteenth century as the site for the proliferation of expert discourses, of which sex was a principal topic, challenging the discourse of a 'natural body' oppressed by society. Foucault of course was most interested in those surrounding the category of 'homosexuality' and he hardly speaks of women at all except to argue that the nineteenth century 'deployment' of sex led to the 'hysterisation' of women. This meant, paradoxically, that women were thought both to lack a sexual drive and to be simultaneously completely created by it,

by itself constitutes women's body, ordering it wholly in terms of the functions of reproduction and keeping it in constant agitation through the effects of that very function (Foucault, 1990:153).

Accommodation with such 'malestream' theorising is offensive to radical/cultural feminists, some of whom who describe Foucault as a theorist of death and the whole post-structuralist movement as hostile to the interests of women and alien to

childbearing (Brodribb, 1992). Brodribb (1992) passionately defends Mary O'Brien's (1981) cultural feminist theory of sexual inequality based on reproductive knowledge. She accuses any feminist who employs poststructuralist ideas of selling out to the phallocracy. The notion that the body is discursively produced is particularly challenging to radical/cultural feminist discourse about female embodiment, because of their heavy emphasis on the notion of natural birth as a foundational metaphor for the liberation of women (Brodribb, 1992). However, it is also difficult to incorporate into a more liberal critique which depends on the ability to find certain scientific knowledge and stable interests (Campbell, 1997). The idea of a body constructed in discourse is a challenging one, but it is worth pursuing the consequences of such an analysis if it has the possibility of accommodating the diversity of women's experiences.

*Mitchell and Lacan: the body, language and psychoanalysis.*

Like Foucault, the British feminist Juliet Mitchell was concerned to avoid basing her theory of the body on the idea of 'the natural'. In *Psychoanalysis and Feminism*, (Mitchell, 1975) she criticised Reich and other 'drive' theorists for their adherence to the notion that without repression, the body and its sexuality would function as a natural and authentic source of pleasure. For Mitchell, who was influenced by the French psychoanalyst Lacan (1982) there cannot be a liberation of the body because subjectivity is bound to linguistic construction not to the material body. Mitchell drew her critique of the Reichian natural body from Lacan's influential seminars, where he taught the type of psychoanalysis which Foucault thought to be non-disciplinary and a harbinger of the new episteme. Lacan's (1977) teaching rested on a complex tissue of structural linguistics, ethological studies and a re-reading of Freud, which replaced the literal reading of Freud with one based on language. Rather than an actual fear of castration, the child has to attain the symbolic world of language and culture, which it does through the father's intervention between the mother and the child and through the learning of language, the symbolic, which carries social power. The symbolic rests on masculine symbols, primarily the phallus. Just as women could never really resolve their oedipus complex in Freud, Lacan believes that women can never attain the symbolic in their own right and speak their own desires, or it appears, represent motherhood (Grosz, 1990).

This does not seem at first reading to be a theory which feminists could turn to their own purposes and Lacan himself appears to have had a joking and ironic relationship with women in his seminar and to have taunted them with the unrepresentability of feminine *jouissance* [pleasure, including orgasm](Gallop, 1982). He argued that it is impossible to represent women's bodily experience because meaning rests on the contents of the unconscious and this is structured in like a language of interdependent symbols, with the phallus as the primary signifier on which all others depend. If women accept the domination of the father and his system of phallic symbols, they cannot represent themselves, but if they do not, they are condemned to meaninglessness. The difficulty of finding the right language to speak about the sexual and maternal, the mind and the flesh, is, in Lacanian terms because they belong in the 'imaginary' and cannot be represented in culture (Lacan, 1977; Minsky, 1992).

Although this sounds very different from the types of feminism which claim that women have the power to speak for themselves or even to invent their own language

(for instance see Daly, 1978), Juliet Mitchell (Mitchell, 1975) saw Lacan's psychoanalysis as positive for feminism, because it allowed understanding of exactly how deeply female oppression is coded into the culture and the subject. Simply speaking or inventing a new language cannot overcome the masculine symbols which are built into the culture and transmitted through language. Within the symbolic, one term will almost always lead to its related symbols, so that claiming, for instance that women are naturally 'different' leaves them open to accusations of weakness and inferiority or to an impossible saintliness. Claiming to be 'the same' leads accusations of being unwomanly or anti-maternal (Annandale & Clark, 1996).

The problem with Mitchell's reading of Lacan is that it does not overcome the split between mind and body because it concentrates only on the symbolic which by definition leaves out the embodied. The idea that women might enjoy breastfeeding or giving birth is so 'obviously ideological' that it cannot be taken seriously as an issue for feminism (Mitchell, 1971). Mitchell's (Mitchell, 1975) project is to extract female subjectivity from biological determinism and place it within the realm of culture - to this extent she excludes rather than theorises the body. Mitchell was writing in the 1970s before theoretical interest in the body became prominent in feminism and elsewhere and her conclusion to *Psychoanalysis and Feminism* is that it is of no theoretical significance at all how women actually have babies.

Foucault died in the early 1980s but the influence of his work on the body and discourse pervaded theoretical developments of the 1980s and 1990s. Bryan Turner's (1996), *Body and Society* appeared at the beginning of the decade and followed Foucault in seeing the necessity of incorporating the body into sociology. By the end of the 1980s the issue was becoming fashionable (Eckermann, 1994:94). Turner (1996:161-163), argues that Foucault's major themes of population, surveillance and discipline can be closely aligned with Weber's concept of rationalisation but he claims that his use of discourse is both relativist and disembodied. Although he believes we are indebted to Foucault for the impulse towards an embodied sociology, we cannot rely on his theories because they are too tainted with structuralism. For Turner there is an opposition between studying phenomenological experience and studying discourse, in which the one implicates the actual flesh and the other is immaterial (Turner, 1996:229). However this sharp distinction is questioned by most of the feminist writers I shall discuss who aim to connect discourse and the shaping of the body.

### *The body and 'difference feminism'*

Just as Turner began to address the issue of the body in the early 1980s, a very influential feminist article appeared which raised similar observations about changes in theory. Addressing the materialist feminist audience of *Arena*, Alison Caddick (1986) characterised 'difference feminism' as being concerned with what makes the female body different from the male body and centring the projects of feminism on body issues. She distinguishes this from liberal feminism for which the body is irrelevant or earlier forms of feminism, which had aspired to a more androgynous understanding of the body

However there are theoretical and political gulfs between the writers Caddick grouped under the heading of 'difference'. As Meaghan Morris (1988) argues, both



radical/cultural feminists and the French post-structural writers attempt to change the use of language and centre their concerns on the female body but there are profound philosophical differences underpinning their work. As already discussed in Chapter 1, Daly (1978) wants her language to represent a literal and unchanging deep reality of female oppression (Pringle, 1998:45; Purkiss, 1996). Irigaray (1985b) and other French writers in the Lacanian tradition employ metaphors which challenge phallogentric language without adopting a fixed position on what women are or what they may become.

The dangers of subscribing to the radical/cultural feminist version of language and power is explained in Diane Purkiss' (1996:19) post-structural analysis of the radical/cultural feminist ideas about the origin and persecution of female healers. The mythology of the male campaign to eradicate witches because they were midwives and healers so often invoked by radical/cultural feminists, is shown by Purkiss (1996:21) to implicate the reader in a desire for a timeless utopia in which the good and bad are clearly delineated, and which appeals to a-historical ideas about womanhood grounded in the natural body. She argues that the desire for a timeless rural utopia can divert readers from practical politics and urban solutions or involve them in an industry of 'country living' and 'natural health' which contributes to commodification rather than undermining it. Purkiss (1996:16) also examines the subject positions implied by the text and argues that by referring to 'the female holocaust' the readers of Mary Daly are invited to identify her, and themselves as victims of endless martyrdom at the hands of men. She finds the depiction of radical/cultural feminists as worthy, if not more worthy, than the dead of the holocaust offensive and argues that Daly's readers are bullied into agreeing with her point of view while being given nothing but a process of psychological suffering and purification as a way of escaping the inevitability of persecution under patriarchy (Purkiss, 1996). The fact that this type of theory does not countenance diversity is attested to by Morris' account of Daly's public appearance in Sydney where she refused to accept any feminist position other than her own (Morris, 1988). Pringle (1998: 45) suggests that Daly's positioning of obstetrics as a global metaphor for patriarchy, as well as the idea that of a simple opposition between childbearing women and male doctors are ideas which have 'outlived their political usefulness'. More specifically, while the idea that the language of obstetrics is part of the problem has been acknowledged (Bastian, 1992), it is suggested that this is a problem which can easily be addressed by changing the terminology, not that language encodes cultural attitudes which operate on a deep unconscious level and cannot be changed by assertion.

### *Is this a 'real' body?*

One problem with theorising birth within a post-structural framework is the degree of uncertainty about whether the body which is being written about is the actual flesh or only an insubstantial metaphor. "Those who claim to be talking about the body often seem to end in talking about something else: gender, power, governmentality, the self and so on" (Morgan, 1998). This is similar to Turner's (Turner, 1996:229) view discussed previously, that reliance on discursive construction of the body means that the understanding of the physical flesh is constantly evaded, language does not contact the 'actual body' only its representations. Helen Marshall takes up the concept

of 'embodiment' to suggest that in pregnancy there are enormous differences in embodied experience not only between women but within any woman's own feeling about herself, which only detailed attention to the phenomenology of pregnancy can elucidate (Marshall, 1996). The post-structuralist feminist writers who appear in the next section would disagree because they argue that discourse does materially affect the body, in other words Turner's opposition between phenomenology and discourse is too sharply drawn.

*Language, the female body and the maternal metaphor.*

Women writers from the Lacanian school aimed, in different ways at defying the idea that women cannot symbolise their own experience in the phallogentric symbolic by 're-writing' women's bodies. Kristeva's (1985; Kristeva & Moi, 1986) writing about pregnancy, birth and motherhood places the 'semiotic' associated with the early relations with the mother, as the unconscious source of energy to fuel the symbolic (Kristeva, 1985). It has been disputed whether this actually means that women become able to speak their own experiences. The maternal, which sounds as if it must refer to women is a conceptual space in the unconscious with "no particular relation to women or the female body either" (Grosz, 1990:161). All subjects must leave the maternal space behind in order to enter the symbolic. In Kristevan terms women cannot 'symbolise' pregnancy and birth because they have no space from which to speak "in so far as she is mother, woman remains unable to speak her femininity or her maternity"(Grosz, 1990: 163). Other post-structuralist feminist writers object to Kristeva's stress on the maternal metaphor, because it privileges heterosexuality and maternity over other sexual orientations and expressions of gender (Butler, 1990). The fact that birth is difficult to represent because it is an intense experience on the boundary between the physical and the psychological is a significant issue for feminist writing and the constant struggle to do so without falling back into 'maternalism' or sentimentality testifies to the power of the symbolic which cannot easily be used for women's purposes.

The repression of early bodily experiences underlie strong feelings of revulsion at shit, phlegm and vomit, all those substances which, out of place, make people want to throw up (Kristeva, 1982). A confronting issue in giving birth is the extent to which bodily control is surrendered – spasmodic vomiting, undignified postures, loud noises and an uncontrollable urge to empty the bowels in public are all part of 'natural birth'. In Kristevan terms, this is both a confrontation with terrible meaninglessness and the potential for the release of enormous energy. This concept does come closer to the difficulty of recounting birth and individual differences in responses to it. Rather than Freud's concept of female masochism or the radical/cultural feminist idea of the 'natural', here is the source of the ambivalence about birth, for some women disgusting torture, for others the source of energy and power.

Irigaray (1985a) on the other hand points out the absence of the maternal in philosophy and compares Plato's dark cave to the womb as the unknown origin of all (male) subjects but according to Adams (1993; 1994) she comes no nearer to representing birth as an activity for women. However, Irigaray's (Irigaray, 1985b) rewriting of the body as desiring differently from the male body, can be understood as language which changes those who read it. No one, or maybe no woman, can read this evocation of the female body as dual and constantly erotic without these concepts

infiltrating the unconscious and changing the way she relates to her own body. If Kristeva's ideas point to the difficulty of writing about childbirth outside the maternal metaphor, writing in an Irigarayan fashion should address the problem that women are meant to be sexual or maternal, but never both. These writers go further than Mitchell (1975) in solving the problem of the relationship between the mind and the body. Vicki Kirby suggests that Irigaray succeeds in bridging this chasm, "although I agree that our minds are literally changed (by reading Irigaray), I want to entertain the idea that our bodies are also" (Kirby, 1991:144). Unlike the feminists who are wary of post-structural writing because it discusses the body and comes too close to the radical/cultural feminist 'natural', Kirby wants to include the 'flesh', the material, tactile body as the subject of theorising.

Grosz (1994) also wants to reconfigure the mind/body relationship as intertwined, like the two sides of the 'Möbius strip' which is connected so that it is impossible to distinguish which is 'outside' and which 'inside'. Using concepts such as 'inscription', she attempts to create a theoretical account of the intimate connection between the body and mind, the subject and social, without writing of 'the body' as inert, the clay upon which cultural inscription works (Grosz, 1994). Grosz distinguishes different types of inscription. Violent inscription involves restraint and supervision, such as that required of corseted, closeted middle class women in the nineteenth century. In childbirth terms, such violent inscriptions might include the early twentieth century hospital regimes of hygiene (shaving, enema, restraint in labour), chronologically regulated times for labour, solitary confinement during labour, deprivation of mobility, bruising and cutting during delivery. However, rather similar to Foucault's idea of surveillance and normalisation, inscription also involves cultural and personal values and expectations, norms and constraints. Activities which appear to be 'voluntary' such as choice of diet, exercise and movement, dress and restraint are also forms of inscription and have implications for childbearing. Grosz (1994:Chapter 1) rejects the opposition of cultural and natural, the body is not separate from the subjectivity of the person and there is no possibility of a natural body outside discursive construction. She rejects the idea that the body contains "sensations attributed to a secret, private, deep, uniting consciousness" (Grosz, 1994:141) which is the reality appealed to by natural childbirth advocates. In place of this, Grosz postulates a disunity of the perceptual body. We cannot always 'know' what the body is about.

As well as inscriptions which occur on the body, there are many new kinds of inscription involved with childbirth, such as ultrasound machines and Electronic Foetal Heart Monitors (EFHM). New ways of 'seeing', visual, electronic and statistical, play a role in the production of knowledge and the operation of the power that is indivisible from it. Hartouni, Petcheski and Stabile (Hartouni, 1992; Petcheski, 1987; Stabile, 1992) argue that electronic images of fetuses as independent beings obscure the body of the mother literally by not representing her within the frame and so they also metaphorically remove her as a speaking subject. This is a tactic of anti-abortion activists, and so feminists decode these images to make their agenda obvious (Stabile, 1992). Within obstetrics, such visualisation of the fetus may lead to the idea that there are two patients, to whom the doctor has separate and possibly conflicting responsibilities.

According to Rose (1990:134), any research technique which produces written records which endure and can be compared is a form of inscription, be that a photograph, a test score or a graph of performances. He says that all such inscriptions reduce phenomena to the two dimensional and can be kept together with other records to form a 'single field of vision'. Foetal heart monitors produce a 'trace', a strip of paper which graphically represents the uterine contractions during labour. This is kept in the notes, or even on discharge from hospital, in the baby's photo album, like the pre-birth ultrasound picture. Foetal heart monitor traces fit ideally into Rose's definition of an inscriptive technology which, "must render ephemeral phenomena into stable forms that can be repeatedly examined and accumulated over time" (Rose, 1990:135). In traditional practice uterine contractions disappear when they are finished, except in the memory of the woman and possibly the midwife. Their inscription creates new types of phenomena such as 'type 2 dips' that are preserved on monitor tape to record the labour and the interventions of the care givers, for comparison, debate and even legal action. Such technologies have implications for the routine practice of childbirth care and shape the ways women and carers work.

Grosz argues that the body in contemporary civilisation is "purchasable, augmentable, replaceable and transformable" (Grosz, 1994). This is reminiscent of Donna Haraway's (1985) wry advocacy of the 'cyborg body' for feminism an image which is calculated to offend radical/cultural feminists (Brodribb, 1992) and liberal rationalists (Campbell, 1997). In her view, not only is there no 'natural body', but the contemporary body will be adaptable through technology in ways which are unknown at present, which are inevitably entangled with webs of global capital and 'technoscience' (Haraway & Randolph, 1997).

Haraway (1997:191) rejects the natural/social and feminine knowledge/scientific knowledge dichotomies which encourage a form of technophobia, because such "preset certainties stand an excellent chance of being flagrantly wrong". She suggests that feminists should not reject science and technology as masculine, but aim to situate it within a social and political system, to understand its genealogy but not to suggest that its social and political connections invalidate it as knowledge within its own terms. She argues that in a world that is increasingly dependent on technoscience, it is more important than ever that critics with an emancipatory concern, like feminists, retain the ability to disentangle its complexities and identify the winners and losers in the game. In this she partly relies on scholars of the 'social studies of science' school, like Latour (Latour, 1991) whose work on science and postmodernism suggests that the natural and the social cannot and should not be disentangled. Applying this insight to reproduction, means that ultrasound pictures, foetal monitor traces, statistically at risk pregnancies are all newly created 'objects', which combine the organic, the scientific and the social; it is not possible to return to a pure nature or to remove the political from the scientific facts. Like the feminist science fiction writers she quotes in her essays, Haraway finds the possibilities of birth technology intriguing as well as alarming. In her view, the task of feminism is not to adopt a puritanical hostility to technology or to write prescriptions for women, but to exercise constant vigilance to monitor the effects of these entanglements. Like Butler, Haraway wants to reject the maternal metaphor as foundational for women, but she wants bodies to be marked by their difference, including their reproductive difference as long as this does not fall into the

prescriptive and the disciplinary. Against Foucault's wary pessimism, she advocates a cautious optimism.

### ***Re-imagining birth***

This chapter has reviewed multiple options for re-imagining birth with the theoretical equipment of post-structuralist feminism. One issue is the significance of the surveillance of populations through perinatal data collections and of individuals through making them visible and comparing them to population norms. This 'governmental' strand invites consideration of power which acts differently from the kinds of domination which were considered in chapter 1. The other major strand is the role of language in the shaping of the body, how it is understood, seen, managed and felt. These ideas challenge some of the taken for granted images of birth and the natural body. Post-structural research tends to concentrate on written and visual texts, but rather unusually, the rest of this thesis considers a particular place and the words of women who give birth there and staff who work there in the light of these diverse theories.

## CHAPTER 4 METHODOLOGY.

My review of the literature of second wave and post-structuralist feminist writing about childbirth and the female body suggests that there is scope to study local examples of childbirth practices and accounts of childbirth in particular locations. This enquiry aims to understand how the three modernist critiques have influenced contemporary practice and how people account for their experiences by drawing upon such ideas. As noted in Chapter 3, these modernist critiques drew upon ideas of anthropology and psychoanalysis to argue for changes in childbirth practice, but they tended to lapse into fixed disciplinary knowledge and understanding in terms of binary oppositions. They tend to portray power in fixed forms of domination and to appeal to the body as a natural biological object, which can be emancipated by removing it from power relations. In such discourses, childbirth in hospital and midwives who work with doctors are portrayed as more highly medicalised and less relevant to feminist theory than independent practitioners and alternative practices. Women are expected to desire natural childbirth and if they do not, this is seen as the result of oppression. In both cases, diversity of opinion and practice amongst women and health practitioners is minimised. I wanted in this study to ask how a contemporary maternity unit actually practices, without subjecting it to this body of assumptions. The analysis and writing up of interviews and observations of the unit then produces a different and re-imagined account of childbirth at the end of the twentieth century.

The methodological framework in which this study takes place is somewhat different from the well-known works reviewed in Chapter 1, which subscribed to a critical epistemology common in second wave feminism. In such studies, interviews and observations are put forward as inherently feminist methods of research. Kellehear (Kellehear, 1998:14) puts forward this critical view when he suggests that qualitative research methods have embedded emancipatory potential. This is because they give voice to and empower the marginalized and powerless by understanding them through their own words. In his view, this is superior to positivist methods, such as EBM, which are the tools of management and technocracy, whilst critical, interpretive methods are the tools of the critic. However, while the epistemologies of empiricism and standpoint theories differ, they share a realist ontology, that is a belief that their research method does in fact access knowledge about the way the world 'really' works although the collection of 'experiences' is never unmediated by theory.

Post-structuralist theorists on the other hand are sceptical about first person accounts being read in a straightforward way as accounts of oppression. Scott (1992) argues against the idea that you can ground knowledge in 'experience' because people can only understand their experience in terms of the discourses that are available to them at the time. Post-structuralist theorists criticise the idea that either scientific methods or the experience of the oppressed are epistemologically privileged. They suggest that analysing the rhetorical strategies by which powerful discourses gain their authority can also be a progressive political strategy.

Post-structuralists are sceptical about creating a dichotomy of 'emancipatory' and 'oppressive' methods. The idea that qualitative methods are inherently more humane

and liberating is suspect from a post-structuralist perspective in which all knowledge implies power. If qualitative methods cannot be held to be innocent, then neither can scientific methods be assumed, as Dorothy Smith (Smith, 1990) does, to be inherently objectifying. As Chalmers (1989:31) points out and as we have seen in the chapter on critical, professionalising views of midwifery and childbirth, Evidence-Based Medicine can be anti-authoritarian and its reports may be used to undermine the operations of entrenched power and opinion.

Butler (1992) argues that critics caricature post-structural writing as a realm of discourse that is disembodied and floats above the real. She maintains that the idea that the only poststructuralist research strategy is the analysis of texts is misleading; terms like 'women' and liberation are still essential in practical political engagement. No research method operates without theory but the theory/method relationship is particularly close with post-structuralism, since in many cases an analysis of discursive construction is not separate from the political intervention but constitutes it.

However, this does not exclude research in the actual as opposed to the virtual world. Donna Haraway (1997:191) appeals to an extended sense of ethnography, "not limited to a specific discipline, an ethnographic attitude is a mode of practical and theoretical attention, a way of remaining mindful and accountable". In studying reproduction, the researcher does not 'take sides' or commit to a pre-given 'feminist position' but remains open and 'at risk' to what is being said and the power relations which are embedded in the practices under observation. The observer is not as a neutral scientist nor as a confessional member/sympathiser with the emancipatory subject, but an individual with her own agenda and desire to make her account carry some weight.

Contemporary feminist thinking demands that the position and interests of the observer be acknowledged and denies that there is a universal subject, which can produce objective knowledge. All knowledge is similarly perspectival and subject to interrogation. The view from below may be argued to be ethically superior or politically expedient, but it cannot claim epistemic privilege, as in standpoint epistemology. The analysis of interviews and accounts of childbirth all give access to the available discourses which women and practitioners draw on in structuring their experience and shaping their practices. Then, for example, oppositions like that between natural and technological childbirth can be seen not so much as a reflection of oppressive reality as an ordering narrative.

### ***Methods used in the hospital case study.***

There is then, within post-structuralist feminist writing, some warrant for carrying out studies of particular settings. Fox (1999:191) argues in *Postmodernism and Health* that 'case studies which are concerned with specific settings and small rather than large scale approaches' are helpful in producing research that celebrates rather than denying difference. Case study methodology is conventionally recommended for studies of contemporary phenomena which do not require the manipulation of experimental variables and for research which asks the questions how or why something happens (Yin, 1995:5). I studied a particular maternity unit in detail to discover how the practices and personnel of this particular institution shape contemporary childbirth. I was also interested to see whether, and how far, women,

midwives and doctors in this setting were using the different discourses generated by the various feminist critiques of childbirth. I interviewed women and practitioners in order to recast the telling of childbirth stories in a way which respects difference rather than accounting for it in terms of grand narratives.

The rationale for studying this particular hospital is that it represents the type of care practiced in a mainstream institution, which is not a teaching hospital and has no birth centre. Case study sites are classically chosen because they represent outstanding or unusual examples of a phenomenon. However there is an acknowledged place for studying a single case because it is ordinary and typical (Yin, 1995:41). I chose this particular hospital because I thought it would not be over-researched, though as it turned out, there were other medical and health promotion researchers recruiting at the same time. I wanted to study mainstream care, the kind offered to women who may not be highly informed about childbirth options. This is in contrast to the focus in much of the childbirth literature that examines minority experiences, such as homebirth or innovative hospital birth centres.

The practices of this hospital are examined from several viewpoints. Accounts by ten women informants were collected during their pregnancy and after the birth of a child in the study year; interviews were undertaken with midwives and medical staff; and contextual observations of day-to-day activities in the hospital were made in the course of collecting the interview data. The fact that I recruited women, midwives and doctors from one maternity unit means this is a study of a single case employing data triangulation. These accounts of birth practices in the study hospital are examined in detail in the light of the prevailing discourses identified in the theoretical sections of the thesis, a form of theory triangulation (Yin, 1995:98). Triangulation is a controversial issue, with some writers suggesting that it is only useful within a positivist framework of 'fixing' reality, but it is still conceded to be a way of promoting thoroughness and reflexivity (Denzin & Lincoln, 1994; Silverman, 1997).

### ***Fieldwork.***

At the outset, I made contact with the Nurse Unit Manager and visited the hospital to discuss my project with her. She responded very positively. Unfortunately, by the time I had gained ethics clearance, there had been a staff change and I had to make contact with a different manager who had not been informed about my work. Between October 1994 and December 1995, I visited the hospital on two or three days a week, spending time in the ante-natal clinic where the midwives were distributing my information letters to pregnant women and in the maternity unit itself, where I met the midwives and medical staff, I distributed information letters to the staff myself and usually interviewed them at work. When I was not at the hospital, I travelled around the area interviewing the women in their homes.

### ***Access and intrusiveness***

Qualitative research in maternity care settings is more challenging than it appears from the literature to have been in the 1970s. This may be because critiques of hospital childbirth resulting from consumer action and the findings of earlier studies have changed the expectations of women and the practices of even fairly conservative



units, like the one I was working in. Shaw (1974) found that in the late 1960s anaesthetised women were labouring in public wards and not being treated with dignity. However deplorable, the professional indifference to women's feelings made it easier for her to make her observations. In the early 1970s Scully (1980) had a struggle to gain entry to the field but once accepted seemed able to pass without comment in the maternity unit and even to participate in the non-medical support of labouring women. In London in the early 1970s Ann Oakley (Oakley, 1979) was accepted onto ward rounds in a large teaching hospital. From their accounts it seems that these earlier workers sheltered under an umbrella of the scientific legitimacy of sociology and the institutional authority of their university. After twenty years of consumer and academic criticism people may be less comfortable about having maternity care practices observed and recorded. On the other hand, my interviews gave the staff the opportunity to put their point of view in a field which has experienced a considerable body of criticism from consumers.

There are positive improvements resulting from consumer critiques of hospitals. Women and their carers are more aware of the need for privacy now, the delivery room doors are closed, and the names of the family posted on the outside and the minimum number of people are expected to enter after knocking. Ethics committees have also taken a greater role in protecting confidentiality and so the types of research carried out in the 1970s would not be seen as desirable now. In these circumstances, I could not observe the actual conduct of births. I was reluctant to intrude on people's privacy, as I share the belief that labouring women should not be subjected to interference from unnecessary outsiders and I did not try to attend any births, though I did accept an invitation when invited. The ethical difficulties involved in gaining access to birth practices may be easier to overcome for professionals carrying out research in their own workplaces (see Hunt & Symonds, 1995). This advantage may be offset though by the problem for 'insiders' of overcoming their professional socialisation and achieving enough distance to question their taken for granted reality.

As I had extensive personal and political experience in homebirth, I approached the study hospital as an informed outsider, almost as a member of another culture. Although I have been personally and politically involved in birth issues, I tried not to impose my own views, but to understand what I saw and what people told me. In my judgement it would be unethical if I devalued the experiences and beliefs of the women who spoke to me. I believe that I was receptive and they did not seem to be reluctant to explain their views on birth analgesia or their criticism of the way in which, for instance, they felt that breast-feeding is 'pushed' in hospitals. I might have expected them to disguise these views if they did perceive me to be very committed to a 'natural view'.

Qualitative research is often described as personally very demanding (Stevens, 1993) and I found it so. I found making notes difficult in public and wished that I had a private area to which I could retreat. Although I became a reasonably familiar figure around the unit, I found it difficult to describe my work in ways that made sense to doctors and midwives. Qualitative methods are increasingly used in health related research (see Mays & Pope, 2000; Meyer, 2000; Pope, Ziebland, & Mays, 2000) but quantitative methods retain their cultural authority, especially amongst the medical profession. The term 'qualitative research' was sometimes greeted with amused scepticism.

### *Confidentiality*

I undertook to keep the interview material confidential and to disguise the identity of the hospital and the participants as is usual in ethics applications for social scientific research.

To preserve people's individuality, while concealing their identities, I have followed Emily Martin's practice of providing pseudonyms for all the participants and for each woman I have supplied a short biography in Appendix 2. To conceal the identity of the hospital, I have used generic pseudonyms and called the study hospital, Town hospital. There is a description of the layout of the maternity unit, but this is unlikely to be identified by anyone unless they were a participant because of renovations carried out since the study was done. Other institutions mentioned are called for example, City Teaching Hospital, Capital City suburban hospital, Interstate and Overseas, to indicate their nature and relationship to Town hospital. People who are only mentioned once are also given functional pseudonyms (eg. Interstate Specialist).

There is a case to be made for identifying the site of a case study and even of the people involved, especially if it is an unusual or critical case, so that people can bring their other knowledge of the site to bear on the findings (Yin, 1995:90). I think I would have had more difficulty gaining access to this hospital if I had not undertaken to conceal its location and some people might not have wanted to speak to me at all, because of conflicts over the management of childbirth and pressure from consumer organisations for change.

The requirement to disguise the identities of individuals also has some costs. Some of the interviewees were unusual characters with fascinating histories. I regret that I cannot be more open about some of what I observed because in small professional groups they might be identified. A particular issue which is difficult to address is sexual orientation, which Rosemary Pringle points out, complicates any dichotomous account of the role of gender in medicine and nursing (Pringle, 1998:63,187). As my interviewees did not raise the issue of sexuality, I cannot pursue the issue even though I heard relevant comments made outside interviews. Some of my interviewees had remarkable intellectual and personal interests, and in a work of fiction these would have added depth to the characterisation, but these issues also cannot be raised.

History and Anthropology are disciplines which also use qualitative research methods but within very different traditions about concealment. In oral history, the tradition is to ask people to consent to being quoted. In Anthropology, it is a disciplinary expectation that fieldwork contains maps and genealogies to identify people. There seems to be some convergence between the disciplines. Historians are asked to have ethics clearance for oral history and Anthropologists are beginning to encounter situations in which the places and individuals they name in their work may object to being so named. . Qualitative research is not a collection of verbal statements that can be manipulated as if they were statistics. "Reality TV" regularly broadcasts explicit accounts of people's experiences, in some cases subjecting human beings to physical or psychological manipulation, so if this can be done ethically, then a greater degree

of explicitness may be possible for qualitative sociology and it may be possible in future to ask people if they wish to be quoted and named. The interview transcripts may also be preserved in a qualitative archive, like medical samples, rather than destroyed, so that they may be reanalysed in future. All of these measures would entail a change in the expectations of ethics committees about the ways in which data are to be treated, but this would do greater justice to the importance of people's diversity and their exact words. I would consider asking the ethics committee and my interviewees for permission to identify them in future.

*Interviews with women who booked to give birth in the study hospital.*

My aim was to interview women who were intending to have a second or subsequent child at the study hospital. Much sociological attention has already been paid to women who are having their first child, (for instance Baum, Coke, & Crowe, 1988a, 1988b; Crouch & Manderson, 1993a; Oakley, 1981b). It is understandable that studies that aim to produce correlations between several variables such as age, social class and type of care, should confine the study to first birth to reduce the number of variables. In feminist writings, first births are of theoretical significance in looking at the impact that the 'transition to motherhood' has on women's working lives and sense of self. I believed that women who had already had children would be a better focus for several reasons. The fact that they had experienced labour would, I thought, influence their choices about pain relief and conduct of labour - they would not be going into unknown territory like most first time mothers. Such women also seemed likely to have preferences based on their previous experience so that it would be useful to see if they were fulfilled. In addition, the experience of childbirth is affected in significant practical ways when one has other children to care for which seemed worth exploring.

The process of recruiting women for the interviews proved problematic and long drawn out. As agreed with the University and Area Health Service Ethics committees, the letters were distributed by the ante-natal clinic midwife and women who wished to take part were to contact me by phone. I used to bring the letters to the clinic and stay in a side room so that I could answer any questions and some women expressed a desire to participate when the midwife introduced me in the clinic.

The practice of information letters being distributed by third parties is recommended by ethics committees to protect people's privacy but is open to distortion. The researcher relies on the third party to remember and hand over the appropriate letter and this person's attitude can influence the reaction of prospective participants. I gained the impression that the clinic midwife was enthusiastic in handing out my letters and positively 'sold' the idea until she felt that I had had a fair share of the available research subjects, and then she was no longer as assertive about the task. The advantage of this method of recruitment was that I did access women who were not attending antenatal classes and who would have been unlikely to be involved in any social networks, which would have been my alternative sites of recruitment. I had decided to recruit through the clinic because I did not want to access people with extremely alternative or pronounced views, which might have been the case if I had recruited through interest groups or advertisements. As it turned out, none of my informants was a member of a consumer organisation and the public patients came from a range of socio-economic backgrounds. None of the women appeared to be

questioning or critical of the medical system as such. Their agreement to take part in my research seemed to be motivated more by a desire to talk to me than by any sense of grievance or militant concern with the organisation of maternity services.

I wanted to interview women at home, so that their accounts would be given away from the clinical setting and I would not be associated with the hospital or medical power structure. I planned to interview ten public and ten private patients. My intention was to arrange two interviews before the birth and two afterwards. The first two interviews were to give me time to establish a rapport with the women and to discuss their previous experiences of childbirth, their expectations of the imminent birth, the 'study birth', and their experiences of ante-natal care. The subsequent two interviews were to allow the recounting of their experiences of the most recent birth after a period of reflection. In retrospect, this was a lot to ask of the women and I had not anticipated how demanding such a schedule would be. Most women were only interviewed three times – twice in pregnancy and once afterwards.

I was fortunate that ten women who were public patients agreed to be interviewed. I only managed to recruit two private patients but neither fitted the profile I was looking for. In retrospect, I believe that the inclusion of a private patient perspective would have strengthened the completeness of the case study and that I should have made more strenuous efforts to recruit private patients, including visiting the obstetricians' rooms as I did the ante-natal clinic. Alternatively, I should have allowed a longer period for recruitment of both public and private patients and if it could have been arranged without a breach of confidentiality, organised a mail out of reminder letters. The absence of the private patient perspective is regrettable, but under the circumstances could not be avoided. Sixty percent of maternity patients in New South Wales do go through the public system (Lancaster, 1995), so a documentation of their experiences is significant in itself. Also, many of the women had been private patients for previous births and they and their carers contributed a considerable amount of material about the contrast between public and private care, which I have included in the analysis.

The women who agreed to be interviewed all had at least one child already, and twelve of these had been born in the study hospital, so the stories of their births assist in understanding the mother's experiences of the institution and its practices. Six children had been born elsewhere in NSW and two in other states, so the stories of these births at times provided interesting contrasts or helped explain their mother's attitudes or beliefs about the study birth. As I interviewed women before and after birth I also have ten accounts of each woman's expectations of the present birth and ten accounts of what actually happened, so it is possible to see both whether women's views and hospital practices changed from one birth to another or whether expectations changed from pregnancy to study birth.

The interviews took the form of long conversations, which covered previous pregnancies and births, the present pregnancy and then the birth of the new baby. Interviews were either taped and transcribed verbatim or recorded in note form and written up as soon as possible after the event. The interviews were open ended and designed to elicit the woman's own perceptions and story about her pregnancy and birth, and any other material about her life that she offered. I did ask some supplementary questions about sources of information and intention to take paid

work. I asked women to tell me the story of their labour and birth, starting with when they realised they were in labour. The interviews were quite diverse and unstructured. Although I used an interview outline to begin the first interviews, the later ones were more conversational. (Interview outlines are included at Appendix 1).

The unstructured interview regime might have allowed my preoccupations as an interviewer to influence what people told me. The very fact of speaking to a 'researcher from the University' who by definition is working and educated must have had some effect on the women's responses. Particularly, I believe, it may have influenced what they said about their employment intentions. I tried to keep my questions neutral and not to 'give away' any particular orientation to the birth, though I did speak about my own children and share some of my experiences, though not my involvement with homebirth. The fact that women told me such things as that 'natural birth' was pushed at people and that good midwives were the ones who validated their desire for an epidural, suggests that I did not make my own position evident.

The interview was also a joint production between the interviewer and the woman in more subtle ways. The form of interviewing which the women were most familiar with was the 'satisfaction survey' and their responses tended to take this form. On the other hand, I was accustomed to the birth story format found extensively in the homebirth literature (for instance Miller, 1990) and so I tended to elicit such narratives. These did not necessarily come naturally to many women who are not familiar with this particular story form. However, of necessity, pregnancy and birth have a linear structure. Some women's 'stories' emerged from the transcript when the coding process had eliminated digressions and exposed the central events.

One of the most troubling parts of writing up my research has been considering whether I had lived up to the expectations of feminist methodology. I approached the interviews informed by Ann Oakley's (Oakley, 1981b) work, believing that a feminist researcher should share information in a more informal and supportive way than is usual between researcher and subject and that being interviewed should be a pleasurable and empowering experience. I tried to adopt a friendly persona and develop a reasonable rapport with the women I spoke to. No one refused a repeat interview and they certainly seemed to enjoy the experience, though the topic is not specifically mentioned in the transcripts. Unlike Ann Oakley's reports of her interviews, no one asked my advice or wanted to continue the relationship. Ann Oakley's (1992b) *Social Support and Motherhood* study used the interview itself as a social support intervention, so it is certainly the case that in depth interviewing in people's homes can be more than a research exercise. One is at least a visitor to the home and one who encourages reflection, which might not otherwise take place. Ann Oakley also reports that people found the interviewing process beneficial and enjoyable. I hope that this is also the case with the women I interviewed.

Quotations from interviews with the women are identified by their pseudonym and some details about the birth which is referred to, whether first, second etc. or the 'study' birth, in other words the birth for which the woman was presently attending the hospital. To contextualise the births they are also described as 'Natural', 'Conventional' or 'Intervention'. Quotations are also marked by the interview they are drawn from, Ante-natal (AN) 1 or 2, Post-natal (PN)1 or 2 and a text number locating the referred to text in the NUDIST 4 database.

### *Interviewing Doctors and Midwives.*

It is unusual for a study to look at more than one side of the maternity care relationship but it was my intention to interview midwives and all grades of medical staff, as well as the women giving birth. Other researchers have undertaken studies with similar elements to mine but I have not discovered one that combines interviews with professionals and women at a particular site. Shaw (1974) and Scully (Scully, 1980) both carried out observational studies of American maternity care, which focussed on the behaviour of professionals. Ann Oakley's (1979) interview study of British maternity patients was informed by a year's observations in the study hospital but did not incorporate the views of the staff. Recent Australian studies (Crouch & Manderson, 1993a), (Brown & Lumley, 1994) consist of interviews and surveys of consumers only. The Cambridge Maternity Services group accompanied a very large postal survey with observational studies in different kinds of maternity units (Kitzinger, Green, & Coupland, 1993). They report that it was difficult to carry out formal interviews with midwives at work but that informal conversations on the unit were preferred, and I found this also.

Doctors and midwives were given information letters through their mailboxes at the hospital (see Appendix 1 for the text of these letters). The subject matter of the interviews was not so personal as the interviews with birthing women and since I was approaching them as professionals in their work places, the issue of third party recruitment was not so salient. I followed up the letters by contacting the midwives and junior doctors at work to see if they wanted to be interviewed and I looked the obstetricians up in the phone book and made follow-up phone calls. As with the patient information letters, recruitment through letter and phone call was frustratingly ineffective. I only received one response by phone to the information letters I distributed to the midwives at work. I requested an opportunity to speak to the midwives as a group to explain the study, but the head of the nursing unit did not think this was practical, because of shift changes. She suggested that I approach midwives individually. As a result, the majority of interviews with midwives took place at the hospital when they could find time. Interviews were done in empty offices, on the balcony and in the coffee room. In each case, formal consent was gained at the beginning of the interview, including consent to tape the interviews where relevant.

I interviewed the midwife who responded directly to the information letter at her home and the interview was taped. I was previously acquainted with another midwife on the unit and she also agreed to be interviewed and taped at home. These two gave me very long and insightful interviews and became 'key informants' (Yin, 1995: 90). Interviewing the other staff at work put limits on the amount of time they spent with me and may have constrained what they told me. However, as well as the two midwifery interviews with Nicki and Caroline (MWs), one medical interview with Stephen (SR) also took place away from the hospital. These three interviews were longer and less constrained. As these three people acted more as key 'informants' than interviewees, it is worth commenting on their social location in the hospital. The senior registrar was already working at a Capital City Teaching Hospital when I spoke to him, so he was viewing the Town hospital from a distance. The two midwives, who invited me to their homes for interviews, were interesting in that they were more

recently trained and occupied intermediate positions within the informal hierarchy of midwifery staffing. They both identified strongly with the identity of midwife, but did not work on labour ward very often. They both had strong views on the way maternity services could be improved. Like many key informants reported in the literature they were “inside outsiders” and I was aware of this in weighing the value of their contributions (Bryman, 2004:300). I also interviewed the two nurse unit managers. These women represent the official authority structure and are responsible for negotiating over staffing and policy. I interviewed five other midwives who were available at work to be interviewed, including the midwife in charge of the antenatal clinic. There were nine midwifery interviews altogether.

I approached the doctors individually and as long as they had time, they all agreed to be interviewed, though some interviews were brief. Formal consent was gained before the interviews, including consent to tape the interviews where relevant. Two of the junior doctors were senior registrars, training to become obstetricians (SR). The others were working either as Career Medical Officers (CMO), GPs on attachment to upgrade their obstetric skills (GP) or Family Medicine trainees (FMP). I wrote to the obstetric specialists, who are all Visiting Medical Officers (VMOs) who combine taking care of public patients with private practice. I followed the letter with a phone call. Two agreed and were interviewed, one in the antenatal clinic between patients and the other in his rooms in the evening. Two refused, one on personal grounds and the other by being so evasive that I concluded that he did not wish to speak to me.

All the interviews with professional staff, except the two that took place in the midwives’ homes, were recorded in note form and written up as soon as possible after the interview. This was principally because of the constraints of interviewing in the work setting and because some staff consented to be interviewed but not to be recorded. The numbers and positions of the staff interviewed are listed in Table 4.1

Table 4.1 Numbers of Doctors and Midwives interviewed \*

Visiting Medical Officers	VMO	2 out of 4	Ian and Peter
Senior Registrars	SR	2 out of 4	Stephen and Robert
Junior doctors		3 out of 6	
Resident Medical Officers	RMO		
Career Medical Officers	CMO		Michelle
GP attachment	GP		John
Family Medicine Programme	FMP		Richard
Nurse Unit Managers	NUM	2 out of 2	Margaret and Stephanie
Other midwives	MW	7 out of 40	Nicki – taped. Caroline –taped. June Alison Ruth Cathy Rose

\*All staff interviews transcribed from notes except two, which were taped and transcribed.

The interviews with midwives and doctors were less open ended than those with the women and based more closely on the interview outline (See Appendix 1). I also used case histories adapted from Oakley and Houd (Oakley, 1990) as cues in interviews with the doctors. These summaries are also listed in Appendix 1. Quotations from staff interviews are identified by their pseudonym, the initials of their position, as

listed in the Table 4.1 and a text unit number which locates the quotation in a qualitative analysis database (QSR Nu\*dist, 1997).

### *Incidental Observations.*

Over the course of a year, while waiting to interview midwives and junior doctors, I spent a considerable time in the maternity unit at different times of day. I talked to people over coffee and observed the flow of events when the unit was not too busy. I kept a notebook with details of my observations and the casual conversations in which I participated to provide context for interpretation. The days I spent at the antenatal clinic recruiting women to interview enabled me to observe the junior medical staff and the antenatal clinic midwife, as the room I used was the staff coffee area. I discovered that whenever possible, an appointment is booked for a fictional 'Mrs. Brown' so that all the staff can gather for a coffee break. This collective time allowed me to witness the 'off stage' behaviour of the doctors, clinic midwife and receptionist and observed the way the antenatal clinic was organised. This helped me to interpret the interview material. I also had several quite extended conversations about maternity services and medical training which allowed me to establish rapport with the staff. It was not part of my study to observe clinical encounters. The notebooks in which I recorded observations and casual conversations are numbered individually and the pages numbered. Where reference to this material is made, it is identified by notebook and page number. Casual conversations that happened outside interview settings are not attributed to named individuals.

The notebooks also cover evening clinical meetings which were attended by the obstetricians, junior doctors and senior midwives. These consisted of formal talks, sometimes by visiting speakers and discussion of policy issues. I attended some midwifery education sessions and the unit Christmas party. The day of the party I was invited to be present at a birth conducted by one of the midwives. I asked the permission of the birthing parents and stayed in the delivery room for the birth – it was a real Christmas present. I was very pleased to feel that at last people were comfortable enough with me to include me in their work. But the difficulty of getting access to 'the research site' made me feel that I had only fully gained entry just as I was about to leave.

### *Data analysis*

The data were analysed with the assistance of a computer programme specifically designed to manage qualitative data (NUDIST version 4). Computer programmes of this type do not perform the analysis or provide measurable levels of validity or significance in the way that statistical packages do, but rather allow a large amount of qualitative data to be handled easily, encouraging thoroughness in analysis. . There are a number of approaches to the analysis of qualitative data ranging from counts of types of items to a less easily defined immersion and saturation in the themes and symbolic systems arising from the texts. In either of these cases the package assists in the rapid sorting and reporting of item counts – it is really best seen as an aid to



filing and retrieving, economically and tidily replacing multiple copies and scissors and paste.

However, the interface between the researcher and the data stored in the package is the process of coding. Coding is a process of dividing the data – either by lines or paragraphs – and assigning labels to it so that it can be retrieved under particular subheadings (QSR Nu\*dist, 1997). Obviously the way in which this is done will depend on what the researcher sees in the transcripts and what they judge to be important, in the light of their research interests and the literature. The interview transcripts were entered into two databases one for professional interviews and observational material from notebooks and the other one for interviews with the women. Coding was carried out separately for each database, although many of the codes were transferable between databases.

My original intention was to perform a ‘grounded theory’ analysis by following the procedure recommended by (Willms, Best, Taylor, Gilbert, Wilson, Lindsay et al., 1990) in which a portion of the transcripts were used to generate codes. For the professional database two doctor interviews and two midwife interviews were read through on the database and codes created quite rapidly in response to the material. The tape recorded interviews were coded once on hard copy while listening to the tape to incorporate and nuances of tone, pace and environment and then again when the hard copy codes were introduced into the computer and the codes already generated applied to the material. Once a reasonably comprehensive set of descriptive codes were generated, they were applied to the rest of the material on the database. This was done in two ways, one by reading and re-reading the interview in the light of the whole set of codes. The other was to search for key words and to review the text surrounding the key word to see if it should be included with this code. For instance a search for “pain” produced the majority of references to labour pain and pain relief. References to “pain in the neck” could be rejected. The accepted references could then be reviewed in their context and included with that or another appropriate code. Coding is complete when codes have been reasonably defined, repeated passes through the material no longer produce no codes and checks of the coded transcript or key word searches show that all relevant material has been appropriately coded. This procedure ensured that I was very familiar with the interview material and that it was broken into thematic segments.

The breaking down of material into thematic codes is only one step – the analysis also has to include a process of synthesis. This involves building the codes up into thematic or pattern codes by various writers (Denzin, 1994). The programme I was using allows various methods of coding – at first I used open codes that were not linked to each other. As the process proceeded, I began to review the codes and to either merge them or link them together in a hierarchical structure. In grounded theory, the analysis depends entirely on the patterns built up from codes within the material, but I was not coming to the data free of assumptions, but with a well developed analysis of different feminist approaches to birth. I therefore grouped the codes I had developed into higher order codes, which related to the issues covered in the literature review. I then generated ‘reports’ of the different codes – in other words, all the text which appeared under a particular code was downloaded into a word processor document, so that it could be examine, summarised and salient quotations included in tables or quoted in the text. Thus the coding structure became the basis of

the sections of the thesis. There were three major divisions; *Birth And The Female Body* was based predominantly on the material from the interviews with women and formed the basis of Chapter 6 on the social shaping of birth. *Unsafe, Unnatural and Unfair* combined material from the women and from the different groups of staff and became the basis of Chapter 7. The viewpoints of doctors and midwives and my observations at clinical meetings contributed to Chapter 8, *Medical and Midwifery Boundaries*.

Kellehear argues that qualitative researchers have an interest in finding the unusual case, rather than the representative one (Kellehear, 1998). While the unusual case can be illuminating, I would argue that understanding a typical case in its individuality can be equally so. Any person or institution closely observed may become remarkable, and whilst not necessarily being unusual or exotic, it can illuminate others that are like it as well as those that are very different. The case study is not a small sample, but an intensive examination of processes in the light of theory, so it does not seek to be generalisable on statistical grounds but on theoretical ones (Yin, 1995:32).

#### *Transparency and Trustworthiness.*

Qualitative data analysis does not have the same criteria of technical criteria of validity used in quantitative analysis, rather it aims at as high a level of trustworthiness as possible (Denzin & Lincoln, 1994:345). There are several ways in which this can be promoted. One method is to give participants the chance to review the interview transcripts and to incorporate their comments into the analysis. In this I have not been as participatory as many feminist methodology texts would recommend (Stanley & Wise, 1990) nor as thorough as case study methodology suggests (Yin, 1995). The reason for not doing so was practical rather than methodological, and I would consider doing so in future. Although as Silverman (1997) argues, this does not guarantee any greater validity in the technical sense, it does encourage reflexivity and assist in returning the research results to the participants

Some texts suggest that material should be check coded by more than one person to enhance validity (Willms & Johnson, 1993). Cross coding would be more important in multi-researcher projects where everyone is not equally familiar with all the material. In a single researcher project where coding is taking place on material you have collected yourself, the repeated revisiting of the coding allowed by the computer package allows a high degree of consistency within the coding of the project. The idea that replicable coding ensures external validity – that two coders in agreement have achieved a measure of reality – does not reflect my understanding of qualitative research. Obviously, agreement might be found between social scientists but obstetricians and midwives reading the material would probably code it very differently. The viewpoint of the observer cannot be eliminated in qualitative research – the existence of the computer records would allow greater visibility of the analytical process (by for instance including examples of coding and code books as appendices) but if researchers make their viewpoints and the process clear, the reader is enabled to assess the trustworthiness of the research report. In my report, each quotation is accompanied by a reference to the interview and the line number, so that it can be traced back to its origin in the database, so a degree of transparency is retained in my analysis.

I have had to consider whether I have actually exploited my relationship with the interviewees for my own purposes. The project was not designed as action research, as recommended by Fox (1999: 185) but very much for the purposes of the researcher, to speak to the sociology and feminist community and for the requirements of a research degree. On reflection, I had not designed the project to benefit the participants directly, except in so far as they benefited from telling their stories. I have become very familiar with them in the course of analysing the interviews and so I have tried, by using pseudonyms and giving them brief biographies, to retain them as personalities who are joint contributors to the research. It has been my intention to represent these women as accurately and sympathetically as I can in order to include their construction of the realities of childbirth in the literature and to have hospital childbirth represented alongside the many accounts of natural childbirth, not only as the disfavoured alternative. I also aim to represent the diversity of the people who work in the maternity unit, whether they are male or female, doctors or midwives

Of course this opens my work to the critique of Silverman and other British Symbolic Interactionists (Silverman, 1997) that it is no more than journalism or sentimentalised romanticism, that the transcripts will be trawled for quotations to illustrate my pre-existing political bias and that I will uncritically believe in all the atrocity stories I am told and use them as a stick with which to beat the medical profession. I am more sympathetic to the desire for empathy and the inclusion of emotion in research work than Silverman (Silverman, 1997), who seems to adopt a somewhat 'neo-stoic' attitude to research with human beings. I also find the tone of his methodological writings destructively critical, in a way that feminist writers generally try to avoid. However, as I am claiming to be methodologically inclusive, I find it useful to use Silverman's criteria as a point of debate, to illustrate how I am or am not conforming to his criteria of excellence.

The strength of my research is that it presents a picture of the maternity unit based on interviews with both women and health professionals together with the contextual observations made in the course of collecting the data. The data were collected after a long period of engagement with issues in the childbirth field. Even if one discounts the value of formal 'triangulation', as Silverman does, there are opportunities for increased reflexivity in the analysis of different types of data (Silverman, 1997). As far as trawling the research for confirming evidence, the whole research was set up to question pre-existing rigid oppositions between the natural and technological, and to examine the ways in which these socially constructed categories are employed. As far as possible, I have analysed the interviews as examples of discourse rather than as transparent reports about what actually happens in the hospital. Nonetheless, I think it is overly rigid to use interviews solely as the topic of analysis and to say nothing about the construction of the wider social structures and practices they are discussing, hence my observations of the hospital in action and other information are included (Miller & Glassner, 1997).

The strength of qualitative methods is the illumination of the general by the particular (Spradley, 1979:204). The empirical part of this study is intended to ground the wider debate on childbirth in industrialised societies at the beginning of the third millennium by focussing on the particularities of practice and experience at a particular Australian

hospital in 1995. The case study hospital is a discrete institution, but it is not isolated - it is part of a web of interconnections, embedded in the health system and the life trajectories of the people who work there, as well as those who turn to it for care. I have written the results of my work at the hospital to try to convey the way the maternity unit operates to produce the particular experiences women encounter and how the health workers and women speak about it. I have used what people told me as a basis for an analytical description of the place, its processes and the way in which its staff and patients call upon ideas based on the theoretical critiques developed by second wave and later feminist writers. As I set out to do, I have focussed on the work of the midwives and the possibilities of change in maternity services, using the framework of feminist theory and alternative childbirth discourses as a background. In retrospect, I would have tried to strengthen the thoroughness of the study as a case study of the maternity unit by making sure that private patients were represented and by collecting more documentary material about the organisation of the unit. However, I believe that there is sufficient data from the interviews and casual observations to form a debate with both modernist critiques of childbirth and with poststructuralist theories of governmentality and the body and so this is how the empirical material is presented in the chapters that follow.

In the first of these, the study hospital and the participants are described in some detail to establish the specific identity of the research site.

## CHAPTER 5 AN AUSTRALIAN MATERNITY HOSPITAL IN THE 1990

This chapter introduces the research site and the people who work in the hospital or who go there to give birth. The purpose of this chapter is to situate the analysis of the interview data which forms the basis for the remainder of the thesis. While critical ethnographies claim to allow the oppressed to speak or to unmask power by producing an authentic account, the purpose of this Chapter is to outline diversity, to undermine the dichotomies of home/hospital, women/medicine and midwives/doctors by introducing a cast of characters whose practices shape contemporary birth in complex ways, drawing on the circulating discourses of rationality, natural birth and equity. It is acknowledged that the writing of this account contributes to the rhetorical shaping of this argument.

Many large towns have a maternity hospital that is ignored by most people unless they are having a baby or visiting someone who has just given birth. The 'hospital' is the site for medicalised childbirth so heavily criticised by feminists and others since the 1970s and so it may be thought that hospitals are places which are sterile, passionless and impersonal. This idea may be reinforced by the bland institutional appearance of most hospitals, which obscures the intensity of the embodied processes and emotional life that goes on within. This Chapter commences the analysis by providing concrete details of the interior of the maternity hospital and personal details about the women and the staff to counteract the impression of impersonality and to contextualise the discussion of the embodied experience of giving birth (Chapter 6) and the impact of the three critiques of medicalisation (Chapter 7). After a description of the setting and the way in which constructs work patterns and birth options, the women, midwives, junior doctors and specialists obstetricians are introduced. The Chapter finishes with a consideration of the moral and emotional quality which pervade their accounts in particular around the setting of the ante-natal clinic.

The theme that runs through this chapter is that, far from being impersonal, the hospital is pervaded by emotional and social relationships, but that these do not fall into easy categories, rather they combine positive and negative attitudes and experiences. Women have an ambivalent relationship to the hospital and its staff. On the positive side, the institution is a known and familiar space for many of the women and the midwives who work there, while staff movements from other hospitals bring changes in birth practices and attitudes to birthing women. Women show a great appreciation of the relationships they form with the staff. On the negative side women often accept 'what is' and do not envisage alternatives. They are sometimes confused and unclear about how staff are organised and what options are offered. The working arrangements of the staff are shaped by wider social and professional changes and their attitudes to women are shaped by gender and social class. The birth practices and the professional relationships which take place in the hospital are influenced by the physical arrangement of the building which in itself embodies assumptions about the way childbirth should be managed and this is where the description of the study site begins.

### *Social location of the study hospital.*

The study hospital is in a small rural town adjacent to a provincial city in New South Wales. The hospital is a nineteenth century building with additions of various eras since, standing at one end of the town, with older residential streets around it. The town had been a prosperous market centre for the rural area and retains some imposing architectural features from its past. As in many rural towns in the 1990s, some shops in the town centre have seen better days but there is a large new shopping centre and cinema complex, somewhat at odds with the heritage buildings, a number of which have been elaborately restored, though others are rather dilapidated.

Several new estates have been built since the 1970s and subdivision is continuing, with a mixture of public and private housing across a range of price brackets. Many workers commute to the provincial city, or take the freeway or train to the State capital. Skilled industrial employment is available for those who are able to travel, in the industry that has now moved away from the town. Apart from agriculture and retail, the sources of employment close to town are a correctional institution, some rural food processing industry and some tourist attractions.

The local population is predominantly white Australian of Anglo-Saxon descent with some Aboriginal families. Some families arrived in the post-Second World War migration from Europe but there are very few people from the Middle East or Asia, the birthplace of many more recent immigrants. This surface homogeneity distinguishes the town from the larger cities in the State. One of the midwives identified unemployment, family problems and lack of part time childcare as the principal issues facing women in the area. Sources of employment do not seem to be expanding as fast as the availability of housing and there is a high rate of unemployment. The senior midwife told me that teenage pregnancy was an issue they were concerned about. There is no family planning clinic in the town and no access to public abortion services locally.

### *Description of the study hospital*

Rosengren and de Vault (1963) have described how the layout of the maternity hospital and its routines structured the flow of women through it and influenced decisions about their care. I thus paid particular attention to the hospital geography, ambience and routines. The hospital is hard to navigate around, with many entrances, stairways and lifts. Women go to different parts of the hospital for different aspects of care and some staff move from building to building in the course of the day. Antenatal care takes place in a clinic building with its own entrance off the main road. The maternity unit is in a 1970s modernist addition to the hospital, sign-posted from the

road, with an entrance through a glass door into a small kiosk/coffee shop. Two flights of stairs and a lift lead upstairs to maternity. These are wide enough to take stretchers or hospital beds, with studded vinyl floor tiles to prevent slipping, which lend a rather industrial air. Like many public hospital buildings, which are subjected to heavy use with the minimum of maintenance, it is rather battered and worn. One of the Visiting Medical Officers (VMO) said that it had been very modern “if a bit cold and clinical”, when it had opened a decade ago, but that it had been left to deteriorate. The carpets were threadbare and the ambience is unattractive, though it is planned to move into a new building. One of the most popular places in the hospital was in the old part of the hospital, a quiet post-natal ward called the Annexe, but this would be closed down when the new building opened. The ambience of the hospital is utilitarian rather than luxurious.

Although the appearance of the hospital was not itself criticised by the women I interviewed, the experience of having a baby must be shaped by the physical layout and feeling of the hospital. These factors certainly influence the options that are available and the way work is organised. The first impression of the maternity unit is not very friendly, because staff are all busy elsewhere. At the entrance to the maternity care floor there is a waiting area with vinyl easy chairs and a coffee table. This area is rather drab and there is no receptionist. If you are there for the first time, are in labour or need to speak to a midwife, there is a notice instructing you ring the bell next to a door on the left. This is necessary because the door is heavy and soundproofed. It gives direct access to the labour ward area, in case a woman arrives who needs to be admitted immediately. The whole floor is arranged on a circular plan. Ahead and to the right there are four bed wards on the outside of the building and offices and bathrooms on the inside. This gives the unit a confusing, maze like feeling and the staff are often out of sight. One of the midwives described how hard it was even for people who worked there to find each other, and thought how difficult this made it for the women

The low ceiling makes the ward area seem dark and cut off from the outside world. The only access to the outside world is a small concrete balcony at the end of a corridor. There are no chairs here to discourage women from going outside to smoke. The ban on smoking is an example of the increased surveillance of pregnant women and mothers (Graham, 1994). Smoking in front of small babies is a newly acknowledge health problem and smoking mothers an issue of concern for the staff, but the unsympathetic attitude makes the experience of the ward oppressive for many women.

And I smoke, but it wasn't just to smoke, it was to get out of the place. I couldn't stand being shut in the place all day, I just wanted to get out into the sunshine. And I asked if I could take the baby with me and they won't let you. They don't want you to walk around with the baby either. That's why I couldn't wait to get home - all the rules and regulations. I'd rather be at home where you can do what you like when you like (Cindy - study birth, 58-62).

The arrangement of the floor influences where staff congregate and how many are assigned to work in any particular area. The “nurses’ tea room” is between the floor area and labour ward, next to the nursery. There may have been more staff rostered on at a time when this unit was designed, but now it is not very heavily used because there is usually only one midwife on duty in the nursery and the rest of the staff are

dispersed around the floor. The floor and nursery midwives did not seem to have much collective identity. It was hard to get them together except for a few minutes between shifts when education meetings were held. With all the midwives from two shifts the tearoom was really too small to be comfortable as a meeting room and people were eager to get away.

Like the size of the tea room, other parts of the building reflect changes in practice over the last decade. One midwife told me that when she arrived at the hospital in 1991 she felt that she had ‘gone back thirty years’, because all the babies were centralised in the nursery. The large nursery is half empty now. The policy of “rooming-in” has moved most babies to the ward areas next to their mother’s beds. The remaining nursery is for the care of babies who are sick, so that is a second focus of midwifery activity after labour ward. The empty half became the venue for the Unit Christmas party

The labour ward is not a separate room but the last area in this circle of bays, divided from the entrance hall by the soundproof door. This final segment of the circle is the primary focus of activity because it contains the main nurses’ desk and the delivery rooms. Opposite the desk are the three labour rooms. They have solid doors with the names of the women who are occupying them displayed and a notice asking for privacy. All midwives, doctors and support people should knock before entering, this is an innovation which reflects the practices of the birth centre in the nearby city. I went into an empty delivery room and found that it was a mixture of the institutional, with blue paint and a high hospital bed and attempts at humanisation in the form of a rather faded Ken Done quilt and a framed print on one wall.

The delivery area is very clearly staff focussed and despite the request for privacy is very far from resembling a birth centre. It is a work area, not disguised as a ‘hotel suite’. The corridor is cluttered with trolleys arranged with equipment for delivery. There is a sluice room and kitchen area in a corridor. The only bath for labouring women is down this corridor to one side of the desk. Like the nursery, this reflects changing practices since the design of the unit – instead of having baths en suite or in the wards where they would be easily available to women in labour, the labour ward bath is at the heart of the staff “off stage” area and only one bath is not really adequate to meet patients’ needs. Overall, the design of the maternity floor reflects an ‘old fashioned’ concept of labour where women were expected to stay in bed until moved to an ‘operating theatre’ style room for delivery. Labour ward is the “backstage” area of the maternity unit, only staff and women in labour come into this segment of the circle. The labour ward area of the unit seemed to be the warmest, busiest and most intense focus of energy. It was the mostly brightly lit, compared to the dark wards.

The doctors and the more senior midwives who work on labour ward congregate by the large desk in front of the three labour rooms. The level of activity here ranges from frantic to bored inactivity. There is a small windowless coffee room next to the central desk. It is too small for all the staff to use together but is heavily used, mostly by senior labour ward midwives and doctors. In contrast to the almost deserted nurses’ tea room, the small coffee room is the communications hub of the unit. It contains the work roster, medical and nursing textbooks, notices from administration, birthday cards for staff and thank you letters from women and their families. There are fund raising chocolates for sale and usually some form of mostly sugary food, for



morning or afternoon tea. People bring birthday cakes to share with their colleagues. The room is almost always untidy, with many notices asking people to clear up their own cups. This room was the site of my 'entry to the field' as I was progressively introduced to the staff. I spent a lot of time there waiting or interviewing people. The fact that my work was centred on this coffee room identified me with the middle range of staff – the labour ward midwives and junior doctors, rather than the floor and nursery midwives on the one hand, or the senior administrators or obstetricians on the other.

This then is the physical setting to which the women I interviewed came to give birth and in which the staff carried out their work. It reflects recent changes in maternity care organisation, has some deficiencies in terms of facilities and decoration and shapes the way in which the staff are rostered to work and the way in which different aspects of childbirth care are practiced and different groups enabled to meet.

### *The Women in the study.*

The rationale for qualitative research is that particular experiences of individual women can illuminate general issues, but it is important that their words are set in the context of their lives, rather than being abstracted as if they were in fact statistics, rather than accounts given by particular individuals. This section is intended to supply enough detail about the ten women whose births I followed for the reader to place their words in context, while ensuring that they are not identifiable. Table 5.1 lists the women (by pseudonym), their ages and the number of previous births at the study hospital or elsewhere.

Table 5.1 Women in the study, their ages and number of previous births at Town hospital or elsewhere.

Name	Age	Number of previous births
Angela -	Late 20s	2 at Town
Beth	23	1 at Town
Cindy	28	2 elsewhere
Deirdre -	31	3 at Town
Julie -	31	2 elsewhere
Kate -	30	2 elsewhere
Laura -	31	1 at Town
Roxanne	32	3 at Town
Sheila -	32	2 at Town
Tess –	26	1 at Town

Biographical details are listed against pseudonyms in Table 5.2. Summaries of this information and some characteristic points from the interviews are listed as biographical sketches in Appendix 2. I hope that, if the women were to read this thesis and identify themselves, they would agree that I have conscientiously represented their stories and their points of view.

In terms of material security, Angela, Deirdre, Laura and Sheila were the most secure because they lived in families with professional or securely employed partners, their own home or the immediate prospect of buying one, long term relationships and a good education or employment history, even if they chose not to do paid work. Beth, Cindy, Roxanne and Tess were less secure in at least one of these respects, either they had less education, poorer prospects of work, their partners were insecurely employed, their relationship was less permanent or they didn't own their own home. Julie and Kate had least access to employment for themselves and their partners and they were materially dependant on state benefits, but they did seem to have supportive relationships with partners and wider family. So four women were securely related to the labour market (S), four were insecurely related to the labour market (I) and two were reliant on welfare benefits only (B).

The women were aged between 23 and 32 and their partners were between 23 and 47. Five of the women had left school at year 10 or before, two had finished year 12, two had done secretarial qualifications at TAFE and one had trained as a nurse. Three of them were actively connected to the labour force, one back at work, one on maternity leave and one intending to return to her casual job. Four of them wanted to take up paid employment, two of these women intended to take further training, the other two felt that it would be hard to find work or childcare. Three did not want to take up further employment in the near future, two of them had made a positive choice to stay home with their children and one felt discouraged and overburdened by childcare responsibilities and could not contemplate work as well. They all had partners living with them, three of these were de-facto relationships. Four of the partners had left school in years 9 or 10. Two had TAFE qualifications, three had University degrees and one was unknown. Eight of the partners were currently working, two were on disability pensions.



Table 5.2 Characteristics of women interviewed for the study

Name Security Age	Education Self	Education Partner	Self - Past Employment	Present Work/wants to work	Partner's employment	Partner Currently working	Own Home?	Marital status
Angela S 20s	Yr12	Degree	Telephone Sales	No – wants to go to Uni	Nursing	Yes	Planning to buy	Married
Beth I 23	Yr10	Yr 10	Factory	Yes	Factory supervisor	Yes	No	De facto
Cindy I 28	Yr 10	N/A	Media	No – would like to work but no child care	Wants welding apprenticeship	Yes	No – want to buy	De facto
Deirdre S 31	TAFE	TAFE	Secretarial	No – has tried but wants to stay home	Truck driver	Yes – wants own business	Yes	Married
Julie B 31	Yr 10 TAFE	Yr 10 TAFE	Secretarial	No - Wants to do open foundation and nursing	Store person	Disability pension	No	Married
Kate B 30	Yr 10	Yr 9	Nurses' aide/telephone sales	No – would like to go back	Labourer	Disability pension	No	Married
Laura S 31	Yr 12	Degree	Financial services	Yes – on maternity leave	Manager	Yes	Yes	Divorced remarried
Roxanne I 32	Yr 10	Yr 10	Factory	No – kids are enough of a job	Labourer	Yes	Yes –from family	De facto
Sheila S 32	Yr 12/ Nursing	Degree	Nursing	No – wants to do community work	Engineering – recently graduated	Yes	Yes	Married
Tess I 26	Yr 9	NK	Fast food – nightshift	No - Looking forward to work– bored at home	Sales/musician	Yes	Yes – partner's house	De facto



Whilst a degree of impersonality may be the case in large urban hospitals, this does not correspond to the reality of life in a country town. Seven of the ten women interviewed had been to the hospital for previous births, several had been born there themselves and so had some of their mothers. One of the women, Amanda, travelled back to her hometown for the birth so that her parents could care for her other children. The hospital was not brand new, like the city Teaching Hospital or prestigious like the nearby Private Hospital, but it was a known and taken for granted space, which women were happy to discuss and tell stories about. They almost seemed to have a proprietorial attitude to the hospital.

Women were somewhat puzzled about what I wanted to know and at first many felt that they were not qualified to speak about maternity care. Lazarus (1994:26) distinguishes two forms of childbirth knowledge; the knowledge of the processes of pregnancy and birth and a social knowledge of the organisation of health care. Although I would argue, following the Foucauldian analysis in Chapter 3, that the biological is both shaped by and known through the social, it is interesting that some women were uncertain about their ability to speak about childbirth, when they all had at least one child. The solution many of them found was to cast the unstructured interview in the familiar form of the satisfaction survey and it is not surprising that women tended to fall back on issues of 'satisfaction' with the care given by the hospital. It is well acknowledged that 'satisfaction surveys' tend towards a positive evaluation of medical and hospital care (Bramadat & Driedger, 1993; De Vries, Benoit, van Teijlingen et al., 2001; Oakley, 1992a).

Even though I took pains to interview women away from the hospital, to facilitate the expression of negative comments, I found that people are generally grateful to hospital staff, it is conventional to express this and to excuse shortcomings. This very marked tendency may be a surprise to many of the staff who felt that patients were not 'grateful' and did not understand the limitations they operated under and may reflect unconscious processes of transference and dependence (Deutsche, 1945:208). Although women were critical of some aspects of care, notably the food, they did gradually claim the right to comment positively and negatively about other issues. They were broadly tolerant of shortcomings in the system, which they attributed to government policy, they tracked changes in the way the services are organised and they identified particular individuals, both doctors and midwives as good and bad examples in terms of their ability to explain and to form relationships. Tessa's overall evaluation was typical.

The antenatal care was good, considering the amount of people that they have to deal with all the time. The hospital stay was great and the nurses are wonderful - you can't fault the nurses. Basically, I found it quite pleasant. (Tess – study birth, 549-555).

Lazarus (1994) found that 'social' knowledge of childbirth care was unevenly distributed. Some women did not seem to have a very clear perception of the different grades of medical practitioner and the relationship between them, for example, "I don't know how the hierarchy works at the hospital but he's not a VMO...". Women knew that some doctors were students, because they had to have everything checked again, and this extended the time involved in the consultation, but this was accepted because, "they have to learn somehow". Women also used the term 'nurse' and 'midwife' interchangeably and often did not distinguish between midwives and female doctors.

My sister-in-law's recently had a baby and she said that one of our female residents delivered that woman and they thought she was a nurse, and when she, my sister-in-law, had her baby, my brother thought that the female resident was a nurse. (Nicki MW - 264)

### *Midwives*

Australian midwifery is heavily dominated by its nursing traditions, which as Kerreen Reiger (Reiger, 2001a:23) points out, were at one time rigid, hierarchical and somewhat militaristic, reflecting the legacy of a generation of nurses who had worked during World War II but this way of organising maternity care has been under pressure to change since the 1970s. As described in Chapter 1, there is a diversity of feminist views of the role of midwifery. Midwifery as a form of feminist praxis, the idea of the midwife role being to challenge male dominated medicine on behalf of women, the idea of an opposition between a medical and a midwifery model and the possibility of midwifery as an extended autonomous role are all discourses which are circulating in Australian birth literature. I was interested which, if any of these were called upon by the midwives at this hospital.

In Australia, midwifery has been defined as an almost automatic part of a nurse's training rather than a separate professional identity. The midwives working at Town hospital had trained in hospitals between the early 1970s and the early 1990s. They were the last generation of hospital-trained nurses, before the transfer to university education. For them a midwifery certificate was separate enough from basic training to do in another city but ubiquitous enough to stay at home and get a 'specialist certificate' if you did not want to go away. Doing 'midder' and working in 'mid and general' was the expected course for most nurses, whether or not they were particularly interested in childbirth.

In those days most people did Midwifery - it was a specialty without going away (Alison MW 6)

I assumed I would go on to midwifery from my nursing, I thought that it was part of the deal (Nicki MW 16)

The Town midwives were like their patients in that they were predominantly local people, many of whom had been born in that hospital themselves. They tended to be settled and to know many of the women who returned several times.

The complicated physical layout of the hospital is reflected in the variety of midwifery roles. Like the majority of Australian hospital midwives, the midwives here do not practice with case loads but take on separate aspects of maternity care (Barclay & Jones, 1996:130). The Ante-natal clinic which is in a different building from the maternity unit is staffed by a senior midwife who works with two other midwives. As well as assisting with the patients at the antenatal clinic, they have recently started a 'midwives only' clinic where they take care of low risk patients without medical supervision, though this has been controversial. In the main building, the 'floor' staff take care of women in the early stages of labour and then post-natally, unless they are transferred to the Annexe, the quiet area upstairs where there is one midwife to look after well women and babies. Floor midwives have an important role in helping with breast feeding, which demands

intensive inter-personal and midwifery skills in the widest sense, but it is not given as much status as 'labour care'

The Labour ward end of the unit is where the senior midwives are most likely to be found, next to the main nursing desk and their coffee room. These senior midwives are most likely to be present at deliveries. Next to labour ward is the nursery, mostly used for sick babies, now that rooming in is practised. In theory, women can go to the nursery for help with baby care, but some women are reluctant to go to the nursery midwives who are seen as too busy. Some midwives also work in the Family Centre where women can go for advice about feeding and baby care once they have gone home. They also worked on the early discharge programme where they do home visits, I did not interview any of the staff who were currently working on the programmes beyond the wards, but I heard about them from the women and from staff who had worked on them previously. Midwifery in this hospital is relatively specialised and midwives move backwards and forwards between areas of skill and prestige depending on their level of education, their personal interests and on the roles they are encouraged to adopt by the managers who draw up the rosters. The midwifery role at Town hospital is segmented and task oriented, rather than the personal relationship with a client idealised in the feminist literature.

Even within the conventional arrangement of work, midwives took up diverse positions which I have called Conservative, Professionalising and Alternative to emphasise the fact that hospital midwifery is not a monolithic opposition to alternative midwifery. There were conservative midwives who continued to see midwifery as a specialist branch of nursing rather than a distinct profession. These midwives tended to see themselves as obstetric nurses, operating within the regime laid down by the doctors. They did not define midwives as separate from nurses; some had moved from nursing to midwifery for reasons not necessarily connected with childbirth. Peggy said the "honest answer" to her choice of midwifery was that she was sick and tired of geriatrics, was worried about the lifting and the effect on her back, and wanted to work with well people (Peggy MW 5). Another woman was working in the Annexe, a postnatal ward, because she had hurt her back and was unable to do the surgical nursing she really enjoyed.

I like TLC nursing, bedside nursing. I like to see people get better - you nurse them to health or you nurse them to heaven.... The young ones don't like to call themselves nurses, but I'm a nurse (Cathy MW 11).

One of the floor midwives said,

I'm not a key labour ward person – I help at the back, in the nursery and on the floor. I'm happy with that. (Julia MW 16).

A different view of the hospital organisation was brought into focus by two long interviews with midwives who were in intermediate positions. They perceived a hierarchy in the way in which work was distributed. Neither of them worked in labour ward as much as they would have liked although they did get occasional shifts. Most of the time they were resigned to working in other areas, the nursery and the antenatal clinic, though they would have liked to keep up a complete midwifery identity by also working in labour ward.



I personally feel I need more experience in labour ward, but there are those who seem to work there all the time and there are those who don't work there very much, and you've got to be a little bit pushy to get there I think, and because I don't want to be there, even though I know I should be there, I don't push to go there. (Nicky MW 124)

This midwife, Nicky took a position I call Professionalising. She identified with 'an expanded midwifery role' and was taking higher qualifications, along with many of her colleagues, including the head of the antenatal clinic and the two Nurse Unit Managers

I have never worked anywhere where so many people are studying; I can't believe it. Everybody is doing something to improve their professional ability, and I think that's really impressive. Well not everybody, that's not quite - There are a few older women who haven't done much and they're probably the flies in the ointment to a degree in that they give different advice to other people, I think - to the majority, probably. (Nicky MW 68)

My other informant, Caroline, had more 'Alternative' views about childbirth. She was the most sympathetic to alternative birthing practices, such as homebirth. She had her own child at home with an independent midwife and found the hospital practices rather alien

... once I started to do my training and you go out into the wards - mostly in labour ward is where you really decide that you don't want (to) be involved in the doctors because you see so much that it's - it's assault, really...(Caroline, MW 8).

One of the Nurse Unit Managers had also some experience of homebirth, but Caroline was the midwife who expressed most clearly an alternative view of childbirth. Although these are small numbers to define a typology, the characterisation of Conservative, Professionalising and Alternative serves to emphasise the diversity of approaches found amongst the midwives, a diversity which could lead to tension and also to an unpredictability in what women encountered when they came into the maternity unit.

As described in Chapter 1, the radical modernist critique sets up a hierarchy in which independent and alternative practice is valued more highly than salaried practice. Most of the midwives saw independent practice as a desirable goal but they varied as to how practical they thought it might be from a financial or time management point of view. Most of them felt committed to 'the family first', like Peggy who tended to the conservative view of midwifery.

I've thought about it but I've never really gone into it - you might be twenty four hours with them and with my set up at home it wouldn't be possible. As the children get older and independent you can manage it - it sounds really nice to me but the family comes first. Maybe when they're older and don't need you, you could do it. (Peggy MW 62).

Caroline said that in a utopian future she would love to be an independent midwife, but that like most of her colleagues, she worked for financial reasons and would find it a struggle to find enough clients to maintain her income. Nicky was the only one seemed to envisage becoming an independent midwife with an expanded role as a realistic future. Although she had two children herself, she differentiated herself from the 'working mothers', who would be unable to commit the time. This may have been because her financial situation was more comfortable and she received a lot of childcare

support from her partner, but it also relates to her focus on midwifery as a profession in its own right based on the care of well women.

Midwifery has a variable relationship with the care of the sick, depending on the history and politics of the professions in any given country (see Chapter 2). It was not referred to as requiring a 'special calling' as it tends to be in the alternative tradition or separate from nursing as it is in Holland or in Britain, as Caroline knows from having done nursing training there.

When I was doing my general training and I went and did my two months in middle, you know, and I was very much a nurse, and I thought the midwives were a snooty lot; you know, I was only nineteen and I was just becoming a nurse and how dare they think that they were better than us, and you'd say "Nurse" and they'd say "I'm not a nurse, I'm a midwife" and you'd think Ohhh. But now I think I'm not a nurse, I'm a midwife, you know, and I get really peeved (Caroline MW 196).

The construction of midwifery in close relationship with nursing is reflected in the way midwifery work is organised by the hospital administration.

They (nursing administration) feel that we're all general nurses, they don't think that midwifery is anything different or special or anything at all. (Caroline MW 244).

So staffing the maternity ward is heavier on the morning shift, as it is all hospital wards, because that is when the nursing load is heaviest, patients are traditionally washed and beds made. In this setting, arguing that birth is 'normal' and healthy has a deleterious effect on staffing levels:

In fact they think that we don't really have very much to do because we've got all able-bodied people to look after so how can we even be busy. Even if we're full, how can we be busy? All of our women can walk to the shower themselves (Caroline, MW 240).

The fact that midwifery was not seen as a separate identity also meant that an enrolled nurse who was not a midwife was helping on the floor during busy times which upset Caroline. She defines midwifery as a separate profession and so believes that all women have the right to the services of a registered midwife. Caroline's comments imply that from an administrative point of view, midwifery is not seen as especially time consuming or challenging. In so far as changes to childbirth care have removed it from the realm of 'sickness care', it has the effect of reducing staffing, rather than changing to a system which caters for its distinctive quality.

Defining midwifery differently would make maternity wards very different from a ward which covers routine surgical and medical work. The work load on the maternity ward is highly variable and difficult to schedule. The start of labour is unpredictable and not well understood, depending as it does on a complex interplay of physical, emotional and social factors. More babies are born at night, but in this hospital there is only one person rostered for labour ward at night. Also, many women experience the start of labour at a time when some external demand or concern has been settled, such as family members being available to care for the other children, for instance at nights and weekends when partners are not working. Midwives told me that 'one to one' staffing was preferable for women in labour but this was not possible under the regime at the time.

The maternity unit tends to be busy, lacking space and understaffed. Hospital midwives are dependent on a wider network of factors to determine their work conditions. Caroline described Town hospital as part of a changing network of maternity services which was putting increased pressure on the hospital, and she was afraid that women would complain about the lack of attention.

...a lot of people do complain about Town because it's getting busier, because now we are the next major hospital after the City Teaching hospital, so anyone from up the Valley with a slight problem - if it's a major problem they'll go straight to the City Teaching hospital - but if it's something that we can deal with they'll come down to us, so we get a lot of non-Town people as well. And, of course, Valley's closing, which means that we get a lot of the Valley people now as well, so our numbers have gone up, so it can be, at times, extremely busy.

None of the whole hospital's got any extra beds. It's, you know, it's just better looking, and members of the public think that there's more beds and there isn't, and they're quite shocked when you tell them that there isn't. It's a major hospital, now, feeding a bigger - a growing area, and we don't get any extra space for it. (Caroline MW 160).

She describes work at a busy time, and her account reflects some of the experiences the interviewees related, such as being unable to get into a delivery room,

The long weekend, for instance, was absolutely horrendous. I was down on the floor, ... and labour ward was full the whole time. Mostly it was four women and we've only got three labour wards, and a lot of the time there were four women labouring, and, you know, eighteen Caesars over the long weekend and about six of them were booked, they were planned, which we thought was absolutely ludicrous, and the nursery had ten babies in it, you know, it was absolutely horrendous. So of course, women go back to their home with negative attitudes because they never could find a member of staff, you know, we were too busy, it was just horrendous. So, because it can get very busy, people do go home and say, "I thought the care was bad" (Caroline MW 160).

Staffing is affected by the practices of the nursing administration and the medical staff. Caroline makes it clear that there can be tension between the professional interests of doctors and midwives. The midwives thought it was ridiculous to book elective Caesarean operations on a long weekend when there were three days on weekend staffing. This may have suited medical staff who were free to carry out surgery without conflicting demands from their private or public antenatal clinics and operating hours, but it put an extra burden on the midwives, who are responsible for both labour ward and nursery care.

The boundary with medical practice is important for the midwives. They have different relationships with junior (RMO, CMO GP) and specialist doctors (VMOs). Midwives have traditionally cared for, and continue to care for the private patients of obstetricians (VMOs) in their absence. Hospital midwives are often more experienced than, and in a teaching position for, junior doctors even though it is the doctors who have the legal responsibility to take decisions about pain relief and intervention. The extent to which midwives are adopting new identities and how their role intersects with that of the doctors is one that recurs throughout the analysis and is the particular topic of Chapter 8

### *Junior Doctors*

The difference between medicine and midwifery is usually explained in terms of philosophy – the tendency to intervene and to use technology, as opposed to a using social support and non-technological methods. However, the cultures of medicine and of midwifery are different for many social reasons, not simply connected to gender or technology. Unlike the midwives, the junior doctors do not work in a particular area of the hospital but have simultaneous roles which take them to the antenatal clinic, the labour ward and the operating theatres. This means that they are often rushing from one task to another and frequently called away. A major preoccupation in the conversation of junior doctors is lack of time to complete their work, to eat or to have a social life. During a discussion of the consequences of episiotomies on women's sexual lives, one junior doctor joked, "If we can't have a sex life, why should they?" which reflects the personal pressure and the gallows humour developed in the job. Unlike the majority of the midwives who were either local people or who were settled raising children, the juniors were on ambitious career trajectories which meant that they often had experience of other hospitals and were not planning to make a home in Town.

The 'senior registrars' (SR) were in training to become obstetricians. They had either recently passed or were preparing for their specialist exams and were almost as capable, if not as experienced as the Visiting Medical Officers (VMOs). The remaining members of the junior staff (Resident Medical Officer - RMO, Career Medical Officer CMO, General Practitioner GP, Family Medical Practice trainee - FMP) were not preparing for specialist exams and worked under the supervision of the SRs and the VMOs. In contradistinction to the stereotype of medicalised obstetrics as focused on pathology, the trainee obstetricians put health and communication with people as a principal reason for choosing the speciality.

They're healthy people, you get good results, you can step in and do something and its really very rewarding sometimes (Robert SR 89).

They're normal women and a normal process. Most people are young and healthy. I find them easy to communicate with, and enjoy communicating with them (Stephen SR 40).

To this extent, obstetrics and midwifery are not so different. But obstetrics is also a hands-on craft, with difficult decisions to be made under pressure and a surgical identity is salient for registrars, who are intending to practise the combined skills of obstetric and gynaecological surgery. Here communication skills get pushed into the background, in favour of intervention, craft skill and making decisions under pressure.

Medicine is good because you can choose - if you like people you can do psych, if you are good with your hands you can do surgery or obstetrics. (Robert SR Notes 31 19).

But if something needs to be done you can make a big difference in a small amount of time - and have a major impact on two lives. There's the excitement of making decisions under pressure and a bit of danger - that appeals to me. And gynae surgery makes a lot of difference to people's comfort, rather than doing it in an emergency (Stephen SR 40-41).

From the point of view of the trainee obstetricians, the good thing about obstetrics is not so much caring for well women because of the intrinsic interest of normal labour as the likelihood that intervention will have positive outcomes because women are basically in a good state of health. This means that it is more satisfying than other branches of medicine and surgery, but the pressure and risk of dealing with emergencies which threaten the life of mothers and babies are also part of the attraction. The male doctors differed in the extent to which they subscribed to a traditional gender identity and conception of the doctors' relationship with midwives and women, some were fairly traditional in their attitudes and others more generally 'progressive'.

The history of the gender difference involving masculine medicine and feminine midwifery, has made it seem 'natural' that women should both assist doctors and do the low risk, communicating, emotional elements of maternity care, but this is appealing to an essentialist notion of gender. It is not questioned that midwives should carry out difficult practical tasks when caring for small sick babies, so it is hard to believe that women are inherently unable or unwilling to do the surgical tasks required in obstetrics. Nevertheless the advent of more women into obstetrics was controversial and a topic of conversation in the coffee room.

There were no female obstetric registrars in the unit, but Dr Michelle was a CMO training to be a GP obstetrician in the country. As Rosemary Pringle points out, female doctors are, like midwives, laying claim to the women's health role (Pringle, 1998). Gender is becoming a factor in employment prospects.

I enjoy obstets. and women's health and paed. - I thought I may as well do obstets., learn to do it properly, not just shared care. There's a huge demand in the country, especially for female doctors. (Michelle CMO 71).

There was considerable discussion of whether women should be preferentially trained, so that obstetrics would become a more 'female' specialty. The more conservative registrar thought this was a ridiculous idea. There were jokes about a rumour that all the female obstetric registrars at one hospital took maternity leave at the same time. Medicine was seen as being a tough option, requiring the ability not to panic and to endure high levels of stress and fatigue. Women were not disqualified from this, as long as they demonstrated that they could keep up the pace. A woman trainee was said to be 'coping well' with a high-pressure job, while another was criticised for 'panicking'. The issues of gender identity and philosophy of care as well as the relationships between the midwives and the junior doctors are important elements of Chapter 7, where the influence of the three critiques is reviewed and forms the focus of Chapter 8 which specifically looks at medical and midwifery boundaries.

### ***Visiting Medical Officers***

Critiques of medicalised childbirth do not usually distinguish between different levels of doctor. However, there are differences in generation, in the era in which they trained and in their consciousness of gender between the juniors and the specialists. Like the registrars, the specialists also differed on their attitude towards increased midwifery autonomy and in their general philosophical attitude towards changed expressions of gender identity.

The major difference between midwives, juniors and specialists is financial. The obstetricians are private practitioners whose principal income is from private patients, unlike the midwives and juniors who are salaried and paid for the hours they work. This is why the specialist obstetricians are called 'Visiting Medical Officers'. While they take care of their private patients at their own rooms and when they are admitted to the Town or the Private hospital, they are also paid by the Area Health Authority to 'Visit' the public hospital, being rostered to oversee the junior doctors and consult with and operate on the public patients. The two who agreed to be interviewed, Ian and Peter, had the same view as the juniors about the appealing parts of the job.

The good things about obstetrics are the intellectual challenge if there's a risk and the satisfaction of following through pregnancy to delivery and a healthy mother and baby. (Peter VMO 127).

The worst thing about public obstetrics is seen as dealing with the lack of continuity of care.

....getting out of bed at 3am to see a woman you've never seen before. She's in distress, that's the time you usually get called in. You have to make a quick decision, knowing that if you get it wrong it will be criticised by your colleagues, the junior medical staff, the nursing staff and everyone (Peter VMO 130).

They felt that they were in a different and more stressful position than the juniors. They were trying to maintain a private practice in a small town with falling birth rates and rates of private health insurance. This had an impact on the way they saw the organisation of health care, government policy and medical indemnity issues. Ian pointed out that obstetricians are to some extent public figures – they have a reputation amongst a network of women who are likely to become clients for obstetrics or gynaecology. "If a baby has cerebral palsy, its on the front page of the paper, everyone knows within a week, especially in a country town like this". (Peter VMO 38).

Ian and Peter had both been in private practice for about twelve years, but they had somewhat different philosophies about the future of their specialism. Peter was looking forward to getting out of obstetrics if he could while Ian was nostalgic for the traditional style of practice. Ian said that although it seemed inevitable that the professional role of looking after women in childbirth for low risk obstetrics would go to midwives and that obstetricians would specialise in high risk cases only, he has reservations about it. "My perception is different...It's nice to have experience of well women"(Ian VMO 89-90). In his view obstetrics and gynaecology are "two sides of the same coin", leading to "a nice long term relationship with the family too, I enjoy that, the greater insight and depth of feelings and understanding is rewarding" (Ian VMO 186).

Alternative accounts of childbirth emphasise continuity of care and empathic connection as qualities of midwifery practice and denigrate obstetricians as controlling and mechanical, but Ian here values the continuity of care and the personal relationships developed in a traditional practice. The patients and the doctor age together, starting with contraception when as he put it, a young woman comes with her mother to be introduced, then reproductive care as she has her family. In this way the lifecycle of the women is symbiotically related to the career cycle of the doctor. When the obstetrician is getting older and isn't up to delivering 250 babies a year, his clientele need more

gynaecological surgery, so he can hand the obstetric component of his practice on to 'younger men' and continue without so much night work until he retires. This view of the obstetric relationship is personal, but somewhat paternalistic. It depends on traditional gender patterns, for the patients and also for the doctor, who will need a wife to support him and his children. It is also predicated on high rate of private insurance and government support for private medicine.

Many private patients from Town were choosing a private hospital in the city, which split the VMOs workloads not only between the Town hospital and their rooms, but took them away from the town altogether.

In general there's confusion amongst the VMOs - there is all over the country. Since the Private Hospital opened, a lot of private obstets going there. This hospital will be more public. (Peter VMO 136-137).

Ian is concerned about the decline in private facilities for obstetrics in peripheral areas and feels that it is discriminating to have private hospitals only in cities. He feels that the decline in support for private obstetrics threatens his "enthusiasm, anxiety to keep up with whiz bang technology and do everything units in the city do – but I don't know if it (support for private facilities in the regions) will happen with the Medicare view of life" (192-196). So he is resigned to being

Not philosophically involved, I look after people who come through the door, tomorrow or on the list...

The government can't go on funding health in the way it has, there will be a blow-out in the budget. It's the only thing that Labor won't privatise, they've sold Quantas and the Commonwealth Bank (Ian VMO 197-199).

The work load has been somewhat alleviated by the arrival of junior doctors, "Previously you had four VMOs heading for burnout" (Peter VMO 131) but this arrangement isn't always reliable,

they have withdrawn juniors at weekends without any notice, we've had to go so far as to transfer healthy patients in labour to the Teaching Hospital because of the work load" (Peter 132).

The junior doctors believed that their presence made it possible for the specialists to do more private gynaecology and that this was why they were enthusiastic about them. One of them suggested that the VMOs were less keen on providing the requisite teaching and opportunities to work in the operating theatre and that they the health authority would not continue to support the positions if they did not address these issues.

The birth-rate has been declining so it is not clear how much the workload has really increased or whether it is changes to the balance of public and private practice which has made the burden seem onerous. One of the older midwives recalled 'the old days', when the specialists were in the hospital round the clock.

The junior doctors have taken work off the VMOs. In the old days Dr. Smith would go to sleep on the linen bags, he would be working round the clock, doing mundane things, signing and ordering drugs. The Medicare set up is very different. (Peggy MW 36-38).

For the VMOs changes in the organisation of medical care meant considerable tension over their future role. They were concerned about the decline in the traditional type of

obstetric private practice, the advent of Medicare and the rise in the proportion of public obstetric patients. There was also concern about high rates of professional indemnity insurance and the possibility of being sued if a mistake was made. The advent of the junior doctors with their training needs and new ideas and, by no means least, the expansion of midwifery roles only added to the pressure.

### *Professionals views of the women*

There is often a social class and communication gap between doctors working in public medicine and their patients (Lazarus, 1994:32), though this is probably less extreme in Australia than in the USA where it is compounded by race and the absence of universal health insurance. The junior doctors I interviewed were preparing to pass oral examinations and tended to have prompt and factual answers to questions. In answer to a question about what they thought the women coming to the clinic were like, Robert listed their characteristics

I'd say they were homogenous, white, Anglo-Saxon, with a relatively high level of obesity, less ante-natal education, not so likely to push for birth centre type care, not so well educated about options and with a high level of unplanned and unsupported births (Robert SR 12-14).

The staff tended to see a gulf between what they knew and expected about birth and what they perceived women brought to the hospital with them, in particular women who were disadvantaged educationally or financially or both. Michelle, a CMO, said

Some women smoke heavily, they have poor nutrition, don't go to ante-natal class - often they're the young ones ...they're hard work - you have to keep educating them but it isn't just education about labour, its about their own health. They don't understand about the cervix, what the uterus is capable of, why they need to stop smoking, STDs, condoms, eating properly. Its all part of the job - educating women about health - you can't just hand someone a healthy baby. Some people have to work at it - but its their responsibility - its their baby and their life and they have to cope if its a scrawny baby with asthma. (Michelle CMO 36-38).

This combines a perception about lack of information and a more moralistic sense that some people lack responsibility. Most midwives felt that women were not sufficiently informed about labour, some just shrugged this off as normal, others were condemnatory or more sympathetic. For instance Alison, a midwife who often taught ante-natal classes, thought that people were unprepared for the reality of birth. She said that it was her impression that some women would come for an induction expecting to be able to read the newspaper, "People think the baby falls out on the bed". Even women who attend antenatal classes do not necessarily 'get' the information or the right attitude "... it goes straight through. They just haven't got it." (Alison MW 37-39).

There is a complicated relationship between intellectual knowledge, motivation and the kind of labour people 'ought to have'. It was acknowledged that some people who have prepared and 'deserve' a good labour don't have one, while the young and undeserving have uncomplicated births. June thought



education makes a difference, some people are motivated, but some of these will have horrific labours. But then you'll get young teenagers who'll just spit the baby out. - they should have a rotten labour to put them off. (June MW 43).

Running through many accounts, both medical and midwifery, were these less professional and more personal attitudes connecting women's level of knowledge, motivation, and attitudes towards the staff, including their level of 'gratitude'. Behind the scenes, staff used black humour in discussing women who were problematic for them, and I heard expressions such as 'labour ward trash' and 'faggers' (smokers), which were understandably not repeated in interviews. Implicated in this is concern about social class difference, including the idea of a 'welfare culture', in which women and babies were at risk of harm, and from which there were thought to be threats to the well-being of the staff.

In the complicated moral economy of who would have a 'good birth', the themes of natural childbirth and of private practice also appear. Some staff find patients who are too assertive threatening and may react negatively (Lazarus, 1994:38). Nicki, the 'professionalising' midwife, thought that few women would come to the hospital explicitly refusing intervention but that they would not be seen positively if they did.

Not very many, they're a big minority. They're probably an increasing minority, but they're still a minority... I'd say fairly negatively. They'd react in the way that they would think "this is a difficult patient, not playing the game by the rules" (Nicki MW 160...168).

The obstetricians were preoccupied with the level of health insurance and the implications for the future of 'the obstetric model'.

Some people still want the obstetric model. Most people now they don't have health insurance, its economic necessity to go to clinic. I think they're generally happy with public obstetrics. Choice of shared care depends on if they are out of pocket - depends on gap for GP and also the skill of the GP - some GPs are not perceived as having good ante-natal skills. Don't know about the demand for the midwives clinic. Probably going to be a combination (Peter VMO 52-55).

Peter sees the decision as one of economic choice, satisfaction and demand, but his fellow VMOs tended to see the lack of private health insurance in moral terms and, the midwives told me that they would often 'berate' patients in the ante-natal clinic for having 'lapsed'.

Nicki, the professionalising midwife gave a thoughtful response to the idea of 'the good patient' from the midwives' point of view. The themes of education, self-improvement and the moral quality of independence construct a 'post-modern' patient, who takes on the role of giving birth with a desire to improve, to use professional expertise for her own purposes and to become independent, neither the passive woman dependent on the obstetrician nor the strident 'natural childbirther' who refuses to play by the rules.

Well, really, probably a good patient is a patient with a positive attitude who is open to suggestion, I guess. Some people, I think, would say that good patients were people who breathed through or people who didn't ask a lot of questions, but I don't know - I wouldn't. I think a good patient is a patient that asks unlimited questions, which therefore challenge you and make your day more difficult in lots of ways because you've got to find the answers, but that's good for you, and that shows the patient is

really clued in and wanting to know all they can know, and it's frightening when they don't, basically. Yeah, no, I think - I mean, starting from the beginning, probably a good patient would be a patient that didn't have fifteen people in tow and expect them all to come through the birth and the labour with them. Probably a good patient would be a patient that didn't - wasn't abusive, didn't lose control and become abusive and yell and scream and shout - that's always more difficult to deal with. And I guess, you know, just a person that was relatively independent - wanting to be independent - wanting to learn and do for themselves and for her baby (Nicki MW 188).

The discourses of the rational, the natural and the equitable create different identities. The characters Nicki invokes, women with fifteen people 'in tow' and women who swear and abuse staff, will appear again in the discussion of social support and equity in Chapter 7. First, it is necessary to start at the beginning, with the women's view of the antenatal clinic and the idea of the 'satisfaction survey'.

### *The Antenatal clinic and satisfaction with hospital care*

Ante-natal clinics were a mid-twentieth century invention, primarily designed to screen women for the, then poorly understood, condition of pre-eclampsia\*. They have been criticised extensively, especially in Britain, for being impersonal, unhelpful and involving a long periods of waiting, especially stressful for women with small children (Martin, 1990; Porter & MacIntyre, 1984), also for being an untested and possibly ineffective form of care (Oakley, 1984). Lazarus (1994) reports that public care in the USA continues with these characteristics. Clinics can be seen as a ritual which women are expected to attend to prove their moral worthiness as much as to screen for medical problems. If the ante-natal clinic is primarily a ritual, it is a good illustration of the kind of surveillance and subjectification described by Foucault (Foucault, 1991) and Armstrong (Armstrong, 1983). Being a 'late attender' is in itself a status indicating increased risk and uncertainty, because only poorly motivated or socially marginal women fail to attend, and missing the 'eighteen week' ultrasound means that the dating of the pregnancy is less certain. Two registrars discussing a 'late attender' said that they couldn't be held responsible for the consequences if anything should go wrong, implying that the woman bears the risk if she does not comply with the regime of surveillance.

Like the antenatal clinics criticised in the literature nearly thirty years ago, this clinic was not well organised to cope with the needs of mothers and children, some of whom had travelled considerable distances to attend. Women had to wait a long time, at times when they needed to be collecting children from school and the waiting area was not equipped to keep small children amused or to provide refreshments. The junior doctors were under pressure of work in different areas of the hospital so the clinic appointments were overbooked for the beginning of the session to ensure that there would be a steady flow-through of women.

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\* This is a physiological disorder indicated by high blood pressure and protein in the urine which can lead to fatal fits unless the baby is born promptly

Well, except for yesterday, every day there's been at least I'd say ten people in there before me, and I take early visits - I get in there about between one-thirty and two-thirty (Tess AN2 407).

This arrangement was to make sure the doctors did not have to waste time waiting, but if one of them was delayed in the labour ward or called away urgently waiting times for women would escalate rapidly. Julie thought the afternoon appointments were too close to school time and Kate found the chairs uncomfortable for heavily pregnant women and complained about noisy toddlers running around in the waiting room 'throwing things'. Like the women interviewed by Lazarus (1994), most women did not expect anything different from the clinic

Good. Yeah, there was a few long waits but most of the time I was there, it was no more than a twenty-minute wait (Beth PN1 43).

In her previous pregnancy, Angela felt that the ante-natal clinic was not reassuring enough, that the midwives and obstetricians were "Really blasé - they deal with it every day"(AN2 75). She felt that it was not worth asking for information any more because the public system was so busy, "They should be more approachable"(AN2 76). One problem was that the number of different people working in the clinic made it hard to get to know anyone.

Yeah, I was sort of seeing a different person every time I went to the ante-natal clinic - ante-natal classes we had about two or three different women through the ante-natal classes so I didn't really know anyone (Angela AN1 195).

There were attempts to provide a better service though. The hospital was trying to run more clinics to cut down waiting times. The junior doctors and the midwives had joined together to give better continuity of care, which is usually not received by public patients and very much desired (Lazarus, 1994:36). Against the heavy opposition of the obstetricians, the midwives were running their own clinic where they had their own ante-natal patients, could spend more time with them and not be called away.

Yeah, the waiting - well it's stream-lined now...it would be nothing to sit there for two hours and wait, but now it's a lot more (like) fifteen minutes or less (Laura AN1 1208).

But when I went to - I went for my first visit last week, it's all changed, they seem to be much more organised now, so hopefully it will be a lot better (Angela AN1 932).

Some women found the midwives clinic better and did not mind only seeing a midwife.

They both ask the same questions and check on the same things (Tess AN2 425).

I like going to the midwives clinic - its quicker, you see the same midwife every time and they know you. You can sit there for hours, waiting to see the doctor. June's quite a nice lady. And they do everything for you, weigh, measure, heartbeat, have a little chat. Instead of sitting there for an hour (Kate AN1 45).

Continuity of care for public patients and how far the midwives could take on the role of looking after well women were controversial issues which are central to the discussion of public and private care and medical midwifery boundaries in Chapters 7 and 8.

The issue of emotional dependency on staff cut across the professional boundaries. Particular members of staff were well regarded by the women, because they felt comfortable with them or because they communicated well. Kate obviously had a good relationship with the antenatal clinic midwife and would have liked her to go on looking after her in labour, though in fact June only worked in labour ward on very rare occasions.

June's still there - she popped in to see me, I've been seeing her from 16 weeks, if she's on she'll deliver the baby (Kate AN2 41).

These complimentary comments were not specific to midwives or to women. Some junior doctors were mentioned very enthusiastically by several women, because of a friendly manner and good communication skills; the enthusiasm and the emotional overtones of these comments suggest that women's preferences are more unconsciously motivated than simply a matter of 'consumer satisfaction'.

He is absolutely the nicest man. My daughter said that she's going to marry him. He's lovely - I've seen him probably the most out of anyone, I think I've had him three times...[The clinic's] been alright. They're quick - they don't waste time, but that's understandable because they're busy. Dr. P, he takes time, he'll sit down and go through it all with you (Laura AN2 35...491).

The only one I do miss is Dr. P- he was wonderful. He's now - I think he's at Teaching Hospital now. But that was a shame - that was a loss for Town ...Now he is lovely - He's a very caring type of person (Tess AN2 427).

Other junior doctors were notably bad:

There is one fellow there who didn't seem to last very long - I haven't seen him for a good long while - I can't remember his name - but he gave you exactly the opposite feeling (Tess AN2 437).

Consumer issues, such as waiting and appointment times and the comfort and convenience of waiting rooms are superficial issues which the women felt qualified to comment on, but the interviews go beyond this and bring in the emotional quality of the relationships between women and the people who care for them. This theme, of emotional intensity, has been the basis for this Chapter which has set the scene in terms of the institution, the way in which it shapes the work process and the process of labour. The women whose birth stories appear in the next chapter have appeared along with the midwives, junior doctors and specialists who will be responsible for their care. All this cast of characters have emotional lives and reactions which they bring to the process of hospital birth, making it very distant from the idea of the 'impersonal' hospital. The relationships between women and individual practitioners, the difference between private and public care, and the boundaries between medical and midwifery practice are major themes in the next three chapters. The next chapter takes up the narratives constructed by the women and deals with the 'drama of birth' in chronological sequence.

## CHAPTER 6 THE CULTURAL CONSTRUCTION OF BIRTH, THE FEMALE BODY AND MOTHERHOOD

In the last chapter I located the study in terms of the study hospital and the town in which it is situated, the women and the different professionals who looked after them. The hospital was shown to be a place inscribed with strong emotions and an intensity of experience for those who work or give birth there. This chapter rewrites the story of birth, departing further from the 'satisfaction' story and following women into the birth process itself, in their words and those of the midwives. Two major organising themes arise from the difficulties of producing an adequate feminist theory to address birth. These are the relationship between the mind and the body and the way in which culture enters into the birth process. The chapter draws on the words of birthing women as a sequential account of the birth process, which like a stage play, can be seen to unfold in Act like sequences. The idea of birth as a drama is from Ann Oakley, (1993) emphasising that the woman is the central player, not the medical team. The idea of a drama also implies the action is not completely spontaneous, but follows pre-existing discursive channels, with some room for improvisation. The chapter suggests that the complexity of understanding the diversity of women's birth experience stems from the intersection of two planes, the personal qualities of the individual, her conscious and unconscious expectations and the contingencies of her relationships with the staff and the way in which the discourses of the culture and its institutional arrangements impact on the embodied experience.

For the woman, the process of labour is an intense corporeal experience in which intellectual knowledge, strong emotions and embodied reality all come into play. Despite the small number of women involved in the study, it is possible to trace in their accounts the trajectory between their past birth experiences, their expectations and the course of the study birth. The process is shaped by the institution, its physical location and set up, its staff and prevailing discourses of risk and intervention, pain and pain relief, natural birth and social support. Changes in practice can be detected in women's accounts and in the diversity of staff reactions. The first Act in the drama is the way in which labour starts, involving uncertainty as to what will make labour happen, when and where, leading to negotiation between women and hospital staff over the appropriate time to 'come in'. The second Act involves the process of labour in hospital and centres around issues of embodiment and pain relief. The accounts highlight the important role that relationships with staff play in the course of labour and the ambivalent relationship women have with technology and intervention. The labour is a journey into a radically unusual state of existence ending with Act three, the birth itself and its immediate aftermath, during which institutional routines, the physical and emotional sensations and the social rituals of visiting family and friends interact to promote or to interfere with a sense of achievement and celebration. Act Four is the resolution during which women return to the everyday social world and devise strategies to cope with breastfeeding, paid work and plans for the future.

*The drama of birth Act One – ‘Is this it?’ The journey from the everyday to the exceptional*

The first act in the drama of birth has two central questions – is this really labour and is it time to go to the hospital? The issue of when and how labour starts is an important one for thinking about how the body functions when giving birth. I have been arguing throughout that birth is shaped by society and culture. This may seem trivially true, but I mean it in quite a thorough-going sense. Women’s diverse understanding of birth and the institutional arrangements for being admitted to hospital do not just influence the subjective experience and subsequent narratives but they have a material effect on the labour and the actual process of birth as well. Conversely, labour is an embodied process with its own logic. Knowledge of and a desire for a particular style of birth does not necessarily mean that the will or the desire can be fulfilled.

An early indication that labour is an activity on the mind/body boundary is the uncertainty about when it will happen. Pregnancy care is organised round a ‘due date’. If birth were a rational autonomous activity then this date could be relied upon, but in fact it is extremely variable. Angela said that in her first pregnancy, “I was sitting there thinking ‘Well, OK, I haven’t had the baby’, because I thought the baby came on the day that they said”. Of course this is very far from the case and ‘normal’ births occur between 38 weeks (two weeks before the due date) and (in western health care systems) anything up to two weeks later. The regime of surveillance of perinatal mortality, whose origins are described in Chapter 2, means that after ten days or so, induction will be under discussion, so very few pregnancies in the mainstream system will last longer than this. There is tension around this boundary. The ‘due date’ acquires a spurious sense of certainty and so that some women feel that ‘letting me go over’ (the due date) is undesirable. On the other hand the anticipation of an induction is problematic for someone committed to ‘natural birth’.

The ‘due date’ takes on a significance in industrial society that it probably did not in the pre-industrial past and does not in alternative communities and village societies of the present. Whilst village societies have been over idealised by ‘natural childbirth’ advocates and they were subject to many kinds of uncertainty, they probably were not so subject to clock schedules and the discipline of wage labour. In a small scale agricultural society, most work can be flexible and at least some women and part-time midwives can break off what they are doing to attend a birth. In industrial society the majority of the actors are committed to outside work schedules and family members may not be close at hand. The social obligations around birth and death are still allowed to interrupt employment schedules to a certain extent, especially these days for partners to attend birth, though probably this would not easily extend to unrelated support people. Women who already have children have to make arrangements for transport to hospital, someone to take care of the older children and possibly provision for partners to take time off work. All these are dependent on when the baby is expected to arrive and the level of uncertainty fits badly with work schedules and calendars. An anxiety provoking level of uncertainty can exist for two weeks before and ten days after the ‘due date’, as everyone waits to spring into action.

This anxiety appeared to be acknowledged by one of the obstetricians who manipulated the due date by adding one standard deviation to the normal calculation, so that women

wouldn't start worrying too early. Louise, one of the few private patients I spoke to, had asked him how he calculated the due date and as she was mathematically literate he told her. In this case, the obstetrician was willing to dispense with the fiction with an educated patient who could be expected to understand probability, but this is not extended to most women.

The last few weeks of pregnancy, according to women's accounts, are centred on their bodily experience, far away from the hospital. Interaction with the hospital becomes a dialogue, by phone or at ante-natal visits, in which women try to determine whether 'this is it'. Deirdre says that a younger woman asked her how you know when it's 'time to go'. She said, "Your body tells you, when the pains get bad enough, you'll know that it's time to go". This is the official view, but in fact the start of contractions can be 'on and off' or 'don't go anywhere'.<sup>\*</sup> Women described the experience of not knowing whether labour was starting as 'depressing' or 'frustrating' especially if they are uncomfortable and want to 'get on with it'. The uncertainty is highly disruptive because it requires a constant process of re-negotiation of the social arrangements for partners and support people to come to the birth and for children to be cared for. The fact that social arrangements and cultural knowledge are so uncertain makes the end of labour anxiety provoking, which in itself may influence not only the woman's willingness to accept intervention to 'end it now' but also the onset and course of labour, the cause of which is quite uncertain.

Part of the uncertainty revolves around the location of what it is that makes the labour start. Labour is an unusual bodily sensation, neither completely external, nor completely internal to the woman herself. It is not under as much conscious control as eating nor is it as close to automatic as, for example, menstruation (though obviously these bodily functions are also shaped by cultural and emotional factors). Orgasm and defecation are two bodily experiences that people may experience as variable and heavily influenced by culture and these may be the closest analogies to the relationship of the self to the operations of the body in labour. In these two examples of embodied experience, there is an unclear boundary between what is a physical process which happens 'by itself' (for instance, arousal to orgasm or the easy expulsion of faeces), what is caused by the woman's own actions (fantasy, masturbation, straining at stool, changing diet) and what has to be brought about by outside intervention (a perfect partner, a vibrator, laxatives).

It is significant that the difficulty of theorising body/mind boundaries which is discussed in Chapter 3, appears in women's accounts as a disjunction between the 'body' and the 'self'. The body is of course, also 'the self'. The women did not usually objectify their own bodies or indulge in abstract speculation about them, but there is a slippage in women's language about labour which shows that it lies on the very boundary between the body as self and the body as object, or even as something which has a life of its own. Some women attributed agency to the body and the process of labour – when 'it happens', 'the pains want to start', whether 'something is happening' while others invoked their own choice in the matter, a birth plan or a decision to go walking or to admit themselves to hospital, informed by alternative, or medical or some idiosyncratic ideas about how labour starts and proceeds. The agency of the hospital and its staff – what 'they want' or will 'allow' form the external intervention but in

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<sup>\*</sup> Ineffective contractions which occur late in labour have a medical label - Braxton-Hicks. The midwives think that some women are more likely to interpret them as labour than others, "Two Braxton Hicks and she thinks she's in labour".

pregnancy, there is another human being involved. Some women attributed the power of starting labour to the baby, whether he, she or it 'wants to come', or is 'doing something'.

Conscious strategies to induce labour did not seem to be very successful, though sometimes the actions women took to try to get the labour started drew on a tradition that frantic activity is a symptom of the start of labour, rather than just a stratagem to impel it to start.

I thought I might walk up to the school to get things moving so I waddled up there. And I went to the City to the supermarket and I cooked cakes and a slice - that should have been a warning (Deirdre - study birth, PN1 14).

I couldn't sit still . All the walls got scrubbed in the house, the floors, the carpet, everything. I was just absolutely wrecked by the Thursday fortnight ago, and I just got to the stage where I couldn't be bothered...I was absolutely obsessive with everything . It's dirty, it's got to be clean. I've settled down (now) (Julie - study birth. AN1 793...809).

Neither the deliberate strategy of taking exercise, nor the frantic housecleaning before the birth which is supposed to indicate the onset of labour (with a socio-biological echo of 'nesting activity'), did in fact precipitate labour, which remained unpredictable and beyond rational control.

Once labour pains start, women have to choose whether to drive to the hospital early and risk stopping the contractions or to wait and risk having to handle strong contractions during the journey. The issue of moving in labour, whether between home and hospital or between the ward and the delivery suite represents a significant difference between alternative (that is homebirth and birth centre) practice and conventional hospital birth. In the alternative literature labour is believed to be halted by anxiety and a shift to unfamiliar surroundings. Once labour stops, the woman is open to interventions, like induction or acceleration with the drug oxytocin so women who want a natural birth are warned to wait as long as possible to go to hospital, so that labour is fully established and interference less likely (Annandale, 1988). It is also believed that women should be admitted into the room in which they are going to give birth to avoid disruptions, but although this happens at the City birth centre it is not possible at Town hospital because of the physical layout.

The accounts of women's movements between home and hospital demonstrate that hospital staff do try to send women home if they are in very early labour, but that if the woman herself insists on staying in, they can hardly insist that she leaves. It appears that in this, as in many other areas, there are traces of different discourses in circulation. The first, more authoritarian one says that you must go to hospital when pains are five minutes apart, and the second, with more 'alternative' influence, recommends staying home as long as possible. Deirdre's experience reinforces the idea that labour can stop because of a change of location. She went into hospital when the pains were five minutes apart, as recommended by the hospital over the phone. On the way they had to stop the car because the contractions were so strong but when they arrived at the



hospital, “nothing, only one cm dilated. They said ‘Do you want to stay here or go home?’ I came home”.

Julie seems to have subscribed to the more authoritarian discourse and felt obliged to go to the hospital and so she had several false alarms. Eventually she rebelled and stayed home anyway,

I didn’t bother calling anyone because Mum had already been here and I thought ‘No, it’s just probably another false alarm . I’ll get sent home again’, and I went up there, they put the machine on and everything stopped. And they had me up there for a couple of hours. And I got dressed again, got in the elevator and got my contractions again. I thought ‘No, I’m going home, I’m not going to bother (Julie – study birth AN1 1029).

This is not a trivial issue: the conclusions that women come to about ‘when to go’ can influence the whole course of events and these decisions form a lively part of the narrative of women’s birth accounts and traverse whether to risk having the baby at home or in the car, how the journey is accomplished and the reception at the other end. The accounts women gave had several possible ‘plots’. You can go too early and end up in hospital not in labour, get it just right, in which case the birth seems to be accomplished very quickly, or leave it late. No-one I spoke to actually had the baby at home or in transit but some women got there only just in time which tended to cause ‘a big panic’.

Deirdre’s story exemplifies the complex dilemmas about organising children and support people, coping with her own feelings and bodily sensations and the drama of timing the trip to hospital.

On Friday morning I thought, this is it - I stayed in bed but was a bit frightened. About 2.30 (am) I went out the back, to the rumpus room but about 4.30 I was worried that if the kids woke up and saw me, they’d be really worried. Rang Mary (friend to take care of children) and hospital and had a shower - that was so nice. They were 5 minutes apart but as soon as the water hit they went to 2 minutes, very strong. Mary could hear me - I said “I don’t want this baby born here”. I don’t remember getting there. (Deirdre - study birth, PN1 15).

Like Deirdre, most women used showers to cope with early labour and others also found that the hot water made the contractions more intense. Women at this stage are on the horns of a dilemma, whether to stay in the privacy of their own homes and bathrooms where labour may speed up, or whether to transfer to hospital too soon or too late. The alternative discourse that it is better to go in later rather than earlier is to some extent reflected in the way women were given the choice about staying in or going home. But the hospital also has to monitor the risk so staff are obviously reluctant to send women home if they are anxious. If the baby’s head has not descended, as it often does not second or later pregnancies, there is a slight risk of the cord descending before the baby, which cuts off the baby’s blood supply. This situation can be managed if there is a midwife with the woman, but not if she is on her own.

Although there is negotiation, the risk or the change of discourse mean that the desirability of waiting as long as possible is not articulated. Anxious women are more likely to come in early. With her first baby Angela went to hospital.

First contractions, 'Quick, lets go to the hospital' ...I was only about three centimetres dilated and they're like 'OK, well you can stay for now', because normally I think they send you home but I was really anxious to be at the hospital".(Angela –first birth, AN1 226).

The focus of midwifery care on the hospital means that the midwives are not really able to 'manage' the tricky transition from home to hospital, except by phone, leaving decisions to be made by the women herself.

Understandably, women rely on previous experience. Roxanne had one birth where she only just arrived in time,

(I was) sitting on the lounge, started screaming and yelling at four. I had a shower and grabbed my things. I only pushed about three times, she was born at quarter to five... I was eight and half cm. There was a big panic, with no doctor there. I went aargh but the lady doctor came just as the head came. (Roxanne - third birth [of four], AN1 62).

So when she happened to be away from home when her fourth labour started, she went straight to hospital in early labour instead of going home first, and this made the labour feel very long. Two women, Angela and Laura, went to the hospital before labour started or very early in labour when it was likely to stop: both of these women ended up with difficult inductions.

Laura's story illustrates the problem with being vague about how the birth is likely to start and where the agency for this is located. At the end of pregnancy she was really uncomfortable because the baby was posterior (facing backwards), so she went to hospital to try to influence 'them' to do something.

I said "I can't take this any more" so he (her partner) took me into the hospital and they had a look and they said I was in pre-labour and did I want to stay there or go home and I said "I'm staying", I said "You're not getting rid of me now" because I thought it might make them do something. So I stayed there the Wednesday and they said if I hadn't started by Thursday they would induce me, which I really didn't want - I knew I didn't want to be induced (Laura - first birth, AN1 317).

Her story shows some confusion about who is going to act in this situation, whether it is her choice, something that her body will do on its own or whether it required medical intervention. If Laura had wanted the hospital to act they might be expected to induce her labour, which she didn't want. Maybe she thought that the labour pains might be provoked into action by the move to the hospital. If she had adhered to the strong alternative ideology she would almost certainly have gone home. In fact she went into labour without induction, but it was very slow and had to be augmented. It is impossible to know for certain, but this would bear out the alternative view that it is better not to go to hospital unless labour is really established.

Waiting until the baby is almost ready to be born requires confidence and self-reliance. Some women are confident enough to stay at home, like Beth, "I'd get labour pains as well, on and off, in that three weeks, but they just never continued". Tess was sewing curtains for the baby's room when she felt a slow leak. As she wasn't in pain and lived close to the hospital, she phoned to say that she would go over when she had finished them. Two hours later she walked to the hospital and had the baby two hours after that.

I suppose it really does make you think just how much like animals we really are because they go in and they have the baby and then they get up and they're fine (Tess - first birth, PN1 60).

The animal behaviour analogy is in one way very 'natural' but not one very much employed by alternative childbirth discourse, because of its determinist or misogynist associations. Other women experienced labour very differently, because of social factors like the distance they were from the hospital, their feelings about the onset of labour and whether they were in much pain. Tess was unusually calm.

Yes, I got (the curtains) finished too. It was funny, I had a friend here, he was having coffee with me and I said to him 'Look, I really have to go' and he said 'Why, what's wrong?' and I said to him 'I'm in labour' 'Oh no' And he panicked (Tess - study birth, PN1 99).

Kate also had quick labours and was afraid that she would not get to the hospital in time. She found that hospital practices had changed so she was in labour longer than she thought:

With the second one, the contractions were 10 minutes apart for half an hour. I rang the hospital because it was so quick with him and they said come in. (This time) they didn't break the water straight away - that's why it was longer. I wish they had done it. I reckon it speeds it up. (Kate - study birth, PN2 23).

The first phase of the drama of birth takes the woman from her home and usual social existence, into the hospital. Just as in Deutsche and de Beauvoir's accounts of labour, (Introduction), it is unclear whether the source of the action is located within the woman herself, whether her mind, her body, the process of the labour or the baby's activity is dominant. The woman can appeal to the staff at the hospital to override the anxiety, but there is no guarantee that the outcome will be positive, and there are a variety of philosophies and changing practices which will influence the action that staff are prepared to take. These themes continue into the next phase of the drama, when the question of getting labour established and tracking its progress is moved to the hospital. The decisions made in Act One, the timing of and the anxiety of the transfer to hospital as well as the arrangements for admission are all factors which affect the course of Act Two, where labour intensifies and the everyday social world is left outside.

### ***Act Two –the subjective and social experience of being in labour***

Once a decision has been made, that 'this is it' and the woman arrives at the hospital, then the drama is centred on the progress of the labour. Women's experiences are very diverse. The fact that labour is affected by both individual and cultural factors, its location on the boundary between the rational, the emotional and the physical means that there are numerous influences which make labour faster or slower. Each woman's previous experiences of birth, her relationship to her own body, conscious or unconscious anxieties, and relationships with partners and the staff all have a potential effect on the progress of labour. Some women have been to other births or are familiar with alternative birth ideas and incorporate these ideas or practices into their own expectations. Hospital procedures also shape events. These change from time to time and confound women's expectations.

Admission paperwork can be onerous if you are in advanced labour and distracting even if labour is in early stages. For one of her births, Roxanne had experienced a very rapid labour and was irritated by the hospital admission procedures, "I was pissed off with the nurses, filling out forms, asking questions, 'Have you used your bowels?' I said 'In four minutes, I'm having the baby'. The alternative view would recommend focussing on the woman and her labour at this stage, not bothering with administrative procedures or defensive practice, like putting on a monitor to get a baseline reading.

Just as the journey to hospital interacts with the start of labour, so the layout and organisation of the hospital affect early labour. If a woman is not in heavy labour on admission, then an important factor in allowing labour to get established is the idea of settling in to a safe space. Women in early labour are, in midwifery parlance, 'not really doing very much'. They go to 'their bed' on 'the floor', which is what the midwives call the ward area. Being given a 'bed' suggests a passive sick role

you just see it so often - they come in and the bed is in the centre and they get out of their day clothes and they put on their nightie and they get on the bed and they become a patient, and the whole sickness thing (Caroline MW 12).

This becomes their base for the labour, from which they go to the delivery room for analgesia, interventions and the birth. At the Teaching Hospital birth centre women in labour were admitted to a birth room for labour and delivery and wherever possible, they stayed in the same room until the next day. This gives more privacy,

I was still sort of coping really well until the woman in the room next door started to scream - I'll never forget that . That was when I got really upset, thinking Oh no. (Angela - first birth Intervention AN1 257).

Women at Town do not have the option of settling into a birth room, but move backwards and forwards between the ward and the delivery room during labour and return to their bed in the ward after the birth. The ante-natal ward, the 'floor' where women go before and after delivery and the delivery rooms are geographically distinct areas, which shape the experience.

you'll be there, labour, labour, labour, and "Yes, it's starting to get a bit stronger, I need something for it or help in some way", you go to the delivery room and then come back- it's just a walk, you know, thirty seconds to your room. And then you'll come back and then you'll do it, and then, when you've had your baby, you'll go back to your bed then. (Caroline MW 287).

This spatial separation within the unit is also an administratively convenient one. Different midwives staff the floor and the labour ward and so moving to a delivery room also means changing the staff who are looking after you.

The way in which women speak of their labour is a form of 'inscription', which influences expectations about the physical process. The dilation of the cervix progresses from closed to ten centimetres, which means full dilation so that the woman can start to push the baby out. This measure is well known to women and they speak of it as a guide to their progress, as the midwives do, for instance 'I was only 2cm', 'I was 6 cm by then'. This has been idealised as a 'Friedman curve', a graph which plots centimetres dilated against the time elapsed (Friedman, 1978). This is a smooth curve, meant to

represents the average progress in labour, though it does not represent any actual labour. It was intended to plot women's progress and to detect potential abnormalities. This measure makes labour sound 'unilinear' but the rate of progress is very variable, labour can speed up or slow down in dramatic and unpredictable ways. Some women found that their own sense of how long the labour was going to take differed markedly from the staff's assessments.

Some women are not in labour when they are admitted and are induced because they are past the due date, others are in early labour which stops and has to be "accelerated". The intervention is an intravenous medication, 'a drip' containing the drug oxytocin, which is meant to start or speed up labour. This produces a labour which can be slower or very rapid in onset. Several of the intervention stories were differently inscribed, because they were marked by the 'turning up of the drip' –

At 11, they increased it from 30 to 60 mls...at 12 they put it up to 90...at 2.30 they put it up to 110, it was unbearable, after five minutes, excruciating (Julie study birth PN1 22...26...34).

Like orgasm and defecation, the body in labour reaches a point of no return, where the physical function is going to happen, whatever the social and psychological conditions happen to be. Once a woman is in heavy labour, then the hospital routines are not so important to her. The issue becomes how to cope with the sensation and what decisions are made about pain relief. Even so, changing location from the floor to the delivery room in heavy labour is a distraction. There are only three delivery rooms at Town hospital. A surprising number of the previous births were said to have happened in waiting rooms or on trolleys, because there was no delivery room free, though all the study births were in delivery rooms. Because of the layout of the hospital, which reflects childbirth practices which are becoming less dominant, the delivery room is a strange space, rather than a known environment in which to cope with the intense experience of labour. The layout and staffing arrangements break the continuity of care and makes early labour appear more medical than it needs to be.

The next section shows the kinds of birth events recounted by the study women, from their previous births and from the study birth. This will lead on to a discussion of labour as a corporeal experience, the embodied experience of pain relief and the importance of relationships with practitioners.

### *Labour experiences: natural, conventional and intervention*

The 'Experiences of Labour' table summarises the factual content of the interviews. Obviously with such a small group of women, generalisation is not possible, but it is likely that very many women and practitioners would recognise these as 'typical' events. Because the interviews were both retrospective and prospective, it is possible to compare their accounts of the study birth with their previous birth experience to see whether practices have changed. It is also possible to comment on the social shaping of individual women's experiences, in the light of the hospital's own intervention statistics and what is known about the wider Australian population as well as in the light of the alternative birth critiques.

#### Table 6:1 Experiences of previous births

Name - number of previous births	Previous births	Labour	Analgesia	Comments
Roxanne - 3	Conventional Conventional Natural	Spontaneous Spontaneous Spontaneous	Pethidine Pethidine Heat/water	
Cathy - 2	Conventional Conventional	Spontaneous Spontaneous	Pethidine Pethidine	
Beth - 1	Intervention	Accelerated	Heat/water	
Angela - 2	Intervention Intervention	Induced Induced	Heat/water Epidural	
Julie - 2	Intervention Natural	Induced Spontaneous	Pethidine Heat/water	
Laura - 1	Intervention	Accelerated	Pethidine	
Sheila - 2	Intervention Intervention	Induced Induced	Gas only Gas only	
Deirdre - 3	Intervention Intervention Conventional	Induced Induced Spontaneous	Gas only Gas only Gas only	
Kate - 2	Natural Natural	Spontaneous Spontaneous	Heat/water Heat water	Membranes broken, rapid labour
Tessa - 1	Natural	Spontaneous	Heat/water	Rapid labour

Table 6:1 shows each woman's previous birth experiences, focussing on how labour started (whether spontaneously or induced) and what level of pain relief was used. The births have been assigned to four categories. The first, termed 'natural', was spontaneous without intervention or pain relief other than heat and water. The second category I call conventional, that is spontaneous labour with low levels of pain relief. Initially I expected that spontaneous labour with only gas and air for pain relief would be the most common category and the most accepted by women outside the natural birth movement but I was surprised to find that only one previous birth was 'conventional' by this definition. Four births were spontaneous but pethidine was used. In alternative birth practice, pethidine is seen as quite a serious intervention. Changes in practice can be seen in the fact that in Table 6:1, the previous births table, five out of six conventional births used pethidine, whereas Table 6:2 shows that in the study births only one out of three used pethidine and this is in line with women's comments that pethidine was less freely offered than before.

Seven previous births were induced, and although induction is commonly reported as being much more painful than spontaneous labour only three of these women reported having had pethidine or an epidural. Two births were accelerated and pethidine was used in one of these. It is surprising that five spontaneous births used pethidine, while two of the intervention births used only water and heat and another four used gas only. This seems to show that changes in practice and individual variation play an important part in the way births are organised.

Table 6.2 uses the same categorisation for the 'study birth', that is the birth which took place in the year I was interviewing the woman. The proportion of 'natural' births in the study year is about the same, but the conventional category shows less use of pethidine. Two of the four 'intervention' births only used gas as analgesia. The two intervention births which used more anaesthesia were evaluated very differently – one was a negative experience, the other felt to be very positive.

Table 6:2 Experiences of the study birth – grouped by birth type

Name	Study birth type	Labour	Analgesia	
Beth	Natural	Spontaneous	Heat/water	Continuous support
Tessa	Natural	Spontaneous	Heat/water	Short labour
Deirdre	Conventional	Spontaneous	Gas	Could have done without gas
Kate	Conventional	Spontaneous	Gas	Slower than previous
Roxanne	Conventional	Spontaneous	Gas	No pethidine this time
Cathy	Conventional	Spontaneous	Pethidine	Previous bad experience
Julie	Intervention	Induction	Gas	Also hot water, very positive
Sheila	Intervention	Augmented	Gas	Pleased not to be induced
Laura	Intervention	Induced	Pethidine	Terrible – wanted a Caesar
Angela	Intervention	Augmented	Epidural	Very happy

It is possible that some women have not remembered or not told me about some aspects of the births, such as the use of pethidine or the reasons for particular types of intervention, so the boundaries of my categories are not completely certain. Nor do I want to suggest that these ‘types’ of birth have a fixed existence. Rather the reverse. The value of analysing these birth accounts in detail is not so much to document objective facts about practice, as it is to understand what women perceive as important and how they evaluate their birth experience. The Table in Appendix 3 summarises the women’s previous birth experiences, their expectations and the events of the study birth.

The accounts do not divide clearly along a natural/technological divide. Women did not speak of a demand for natural birth, though those who experienced one seemed to feel that it had been a fortunate circumstance. The women who experienced intervention valued it differently – it was not the intervention as such, but its subjective meaning which was important. Even where the evaluation was quite negative, it was posed neither as a complaint about the health system, nor as a wish to have had a different experience. Angela had experienced quite traumatic post-partum bleeding with her first birth, but she went back to Town hospital and even had the same registrar deliver her baby. Louise was the one woman whose birth story seemed to me to be distressing – she describes herself as having ‘begged for a Caesar’, but even she told the story with equanimity and without any air of criticism. All the accounts have an air of fatalism– as one woman said, what will be, will be. Within an overall acceptance of ‘what is’, these tables demonstrate that what happens in a birth is quite contingent on social factors, the practices of the particular staff at the time, and decisions taken, for example to have or not have pain relief, which could have been otherwise.

Although women’s experience of the different types of birth was not uniform, the following quotations give a feeling for issues that were important: Beth’s study birth was ‘natural’.

I didn’t have any showers this time - with D I had lots of showers. I was a bit upset because I liked having the showers - I think the water relaxed me a bit. But I had the midwife, she was really nice, and she stayed with me from the time that I was admitted to the hospital to the time she took me up to my bed after I had H, and she was terrific.

Well, I didn't do anything – I didn't have any gas and I didn't have any pethidine. I started to get a bit of pressure in my back and the midwife massaged that and that helped that, but other than that I just sort of breathed (Beth - study birth, Natural PN1 150).

The Town maternity unit only had a single bath and the showers were very small and not conveniently located. It had been designed before water and heat were so commonly used for pain relief, so these were difficult for women to access and often not available. Beth relied on the midwife's support and massage to handle pain. Beth's idea of 'natural' childbirth seemed based on ante-natal classes and her own intuition, she did not refer to any particular books, but she had a firm expectation of not using pain relief and seems proud that she did not have to.

Deirdre had a positive experience of a 'conventional birth'. She accepted the offer of gas, even though she felt she might not need it.

At 5.45 they said "How far do you think you are?" and I said if I'm half way I'd be happy - but by 6.16 I'd gone the rest of the way. They said - Do you want gas? And I thought I'll be here for hours, I won't have it yet. R said, have it. Dreadful pressure on my bowel - and I had to wait - and they had to turn the gas off. They got the mirror and this time I watched and it made such a difference. Ross and I pulled him out and put him on my tummy. Dr M, she was just beautiful and the Midwife - the same one as on Tuesday came back to visit us "I said Yes I'm going to have it this time" - no trouble at all. No stitches, that makes a darned difference, your recovery is so much better. (Deirdre - study birth, Conventional PN1 23).

Deirdre's story demonstrates the way that women 'track' their progress and also that dilation does not proceed in a linear fashion but can be slow or fast in unpredictable ways. It also shows a close and contingent 'margin' between natural and conventional births. If it had not been for her husband's concern, she would probably have done without any anaesthesia. The fact that she stopped using the gas and that Dr. M and the midwife used 'natural birth' practices shows that there is mutual influence between alternative and hospital birth. The skilled delivery without stitches (as advocated in the alternative model) is something she particularly values and her language demonstrates her emotional attachment to her carers, both the quality of their care for her and the fact that the same person came back to see her.

Angela's second birth demonstrates the negative and the positive experience of intervention.

I went to hospital about eight o'clock on Sunday morning and they put a - oh, the drip in - and basically sort of just left me - You know, the labour started almost immediately, but they were very mild contractions up until about lunchtime, then they turned it up a bit because nothing happened. By this stage they were thinking of turning the whole thing off. No thank you. So - Then they turned it up and everything - then it went really fast. So five o'clock in the afternoon the contractions were not even a minute apart - they were continual - and there was nothing I could do, I felt, to sort of control it. I sort of had hair pulled out of my head (because it was so painful). It was horrible. Then they said that I was only three centimetres dilated and it was, oh, ...(depressing). Then I had the epidural about half-past-fiveish I think ... (That was) wonderful. I wouldn't have a baby without one. Just - I didn't even feel it go in - I think it was the pain from the labour, I don't know. And then half-an-hour later I was sitting up playing cards thinking "This is great". You sort of just feel a tightening, not actually any pain. But you



couldn't move . that was the bad thing, sort of being stuck there (Angela - second birth, Intervention AN1 529).

Angela's account also shows 'tracking progress', this time by the turning up of the drip (an external rather than an internal measure of the progress of labour). It also shows that, like Louise, she was active in choosing to continue the intervention when the hospital was prepared to abandon it and presumably send her home. Rather than feeling that intervention was being forced on her, she was alarmed at the idea of giving up after everything she had been through, 'No, thank you'. She gives a vivid description of an unpleasant induced labour and the enormous relief of the epidural.

Angela's story demonstrates by its great contradictions that women do not necessarily have firm identities around birth practice. She was someone who had expressed a great commitment to natural birth ideas, who described her first birth as 'enjoyable' and even contemplated a home birth, but nevertheless she insisted on continuing with an induction for this birth. The unpleasant nature of the induction might have led to her adopting more firm 'natural' views, but rather she became an advocate for epidural anaesthesia, despite its disadvantages ('being stuck there'). There are no staff relationships in this account: only the anonymous 'they' who want to abandon the induction or who turn the drip up. So unlike Beth and Deirdre's story, there is no emotional attachment to a person, only Angela herself, coping or not coping with what is happening in and to her body.

This section has established the range of experiences women reported and a schema for describing them, while pointing out the complexities and ambiguities involved. Appendix 3 lists women's previous experience, expectations of the study birth and outcome of the study birth for reference. While the labour categories in this section have necessarily been somewhat abstract, the next section examines labour as an embodied experience.

### *Labour as a corporeal experience*

If birth is to be understood without resorting to either biological or psychological determinism, it is necessary to analyse it as a 'corporeal' experience. This does not contradict the idea that birth is socially shaped, but it requires the inclusion of the actually experienced body, embedded in cultural discourse and human relationships and with its own material limits, to be included in the account. The concept of corporeality also goes beyond the idea that women's own account of their 'experience' has primacy. In order to describe an 'experience' one must have access to concepts and discursive practices which shape what one is able to say, indeed what one expects and knows, on either a conscious or an unconscious level, may actually shape what occurs. Some women have more or less access to an organised vocabulary, including biomedical or alternative, but none of the women I interviewed were thoroughly imbued with either of these ways of speaking.

The second scene of Act two begins once labour is properly established. The experience of established labour (or an intense induction) means that the woman is thoroughly involved with her own bodily and emotional processes. The presence and actions of others, her family and friends and her professional carers, become very salient. While it seems hard to find the words to describe labour, women do speak in very emotional

language and they convey their feelings about the role of their carers in strong terms, fear and trust, affection and dislike are very heightened during this time of increased bodily intensity. The hospital is a familiar but public space for the women I interviewed and it is not easy for them to cope with novel sensations in a semi-public space.

Because it was being induced, friends coming in when I was in intense pain contributed a lot to the stress. At that point, it was, I couldn't stand anyone looking, not very dignified, rolling around on the ground (Angela second birth AN2 58).

Bodily functions can be embarrassing and cause shame when they break through the normal boundaries of the everyday. Indeed, one of the roles of health professionals is to handle this by adopting a professional, even impersonal attitude (Lawler, 1991), which somewhat contradicts the emotional dependency that women express. There is a tendency for both biomedical and alternative birth discourses to disguise the raw physicality of labour and birth: the first by making it biological and clinical and the second by leaning towards the psychological and mystical. They thus evade the issue of the complex interconnection between the two.

The corporeal experience of labour involving writhing movements, moaning, sweating, grunting, being hot, flushed skin, red face and undignified in posture and demeanour is confronting and difficult to deal with unless the sights and sounds have been made familiar and meaningful, for instance from having witnessed another woman in labour. Although this comparison is not encouraged in hospital, labour is like sex in that it is embodied, unpredictable and breaks the bounds of everyday modesty. Like the teenaged girls who found that the reality of sexual experiences was an awkward actuality of bodily smells, discomfort and the management of body parts contradicting the prevalent representation of sex as transcendent, romantic and emotional (Holland, Ramazanoglu, Sharpe, & Thomson, 1994), labour often turns out to be more than a clinical phenomenon or a straightforward 'natural' event. Unlike managing sexual encounters, which can usually be repeatedly worked on, most contemporary women have only one or two attempts from which to learn how to manage labour.

Educating people in this area is difficult. Films of labour can be informative but can be confronting when pain and nakedness are portrayed in two dimensions, without the artistry to convey the depth of emotion involved. Official antenatal class films tend towards the bluntly educational rather than dealing with the emotional and cultural. Several women told me that they found the depiction of labour in ante-natal class films frightening and one of the midwives thought that media depictions of labour were usually unhelpful.

(Northern Exposure was) the best one I've ever seen on television - born at home, she was sitting upright, her husband was behind her, supporting her, the doctor - well I mean because it's a little country town - he was there, but he hardly did anything and everybody was positive, and I just said to G "That was lovely. It made me feel the way I feel when I see it at work and it's a good experience". And the ones on all the other programmes are so negative that I come away just feeling angry and another reinforcement to women and their children, you know, these future women who are going on to have their babies, that this is the way it is done: the husband isn't allowed in the room, that everybody's got to have the masks on and the women in the stirrups and having it take out of their control. So I just find the media is one of the most negative things about women and childbirth (Caroline MW 12).

Judging from interviews with both midwifery and medical staff, they would like women to be more prepared. However, they tend to see the nature of the preparation as cognitive learning, rather than emotional socialisation or cultural induction into practices that make it acceptable to depart from everyday demeanour. I have already discussed the way in which midwives and doctors spoke of childbirth preparation as a matter of knowledge and education. But this raises the question of whether women would be better off if they read or learned more.

There should be more education - though that depends a lot on motivation - people who want it will get it whatever, people who don't won't (Stephen SR 56).

However, intellectual knowledge does not necessarily prepare someone to deal with the very difficult combination of being in an unfamiliar institution whilst experiencing an intensely private bodily experience.

The same midwife who commented on media representations of birth suggested to me that obstetricians are more distanced than midwives from the actuality of labour and in her view, this accounts for their tendency to intervene. She speculated that women are seen in the obstetrician's office wearing smart clothes and make-up, in other words giving an everyday performance of being competent and self-assured, with their body properly dressed and deodorised. The intense physical experience of labour challenges this presentation of self. "Of course she's hot and sweaty and screaming, she's having a baby, it's not like going for a walk in the park" (Caroline MW 104). In this scenario the midwife who has seen a woman through the process of labour judges that she is coping well. The obstetrician is confronted by a woman who is very different from the social self he met and he assumes that she needs pain relief. Caroline believes that the midwives are more accepting of the corporeal aspects of giving birth and this is why they are more likely to be positive about what the woman can achieve without intervention.

Women do not all have the same relationship to the institution and its values. Some women felt oppressed by things which the childbirth movement considers liberating. For instance one woman felt her midwife was treating her cruelly by making her walk around. Issues of modesty and coping with bodily fluids and sensations are difficult, for many women, who can be offended by the midwives casual comments about body parts, and who certainly do not reach the level of comfort with nakedness and self expression that some alternative birth manuals advocate. The staff also can be offended by couples who highlight the sexuality of birth in their work setting. Some women may feel disadvantaged and uncomfortable in hospitals because they find the staff militaristic and unhelpful.

I've been there (the Teaching Hospital) with...my sister and a friend and the midwife ...was like a drill sergeant, the rudest person I've ever met ...I don't like being told what to do (Cindy- study birth Conventional PN1 80).

### *Relationships between practitioners and birthing women.*

The relationship with the midwives and doctors is very intense because of the vulnerability women feel in labour. Kindness is remembered vividly. Beth's second birth was quite routine from a medical point of view, but she was very emotional. She was fortunate that a midwife was able to give her one to one care. She gave birth to her

daughter without any intervention or pain relief, a model natural childbirth in the public hospital system.

Someone couldn't come in because they were sick and she was called in for the night, so she said she'd been doing work at country hospitals, just doing casual work, so I was pretty lucky because she was a really nice lady...I just didn't get to get there (to the shower), you know, because I was just getting all these dizzy spells and I was really emotional during this labour - I sobbed my heart out the whole way through it. Not because it was painful or anything I just sobbed, I just - ...I don't know why but I just cried and cried and cried, you know. (Beth - study birth, Natural PN1 165...195...205).

In some respects this birth experience fits the alternative model, but it is interesting that the personal relationship was more important than the soothing hot water and that this was not a 'known midwife' – she was a casual, just called in for the night, working in a place she did not know. In this case, it appears that this worked in Beth's favour. The casual midwife was left alone to give sole care to a distressed young woman, which she did without an excessive resort to psychologising, "I don't know why I was upset" nor to medical technology to blunt a pain which seems to have been as much emotional, as physical.

Not all commendations of midwifery care fit the alternative model. Angela's 'good midwife' supported her choice and didn't make her feel guilty for using pain relief.

they were really wonderful, ...Well, the midwife I had during the labour, her name was M - she was an older lady, she would have been fifty plus I think, and I was sort of a bit worried - I thought, well, gee, she's really old to sort of be in there, but you couldn't have asked for a nicer lady. She sort of left me to myself and didn't sort of interfere. But she was really good – really encouraging and - Like didn't make (me feel guilty)- When I said I wanted an epidural she said "Oh, good girl", she said "I'll go and call the anaesthetist for you". You know, she was - ... "Oh, good girl, I'll go and get one for you" and - She thinks that all women should have them (Angela, - study birth, Intervention PN1 572).

Angela's determination to have an epidural, was understandable because of two traumatic post-partum haemorrhages and a very distressing induction. She had already expressed her intention to have an epidural to me and it is unlikely that she would have changed her mind, even if she had met with a very alternative midwife. If she had received the kind of one to one care that Beth did, this might have changed the outcome, as it was, she was grateful for this midwife's support. It is not clear whether the midwife's age and experience meant that she was able to focus on and support whatever choice had been made or whether she had a more conservative view of the need for pain relief, "she thinks that all women should have them". This in itself might demonstrate a generational shift in which the older midwives are more accepting of pain relief than the younger ones. The issue of midwifery ideologies will be discussed in the chapter on professional boundaries.

The fact that midwives work shifts and there is no continuity of care means that a relationship which has developed does not continue through labour. The personalities of midwives differ and do not suit everyone. Brusque or unhelpful midwives and doctors were remembered with bitterness. Cindy saw the midwife at her second birth as a tyrant for insisting that she walk around in labour, which a natural childbirth advocate would have welcomed.

I was pretty happy with the staff there - they're much, much nicer than the Teaching Hospital...Its like you get a nice one and then the shift changes and you get this dragon lady. (Cindy- study birth Conventional PN1 80).

After this earlier miscommunication, the Town midwife's considerate behaviour was a pleasant surprise.

She was really good, she wanted to examine me and I told her - I don't want to be on my back when it starts again, so she said you tell me when its starting again and I will make sure you're not on your back. And she did!(surprised). That midwife at the Teaching Hospital was a bitch - it was do it her way or don't do it at all (Cindy- study birth, PN1 94).

These quotes exemplify the polarised emotions which women expressed about care they experienced in labour. Both doctors and nurses who were sensitive and communicative were described warmly, as wonderful, caring, nice people. Kate said that her midwife "reminded me of my mum" (PN1 431).

### *The embodied experience of pain relief*

A major issue in coping with the bodily sensations of labour is the availability of and practices surrounding pain relief. The pain of labour is commonly supposed to be the most intense that most women will ever experience:

Yeah, painful, you don't forget, do yah? There's nothing worse than labour pains (Roxanne - study birth, Conventional PN1 50).

I was told to think of the worst possible pain and multiply by ten. Every female I know told me that. A friend was in labour for 48 hours and I was expecting that (Tessa first birth, Natural AN1 29).

Pain relief involves a complex of issues of embodied sensation and relationships with carers: it is not just a matter of rational choice, nor of 'resisting' the imposition of patriarchal or medical control. Some people find, like Tessa, that labour is faster and less painful than they had been led to expect, others that it is incomprehensible and beyond their control. Angela said that the pain of being induced was 'disgusting' and that she felt at the time "it shouldn't be like this". The regime in Australian hospitals is not rigid, so the issue of choosing pain relief is a complex negotiation between what is offered and available and what the woman herself wants. The interviews show a range of reactions to the pain of labour and the analgesia that is available, as Table 6:4 shows.

Three of these examples are fairly clear cut. The first wanting pain relief and being satisfied with it (Angela, second birth), the second feeling that the pain relief you needed was denied to you (Cindy) and the third, being happy to do without pain relief (Tessa). The positions on the table which are of most interest are the borderline ones where pharmacological pain relief was expected but it was not available and this was acceptable (Sheila), or pain relief was given which was unnecessary or unwanted (Deirdre and Roxanne). Deirdre and Roxanne are quite close to rejecting the usefulness of gas and air altogether and there is obviously potential for changes in their expectations. There are wide differences in women's experience of past and present labours which condition these expectations about pain relief These differences in

interaction with diverse staff attitudes seem capable of shifting hospital practices and the rates at which particular methods are offered, accepted and refused over a relatively short period of time. Women detected subtle changes in practice between their pregnancies, especially a change in the likelihood of being offered pethidine, but women are hesitant about articulating it as a change, even Sheila who was herself a nurse.

Table 6:3 Pain relief options.

Pain relief offered	Pain relief wanted	Pain relief unwanted
<i>Positive comments</i>	<p><i>Accepted</i></p> <p><i>'As much as they can give me. I'm not a martyr</i></p> <p><i>(Laura, anticipating study birth AN2-791).</i></p> <p><i>'I was sitting up playing cards thinking 'This is great''</i></p> <p><i>(Angela, second birth, Intervention – epidural PN1 554).</i></p>	<p><i>Refused when offered</i></p> <p><i>'They kept asking if I wanted pethidine – I said no</i></p> <p><i>(Julie study birth, Intervention PN1 28).</i></p>
<b>Negative comments</b>	<p><b>Accepted but not useful.</b></p> <p><b>'It makes you feel a bit light headed, and makes you forget about the pain, because you think you're on something, I don't think it does much for you, made me sick more than anything, I vomited, so in the end I put the gas up and just let nature take its course</b></p> <p><b>(Roxanne – study birth, Conventional PN1 126).</b></p>	<p><b>Accepted and regretted</b></p> <p><b>I got sick on the gas - dry retching, I said I don't want any more (Deirdre – first birth, Conventional).</b></p> <p><b>it's just in your head that its working - a couple of times I wasn't even using it when I was supposed to</b></p> <p><b>(Deirdre - second birth, Conventional AN1 141).</b></p>
Pain relief not offered		
<i>Positive comments</i>	<p><i>Pain relief not required as expected</i></p> <p><i>'I didn't worry about it - I didn't really need it - but I just wanted to have it there...they didn't offer it'</i></p> <p><i>(Sheila - study birth, Conventional PN1 1255...1271).</i></p>	<p><i>Alternatives used</i></p> <p><i>'And I found that I didn't need any pain relief at all, I just sort of went through the birth really well'</i></p> <p><i>(Angela – first birth, Natural AN1 134).</i></p>
<b>Negative comments</b>	<p><b>Not given wanted pain relief</b></p> <p><b>'they only let me have gas – I breathed gas for two hours solid, terrible pain'</b></p> <p><b>(Cindy - second birth, Conventional AN1 107 ).</b></p>	<p><b>Regrets about not having had pain relief</b></p> <p><b>I wouldn't even consider pain relief, whereas maybe I should have...There were times there that I really didn't cope as well as I thought I did</b></p> <p><b>(Angela - first birth, Natural AN1 1115).</b></p>

Pain relief available to women can also be non-pharmacological, including the use of hot water, massage, hot packs and social support. Referring to these as forms of pain relief, which they are, avoids the natural/ technological opposition which suggests that the only alternatives are to accept pharmacological analgesia or heroically 'do without anything'. Tessa starts by saying that she 'didn't have anything' – and then includes the hot pack

Interviewer: What did you find helped most?

Tessa: Um, yelling, believe it or not. I didn't yell with D... No, it was sort of a low-pitched growl with D, but no, with A, I screamed. So he's going to be - I'd say he'll be a very loud child. But, no, nothing really seemed to - No, I tell a lie, a hot pack, because I had a lot of back pain, and the nurse said to me to pull it away every now and then because it just gets hotter and hotter, but every time the poor nurse went to touch it I'd just about rip his arms off. 'Leave it there' (study birth, Natural PN2 144-162).

Tessa's account highlights the point that 'natural birth' is a lot more than 'doing without anything' because it involves non-pharmacological technologies, like a good supply of hot water and staff who are experienced and free to give positive support. It also involves a particular relationship of the woman to her own embodied sensations. Her description of the study birth experience of handling the intense phase of labour using non-pharmacological pain relief provides a good illustration of this and of many of the other issues already highlighted in this Chapter including: the fact that natural labour is intense and painful; the role of uninhibited bodily expression (screaming, yelling); the active presence of the child who is being born (and the effect on his or her character); the interior focus of the experience (concentration, hostility) and the bonding to the midwife ('she was lovely').

Oh, extremely painful but, well I didn't have drugs, I didn't tear, the baby was fine, he didn't need anything (Tessa – study birth, Natural PN1 51).

I have to concentrate on what I'm doing because otherwise it just hurts too much. But they were great. The midwife was really good - yeah, she was lovely (Tessa, study birth, Natural PN1 186).

Tessa, who had read some 'active birth' literature, explains quite well the way in which she uses an interior focus on her own sensations to cope with the pain. She seems to have developed a successful strategy to cope with her very rapid labours. Other women describe trying to sleep, watching the monitor or lying very still as coping strategies, but most of these required pharmacological pain relief.

The interviews link pain relief methods in a hierarchy, the order in which they are offered by midwives and expected by women. Cindy describes her method for handling labour, which is rather more passive than Tessa's.

I'm real quiet when I'm in labour - I just lie on my side - I can't bear to be on my back, that's really uncomfortable, the pain's just agony - but I just try to breath through it and when I can't then its the gas! (Cindy recalling previous births, Intervention. PN1 23).

The women acknowledge that use of gas in childbirth has positive and negative aspects

they put me in a big hot bath and I managed to get some sleep and I sucked the gas bottle dry (Kate - study birth, Conventional PN1 33).

I got into the gas pretty well which made me sick, so every time I had a contraction, afterwards I'd be throwing up, but it was worth it – I couldn't have [done without it] (Laura- first birth, Intervention AN1 584).

And most women described it as a form of intoxicant:

...it makes your head spin and you go a bit funny, really psychedelic. (Cindy first and second births, Intervention. PN1 25).

It really spins me out, the gas, I feel like I'm on a different planet. That's probably normal. I don't know what other women say. Do they all say that? (Laura - study birth, Intervention PN1 859).

I know that if you have too much gas you'd go zippy and at the end I was pretty zippy. I couldn't speak – yeah, I might have had too much (Sheila - study birth, Conventional PN1 245).

The next step up the ladder is pethidine, a morphine derivative which is known to repress the baby's respiration, if given soon before the birth. It is still used in early labour but some women had absorbed the idea that it was better not to use it and refused it when offered. Sheila thought it was unwise and Julie felt that it was better 'for mother and baby' not to accept it, "pethidine makes you dopey even afterwards". The interviews indicate a shift away from offering pethidine but many women had positive memories of using it, or at least it made the pain harder to remember:

I had gas and I believe I did ask for pethidine and did get it - I don't remember. They tell me that I had pethidine as well...I would have had anything actually, I was begging for a Caesarean and they're saying, "No you can't, it's too late"(Laura - study birth, Intervention 246-256).

I don't remember (much), the pethidine, made a difference, blotted out a bit of it (Roxanne - second birth, Conventional AN1 36).

Oh no, I was fine - they gave me two pethidine needles and three penicillin, so I was a bit spaced out (Julie previous birth, Conventional AN1 163).

And I had a shot of pethidine - that's pretty good, it doesn't take the pain away, you can still feel it but it goes away quicker - so that you can relax more in between, you're not worrying about it. If you're lucky you might even get to sleep for a minute or a minute and a half before the next one (Cindy study birth, Conventional PN1 26).

Cindy and Laura both found that the drug made sleeping possible, but Laura also felt that it slowed her labour down.

I did have pethidine at about eleven, eleven thirty, which was probably the worst thing I could have done because it put me to sleep, which delayed the end result probably by a couple of hours (Laura - study birth, Intervention AN1 599).

Although women show a clear awareness of the natural, gas and pethidine levels of pain relief, no one spoke of wanting an epidural or of requesting one, except for Angela who



was having her third child after two frightening haemorrhages and a traumatic induction. Epidural anaesthesia does not appear to be on the normal menu for public patients. While it is controversial amongst natural childbirth advocates, because of side effects, it is an extremely effective form of pain relief. Angela was very enthusiastic.

Wonderful. I wouldn't have a baby without one. Just - I didn't even feel it go in - I think it was the pain from the labour, I don't know. And then half-an-hour later I was sitting up playing cards thinking, "This is great". You sort of just feel a tightening, not actually any pain (Angela-second birth, Intervention AN1 549).

Because of her special circumstances, she asked for and got an early epidural for her third baby, even though she was a public patient. Although there are fears that it increases the rate of forceps delivery and has side effects, such as backache and headache afterward, Angela's was obviously a very good epidural carried out in elective circumstances. Angela found that she was able to push the baby out without pain and made a quick recovery.

Well, see, it was good because there was no pain whatsoever, there was absolutely nothing, it was just pushing, and I really did get a strong urge to push, which I didn't expect. I expected forceps and an episiotomy and all that sort of thing but no. (Angela - study birth, Intervention PN1 255).

The issue of whether everyone should be able to make an informed choice about this kind of pain relief is an important one. Transcending the idea of the natural body may mean that women are more likely to choose this birth technology and miss out on the intense embodied experience described by Tessa. However, the idea that pain relief is a ritual in which you suffer at one stage in order to earn the right to go on to the next one, is not necessarily a positive one, as Cindy and Angela's early experiences show.

These forms of analgesia contribute to the three kinds of birth, the natural, the conventional and the technological. Each of these can be experienced positively and negatively. Beth and Tessa exemplify the issues involved in the social construction of natural birth, which can be facilitated by close emotional support from a midwife or the woman's own knowledge and willingness to 'concentrate' on her physical experiences, including giving vocal expression to the pain. This can be a very positive experience, though for Cindy the feeling that she was being denied anaesthesia for ideological reasons felt like a betrayal. In retrospect, Angela wondered whether her first birth, which at the time she had felt to be a wonderful experience, might have been better with an epidural. On the whole the natural birth category applies to younger women who had rapid labours together with the strong expectation that they were not going to use any drugs.

The conventional category is the one in which women felt that it is really impossible to go through labour without some form of analgesia, because there is no point being a martyr. Women had used gas or pethidine in previous labours espoused this point of view. In some cases, like Deirdre's, it was her partner who suggested that she took the pain relief. There is a suggestion of indulgence and intoxication about the way that women describe the effects of the drugs and they suggest that they allow escape from the pain into sleep. On the negative side, they describe the experience of being sick or spacey, and cast doubt on whether the drugs actually relieve the pain. Although this is the dominant category, there appears to have been a shift away from pethidine towards

gas only. However, there is still the expectation that you start off 'trying to be brave' and each level of suffering leads on to the next level of pain relief. For public patients, this rarely includes getting as far as an epidural, because it would be too late to arrange one. Women's own accounts suggest that this is a highly mobile category – slight changes in practice, such as a changed midwifery ideology or closer midwifery support, might change the uptake of drugs which do not relieve the pain, but distract from it. A clearer understanding that the woman herself has a choice of actively dealing with the pain with hot water and massage, or opting for an epidural might make this whole hierarchical procedure obsolete.

The intervention category is the one which most strongly violates the natural/technological distinction and shows the diversity of women's experiences. Angela moved, over her three births, from being a homebirth advocate to praising the idea of epidural anaesthesia. None of the other women discussed epidural as a possibility, even though many had painful induced labours. Laura in particular weathered two quite unpleasant inductions with only conventional anaesthesia and felt that she really 'lost it' the second time. Her story certainly suggests that an epidural might have been preferable to this rather harrowing experience. By contrast, Julie's labour was also induced, but she managed very well with only gas and she and her partner had all the ceremonies of looking in the mirror and cutting the cord, which are more usually associated with natural birth.

Like their uncertainty about the location of the agency in birth, women's accounts of anaesthesia were various and somewhat contradictory, in respect of the characteristics of pain relief, the comparison between births and even different accounts of the same birth. Just as the unborn baby was spoken of as an actor in the beginning of labour, so accounts of labour and pain relief include numerous references to the well-being and activity of the baby who is being born, including Tessa's idea that if the baby had pethidine, he might have fallen asleep and so slowed the labour. As the labour concludes, the baby him or herself is spoken of as an active partner in the birth and in the next Act they make their appearance.

### *Act Three – Interior focus and the moment of birth*

After all the pain, the moment of birth is the most vividly recounted. The woman at this point is both the main actor and also the object of the professionals' activities. One of the issues at stake between the alternative account of birth and the biomedical one is whose achievement this is – the woman 'giving birth' or the professionals 'delivering'. At this point the birth is very close, the uncertainty of the beginning and the difficulty of the dilation stage are over. This moment can be so intense that it has a timeless quality:

It felt like I was pushing forever, so - But I wanted to take it slowly so I wouldn't tear - I was sort of trying to do it that way, which I didn't, which was good... Yeah, I was really - I was proud of myself then (Angela - first birth AN1 333).

So, 'pushing' is an activity which appears to involve the woman's own efforts, reasserting her conscious control, but the power of the contractions and the relationship with the staff remain important factors. Women call upon knowledge of their own bodies in anticipating and managing the pushing stage. Kate asserted a superior

knowledge of her own body over that of the staff. She had told me from the beginning that all her family had quick labours, so she was sure that the study birth would also be rapid:

Then this doctor kept saying to me - she'd done an internal and she said - it was about half-past-six and she'd done an internal and she said "You're only four centimetres dilated". She said "You'll probably be a couple more hours". They wanted me to do something and I didn't want to do it - Oh, they kept saying "Your water's got to break yet and it'll be a couple of hours" and I said "No", I said "Once the waters break the baby will becoming straight out after it". "Oh no, no, no, that never happens". Bull it doesn't. The water broke at quarter-to-seven and I had her at ten-to. Two big pushes and out she came (Kate- study birth, Conventional.PN1 40).

Here again the baby is spoken of as an active partner, "out she came". Beth, whose fears had been allayed by being supported throughout labour by the same midwife, gave birth without any intervention and attributes the agency to her baby daughter, who 'came by herself'.

I probably started pushing about eleven. I don't know how I - I don't know, the nurse just said to me, you know, "If you feel like you've got to push, push" and I just started pushing...this time she just came by herself, so it was good...I was so glad. That really frightened me, to have stitches. I was really terrified about having to be cut and having stitches (Beth- study birth, Natural PN1 232...260...277).

Angela's birth was also rapid, despite the epidural:

Just a feel of pressure, yeah, it was a really strange feeling. It wasn't any pain or anything like that, it was just like a pressure feeling and the midwife said "Oh, there's the head" and she - so it was really quick. (Angela study birth, Intervention PN1 229).

The moment of birth is described in the context of the relationships with staff, both good and bad – up to now, staff may have come or gone, been present or not but this is the moment where everyone wants to be present, the midwives who have been on duty during the labour, the junior doctors who want experience, the partner, family and children.

They got the mirror and this time I watched and it made such a difference. R and I pulled him out and put him on my tummy. Dr M she was just beautiful and the Midwife - the same one as on Tuesday (Deirdre - study birth, Conventional PN1 27).

The accounts show the use of 'alternative' practices, such as watching the birth in a mirror and putting the baby naked to its mother's skin. But birth is a decidedly embodied event, not in any way ethereal. Just as coping with labour can be a confronting bodily experience, so the actual birth can also be a moment of abjection – babies are often streaked with blood and often covered with white greasy vernix. There may be mucous or a rush of amniotic fluid, which when it is clear has a distinctive smell, somewhat like seminal fluid. Sometimes the fluid is stained with greeny grey meconium, the labour can expel faeces which add to the smell and there is often bleeding. Kate, who had described herself as shy about being examined in labour, told her birth story as a carnivalesque farce

Then I climbed up on the bed, (and hit) the old gas bottle. That's the first time I had to have anything (PN1 101).

The end of the bed got a bit of a work-out - my fingers were killing me. I think they were still bruised when I came home. I had hold of G this side and this side cursing I ... I was climbing half-way up the bed, the back of the bed - I was on my side most of the time till my water broke. It took three of them to lift me and roll me over - I wasn't budging - But they wanted me to roll over before my water even broke and I just couldn't get over quick enough, so G just come over and my water broke all over the nurse. (He's) gone" Oh, yuk". It was a horrible sight, wasn't it? (PN1 757).

[The gas was] beautiful- I was that out of it - when my water broke I was still laying on my side, completely plastered - they didn't have time to get raincoats or nothing on. It was a lovely mess. I just looked at G and said" Yes, this is it". But she was a quick delivery - she was a good delivery (Kate- study birth, Conventional PN1 126).

Not everyone found that pushing the baby out was easy and quick. Laura was expecting a 'transition' followed by 15 minutes of pushing and she was concerned about the possibility of an episiotomy. Instead, the more corporeal issue of having an empty bladder became significant:

They wanted me to go to the toilet to start with, to empty it out, they said that would be easier, and they really nagged and nagged and nagged me to do that and I just couldn't - I just couldn't do anything- I didn't care whether I went or not -and then they said "Start pushing" which I did, and it was frustrating because I could see the head and then it would slip back, and this went on for probably three-quarters-of-an-hour, and I just felt like I was getting nowhere, I was exhausted in that time (Laura - first birth, Intervention AN1 708).

Knowledge from intellectual preparation does not always help. A birth plan and an abstract commitment to non-intervention can all be displaced by the actual events. A junior doctor who was anxious about the baby and the arrival of the paediatrician put pressure on both Laura and her doctor to act and she abandons her previous expectations about consenting to intervention:

And then when I started doing that the doctor thought that it was going to be close so she called the paediatrician -I think it was Dr. ..., I'm not sure so she called him in because C was in distress and her heart-rate was dropping, I think, by this time, so she got him ready, and then because I still couldn't get her out I think that's when she started to panic because "Well, I've got him here now so I'd better get this baby, you know, here", and I had said to N (partner) before, you know, no episiotomy, blah, blah, blah, and I said to him "If they want to do it, you know, make sure I'm aware of it, don't just let them go ahead and do it, I want to know what's going on", and so they said to me, you know, "We think that this is what you need to have done" and I said "OK" and N said "Do you know what they're saying to you?" and I went "I bloody know what they - just get it out" by that stage(Laura - first birth, Intervention AN1 722).

Laura's birth is the furthest away from the ideal of the alternative birth. Study births included diverse elements of alternative and conventional practices. Women mentioned watching the birth in a mirror, not having to have stitches, or that they or their partner lifted the baby out. Staff seemed to have been promoting these 'alternative' practices whether or not the birth was spontaneous or induced and whatever kind of pain relief had been used.

Act three contains the climax of the process of birth, the moment of transition between the baby emerging and taking its first breath. Whatever has happened up to now, the most important thing is that the baby starts to breath independently. This is a moment of great suspense and sometimes terror, whether the birth has been natural or highly interventive:

When I first pulled him out, or when she first gave him to me, he didn't cry, and I just said to her "What's wrong with him?" and she said "Oh, nothing, he just hasn't caught his breath yet", but he must have had a bit of yuk in his throat. But shortly after that he gave a little bit of a whinge, but nothing serious (Tess - study birth, Natural PN1 278).

The baby in Tess's account emerges as a separate person, with his own feelings and independent existence.

No, he was fine, he was fine. I think possibly because it was so quick, too, he didn't know where the hell he was (Tess - study birth Natural PN1 292).

The intense emotion of this moment is conveyed by Angela's story of her baby being delivered by the same SR who had been present at her previous post-partum haemorrhage. He had, possibly unfairly, been reprimanded in her hearing for the way he handled it.

He was wonderful – you couldn't have asked for a nicer man this time, he was absolutely wonderful. Because when she was born, like I said, she had the cord around her throat and they had to suck ... her head was just still ... so they could suck her out and that was fine and then she did come out and then they put her on my belly and I sort of - I went to pick her up and normally after the babies have got a little bit of - well she was just - she just flopped and she wasn't breathing and she was still blue and I just said "What's wrong with her? I think she's died", because just before her head came out the heart-rate monitor was going really erratic and what-not and I really thought she was dead and he said "No, she's not, she's fine". He put my hand down so I could feel her heart-beat... (Angela - study birth, Intervention PN1 387).

She vividly conveys the moment of fear before the baby turns from blue to pink and the touching intimacy of the doctor reassuring her by touch that her baby's heart is beating.

### *Being together after birth*

During the labour, the women's stories are centred on themselves, they have no decisions or social responsibilities apart from giving birth and everyone else arranges themselves around this fact. After this peak moment during which the baby starts its independent existence, emotions remain high.

M (partner) said it didn't happen this way but I'm sure it did. I'm positive Teresa (the midwife) told me to put my hands down, so I reached for the baby, and I'm sure I pulled him out. M was at my head so he could only see what I was seeing, but I'm sure that's what happened, because his shoulders and everything were out and I couldn't see the rest of him, and I pulled him up onto me and we cleaned him up a little bit and then I fed him too... so I was in there for about forty minutes with him. (Tess - study birth, Natural PN1 240).

There is the need for sociable celebration with family and friends but also practical issues of dealing with the placenta, stitching tears, bathing and food. The slow reassertion of everyday life begins. Laura and Angela describe how they felt immediately after births which had involved a good deal of intervention.

Well they stitched me for about an hour after the birth...Oh it was a bit painful, but I was sort of over the moon then and I wasn't paying attention to that - I was just sort of lying there and I was more interested in what else was happening. C was alright and they (sucked) her out and wrapped her up and I had a bit of a look and then everyone else had a nurse because I couldn't sort of hold her much...- I was - yeah, a bit shaky... Yeah, (she had) a little bit of really dark hair and wrinkly and pink and beautiful. (Laura - first birth, Intervention AN1 828).

Even though the birth had been difficult, Laura felt 'over the moon' but Angela had been disappointed about being 'stuck to the bed' while everyone else looked after the baby.

And then all I ... with the other two, I was strapped to the bed, I couldn't get up, my husband sort of went and weighed the baby and bathed the baby and what-not. I couldn't have anything to eat or drink and they might have had to take me to theatre and what-not, couldn't have a shower, whereas this time the epidural wore off I went in and had a shower and had something to eat and my other children came into the labour ward after I'd had her and then everyone went home and we took her up and bathed her together and so it was really good. (Angela - study birth, Intervention PN1 313).

Whether they had intervention or not, many women felt shocked and shaky during this time,

I went and had a shower and I think I went straight from there and watched her have her bath, but I couldn't stand up - I kept feeling like I was going to faint every time I stood up, so I sort of watched that, and it was about seven o'clock, I think, by that time. (Laura - first birth, Intervention AN1 920).

I went into shock with D [first baby], physically shaking - I couldn't hold him... Mm, I couldn't hold him at all. They did give him to me straight away but I nearly dropped him and they had to take him away, but no, not with A [study birth] - I didn't get - I think I knew what I was in for, too, and I was prepared for it. I'm very pleased that they were both fairly short labours - D was only four hours, so if I have any more I won't make it across to the hospital (Tess first birth, Natural PN1 306).

Practices in the immediate few hours after the birth are changing in response to alternative ideas possibly because of the existence of a birth centre at the Teaching hospital leading to an interchange of staff and ideas. Women were aware that practices had been changed: babies were not rushed away for washing and early procedures were done in the room. They appreciated that they were being left alone with their baby and the family, and encouraged to feed the baby straight away.

Everything, the bare weight, the measuring, with L, which was only four years ago, was taken down in the nursery, but now it's all done in front of you - which is a good thing, I think. Because if she had've had oxygen down in the nursery I'd be thinking Oh, what's going on, what are they doing, whereas I could visually see it, that she was really OK. And we actually got a chance to give oxygen ourselves which was good. (Sheila - study birth, Conventional PN1 467).

Much of this type of alternative practice is motivated by the concept of 'bonding' and the desire to have breast feeding established very early. De Vries (1984) describes the way in which such socio-biological concepts generate interventions which can be easily fitted in to a medical setting – even to the point that they become normative, whether the woman wants them or not. The reports of these bonding practices are pervasive, by women who had intervention as well as by those who had normal or conventional deliveries, so this is obviously practiced wherever possible. While this effort is made in respect of the woman and baby, these accounts do not show a wider social awareness, of the importance of keeping partners and supporters around, of the women not being left alone. In the 'bonding model', it is the mother child pair that is the important focus, other relatives may act as a distraction to the important issue of establishing bonding.

The layout of the hospital, especially the way women had to move backwards and forwards between rooms makes having a lot of people around difficult, especially at night when other women and babies are asleep. Part of the definition of a 'good patient' is that their supporters are under control,

Probably a good patient would be a patient that didn't have fifteen people in tow and expect them all to come through the birth and the labour with them (Nicki, MW 188).

Julie might possibly have been one of the people the staff found too gregarious. She said she had visitors already coming to see the baby in the delivery suite, so 'they kicked us out'.

We had visitors coming and going - J got his mum, quite civil in same room with his sister. We had to throw them out at 9pm - except C (best friend, birth supporter) –they didn't want to walk home in the dark (Julie - study birth Intervention PN1 79).

After a short period of sociability, relatives and supporters are expected to leave to allow the woman to rest. In several cases, this meant that partners left to transport elderly relatives and children home, leaving the woman alone. If, as was reported by some women, the staff are working elsewhere on a busy night, women felt abandoned and the 'alternative' policy of not aggressively cleaning up after the birth meant that they were sometimes left alone in a pool of blood, with a desperate need for a shower.

They showed me how to put her on the breast and N had to go - he had to take J home, Mum and Dad had to go so they all just sort of vacated and - including the hospital staff - and me still sitting up on this bed, still in the condition that I was in from labour, with this baby there (Laura - first birth Intervention 864).

It wasn't several hours, no. To be fair it was probably about two...Well I ended up getting up and saying "Could I have a bath - like, a shower?" because they just disappeared. But they do that to give you, like, time with your family, which is fair enough, but ...(Sheila - study birth Conventional PN1 640).

The social effects of the change in policy are not completely addressed, It is not clear why relatives and supporters have to leave so quickly or why they could not have a role in holding the baby and assisting the women in the shower. This is a particular cultural construction of the length of time women need to have their family and supporters near

them. In the alternative birth community cleaning up, going to the shower and handling the baby, keeping him or her near to the new mother are all tasks done by supporters in a convivial atmosphere, the problem is that the hospital is professional territory and if the staff are busy, they do not appear to delegate these functions. After the initial few hours cleaning up from the birth and spending time with the baby, the process of returning to the normal social world continues as the woman and baby are transferred to the ward.

#### ***Act Four- Breastfeeding and the return to the social world***

Just as the hospital was not a neutral space for the beginning of labour, it also shapes the emotional and physical stresses of early motherhood. The rooms themselves were invested with meaning by some women. For instance, Julie was disappointed that she hadn't got her 'lucky' labour room, but was delighted to be put in bed 19 in the ward, which she had been in before and which she felt was a good omen. Women spent between eight hours and five days in hospital, depending on the health of the baby and their own needs and wishes. The system acknowledges that women need their own space in these few days. In principle, as the midwives described, women have a home base on 'the floor' and return there after the birth. Most people found it more homely and easier to rest in the 'the Annexe', which is for women who are well and whose babies are not having problems. There are fewer staff there and more space, with less likelihood of being disturbed by women in labour or other women and babies.

Speaking about this stage, women expressed a primary need to rest after the physical challenge of labour. The staff priority, on the other hand is to make sure that breastfeeding is established, so that the baby has the best chance of being breastfed for at least two months. Some women also placed a high value on being able to breastfeed, others found it hard to adopt and the practices meant to promote it contradicted their feeling of wanting to collapse in sleep. Like labour, breastfeeding is an intensely physical, even erotic experience with strong emotional overtones. There is a distinct need for a safe, private space in which to come to terms with these new experiences and to recover from the birth experience. Just as labour is a private, corporeal process carried out in a semi-public setting, so is the establishment of breastfeeding. Although the physical challenge of establishing breastfeeding is not as intense as that of giving birth, it is also similarly less frequently observed in contemporary society, so women have less practice and less experience of seeing other women breastfeeding.

There is such a diversity of practices and considerable change in culture between generations so that women very frequently receive contradictory advice from relatives or even practitioners. The previous conventional practices of hospital birth between the 1930 and the late 1970s were to remove the baby to professional care, bottle feed and allow the mother complete bed rest for up to ten days, and this regime is still part of people's knowledge of childbirth, reinforced by relatives' stories and the practices of older midwives. Contemporary policy effectively reverses this priority, leaving the baby with the mother continuously. This is called 'rooming in', and is in some ways a response to the alternative critique of hospitals, but is also grounded in psychological



theories of attachment and the behavioural research of Klaus and Kennel as well as biomedical research about the value of breast milk to small babies. De Vries (1984) points out that more energy has been invested in changes which are grounded in such ideas, than in demands for changes which are purely social in character.

Changes in feeding practice created an area of tension at Town hospital where rooming in had been adopted relatively recently. The head of midwifery told me that they could not implement a 'baby friendly hospital' programme, because it was not culturally appropriate in this hospital. Traditionally midwives calmed the baby with water or formula (comp feed) so that the mother could sleep. The new policy was for the mother to breastfeed the child whenever it was crying and this appeared to be a major issue for staff because they could not protect the mother's rest in the way that they had been used to. A memo was sent out pointing out that midwives who gave 'comp feeds' to babies without a signed consent form from the mother were guilty of administering a medication without consent and would be disciplined. This effectively disrupted the old system, because if midwives have to wake a woman to sign a consent form, they might as well let her feed the baby. The incomplete transformation of infant feeding practice, which is in process, is represented by women's ambivalent attitudes to 'rooming in', feelings of having 'breast feeding pushed at you' and the experience of receiving 'contradictory advice'.

Like labour, establishing breast-feeding encompasses the material, emotional and cultural being of women at a point of transition, between the intensity of labour and the transition to everyday life. It is the subject of similar discourses as childbirth, a discourse of 'the natural', a discourse of resistance to medical interference and a discourse of scientifically demonstrated efficacy. As with birth these critiques are elided as if they exactly coincided, but in fact they have somewhat different emphasis.

In alternative birth circles, natural birth and breastfeeding go together as radical resistance to technology, drawing on the first two of the three discourses – that breastfeeding is natural and a measure of resistance to medical domination. On the other hand, the Nursing Mothers' Association (NMA) which developed in the 1970s as a strongly consumer focussed movement, is somewhat more conservative in feminist terms than the natural birth movement. It draws on the first and third discourse, asserting the scientific superiority of the 'natural' in its attempts to influence professional opinion and practice. Reiger (2001a) suggests that it was somewhat less confrontational than the natural birth movement and so more successful in introducing new ideas to hospitals (See Blum & Vandewater, 1993 for the equivalent organisation in the USA).

There is no doubt that even though NMA are a non-professional, volunteer organisation they have developed a highly successful set of practices designed to promote breastfeeding in industrial society. They produce leaflets about how much rest, fluid, nutrition and housework women should do, they have a set of diagnostic techniques for discovering why babies are not feeding satisfactorily, support groups and a help line to assist women. In short they have designed an 'orthodoxy' to recover this method of infant feeding from the devastation caused by twentieth century medical advice and hospital promotion of bottle feeding. Even though midwifery lays claim to expertise in this area, it appears that the midwives' advice is not as consistent as the NMA orthodoxy, because of the different training regimes and the varied professional

identities that midwives adopt and this was borne out in the interviews with both women and midwives.

Like labour, breastfeeding is not so much 'natural' as it is a culturally shaped embodied experience. No doubt the NMA regime works for most of those who embrace it, just as the 'old fashioned' labour ward practices were valued for allowing women to rest. In many societies women carry babies in slings and feed them virtually continually (Robinson, 1999) which would be a very different subjective experience, somewhat similar to very alternative practices in the homebirth movement (Umansky, 1996). In Europe before the twentieth century it was common for upper class women not to feed their own children and for working class women to be wet-nurses (Salmon, 1994) while in contemporary society the idea of feeding someone else's baby is quite abhorrent to some women and practiced by others. Breastfeeding women are not functioning in a context where there is a taken for granted body of knowledge, but many contradictory discourses.

Breast feeding emerged as an important issue at post-natal interviews elicited by discussing the new baby and including anecdotes, reminiscences and comparisons with previous children. The diversity of women's approaches to breastfeeding and mothering are evident in the interviews, showing both the scope for cultural shaping and women's individual creativity in the way they invoke the different strands of discourse. Women seemed rather less passive with respect to breast-feeding and more likely to demand action from professionals or take decisions contrary to professional advice.

The discourse of the natural in respect of birth and breastfeeding places them in an intermediate zone between different bodies of social knowledge and the realm of the professional. Returning the responsibility of handling intense bodily sensations to the woman may be empowering as the alternative critique suggests, but the lack of familiarity and social support means that women can be paradoxically isolated. In hospital wards women may be in public view, disturbed by other mothers and babies, and very alone with the unfamiliar sensations and emotions. At home, they are often left alone, in some cases to arrange an elaborate christening party or subjected to contradictory advice from family.

### *Multiple styles of managing breastfeeding*

There was a wide range of experiences and practices of infant feeding, even though it was set in a climate of breastfeeding as the new norm. In the following section I identify four different styles of managing breast-feeding, which are identified in Table 6.4, column one. Four women were natural/nursing mothers, they were enthusiastic about breast-feeding, were willing to stay home to facilitate it and they invoked either alternative lifestyle or conservative ideologies to justify that decision. Three others, the 'scientific/working mothers' were women who needed to tailor breast-feeding to work, who were determined to persist because they believed it to be the healthiest option for the baby and who obtained professional support to learn how to express milk and maintain lactation. The two I have called old fashioned/subordinated style were the women who invoked either problems with milk supply or problems with managing their family as justifications for giving up breast-feeding, despite professional pressure to do so. This style is subordinated because it is not professionally approved, even though some of the more conventional midwives appear to have a sympathy for it. I have put

Angela in a category on her own, as ‘post-modern’, because she was willing to defy professional advice and create her own identity around competent motherhood while switching to bottle feeding even though she had no physical problems to justify her doing so.

**Table 6:4 Breast-feeding experiences from post-natal interview (around three months).**

Name and breast feeding (BF) type	Previous Children (P) BF Experiences and time of weaning.	Study birth – Experience and weaning	Comments
Cindy Natural/ Nursing mothers	P1 Colicky prem baby 3 months	?Reflux Still feeding	Cereal in bottle 7 weeks (NMA unorthodox)
Deirdre Natural/ Nursing mothers	P1 No - Prem- baby P2. 3 weeks early – ‘too little milk’ P3. No problem 12 months	Still feeding at - very happy	Women must ask for the help they need. (conservative motivation)
Julie Natural/ Nursing mothers	P1. BF P2. BF but reflux	Still feeding	Raspberry leaf tea to promote milk (alternative motivation)
Sheila Natural/ Nursing mothers	P1 and P2 BF	Still feeding	Trying solids, ‘baby too thin’ (NMA unorthodox)
Beth Scientific/ Professionalising	P1 BF No problems	Still mostly Feeding	Back at work Expressing and bottle
Laura Scientific/ Professionalising	BF ?6months Weaned to cup	Still feeding	Wants to express at work
Tess Scientific/ Professionalising	P1 Gave up after a few weeks Bleeding nipples, pain	Still feeding	Help from Midwives 2 visits
Kate Conventional /subordinated	No information	Comp feeds then bottle Stopped BF at 3 weeks	‘took too much out of me’
Roxanne Conventional /subordinated	P 1-3 BF Too much milk	Gave up 8 weeks	Too tiring with other children
Angela Post-modern	P1 2/3 weeks – problem establishing milk supply P2 Six weeks. Allergy to breast milk	No problem but stopped at three weeks	Changed from “Dying to feed” to “Want my body back”

The second column in Table 6:5 shows women’s previous experience with breastfeeding and the third and fourth columns the experience with the study baby. Four women described some previous problems, either with establishing the supply or with a baby who was unable to settle, this was attributed to colic, reflux or an ‘allergy’ to mother’s milk. Deirdre felt that her experience of the inability to breastfeed underlay her experience of postnatal depression and her decision to have a third child. The distribution of ‘problems’ does not seem to be connected with breastfeeding type. Women who, like Deirdre, were determined to breastfeed went to great lengths to do so. Angela was not experiencing any physical problems but chose to change to bottle-feeding.

Most of the study babies were still being breastfed during the post-natal interviews, between three and five months. Five women were happily feeding and reported no problems. Four women reported problems, but of these only three had given up completely, Katie and Roxanne because they felt they could not give the baby enough milk, and Angela because she 'wanted her own body back', even though she felt pressure from the midwives to continue, because she had 'such a good milk supply'. Those who subscribe to the new breast feeding orthodoxy do so on different grounds, some appeal to ideas of the 'natural', bonding, family time and flexibility, others to appeal to scientific rationality and professional authority. However, there are other discourses shaping breastfeeding practice, on the one hand, remnants of previous orthodoxies which I have called 'old fashioned' which tend to be appealed to apologetically and, in one case, a rejection of the discourses of the natural or the scientific and an adoption of the discourse of rebellion against medical authority in favour of bottle feeding to suit herself. I have called this post-modern, because of the contradictory currents of identity running through the interview.

### *Looking ahead to combining mothering and paid work*

Although the focus of this research is on the actual act of childbearing, it is impossible to extract this completely from the understanding of motherhood. This is where the drama has its resolution, in the return to the social world. Chapters 1 and 3 dealt with the various ways in which feminist theory has addressed motherhood, as a rational choice, as a material disadvantage, as a more satisfying alternative to the world of work, and as an optional component of a post-modern identity. Table 6.6 groups the women according to their plans to combine paid work with motherhood. Three women adopted a 'Dual focus' and took it for granted that they would return to work, all three of these women had working partners, but they had very different levels of type and security of employment. Three 'Aspirational' women had plans for combining motherhood with paid work by getting better qualifications. Two 'Mothering identified' women had made a positive choice to stay home, even if that meant living on one income, while the two marginalized women would prefer not to be at home but are discouraged about finding childcare and employment. Only one, Roxanne spoke of being trapped by motherhood with no possibility of finding work and finding it exhausting.

Table 6.5 Four styles of combining mothering and paid work.

	Mothering	Paid work
1. Working as a matter of course or necessity.		
Beth	Shares with mother and friends	Starts at 4.30 in the morning
Laura	Living with mother	Returning from maternity leave
Tessa	Partner away a lot. In laws not helpful. Wary of other carers	Will be glad to get back to work (casual nights when partner at home).
2. At home, wanting more education		
Julie	Partner unemployed, helps with kids – "I worry about them more"	Would like to do Open foundation and midwifery
Angela	"Have to have a system which suits us". Partner helps with childcare.	Take turns to go to University
3. Making a positive choice to		

	Mothering	Paid work
stay at home.		
Deirdre	"I don't like to leave them with anyone else. The kids are my work"	"Felt I had to 'contribute' – the money was useful, but having to get mum and dad in to help We have a couch and a TV, we have enough"
Sheila	"Want to spend a lot more time at the school". Very community minded	"Don't intend to work. Being short of money makes you value things"
4. Would like paid work but can't arrange childcare		
Katie	"She stays with her Dad".	"I was good at customer service". Can't get childcare Buying second hand, the kids are happy with it.
Cindy	Children's mess and behaviour very trying Partner at work.	Enjoyed her work, but hours too long for family Can't afford childcare
5. Can't imagine paid work,		
Roxanne	Kids "wear you out" Haven't been to the cinema for two years	"I am working, kids are work".

### *Birth, breast feeding and mothering styles*

his concluding section draws together the birth, breastfeeding and mothering styles. Table 6.6 summarises the data from this Chapter to show that the combination of birth, breast-feeding and mothering styles are quite idiosyncratic and do not follow consistent patterns of identity. The rows follow the order of the birth style, arranged from the least intervention to the most. Contrary to the naturalist discourse that birth, breast feeding and mothering are continuous, female focussed experiences, Table 6:5 shows that both the women who had the most natural births were focussed on the labour market and saw breastfeeding as a matter of professional knowledge, rather than embodied wisdom. The four women who had conventional births were divided between those who followed breast-feeding orthodoxy and those who followed the subordinated 'old style'. Of the four women who had birth intervention, two followed breast-feeding orthodoxy, one had a professional attitude to it and Angela rejected the 'breastfeeding' identity and constructed her own ideal style of motherhood.

Table 6:6 Birth, breast feeding and mothering style in order of degree of study birth intervention (least to most).

Name	Study birth	Labour	Analgesia	Birth Comments	Breast feeding style	Mothering style
Beth	Natural	Spontaneous	Heat/water	Continuous support	Professional	Dual focus
Tess	Natural	Spontaneous	Heat/water	Short labour	Professional	Dual focus
Deirdre	Conventional	Spontaneous	Gas	Could have done without	New orthodox	Mothering identified
Kate	Conventional	Spontaneous	Gas	Slower than previous	Subordinated	Marginalised
Roxanne	Conventional	Spontaneous	Gas	No pethidine this time	Subordinated	Oppressed

Cindy	Conventional	Spontaneous	Pethidine	Previous bad experience	New Orthodox	Marginalised
Julie	Intervention	Induction	Gas	Also hot water, very positive	New orthodox	Aspiring
Sheila	Intervention	Augmented	Gas	Pleased not to be induced	New Orthodox	Mothering identified
Laura	Intervention	Induced	Pethidine	Terrible – wanted a Caesar	Professional	Dual focus
Angela	Intervention	Augmented	Epidural	Changed from homebirth to epidural	Postmodern	Aspiring

These are very small numbers and so the data can only be discussed descriptively. However, the birth style does not seem to be closely associated with breast feeding and mothering style. In this group, natural birth is associated with professional and work orientation and the woman who was most committed to a natural breastfeeding and mothering style had experienced quite a lot of intervention. The conventional birthers in this group may be the women with less ability to influence their experience or to construct it positively. Deirdre enjoyed breast feeding and was happy to be identified as a mother, she came very close to having a 'natural' birth, but her husband persuaded her to have gas. The other women in the conventional group either felt marginalized in the labour market or otherwise unhappy with how life had turned out, two of them had rejected breast feeding orthodoxy, but they were not able to construct it in such a positive way as Angela.

Motherhood practices do not seem to correspond exactly with the type of birth experience, which would be expected, if people adopted them as a form of identity or ideology. For instance, Laura and Beth were at opposite ends of the spectrum in their birth experience, but they are both returning to full time work. Deirdre and Sheila were conventional in their births, but are the most committed to full time mothering and appeal somewhat to an alternative ideology. Roxanne also had a conventional birth and is also at home full time, but feeling much less happy about it. There is a complexity in the issues of desire to work, feelings of responsibility and possibilities of arranging childcare, financial security and the role of the partner which means that patterns are blurred

### *Feminist critiques and motherhood*

The different options which women adopted to manage their lives after childbirth, can be usefully discussed in the light of the feminist critiques of childbirth, discussed in Chapters 1 and 3, while acknowledging the limitations of the analysis. I suggest that the critiques are most useful as lenses through which to examine the issues, rather than being seen to represent actual modes of being.

In the materialist critique, the most important issue is not the physical experience of birth and breast feeding, but the lack of equality in both the external and internal division of labour once the baby is born. Apart from Laura and Beth who were in paid work, the women I spoke to were primarily dependent either on their partner's earnings or on government benefits. Julie and Kate were in partnerships in which the male

partner was less employable than they were due to injury and the difficulty of finding manual work and both of them envisaged returning to work or education in the future, but neither of them mentioned the possibility of relying on their partners for full-time childcare. Most partners were said to be helping with childcare and some domestic tasks, but the interviews with the women do not depict men taking equal responsibility. Even so, half of the women spoke about work as a desirable part of their life plan and thought of ways in which they could improve their education, so they were managing this aspect of their lives to some extent, combined with their apparent executive responsibility for homes and children.

As I have described the radical or cultural feminist position on childbirth, it involved appreciating the pleasures of the female body in birth and breast feeding and valuing the simple life that allows time to enjoy the sensual pleasures of motherhood. Sheila and Deirdre both appeared to subscribe to this view of life. Sheila's country existence was slightly more 'alternative', while Deirdre's values seemed to be quite conventional, though she adopted an anti-consumerist stance and was a passionate advocate of the pleasures and achievements of breastfeeding, possibly gleaned from her independent midwife's antenatal classes. This conjunction raises the issue of whether 'cultural' feminism's valuing of motherhood places it so close to conventional ideas about motherhood that it is indistinguishable from them.

Roxanne's experience did not fit into any of categories of feminist critique, she seemed to represent exactly the oppressed situation which second wave feminism sought to remedy. She had worked in the same processing plant as Beth before her children were born but did not want to return there, she was not using her time on family benefits to plan a return to work or education, nor was she relishing a non-materialist existence, taking pleasure in the sensuality of her baby. The discourse of any of the strands of feminism might have impelled her to think about changing a life that she seemed to find tedious. She regretted the loss of her figure and her inability to go out and couldn't wait for the latest baby to grow up, she seemed to be the casualty of a rather traditional 'femininity' in which women are objects of desire rather than authors of their own lives.

Angela on the other hand, was at the other extreme and stands in this analysis for a post-structural position. The high level of intervention she had experienced had not diminished her sense of control, if anything it had enhanced it. She was in control of the circulating discourses about natural birth and parenting and chose the elements that suited her. She took great pride in her autonomous decision-making and although she said that motherhood was not something she had planned on at this stage in her life, she was proud that she had taken control and had a happy, contented baby despite rejecting professional advice and scientific knowledge. She described mothering as a skilled occupation, she and her partner appeared to be the most egalitarian couple in that they envisaged taking turns to be at home with the children and alternating going to University to improve their qualifications. The rapid shifting of identities, the taking responsibility for rejecting professional advice makes Angela stand out among this group and suggests a post-modern sensibility, in which motherhood is an important but subsidiary part of a woman's life, and in which she has possession of her body, only temporarily to be 'lent' for the purposes of motherhood.

## *Conclusion*

In this chapter, the story of birth has been re-imagined based on the data from the interviews with childbearing women. The theoretical issues that have been addressed in this account are those raised in the opening chapter of the thesis, broadly, the problematic status of childbirth as it is conventionally treated in feminist theory. The analysis illustrates the theoretical potential of childbirth when it is treated as both socially constructed and embodied, this analysis accomplishes the theoretically important tasks of avoiding both biological and psychological determinism, while emphasising the plasticity of the corporeal event as well as the degree of uncertainty and bodily limitation involved. This treatment of childbirth leads to an understanding of the diversity of women's experience of childbirth and avoids any reliance on an opposition between a socially constructed 'natural' and a supposedly objective technological mode of birth with their attendant political and theoretical ideas about the power relations between men and women, patients and carers, midwives and doctors. It has been an empirical demonstration of the application of post-structuralist concepts to childbirth and maternity care (Annandale & Clark, 1996).

The story has addressed the women's perspectives, but without granting them epistemological privilege or relying solely on the authority of experience. Rather women's accounts have been situated as the products of social structures, cultural discourses and unconscious causation. This understanding of birth illustrates Foucault's thesis that both soft and hard human sciences have a tendency to 'objectification' whereas anthropology and psychoanalysis leave space between the subject and the object for comprehension and mutual influence. In my analysis, the woman giving birth is the central figure at the crossing of the axes of consciousness and culture.

By following the women through the drama of birth from the beginning of labour to the resumption of ordinary social life with a new baby, this Chapter has addressed three issues of key importance to my argument, firstly the necessity of understanding labour in a way which overcomes the separation of mind and body, secondly, the ways in which the regime of the hospital including its practices of intervention and pain relief shape the course of the labour as well as women's experience of it and lastly the diversity of women's relationships to 'the reproductive metaphor'. In the next Chapter, I continue this argument by examining hospital practices in the light of the three feminist utopias discussed in Chapter 1.



## CHAPTER 7 THREE CRITIQUES OF MEDICALISED CHILDBIRTH PLAYED OUT IN PRACTICE

Chapter 7 follows the argument of Chapter 1 that the 1970s feminist and non-feminist critique of medicalised childbirth was not, as frequently appears, a single argument, but three separate critiques that attacked the regime of hospital childbirth as unsafe, unnatural and unfair. These critiques are: that medicalised childbirth is ineffective and can be harmful, that medicalised childbirth is unnatural, ignoring the potential of the female body to give birth normally and that medicalised childbirth is unfair, because it is centred on private obstetric practice, does not meet all women's needs equally and that a midwifery centred practice would pay more attention to the needs of the disadvantaged. Just as Chapter 6 was an analysis of women's accounts of childbirth in the light of the cultural and theoretical issues raised in Chapters 1 and 3, so this Chapter explores the extent to which the three critiques outlined in Chapter 1 are relevant to practices and beliefs within the study hospital. This Chapter introduces the voices of the staff as the principal contributors, thus adding another facet to the material in Chapter 6, the women's construction of their childbirth experience.

Each section of this chapter reviews two or three issues highlighted by a particular feminist critique and considers their relevance to the study hospital and the women who use it. Particular emphasis is placed on the extent to which the critique has had an impact, or not and the extent to which it is questioned by a post-structuralist revisioning of the issue.

### *Critique 1. Medicalised childbirth is ineffective and can be harmful.*

Discussion of the effectiveness of medicalised childbirth deals with three key issues. First, the extent to which concerns about 'physiological labour' and the side effects of drugs used for analgesia and the induction or acceleration of labour appear to have been taken up in this hospital. Second, the role of EBM, how it is spoken about and how the discourse of evidence operates in the social and political context and third, the extent to which the hospital system allows or encourages women to make choices in decisions about birth.

As observed in Chapter 2, one strand of the critique of childbirth emerging particularly in the USA from consumer representatives like Doris Haire (1972) is concerned that the side effects of drugs and interventions make medicalised childbirth less safe than it claims to be. They argue that removing intervention and promoting more suitable 'physiological' practices such as upright positions in labour would be more effective.

A second strand of the debate over effectiveness emerged from the Evidence Based Medicine (EBM) movement in Britain which, as described in Chapter 1, argues against the building up of medical practice by tradition, anecdote and clinical experience and maintains that many of the practices so developed have no evidence to support their effectiveness (Chalmers, 1989; Sackett, Richardson, Rosenberg et al., 1997). This version of the critique argues against many traditional obstetric practices, but also

expects alternatives to be rational and supported by evidence. This style of reasoning is sharply at odds with the other critiques, especially the ‘natural’ critique which gives most credibility to emotional and experiential evidence about childbirth. The focus of the EBM strand is any medical practices that are idiosyncratic and not based on evidence, especially where it is clear that there are very different rates of intervention for social reasons.

*Reducing interventions including the use of pharmaceuticals*

In this section, I examine evidence from interviews with doctors and midwives which bears on the discourse of intervention as potentially harmful, in relation to the use of pethidine as an analgesic, the use of epidural analgesia for the mother’s comfort rather than for medical reasons, and induction or Caesarean sections for social reasons. If the discourse of intervention as harmful had been influential, then these might all be seen as instances of the imposition of unnecessary risks of iatrogenic harm (Smeenk & ten Have, 2003:). In fact, the interviews show that decisions about these practices take place within a calculus of risk, between ‘what women want’ and what the doctor thinks will produce a safe outcome. Against the assumptions of the critique of medicalization, women are not assumed to be opposed to intervention; in fact the staff often cast women in the role of demanding intervention rather than rejecting it.

An example of the discourse of intervention as harm was outlined in Chapter 6, when Julie refused pethidine because she thought it was bad for her and the baby. There was also some indication in the interviews with the women of a change, since their earlier births, in the way analgesia is used. From their accounts and their perceptions of the care they were offered, it seems that pethidine is less commonly employed now than in the past. This was partly supported in the interviews with professionals, though they tended to downplay differences between practitioners, between places and between times. Even when changes were noted, they were not explained by the concept of ‘harm’. The idea that hospital practices might cause harm in the past or present is not readily countenanced and it certainly does not seem to be a subject of conversation.

There appears to be a disagreement about whether, in the scale of increasing analgesic techniques, there is still a role for pethidine or whether epidurals are preferable as the last resort. Robert, the more conservative of the obstetric senior registrars, said that he would consider women’s requests for epidurals, but “I’d like them to try nitrous and pethidine first - try everything else” (Robert, SR 35). Ruth’s position is more representative of the midwives and junior doctors when she puts gas, heat and water together on the lowest rung of the analgesia ladder, (this was described as conventional birth in Chapter 6).

If she can’t cope with the gas, showers and hot packs - we get on to the RMO and assess them - where they’re up to. You can get caught though and the baby ends up in the nursery needing narkan (opiate antagonist) - we use so much less pethidine now. (Ruth MW 34).

Here she warns that if staff use pethidine too close to the birth, it will depress the baby’s breathing and this will mean a need for treatment after birth which will involve separation from the mother. Concern about pethidine use appeared at one clinical

meeting resulting in a protocol for paediatric assessment if a baby had received pethidine within three hours of delivery (Notes clinical meeting 1. 93). Even though pethidine was seen as a hazard, Ruth saw it as less risky than an epidural,

I don't offer epidurals unless they're high risk (from high blood pressure) They can back fire considerably. (Ruth MW 32).

So Ruth, who trained in the 1970s perceives a considerable change in Town practice away from pethidine, but Nikki who trained more recently at a city hospital, felt that Town was still using more pethidine and not enough epidurals, though she hesitates to sum this remark up as a criticism

They gave more epidurals at (City Teaching Hospital). They gave ... no pethidine, barely, whereas they give heaps of pethidine at Town, and I guess my inclination would be epidural before pethidine, probably, so that's - that's something I've noticed (Nikki MW 216).

The 'effectiveness' critique certainly points to a risk of harm from epidurals. Some women report long term headaches and paralysis and an epidural that goes wrong can require intensive care (see Lazarus, 1994:35). Table 7.1 shows some answers to my question about women choosing epidural anaesthetic for early labour, without having gone through the 'escalation' of techniques and without any other medical indication, such as high blood pressure.

Table 7.1 Would you agree to epidural anaesthesia in early labour

Name and position	Elective epidural
Peter VMO	Very few people ask for them (59)
Michelle – CMO	Most people are scared of them – negative image, side effects - never seen 'headaches', but have seen paralysis of breathing Can be good – let them wear off to push, baby happy Better to have an epidural than a bad birth experience (54)
John – GP	Multip – almost never been asked, happy if she understood the downside Primip – have a go first – most women are fine without, epidural can slow progress (43)
Robert – SR	I don't like to be told what to do. Agree if I thought it was appropriate – try everything else first, including pethidine. Have done them for women who were 1-2cm (31)

I was present in the unit when the staff were coping with the 'paralysis of breathing' effect to which Michelle refers in Table 7.1. This was obviously a cause for concern, and it must have been frightening for the woman, but there was also humour at the expense of the doctor whose epidural had 'gone wrong', which made me feel that the staff were perfectly confident that they could deal with the situation.

Peter, Michelle and John deny that many women would request epidurals, John would agree for a 'multip' who knew what labour involved but not for a 'primip', having her first child\*. Michelle thought that women did not want epidurals because they were afraid of them, and that this was unfortunate.

Used really well they're good - there are a lot of scare tactics around - you can let them wear off - a good working epi, the baby's happy and a normal second stage, you can

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\* Multip and Primip were often used in conversation to refer to women

push quite well with it in. They work if they're regularly topped up – (Michelle CMO 56).

Robert would not necessarily see such a request as 'appropriate' and reserves the right to make the decision. He insists on the hierarchical view of pain relief, trying everything else first. It is worth noting from women's experiences reported in Chapter 6, that Amanda's last epidural labour was an example of the 'good working epi' to which Michelle refers. She had earned the right to 'demand' an epidural because of her previous bad experience at the hospital. Laura's unpleasant induction experience may well have been an example of a labour that would have benefited from an epidural, if she had asked in time.

While the doctors give their considered judgement, as they are accustomed to doing for medical viva voce examinations which typically require a rapid and accurate response, the midwives respond in a different fashion, recalling cases as they actually occur day to day.

Some women, one in particular, wanted the epidural in before she started the labour, it was an induction. She got it. She thought the sun shone out of the obstetrician, mind you there was a lot of political backing from the husband (Rose MW 55).

It seems that the decision about pain relief has moral and social dimensions rather than being based only on considerations of medical risk.

Another example which highlights the issue of intervention as harm is that of induction, starting labour off with drugs (Oxytocin), through a drip or as a pessary (Prostaglandin). A sample case history about intervention reported by Oakley and Houd (1990), involved a woman who was three days before her due date who wanted an induction so that her mother could be present before she had to return overseas\*. Such a 'social induction' is a clear example of medically unnecessary intervention, so when this example was posed to the staff, it is interesting to see that there is a range of views about whether it is worth the risk.

Table 7.2 Views about social induction

Name and position	
Michelle – CMO – GP Trainee	Would like her to understand why we don't routinely induce – potential problems, I'd be reluctant, explore alternatives – send mum a video (98)
Ian – VMO	Yes, if cervix favourable – but nothing worse than failing to induce – clinic women say, "I want to be induced, last week he said he'd induce me" and I have to say no (227)
Peter – VMO	Tell her the pros and cons, would agree (101) Seeing an increased demand for minor reasons – husband's shiftwork, public holidays (62)
Robert – SR	Yes of course, with informed consent to slightly higher risk (109)

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\* The case histories are listed in Appendix 1

The answers in Table 7.2 invoke the concepts of women's preferences, informed consent, personal experience, side effects and the doctors' responsibility. The various shades of opinion go some way to explaining why women's experience of childbirth care is so complex. Some show a reluctance to intervene, while others see intervention as relatively unproblematic.

Michelle and Robert take opposite stands on this. Michelle is reluctant to agree but wants the woman to understand why she is refusing her request. Robert, who was most reluctant to agree to demands for early epidural anaesthesia feels that the social induction is unproblematic as long as the woman has given informed consent and Peter agrees with this position. Ian takes a more conservative stance and reserves the right to refuse if he feels that it will be unsuccessful. His reference to 'nothing worse than a failed induction', puts into context Amanda's 'horrible induction' referred to in Chapter 6, which seems to have been performed because the obstetrician was about to go on holiday. Midwives told me that the obstetricians varied in their willingness to induce for very slight reasons, for example "Dr. X is the best for them, he says, Oh, well, if she's uncomfortable..."

Oh, I mean, they seem to do them (inductions) at unbelievable stages - much earlier than anybody else thinks they should, including the paediatricians, again, that's another little power play at Town Hospital (Nicki MW 252).

Judging from Nicki's remark and from debates at clinical meetings there was some rivalry between obstetricians and paediatricians. The agreement to a protocol involving the paediatricians in the care of all babies who had been given pethidine was a minor victory for them. In the context of this discussion, it can also be seen as an admission that a previously common practice had been causing harm.

Apart from the pethidine issue, the discourse of intervention causing harm does not seem to have very much influence. Risks are acknowledged but the hospital is there to handle risk. If the pethidine is given too late, the baby goes to the nursery and the paediatricians check it out. If the epidural goes wrong, the anaesthetists can retrieve the situation. The atmosphere in the unit when this actually happened was one of grim humour and criticism of the practitioner involved, rather than panic. The senior midwife present said sarcastically,

Shall I phone him and tell him his epidural went wrong? And we had to call [another doctor]. Do you think we should, as a Quality Assurance measure? (Notes 81 36).

In contrast to the previous quotations, which seem to draw a utilitarian balance between benefits and harms, midwife Caroline's position was more ideologically committed. She used the word interference a great deal about birth practices and said that she had seen 'terrible things', including deaths of babies that she believed were due to the intervention of obstetricians. She puts the 'cascade of intervention' (Tew, 1995:33) argument, which does not so much concentrate on the toxic effects of individual substances as it does the possibility that one form of 'interference' will lead to others (Lumley & Astbury, 1980:105).

They've had the pethidine or they've had the epidural - well that generally leads to some other form of interference, then, because then the baby's - had the pethidine, the baby's heart-beat might go down and, you know, they might then need to have something else, or the pethidine could stop the contractions, which it often does - well

then they have to have the syntocinon and then the baby's heart-beat goes down because it doesn't want the syntocinon and so then, you know, on and on and on, and then they end up in theatre and you think God, why did you offer them that - they were doing alright (Caroline MW 104).

Invoking such a cascade of intervention does not carry very much weight though, if addressed to people who do not share the commitment to avoiding interference. As we have seen, other practitioners are operating a calculus of risk and benefit, within a cultural climate inside the unit that conditions every day practice and in a cultural context that conditions women's expectations and requests (De Vries, Benoit, van Teijlingen et al., 2001). Intervention practices are not so much ideological as they are the product of a micro-culture, each unit operates in a particular climate, the product of individual clinicians knowledge and experiences, women's expectations and the relationship between the two. Even within each unit, the midwives and the doctors have their own professional opinion about what is safe and appropriate to offer, which partly accounts for the disparity in women's experiences and the occasional confusion.

### *The social practice of evidence based medicine*

The calculus of risk and benefit I have described is operating within competing discourses of what the 'evidence' shows about harm and what women are likely to request, or what it is seen as appropriate for them to request. Understandably enough, what women want or are believed to want is balanced against what the doctors and midwives believe is safe practice. In this framework, this should be, and frequently is, based on high quality published evidence (Sackett, Richardson, Rosenberg et al., 1997), but inevitably, personal experience and authority play a part.

This can produce outcomes that must seem inexplicable for individual women, as they are given choice up to particular limits, but there are lines which, once crossed, bring into play evidence based interventions which the doctors are unlikely to ignore. The doctors' interpretations of these limits differ. One of these crucial points is how long overdue a pregnancy should be allowed to proceed which relates to the issues of 'when to go in' and 'when will labour start' which were the starting point for the last chapter. It is not likely that most women are aware of controversies over this issue. It was a point of dispute in the 'managed care' debate in Britain (Chard & Richards, 1977) and in controversies about independent midwifery (Mehl-Madrona & Mehl-Madrona, 1997). It has also featured in NSW cases where a midwife was deregistered (Nurses Tribunal Enquiry under Section 61 of the Nurses Act 1991, 1998).

Table 7.3 shows some doctors' comments about handling such a case. All the doctors are conscious of the risk of an overdue baby, but they vary in their tolerance from 7 to 17 days past the due date. They talk about options, recommendations and informed consent modified by what the woman wants. Michelle leans towards not intervening, if that's what the woman wants and would try a prostaglandin pessary to get labour started towards a more 'natural' birth. Robert and Peter both expect that women who are overdue will want to take action, but Peter concedes that a woman has the right to refuse intervention, once informed of the risk. However, the idea of making an informed choice is not simple. As one of the midwives said,

For the clinic patients, I'd like to think that the midwife, mother, registrar cooperated in making informed choices, but there's ways of presenting questions and ways of presenting questions. Do they really ask them open ended? I don't know (Margaret NUM 65)

Table 7.3 Choice of induction for 'post-dates' (12 days overdue).

Name and position	Induction for post-dates
Michelle – CMO – GP Trainee	12 days over, scan for liquor volume – have some options for the next two days - Is she happy to wait? Prostaglandins are good – end up with a normal vaginal birth (83)
John – GP attachment	12 days over, would recommend it – could wait another 5 – but baby will only get bigger (53)
Robert – SR	If she wanted, we could help get her started. I'd offer her an induction but I wouldn't insist (97)
Peter – VMO	I would tell her the evidence is better 7 days over, option of induction if cervix favourable. Monitor closely Her decision not to, if she understands the increased risk (89)

In response to the idea of risk, John said that his main concern is to persuade the woman to agree to action he felt was necessary.

(If) I'm worried and they're not, my main objective is to get them to behave the way I want them to without transferring my anxiety (John GP 72).

It seems likely that the woman gets a clear idea of what the doctors' preferences are. Given the lack of strong commitment to alternative childbirth practices amongst women and even an air of fatalism about hospital decisions described in Chapter 6, it seems unlikely that many women make strong representations against what they are being recommended to do.

As well as awareness of the evidence, organisational pressures shape the intervention of technology, rather than considerations of medical benefit. The consumer movement opposes electronic Fetal Monitoring (EFM) because it leads to women being confined to bed and lying down – which is not a good physiological position for labour. It has also been reviewed by the Cochrane collaboration and the evidence is that there is no need to do it routinely (Thacker, Stroup, & M., 2004 is the latest update of this review). This conclusion by Cochrane led to Oakley (1990) including the issue in her study and I also asked the doctors whether they thought that routine foetal monitoring reduces the perinatal mortality rate.

My gut feeling is that it doesn't - intellectually you hope that it does, though I think it mostly makes the doctor and the midwife feel better. There's no data to support it - We do it for something to do - we can reassure people anyway.

I think there's a place for it - but we overuse it especially when you're busy - you can hear without being in the room. It's no more effective than a midwife (Michelle CMO 129).

The technology substitutes for the lack of one to one staffing:

There is no evidence that it lowers the pmr (perinatal mortality rate). (It's) easier for the midwives, they don't have one midwife for each patient - usually one for each two or three (Peter VMO 115).

However, there is an indication of evidence leading to a change in the options women are offered. Table 7.4 shows doctors' comments about another debatable issue, how long to wait before an induction if a woman has broken membranes without labour, a condition which carries a risk of infection. Answers here range from four hours to two days. Robert's (SR) and Michelle's (CMO) responses reflect recent research to see if it is safe to leave women to go into labour themselves, a response to the critique of excessive intervention. John's (GP) answer, immediate induction, reflects a previous view rather than the latest evidence. The two VMOs hedge their bets, but lean towards intervention. It is worth remembering that Tess's 'natural' birth took place after her waters broke and she stayed home to finish her curtains. When she got safely to hospital, some of the staff felt that she should have come in sooner. Roxanne went to hospital because her waters broke on the way home from football, but that actually made the labour feel much longer than if she had waited until contractions started.

Table 7.4 Induction for ruptured membranes

Name and position	Induction for ruptured membranes
John – GP attachment	Wait another four hours and then start on synto (68)
Ian – VMO	Depends on where she lives and history Come back in six hours (229)
Peter – VMO	Hospital overnight, swab, induction next morning. If she refuses, go home and monitor temp (103).
Robert – SR	48hrs at home and then a drip to start them (113)
Michelle – CMO	No evidence to keep them in, swab, 48 hours then induce (104)

The differences in recommendations between different staff show how evidence based medicine operates within the social context of the hospital. The registrars who are preparing for exams are the ones with the most up to date information. At clinical meetings, the specialists referred to them for information. This was used to set the basis for protocols used by midwives and registrars for clinic patients. The VMOs reserved their judgement about their private patients and tended to make widely different judgements about clinic patients when it was their rostered time to consult, leading to confusion amongst women and infuriating the junior doctors.

VMO decisions could change in a matter of hours, depending who was on call. One woman was being induced and when the next VMO came on it was "stop the induction, send her home". Another woman had been seen by 3 out of the 4 VMOs and told to wait and see, the 4th one came in and said "That's it, Caesar her now". For a whole week we'd been saying It's OK, don't worry, the baby's fine, you can have a trial of labour and then all of a sudden she's having a Caesar and she's saying "what's happening?" We provide the backbone of the care but important decisions are differing according to whose making them. It causes confusion for patients and problems for us - made us look like fools. (Stephen SR 7).

Evidence based medicine is the gold standard, but doctors are only human. Personal experience and the teaching of respected elders still emerge as influential. I heard this



discussion between two senior registrars about techniques for delivering breeches vaginally, a practice that is dying out to the extent that a Caesarean section – a major operation - is seen as the more conservative option than trying to deliver the baby vaginally.

(SR 1). They say don't pull till you see the nape of the neck but actually you can as long as you pull down to maintain the flexion, if you pull out, that's going to cause trouble, but you can pull towards the floor. Not many people know that - I learned it from an old guy in (Coastal town).

(SR 2) Nearly all Caesars for Breech at Teaching hospital - I guess if you have a really bad breech then you think, you'll never have that again. The [obstetricians] practice more conservatively (Notes 21 10).

The specialists in their turn argue that they do repeat Caesarean sections and Caesar breeches because that is what women want, even though there is evidence that they are not necessary and they are widely criticised by the alternative birthing lobby. This SR showed the way in which the social aspects of Caesarean sections can seem persuasive. He illustrates his case with anecdotal evidence and personal opinion.

(I) would do an elective Caesar with informed consent. If I was a woman I would consider it. I can understand women not wanting dyspareunia. (In my) wife's exercise class women who had Caesars were having normal sex two months later - more comfortable than women who had vaginal births (Notes 81 13).

You know the date – the husband can take a week off work, be sure to be there. (You) know you won't be in pain and lose control and dignity. (It) preserves modesty - not put in lithotomy position have people observing intimate parts of your anatomy, being 'on show' (Notes 33. 32).

This very interestingly echoes the concerns with modesty and embodiment discussed in Chapter 6. For this highly educated obstetric registrar, whose chosen career involves dealing with labouring women everyday, a major abdominal operation with the possibility of infection and the pain of the healing scar appears relatively less important than the loss of dignity and the early resumption of 'normal sex'.

In all these cases, the 'evidence' appears to be internalised by the doctors as a balance of risks which they have to weigh up, rather than something external which they and the woman consider together. With a few exceptions, knowledge of the risk and responsibility for the outcome is retained by the doctors. It is not put on the table for consideration. Some doctors were said to be better at communicating though. Dr G (the 'lovely doctor' that Louise's daughter wanted to marry) was acknowledged to be very good at giving women reasons and choices.

Michelle, (CMO) she was wonderful. And she talked to me - it wasn't like I'm up here, I'm the doctor and I'm not going to talk to you. And that other man they have at the clinic - I've heard he's very good (Deirdre PN2 26).

(We should) try to get away from the idea that whatever we say is law and has to be done. People should have control of their own bodies. Dr ... (obstetric registrar) is good like that - he gives a thorough explanation, this is the consequence of doing it, this is the consequence of not doing it (Rose midwife 37).

### *Women taking part in decision making*

The idea that women should have the power to choose their method of birth and birth anaesthesia is a controversial one, it has been problematic since the late nineteenth century when doctors resisted women's desire for the 'twilight sleep' anaesthesia, which became so prevalent in the USA (Leavitt, 1980). The doctors see decision making as their province because they are responsible for the outcomes, as the senior registrar Robert said, "I don't like being told what to do". If one assumes that truly informed consent requires the willingness to treat women as equals, even if less informed, then the ways in which they spoke about their relationship to the staff is also relevant. Michelle and some of the other junior doctors were seen as people who 'didn't talk down to you', but not everyone felt that confident to make choices themselves. Women varied in the extent to which decision-making was something they felt able to do. They had different relationships with the hospital and its staff and different perceptions of what they wanted, and whether they were allowed or permitted particular courses of action. Some women's accounts of medical information were rather garbled, which indicates that they had not understood what they had been told, though they often shaped this information to meet their own ends, such as the desire to have or not to have another baby.

Interview material which bears on each woman's apparent ability or desire to make their own views known or to make choices, rather than accept what is offered is summarised in Table 7.5 Most women did not have the knowledge to make informed judgements or the social power to enforce their own wishes against the routines of the system. To that extent they are still somewhat dependent on the authority of the practitioners. Women's descriptions of relationships with carers showed that they valued egalitarian styles of communication, with some emotional empathy and these qualities were not gendered but appeared in accounts of both male and female practitioners. Roxanne preferred her previous more traditional obstetrician to the egalitarian midwives clinic, "I wish Medicare had never come in. He was an excellent doctor, he reassured me so much but I couldn't afford it" (56). Most women had mixed attitudes to the hospital, they felt able to criticise some aspects of care and assert their own knowledge and authority. Their actual knowledge and ability to influence decisions was quite limited though, except for Amanda who had the moral authority of having been previously mistreated in the same unit. The hospital's routines and the regime of balancing risk is quite opaque to most women and they are not clear about how far they could affect the course of events.

Table 7.5 Women's willingness to take decisions and debate professionals authority \*.

Name and birth type	Summary re decision making
Amanda Intervention	Confident Choosing epidural – 'I've told them I want one'
Beth Natural	Fearful, couldn't make judgement about care 'don't know what I would say'
Tess Natural	Confident. Waters broke, went to hospital when ready – discounted staff criticism of her delay
Julie Conventional	Worried about what 'they' will allow, has some odd medical information about drips and iron tablets, had arranged to reverse sterilisation though
Sheila Conventional	Insider knowledge so appreciated staff point of view but felt ignored because she was a nurse-
Deirdre Conventional	'They are doing their best' – confusion over antibiotic cover, took action over thrush infection – not afraid to ask

Katy Conventional	Felt shy at being examined, strange ideas about rubella Knew she was going to have a rapid birth when water broke
Roxanne Conventional	Rather dependent, worried about midwives clinic Wanted reassurance from obstetrician
Cindy Conventional	Distrusted staff, thought doctors stupid, midwives bullying Surprised when the midwife did what she wanted
Laura Intervention	Rational attitude, trusting what will happen. Thought that she would be more assertive the second time.

\*Summary of interview material.

The doctors appear to expect women to want intervention more than the ‘alternative’ critique would expect, but their agreement depends on their assessment of the risk, and in some ways on moral categories. I was told that a ‘primip’ would not be given a Caesarean to preserve her vagina for cosmetic reasons (Peter VMO 64). A midwife told me that very young teenagers and women whose baby has died *in utero* are given epidurals without any question, to spare them the pain of experiencing a birth that is presumed to be inappropriate or tragic (Julia MW 32). So the equation of risk is not purely a bio-medical one, it incorporates social and emotional aspects. In a truly liberal view, properly informed women who chose pain relief or Caesarean section should be able to do so without censure. It is clear from the discussion of reducing harmful intervention and the practice of evidence based medicine, that this utopia is rather remote from the everyday social world of the hospital and its established practices.

However, the picture in this hospital is very much more complex than simply the imposition of medical authority. Doctors differ in their opinions, depending on how recently they have trained and read the evidence, on their clinical experience and on the climate of opinion in the centres where they have worked. Midwives also have different sets of beliefs and practices about how they handle women in labour and how they mediate between what women want and what different doctors expect. They all assess, rightly or wrongly, what they think women want and what information they are capable of absorbing. Members of staff have different personal styles and levels of ability to communicate with women whose education levels are very different to their own.

Q. Do you think women have the right to choose the kind of care they get

Yes of course, but they don’t have the right to demand it. The obstetrician has to be able to agree. For instance I would refuse a primip who wanted a Caesarean because she didn’t want to go through labour. It’s an excess risk, it’s non-standard practice, it’s an unnecessary operation (Robert SR 129).

Implicit in their discussions – and it seems to be kept very implicit, because of the tension between allowing women choices and retaining the responsibility of providing ‘good care’ - is the fact that women have a legal right to make whatever decision they want about their own medical care. The midwives know that this is the case.

It used to be that as soon as they’d walked in the door, that was permission to do whatever we want. Now it’s more to give them the control - a lot of women [don’t realise that]. The ones that do are pushed down, and those that could don’t. We’re not rulers we’re [there to do what they want]. It used to be that [as a woman in hospital] you did what you were told, it’s changing but it’s very slow (Rose MW 11).

One obstetrician said to me “I want her to have some pethidine” - when I went in she said, “don’t you dare” - so I didn’t. I could have been charged with assault. He was cranky that I hadn’t. He took it out on her too (Rose MW 61).

This knowledge puts the midwives in a difficult position when they see women experiencing interventions which they think are unnecessary, but which the women don’t realise they have the right to refuse.

...they don’t know any different, and that’s what I’ve found so sad... What can you say to them, you know, “Don’t put up with this, don’t take this as what’s meant to be”, but you can’t interfere in their... sort of experience - you can’t make it sound like “Look, he’s the big baddie and he’s going to do horrible things to you and you’ve got the right to say “I don’t want that”. You just don’t know what position to take in order to make experiences better for them (Caroline, midwife 12).

And particularly in respect of the authority structure in the hospital, the midwives are powerless to refuse to carry out the doctors’ orders unless the woman and her family indicate their wishes.

[The VMO] will say “I want her to have a drip and syntocinon” and there’s not a lot you can do unless they [the couple] say “Can’t you wait a bit longer”, which riles me, but you can’t intervene - you’re treading a fine line if you want to keep your job. They have a lot of clout, the VMOs, even if they only have visiting rights (Rose Midwife 40).

As described in this section, there are changes in the extent to which women’s views are taken into account, but at particular points, they will be overridden by the necessity to provide care which the doctor feels is optimal. Changes in labour position and analgesia are the easiest ones to make because they primarily affect the woman’s own comfort. Decisions which affect medical decisions and outcomes, such as monitoring, drugs and having an episiotomy to prevent a bad tear are more ‘challenging’, except that women who do refuse absolutely have to be catered for.

The position they want to labour in doesn’t really matter very much, and hot packs and things like that are very readily handed out. Yeah, it would be more a medication issue, I think, that would be difficult. Some people don’t like being monitored and that sort of thing - that would be seen as a difficulty should they - should the staff member feel that the need was there to do that (Nikki midwife 180).

if it looked like she was going to tear, I’d say look, I think this needs to be done - she’d normally be anxious to get it over with by then. I’ve never had a problem - but if it looked like a bad tear I’d say, look I am going to do this. Unless she was saying, “don’t you dare touch me” - that would be assault (Robert SR 38).

To pursue a really liberal view, and allow women a genuine choice between interventions with informed consent and properly prepared and supported natural childbirth is quite controversial. Just as practitioners are reluctant to give up the interventions which in their opinion contribute to safe practice, those who advocate less intervention have a problem in educating women and genuinely allowing them a choice, without being as coercive as the medicalisers

do you just say “Here, read this book” and hope that she discovers it for herself ... [if you say] the way you’ve chosen to have a baby isn’t safe - then you’re really doing just

as bad a thing as the obstetrician who says “If I don’t induce you today your baby will be dead. What do you want me to do?” you want the woman to find it out for herself without you having to point it out to her that this is ...the wrong thing for you to do, you know, who needs all that guilt laid on their shoulders? (Caroline MW 340).

While there have been some changes in the regime at the hospital, Stephen feels that the prevailing culture does not give women as wide a range of choices as some people maintain, especially in supporting alternative pain relief and physiological labour positions.

There’s not a lot of choice during labour - there’s a lot of talk about ‘natural’ and women being in control, but when it comes to it, they nearly all say “get on the bed, It’s time to have the baby now.” Nearly all women deliver on the bed and most women are pushing supine. They do offer the bath and physical pain relief, but not a lot of control, there’s a lack of education in patients and in midwifery and obstetric staff (Stephen, SR 12).

But he feels sure that women who are assertive are likely to get what they want, whether that is a natural birth or intervention, but their educational capital and insurance status make a positive difference also.

I’ve noticed that tertiary educated women using the birth centre are very high in assertiveness - and people who demand things tend to get them in the end, whether its an epidural or whatever. There are more elective caesars in private patients. and emergency ones too I think.(Stephen SR 31).

In a liberal feminist utopia, women as mothers would be seen as intelligent beings who could be given information on which to take decisions. There are situations, like deciding whether to stay in hospital in early labour, whether to have a labour accelerated by putting up an oxytocin drip, where there are differences of professional opinion. The liberal ideal is that women should be given frank and open options, not manipulated into having services which are conventional or convenient, whether these are ‘natural’ or not, providing that the decision is properly informed and based on evidence. This would be at odds with both the critique of harmful intervention and the critique of ‘natural birth’, unless you assume that any rational woman would reject intervention if she were properly informed.

#### *First Critique. Care that is safe, evidence based and freely chosen*

The challenge that medical care does more harm than good strikes at the very rationale for women going into hospital and challenges the belief that the hospital is giving ‘good care’, in conformity to professional standards of competence. Staff were eager to reassure me that the hospital was delivering a good standard of care. This may be a reaction to the knowledge that hospital childbirth is not uniform. It is well known that there are differences between past and present practice between places and between different specialists. Within a discourse of rationality and the universal body, it would seem logical that such changes have to be accounted for. Acceptable explanations might be ‘improvement’ in practice or possibly differences in what women want, within the boundaries of what the obstetrician will ‘allow’ and the evidence will support.

Both strands of this critique rely on rationality and assume the objective existence of scientific knowledge and a universal body about which reliable and valid evidence can be collected. This view of knowledge and the female body is consonant with liberal feminism in that it assumes that women, doctors and midwives will all act rationally in collecting evidence and making informed choices. Unlike the other critiques, gender, community and emotion do not have a large role to play.

It is uncomfortable to address differences in this framework. The VMOs disputed the idea that there are different Caesarean section rates between private and public patients, although it is quite well established (Fisher, 1995; Lumley & Astbury, 1980:119) and one specialist assured me that all competent obstetricians practice in similar ways and would come to similar decisions. This is evidently not the case, as these examples show and both junior staff and midwives commented on the differences in practice style and the gulf between the care given to public and private patients. Doctors and midwives speak about 'what I would do' and 'what is demanded by women', but almost never of systematic systems of belief about different ways of handling labour, or different systems of belief and values or, very often, about differences between individual women. It appears then that the overarching discourse of rationality means that differences have to be played down, and the position taken that 'what is, is right'.

## ***Critique 2. Medicalised childbirth is unnatural***

The critique of medicalised childbirth as 'unnatural' is somewhat different to the idea that intervention is harmful and counterproductive, though it can sometimes incorporate aspects of this critique. This is a more positive and more emotional approach to birth, which emphasises the strength of the female body and the importance of female solidarity. This feminist utopia envisages a less materialistic, rushed and technologically driven world in which there is time to appreciate the rituals of life, birth and death and it includes the idea that the emotional and irrational have a role to play in the provision of birthing services – that they are ceremonies, not just utilitarian. The three areas which are examined under this critique are; the extent to which women want 'natural' birth and how far the hospital accepts and practices elements of it; material from staff interviews which reflect the idea that birth is in the realm of the emotional; and the attitude of the staff towards having non-medical supporters for women in labour.

### *Elements of natural birth in hospital.*

It is clear from the accounts of birth in Chapter 6 that many alternative practices, derived from the natural childbirth movement, have begun to creep into hospital routines. Women's stories feature practices such as watching the head crowning in the mirror, babies being routinely delivered onto their mother's naked stomach for skin to skin contact and fathers cutting the cord which are appearing as routine parts of hospital childbirth carried out whether the birth has been 'natural' or not. Laura, who had one of the most intervention prone births, was delighted with the 'alternative' aspects of her delivery.

Dr..., he is wonderful, he is really, really good, and they were saying when her head was crowning they were saying, like getting my hand and letting me touch it, and then when her head and shoulders were out he actually said "Now you do the rest". He passed the shoulders up so I delivered the rest of her, which I thought was marvellous (Laura study birth Intervention. PN1 275).

These are all practices that originated in alternative circles and, in my experience, usually accompany birth at home. The previous chapter demonstrated that, with the exception of one midwife who had herself had a homebirth, most staff did not seem to have an ideological commitment to the idea of 'natural' birth but this has not stopped them adopting practices in a hybrid way, accompanying varying levels of intervention.

To situate the discussion, Table 7.6 lists the women in the order of their study birth type. It is clear from Chapter 6 that women varied in their knowledge of and desire for the elements of what I described in Chapter 1 as the 'natural' birth, involving a rejection of intervention and pharmaceutical analgesia, a trust in the ability of the body to give birth and a belief in the necessity for female support, from both midwives and friends.

Table 7.6 Women's study birth and expressed 'natural birth' ideas \*.

Name and birth type	Summary of comments re natural birth
Beth Natural	Believed in 'natural birth' and received emotional support from midwife. Friends' support at home.
Tess Natural	Read Balaskas' Active Birth. Inward focus in labour and confidence in body. Interested in diet – vegetable juice, but also likely to take amphetamines to lose weight. Partner but no friends. Distrusted people in the neighbourhood.
Julie Conventional	Read Sheila Kitzinger. Partner had alternative beliefs, wanted waterbirth, she did not Induction but no other intervention – very happy with birth. Network of female supporters
Sheila Conventional	Commonsense approach to childbirth – nursing training. Some alternative attitudes to breastfeeding and community life.
Deirdre Conventional	Shy about children seeing her in labour, lack of confidence in ability to do without pain relief – encouraged by partner Great desire to succeed at breastfeeding. Some support from friends after the birth
Katy Conventional	'Old fashioned' language of birth – bearing down pains, dry labour, rather than 'natural' discourse. Thought that breaking waters speeds up labour Fast labour – some shyness about body and birth process. Husband cut the cord.
Roxanne Conventional	No expressed confidence in midwives or in own ability to take charge. Desire for obstetrician reassurance. No friends or supporters mentioned
Cindy Conventional	Very traumatic birth experiences, distrusted midwives and felt that moves towards 'natural birth' disempowered her, wanted to be 'left alone'. No friends in support
Laura Intervention	Expected to be able to plan and 'think out' birth. Not committed to 'natural' ideology. 'See what happens' - had a lot of intervention. Did not want family present until after labour
Amanda Intervention	Chose intervention because of previous bad experiences. Did not want family present

\*Summary of interview material.

Table 7.6 is arranged in order from the 'most natural' to the least. Although two women spoke about reading 'natural childbirth' texts, no one discussed birth in ideological

terms. There were some contradictions, such as Julie's induced birth, which went on to be otherwise quite natural, and Tess's 'natural body consciousness', which did not exclude taking amphetamines to lose weight. 'Conventional' births had a wide span from Deirdre who almost did without analgesic to Cindy who 'just wanted to be left alone', a characteristic that she shared with Laura and Amanda whose births were very high in intervention and who also preferred to labour without friends or family. The point was made in Chapter 6, that for these women who were not committed to a natural birth ideal, their experience depended greatly on the climate of the unit and the particular attitudes and experience of the staff they encountered. Nicki, a midwife and Stephen, a senior registrar, whose views were relatively progressive both expressed some sympathy for a natural childbirth ideal.

You know, it's a normal, natural thing. Women's bodies were made to have babies, and the very great majority will do it well, left alone (Nicki MW 611).

Women who want no intervention - generally fine, they'd never be forced (Stephen SR 36).

Staff expressed widely differing views about how influential 'natural childbirth' ideas were, and how much they were reflected in what women asked for.

Table 7.7 How many women expect a natural birth?

Alison MW	The majority are cool, calm, don't ask for much. Sometimes demanding but the run of the mill don't expect a lot, grateful for what they get (41)
June MW	For a while there was a lot of pressure - everything had to be natural, you couldn't (even) describe (contractions) as being painful. Some people will try natural (30)
Nicki MW	Not very many. They're a big minority. They're probably an increasing minority, but they're still a minority (160)
Julia MW	Natural birthers - there's a trickle of that (30)
Ruth MW	The average person is expecting a 'natural' labour - it goes round communities and they learn about it in ante-natal classes (55)

Stephen felt both that women did not demand as much 'natural' birth as elsewhere

The (Town) patients are not very assertive - one woman who had booked for the Teaching Hospital birth centre, came into Town, she was very assertive and delivered in a bean bag on the floor (Stephen SR 14).

and also that there was less knowledge about how to provide it.

At the Teaching Hospital, there's more input, women are encouraged to use the birthing stool, give birth in the bath or on all fours. It's the influence of the birth centre and the education they give staff and patients. The midwives clinic will be good, it will provide continuity of care (Stephen SR 18).

Table 7.8 shows that the staff are somewhat wary of people who want 'natural birth'. The table illustrates that issues of informed consent and a right to choose run against the need to provide good, standard care, in a manner similar to the conflict which emerged with the issue of evidence based interventions. Several staff feel that the demand for



‘natural birth’ has peaked or moved elsewhere. Midwife Peggy’s slip of the tongue, that ‘usually they’ll get *your* confidence’, shows the slightly wary attitude of staff to people who threaten to choose non-standard care and the suspicion that they will be ‘difficult’ until they prove otherwise. There is a suggestion that such people are irrationally needy and over focussed on the details of the birth itself. It is interesting that psychological and emotional explanations enter into these discourses, whereas the demand for ‘epidurals’ or social intervention was seen more as a consumer demand, not a sign of emotional inadequacy.

Table 7.8 What would you say to someone who wanted a natural birth?

John, GP	I’d ask them to come up early in pregnancy, and say, it’s your choice, but its my duty to explain why this is a standard practice - and then I’d acknowledge her right to choose. I’d be interested in listening, is there a good reason for why she wants this? (39)
Ruth MW	Not sure about ladies going cold turkey and avoiding pain relief - here they use back rubbing, gas, pethidine, epidurals and other options (16)
Nicki MW	I think - there’s a new wave of staff that probably cope very well with that, to be fair to them.... I think it’s more an issue with drugs that’s difficult, if they don’t want their baby to have (Konakion) (176)
Peggy MW	Natural birth is OK as long as they will allow us to do obs. They say no to synto and Vitamin K – we don’t often get them. You keep them informed, usually get your (sic) confidence, they’re normally low risk (51).
Ian VMO	Women who are against any form of intervention are less common than 4-6 years ago - may have gone to Independent midwives or birthing centre - I’ve always been happy [to listen]- I’ll often be less interfering than they [the women] are (127)
Julia MW8	The focus is so big on that one day - they’ve got them for 18 years- should focus on that in ante-natal classes (78).

As already examined in Chapter 6, a principal import from the ‘natural’ birth discourse is non-pharmacological analgesia in labour, although the provision of a reliable source of clean hot water and heated packs to ease pain are actually technological solutions, though they are not seen as such because they are neither surgical nor pharmaceutical. As has already been explained, there was a lack of physical facilities such as showers or baths to support these practices and there was a long trek between the bed and the delivery room.

They’re a bit behind here in offering an active style labour, here they’re basically expected to lie in bed or walk around, not encouraged to use a mat or a low bed. There is a mat but it isn’t really used and the beds don’t have kneeling bars like other places. The biggest drawback though is that there’s no private spa or bath - there’s one bath but it’s very public, only has a curtain and you can hear everything (Robert SR 55).

But Table 7.9 shows that midwives feel that there has been significant movement towards more natural practices. The language midwives use here is interesting and resembles more radical/cultural alternative childbirth speech. The care they give is ‘making people feel special’, ‘it’s magical for some of them’, giving confidence through (positive) visualisation and hot packs, becoming more humane and caring, making the event more enjoyable and relaxing.

Although the doctors feel that things are changing very slowly because women are not demanding and staff are not well trained, Caroline is optimistic,

I think mostly they're changing because the women are making them, actually. Because they walk in to the woman and the woman's standing by the bed, you know, and nothing else. "Well, let's get back on the bed" and she might say "Oh, I just can't, I can't", you know, and so she stays there. So whether they're just changing because of that, but it's not a great drastic change, it's just when you look back at what they were like in '91 and then now, in '95, you can say "Yes, they are changing, yes" (Caroline MW 148).

Table 7.9 Labour ward practices reflecting 'natural birth'

Stephanie NUM	We cater for the demand - bath, back rub, shower, whatever the community wants. Also making them feel special when they come in (23)
Ruth MW	It used to be that you hit a bed and there you stayed. Now they can walk, and use hot showers and a bath - it's magical for some of them. One lady I had, I piled her in and it helped her relax so much - she did very well (16).
Alison MW	One on one's the ideal - if you're with someone you can follow them through - give them some confidence. You can have someone screaming in pain, but that's just her perception, she's got a low pain threshold, you feel her tummy and you think, well you've got 18 hours of this, how are you going to cope? It's ideal to stay with them, you can do visualisation and hot packs and I think it holds off the injections and the epidurals - they recede into the background (75)
Peggy MW	Changes since my training, people are becoming more human and caring, trying to establish a sense of family lost through changes in the wider society. We get them out of the room and toddle them, they enjoy music and light - like to walk around Water births - I don't know whether it'll get as far as Town hospital (22)
Caroline MW	But I spent a lot of my labour in the bath and then got out at the end when I was getting cold anyway, ... it really helped me...so I encouraged women, when I worked in the labour ward, to get in the bath, or at least in the shower, but I prefer the bath - I think it's more relaxing,... I think it's great. So I hope that anybody can have access to the bath (45)

So far this section of Chapter 7 has shown the extent to which, although neither the women nor most midwives are ideologically committed to alternative practices, changes have been made in the approach to birth in the hospital. Additionally, the 'natural critique' extends beyond external, practical arrangements to an understanding of birth as emotional and midwifery care as intuitive rather than scientific. In the same way that a fear of the harmful side effects of intervention underpins the 'rationalist' critique, the spiritual and psychological understanding of birth is the rationale and explanatory principle for alternative birth practices. The extent to which these understandings are found in the hospital is addressed in the next section.

### *Childbirth and emotion*

Enough has been said in Chapter 6 to demonstrate the intensity of the relationship between women in labour and their carers, but this does not seem to be heavily gendered, rather women seemed to be attached to some practitioners because of their characteristics, whether they were male or female. This is somewhat at odds with the 'natural' critique derived from a radical/cultural feminist sensibility about gender, which would suggest that it is female carers who are more likely to develop close relationships and to adopt emotional understanding of birth. Only Caroline, a young midwife with a personal commitment to natural birth explicitly called upon gendered explanations for the difference between nursing and midwifery care.

But because they're men, basically, and it is what it is, I'm sure, they can't even perceive what it's like, and because they don't stay with the woman from the moment that she comes into the hospital where she might be having minor contractions but they're alright, until she gets to the stage where she could quite literally chew her own hand off, then they just walk in and see this woman who is totally going to pieces, in their opinion – "Well, we'd better give her something to stop this pain, because I'm a doctor and doctors stop pain" (Caroline MW 46).

'Continuity of care', which for the rational critique was a problem of constantly changing advice, in this framework becomes a matter of relationships, being familiar with the midwives and doctors who will take care of you in labour. There have been moves in this direction, but gender does not seem to play a part in this. Stephen felt that continuity was more important than the actual birth philosophy.

One thing about Town that I liked was we tried to arrange it so that public patients saw the same person at their ante-natal visits, so they had some continuity of care, even if that person was very junior - they could consult if needed. Gave us the opportunity for some ongoing education, even though we had different styles and levels of intervention, such as ordering tests. I think it worked very well (Stephen SR 20).

One of the Nurse Unit Managers suggested that the emotional importance of seeing the same person can become over-emphasised, and indeed Beth's labour with a supportive midwife she had never met before demonstrates that Margaret's point may be justified.

In the clinics we're getting to know them, making an effort towards getting to know them, but I don't think its so important - as long as they've got someone with them - husband, mother, the midwife is the extra person - all this hoo-ha about continuity of care - It's not continuity of care, it's continuity of advice - we need to all be saying the same thing for the same reasons. Things you truly believe, then women can gain confidence and believe that she has skills to go through labour. I don't think mothers care about seeing the same person. Unless they are particularly needy of the experience of labour - some of the ones who want homebirth - I sort of doubt that motivation (Margaret NUM 67).

Here Margaret calls upon the 'alternative' practice of seeing labour as an emotional or psychosomatic issue but attributes emotional problems to someone who is 'needy of the experience of labour'.

The dominant discourse in play is the one of evidence and scientific knowledge but references to emotional and intuitive aspects of birth were present though somewhat scarce. Table 7.10 brings together some comments which illustrate this, for instance, reliance on intuition in caring for birthing women, "if she's terrified, I get terrified too". Intuition sometimes acts in favour of technological intervention as Rose's example of an irrational gut feeling to use a scalp monitor (the most intrusive kind) shows. Other comments draw on a psychological understanding of the birth process, such as the role of confidence in delivering a breech baby, or the power of suggestion where constant warnings of a 'huge baby, an elephant, a monster', appear to prevent a normal birth.

Table 7.10 Birth as emotional and intuitive

Michele CMO	Intuition worries me, if she's terrified, I get terrified too - I don't know if there's any evidence for that. If a high-risk woman feels comfortable - that means she's well looked after. You need to appreciate the risk, but be confident to labour (125)
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Rose MW	Mind you sometimes gut instinct tells a person - I had a case where I said "I don't know why but I want a scalp clip" and she had an IPH (intra-partum haemorrhage) – it's lucky that child's alive (26)
Peter VMO	Breech deliveries, I believe strongly that a well-motivated woman who wants to deliver vaginally, she'll do well. (But) some people have unrealistic expectations, you have to modify them without banging them over the head (236).
Nicki MW	I was induced after - I forget - four hours, and not having had any pain relief I made a very calculated decision to have an epidural, have a sleep and have a baby. I had the epidural, went from four centimetres to ten centimetres in twenty-five minutes, which just goes to show I was very controlled, but I was also very tense (340)
Caroline MW	<p>...this was something like her sixth or seventh pregnancy and she'd had perfectly normal deliveries all through,...she'd had sort of six pounders, seven pounders - all the way along she'd been told that this was a very big baby - this may be even ten pounds, you know, it was just huge, an elephant, a monster. Well, this poor woman laboured and laboured and laboured and got nowhere and went to theatre eventually, after so many hours, and had an eight-pound baby... You know, why wouldn't she have been able to have it? It was eight pound. She'd been told "No, no, definitely not".</p> <p>Oh yeah, she had a caesar for 'Failing to Progress'. How's the woman supposed to feel about that? She failed to [do] this, to give her baby a normal delivery. There's loads and loads of things, of negative terminology, which is all, I mean, down through the years, you know, tradition, that's the terminology that you'll find in all the text books, and that's all just one more thing to undermine women's confidence and that they are in charge. ... We definitely need to empower women (364).</p>

The comments in Table 7.10 show that hospital staff have clinical and personal experience of how emotional and psychological issues affect labour, for instance Nicki's reflection on her own experience of rapid progress from four to ten centimetres in twenty-five minutes, because, she believes, her tension and control dropped when she had an epidural and she believes that some women ask for intervention because they are frightened and tense.

Often people ...are so terrified of labouring that they are going to end up with the works, basically because their body is so tense that its not really going to work according to how it should (Nicki MW 200).

These comments from the more progressive and reflective staff show that there is a consciousness of the sort of explanations usually relied upon in the alternative discourse, but these take place within the dominant discourse of 'good care' and within the institutional constraints of the hospital.

Margaret, a Nurse Unit Manager, reflected on the difference between a technologically driven hospital in which she had first had a management role and the intimacy which was possible because she insisted on one to one care for women in labour.

We had 13 wards, 15 toilets, everything that opens and shuts, but no kettles, nothing humane. We had so much technology, monitors, epidurals...It was then that I wrote the first paper about loneliness in labour. It was so striking to walk in the rooms – the cold, one-eyed cyclops (the operating light) staring at you - the image of loneliness.

So we had one to one (staffing) and it really allowed midwife to woman bonding. It was then that I began to enjoy being a midwife - after 15 years of practice. I always enjoyed looking after women, I hadn't known I was allowed to embrace that pleasure. I was too busy being a health professional, too afraid to expose vulnerability and experience intimacy. (Margaret NUM 28).

This comment, by a highly qualified and very busy nurse unit manager, shows a consciousness of the emotional importance of the relationships between carers and birthing women, equal to any in the alternative literature. But the job of being vulnerable and supporting intimacy in a public hospital is far more challenging than for a private midwife with a select clientele who share her alternative values.

The problem with midwifery practice is that women range from really informed to the ones who couldn't give a rats, the baby means \$250 more from social security. ...So you have to change demeanour the whole time - according to who you're dealing with. And we don't have a lot who say thank you.

There isn't a day I've come to work that I haven't found always some refreshment - either in a woman or one of the staff - it's just sometimes the outcomes in the street [in other words the difficult lives that some babies have when they leave the hospital]- it gets you down (Margaret NUM 47).

### *Labour support in hospital*

In alternative birth circles support people play almost as important a role as professional carers. This is viewed rather ambivalently in the hospital, because of conventional expectations about couples and family formation, because of differences of class and culture and for organisational reasons. Who is present at the birth is a significant issue for the way birth is understood and conducted, as well as for the boundaries of professional power. The senior midwives remember the 'battle' to allow even partners into the delivery room,

The fathers started to come in and midwives fought the battle between the parents and the doctors. Some doctors would permit it, some wouldn't. A lot of midwives felt threatened - someone looking over your shoulder. If you took the mothers' side you risked the wrath of the medical staff. It was the beginning of client advocacy (Margaret NUM 21).

Margaret sees this 'battle' as an important advance in including client advocacy as part of the midwives' role but also points out that not all midwives took the radical view, some felt as threatened as the doctors. The process has advanced to the extent that husbands are expected to be the most usual supporters, especially if they are in 'stable couples' and capable of actively supporting their wives, either from previous experience, from antenatal classes or from some kind of occupational training. The midwives teased a young doctor who was finishing a ward round and almost failed to arrive at his own child's birth because, implicitly, he had left the labour supporting to the midwives.

Table 7.11 Staff views of supporters, especially mothers and husbands.

Peggy MW	Husbands - some are magnificent - especially if they have nursing or ambulance experience, others are a bit stunned ...[It's good to have] Mothers, in-laws, sisters and good friends, to be there all the time with ice and talking especially if you're busy and can't be with her all the time (73)
Nicki MW	I think it's very comforting to have your husband there. I don't know that they really know what to do, and I don't know that anybody really does unless they've had a baby, to be honest with you... I think a support person who's had a baby is a much better support person than

	<p>one who hasn't. So that perhaps husbands the second time around are better at it, but I think it's of great comfort to the mother to have her husband there.</p> <p>I've been doing a lot of reading about this - I don't know about mothers to be honest with you...It's often been a long time since mothers have had a baby and everything is very different, and I think mothers get very anxious...just sort of distressed at watching their daughter in so much pain...and forgetting of why that is happening, yeah, and perhaps a little bit unhinged because of that...Yeah, in my experience I guess they're useful support people, mostly (308)</p>
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Table 7.11 shows comments by midwives about husbands and mothers as support people. Against the idea that your husband is the most useful supporter, Nicki makes the point that it is better to have people who have had babies themselves, a point which echoes the ideal of 'natural birth' as female centred. In her thoughtful way, Nicki has been researching the role of the woman's own mother and wonders whether she is always the best person either. With some reservations, husbands and close family are seen as appropriate and helpful to the midwives in providing the labour support that the midwives are often too busy to give. This includes keeping the woman company and giving her ice to suck to keep her cool and her lips moist, a 'natural' remedy which owes its origins to alternative birth practices, but which is also highly dependent on the benign technologies of electricity and refrigeration.

The midwives draw a balance between the help that supporters can give and the problems they cause by being 'stunned' or 'unhinged'. Young children often attend homebirths, a practice which underlines alternative beliefs about the wholesome and 'natural' nature of birth and sexuality. This idea challenges more conservative views of the impact of bodily processes on small children,

I'm not sure about having children at the delivery, we don't have a policy. Dr H says we need a survey about psychological damage. The main stipulation is that they need their own support person and a little education to prepare( Peggy, MW113).

Table 7.12 Midwives views of large numbers of supporters.

Julia MW	Support people - socio-economic level determines how they are. The lower group, it becomes a sideshow. More stable couples are more intimate. The younger unmarried ones phone several people - fathers, brothers, boyfriend and mother - some are supportive. Most partners are heaps improved especially with classes (47)
Alison MW	Support people - not a lot of good ones, they're there for the circus, the mother's crying, everything's falling apart. (But) I had a guy the other day - he was wonderful - when she started contracting he breathed with her - she was gasping and he got her calmed down - not a word spoken. He said he was one of eight, "mum taught me heaps" - he was breathing her through (30).
Nicki MW	Oh, well I think they're hugely important, but I don't think that you can concentrate on more than one or two, and I don't think that more than one or two concentrate on you - you get forgotten and the room starts to buzz between themselves. Depends how the person in the bed's coping, to a degree, if they're positive and they're coping well, then yeah, it can be a sort of party atmosphere, but if they're screaming and shouting, then they agitate the support people and the support people agitate the staff and it goes down from there (296)

As described in Chapter 6, midwives particularly see large numbers of supporters as problematic, especially if they are from a social class group who are not expected to

know anything or behave properly. They do not usually see large groups as convivial and supportive. They fear that labour will end up as a 'circus', with the labour as a 'sideshow', with everything going downhill and everyone upset, including the staff. However, the placement of Alison's concerns with her story of the young man from the family of eight who knew how to calm his partner without a word and help her 'breathe through' the contractions suggests that sometimes the staff's judgements about unfamiliar people are unwarranted. .

There are barriers against providing the close emotional support which the midwives know is possible. The number of staff and the time they have to devote to particular women or to training support people is combined with problems coping with social difference and marginal social groups, the ones who are 'too young' or 'just walk off the street'.

Some of them walk in off the street - no ante-natal care, they don't have a clue what they're in for - the pain can be devastating. With a 2nd and 3rd baby, at least they've got some idea. Single mothers and the very young ones - they're not adult enough - its a very large shock, they don't cope very well. They scream and yell - "get this out", abuse the staff. I try to be nice, "You're going fine", explain as you go - and give whatever pain relief is ordered. You can spend a lot of time with people - it helps if they have a good support person (Ruth MW 22).

Ruth's comment shows that the need for adequate support and one to one midwifery care is great, especially by people who are already socially marginalized. The barrier to this is suspicion of them, their capabilities and their qualities as parents and hostility by some in response to the staff's efforts.

Although the midwives and, to some extent the medical staff, are familiar with aspects of the 'natural' critique of childbirth, they are uncomfortable with what they know about the homebirth movement. In an unguarded moment one of the midwives told me that very alternative women are called 'daisy sniffers'. Table 7.13 shows some interesting contradictions in comments about homebirth. The senior registrars' comments reflect the preparedness of the examination candidate to have an answer for every case. All the junior doctors told me that 'homebirth is five times as dangerous as hospital birth'. Quoting the absolute risk in this way makes homebirth sound as if only someone who was 'unhinged' would take the risk. The relative risk, from the paper they were relying on, suggests a perinatal mortality rate for full term births of 10 per thousand at home as opposed to 2 per thousand in hospital (Bastian, Lancaster, National Perinatal Statistics Unit (Australia), & Homebirth Australia, 1992). This is still a high risk but not totally unreasonable to the lay person, being in the range of risk which is hard to subjectively calculate, whether your baby was more likely to be one of the nine hundred and ninety, rather than one of the ten (Hoff & Schneiderman, 1985).

Table 7.13a shows a relatively benign attitude to homebirth by staff, balanced as always by considerations of risk and informed consent. Margaret has in the past taken a stand on homebirth and enjoyed it. Stephen would do a homebirth if it was financially worth his while and while Ian would not, he says that he would help find a midwife.

Table 7.13a. Positive and Neutral Comments about homebirth.

Margaret NUM	There was also conflict in society (in the 1970s): homebirth had been around for years but it was coming to the fore. There was a group in the hills - you were asked to make a choice. I'd always
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	gone to work and did my best - I'd never had anything to confront before. With this I was forced to make a choice – I enjoyed working with those people (24).
SR in Antenatal clinic	Well even low risk is still a risk, the homebirth perinatal death rate is five times the hospital one. But if it was low risk, I'd take every step to dissuade her and charge a higher fee. As long as I had something to deal with PPH and a flat baby I'd do it (Notes 33 21)
Ian VMO	Very emotive issue, people are naïve, because they eat yoghurt and celery and exercise and are well read - they think that guarantees a good outcome. Though I wouldn't ever want to make them feel bad. Home delivery - it would be her choice. I wouldn't do a home delivery. It's not the way I work, need the tools of the trade - blood, back-up, blood gases, IV cannula, rhesus, effectively good light for perineal repair. No hang up about it, find a midwife to do it. (214)

The comments in Table 7 13b include off-stage remarks which were more disparaging and Nicki's experience of seeing homebirth transfers at the Capital City Teaching Hospital convinces her that the hostile attitudes to those who 'don't play the game' continue. Caroline who had her own baby at home and planned to do so again, found that her colleagues did not criticise her to her face, but she suspected that they were not being entirely frank.

Table 7.13b Suspicious and hostile comments about homebirth

Midwife	Then about this home delivery where she wanted to deliver in the bath and have the baby under the water for 20 minutes because she's so spiritual - well, we said the baby'd be very spiritual after that (Notes 7 16).
JMO	Why do they want homebirths? Disaster last weekend, can't remember what (Notes 91 24)
Caroline MW	I said "I've heard you're having a home birth" and she said "Oh no, that's far too dangerous". Because I wasn't then the pregnant woman who was about to have the home birth. So she never said that to me when I was the pregnant woman, but now, afterwards, when I'm out of that, you can say what you like to me. "Oh no, it's far too dangerous". Probably a lot of them did think I was doing a dangerous, stupid thing. But I never heard anybody negative (348)
Nicki MW	A few came in that had gone wrong and they were so badly treated, and I used to think, "This is terrible". You know, I don't think I would have a home birth because if it went wrong you would be treated so badly just because you didn't play the game by the rules, you know, and I think that we've got to come a long way before that's going to be much better, and that's still the situation at Town (587)

The natural critique is quite closely associated with homebirth practices (Gosden, 1990; Noble, 1997; O'Connor, 1993; Peterson, 1984; Peterson, 1983; Sakala, 1988). Many of the elements which have been incorporated into hospital childbirth would never have been tried without the homebirth influence. However, the suspicion of 'homebirth' discourse as irrational and dangerous may prevent hospital staff from openly embracing the idea of birth as emotional, social and convivial.

### *Making hospital more like home*

It is unlikely that hospital staff would ever become completely devoted to a 'natural childbirth ideology'. This does not necessarily mean that the positive aspects of alternative birth practices cannot be reformulated to fit into hospital, but they are unlikely ever to be used alone. Heat and water are, as pointed out kinds of technology



but they are not the only ones which are seen as beneficial in their effects. Margaret reflects on the effects of ultrasound on women's confidence.

(It) validates their dreams of perfection. Women are a lot more confident. There's less fear of the unknown. I've spent days with women having nightmares about having a monster - the burden of not knowing what they're carrying. Don't know about fathers because I don't spend a lot of time with men - must have been some burden on the fathers. Being afraid that it's got three heads, or one arm, just knowing that the baby's perfect is very reassuring (Margaret NUM 38).

She also says that an oxytocin drip to stimulate contractions during labour or to prevent bleeding afterwards is much better than the pitocin or intra muscular syntocinon which she used to use, that epidural blocks for pain relief are better than heroin and

From the woman's point of view, the contraceptive pill, so they've got some choice when and where to have a baby" (Margaret 45).

This does not mean that the 'natural' critique has no effect on the thinking of hospital staff. As well as some suggestion of thinking of birth as an emotional issue, there was some consciousness of making it less institutional. Nicki was one midwife who gave considerable thought to improving the experience of hospital birth for women.

Oh, where would I start? Well, I'd make all the beds double beds so the babies could sleep with their mothers and the fathers could be there if they wanted to.

The actual physical layout of the ward is a nightmare. There's just not enough space for people and I see that as a real problem...I really think we need laundry facilities for the ladies - we need a place where they can wash their nighties and hang them and be a little bit more self-contained.

And I know they're working on things like fixing the food - the food is atrocious - and they're trying to make it that the ladies can actually serve themselves from a bain marie or something that keeps the food warm over a given period of time, rather than having a meal that comes up and disappears before they've even got to it.

Well, just more comfortable I think, really. Less hospitalised, less pathologised, as you said, yeah (Nicki MW 498).

Set against this are the constraints of working in the public system, the cultural differences which make delivering maternity care more problematic and the difficulties of negotiating a complex mixture of public and private care.

The idea that an understanding of 'the natural body' is a cultural construct which can be learned, raises the question of whether all women would benefit if they were inducted into alternative cultural ideas about the potency of the female body and whether this is possible or desirable. Women in the alternative birth movement are more often present at other people's births, so that they have first hand knowledge of the physical phenomena of labour. Alternative birth literature (such as Miller, 1990) encourages women to be comfortable with nakedness by including many photos of women giving birth unclothed, being embraced by their partners and supportive friends. Nakedness is taken for granted as part of 'relax into' labour and responding to the sensations. Images of the baby's head crowning are included as emotionally significant family photos, rather than clinical images. Conveying this to people outside the alternative 'community' is not straightforward. Even showing films which illustrate alternative

practices may not have the desired effect as they are often made by amateur photographers and may not be successful in conveying the atmosphere of birth in two dimensions. The fact that they may be frank about the sexuality of birth such as nakedness and kissing, or the raw physicality of birth, such as the stretching of the perineum or having your bottom wiped by someone else can be confronting as much as reassuring. Insiders to the alternative culture have learned that these are the elements of a 'beautiful birth' but they can be upsetting violations of privacy for outsiders. Extremely alternative birth practices can also offend staff by their lack of modesty. The culture of alternative birth was something that midwives seemed aware of, but they tended to distance themselves from extremely 'alternative' views and birth practices. The name 'daisy sniffers' seems to indicate an amused but rather dismissive tolerance. The most alternative midwife had her own child at home so she spoke with more insight and sympathy about alternative practices.

There is not a thorough commitment to an ideology of 'the natural', and the circulation of different elements of the three discourses I have identified is uneven and contradictory. This section of Chapter 7 has addressed the extent to which women demand and staff accept 'natural childbirth' and whether these ideas are associated with gender and with midwifery. The 'natural' critique puts heavy emphasis on the emotional and psychological aspects of birth, which contradicts the 'evidence' based approach of the rational critique, nevertheless there are elements of personal, intuitive and emotional discourses running through all the interviews. Other aspects of the natural critique involve the idea that birth is a community rite of passage and so this section has examined the role of friends and supporters, including younger children, who are often welcomed at homebirths. The issue of the intersection of hospital services with the homebirth movement was also raised here and the last two sections suggested barriers to the wider use of 'natural' elements in the hospital, since emotion and conviviality tend to be associated with undesirable behaviour, risk taking and lack of control of the birth.

### ***Critique 2 Medicalised Childbirth is unfair***

Another critique of medicalised childbirth is that the medical system is inequitable, that is it does not provide an appropriate standard of care to all women irrespective of their social class and material means, and that a midwifery centred service would be more equitable. US writers describe discrimination on the basis of class and race, as well as the over-servicing of women who have private care (Shaw, 1974). British writers describe the impersonality of a large bureaucratic system and a lack of attention to the material needs of women as mothers, including the impact of poor housing and social stress on the actual outcome of the pregnancy (Oakley, 1992b).

The complex division between public and private care in Australia, which was discussed in Chapter 2 has considerable impact on Town hospital and this is the topic of the next section of the chapter. The following section addresses the obstetricians' concerns about the future direction of the system, whether they will be able to continue with conventional private obstetric practice and whether there will be changes in the role of midwives. The aspect of the critique which argues that midwifery is less elitist than obstetrics and more suited to supply the needs of disadvantaged women is addressed in the final section.

### *The public/private split*

As Chapter 2 described, one of the unusual features of the Australian health system is the complex mixture of public and private care and this certainly is reflected in Town hospital. As the first section of this chapter discussed, the boundary between public and private care was a salient issue for VMOs and registrars because of the impact it had on decision-making, the problem being that public patients did not have continuity of care and the registrars had to implement clinical decisions that could change from day to day.

The main thing about Town Hospital is the very strong public/private split. Private patients have better continuity of care because they are seeing the same obstetrician. Public patients are very much 'ours' [left to the junior staff]... We provide the backbone of the care but important decisions are differing according to whose making them. It causes confusion for patients and problems for us - makes us look like fools (Stephen SR 4).

Midwives also have to adapt to the individual styles of four different Visiting Medical Officers, as well as taking care of public patients in the ever-changing regime involving different obstetricians on-call each day. The midwives and the junior doctors have more responsibility for public patients and some midwives felt that they had more of a say in their care.

Especially the clinic patients - not so much the private patients, but the clinic patients, where you just have to deal with the resident or the registrar, they'll just say "I think that's what should be done" and the doctors will say "Yeah, OK" and they'll write it up and that will be it. So, yeah, there is that - they do make the decisions, well, definitely with the clinic patients. With the obstetricians, they would call them first and they would come in and say "Yes, I think they need ...", but the midwives wouldn't make that decision, but they would call them. (Caroline 116).

The professional boundary in hospital care of public patients can possibly be more usefully drawn between midwives and junior doctors on one side and VMO specialists who are also running a private practice on the other.

The distinction between public and private care was obviously a sensitive issue. In order to disguise conversations about insurance status the staff use the convention of numbering the case files of public patients 00 and private patients 01, "Is she an 00 or an 01", "this policy is for 00s".

Never have I worked anywhere where the health insurance status is such an issue, and they want to know someone's health insurance status before they will even answer a question about management. That's their first question - What's their health insurance status? "Are they MBF positive?" has been said (Nicki MW 60).

This was an obvious cause of concern for midwives and registrars. Stephen said that while they had tried to get some continuity in the ante-natal clinic, "There is no in-patient continuity of care - public patients see a different obstetrician every day - a woman who stays eight days should have the same consultant" (Stephen SR). Apart from the rational desirability of having continuity of advice and the emotional and psychological benefit of getting to know their carers which have been discussed in

previous sections of this chapter, both midwives and registrars noted the difference this made to the type of care offered,

A woman who wanted no pain - for private patients that's fine, they could have the epidural. For public patients, we would offer them various options and inform them of the risks of complications. They wouldn't be likely to have an epidural until they were in established labour. And if they were 9 cm I'd encourage them to hang on - the baby's nearly born...If a public patient did have an early epidural - the VMO's didn't allow them to push. They didn't have time to wait for the epidural to wear off, they'd rather move immediately to forceps (Stephen SR 26). Midwives and junior doctors could band together to give women a better experience, despite the VMOs usual practice.

Sometimes we didn't call them or we'd say "she's not quite ready" and then "Oh, she's pushed the baby out" (Stephen SR 29).

But other issues, such as the timing of Caesareans, which they could not influence, caused them quite considerable distress because public patients were not given the same consideration as private ones.

And then when they've ascertained that (the insurance status), they'll decide what happens, so that if, for example, someone's not progressing very rapidly in labour and the writing is on the wall - they're going to need a Caesar - it will be done at their convenience rather than at the convenience of that lady who, at that point, is probably not going to get any further in the vaginal birth process. So it's really distressing to nursing staff much of the time, in labour ward, and that's why I don't work in labour ward, because I find that horrible. (Nicki MW 60).

Nicki and Stephen were the most vocal about this, partly because they both had a reflective and open minded attitude towards their practice, but also because I interviewed them away from the hospital, so they may have felt more freedom to criticise hospital practices, including those of the VMOs who are influential in their careers.

Any suggestion that continuity of care could be improved for public patients was denounced at some length by the VMOs. At a clinical meeting to discuss a baby who had been born with a severe handicap, a paediatrician suggested that continuity of care would help in communicating with the parents, that patients should be admitted under a particular obstetrician according to the day and always see the same specialist. This was vehemently rejected, "that would mean universal streaming - we can't guarantee that the same doctor will be there because we do a one in four"(Notes clinic 1 45), that is each obstetrician was on call one night in every four and took care of all public patients in the hospital. They argued strongly that continuity of care for public patients was impossible because of the decline in private health insurance and the fact that registrars' work shifts instead of being on call, "very sensible, but they do half what we used to do" (Notes clinic 1 49). Obviously this view was not shared by Stephen, the paediatrician or some midwives who had worked in the UK and seen public patients cared for by particular consultants and who could see quite clearly that public patients would benefit if they were not subject to constant changes of opinion. The fact that the change was opposed demonstrates the lack of acceptance of a universal access public health system by most private obstetricians. Ian said that the polarisation between public and private medicine

was “OK for socialists” (32) but that there was unlikely to be much change to regional hospitals under the “Medicare view of life” (196).

The issue of how public patients are treated is partly one of organization but also has moral and political overtones. The VMOs, and other supporters of the Australian private/public mixed system, see private health insurance as a positive good, because they think that it encourages responsibility in patients and supports the viability of private medical practice, including obstetrics. The difference in care which the midwives and juniors disliked is connected to the organisation of a two tier system first because the VMO’s responsibility for public patients conflicts with the demands of private practice and second because they believe that there should be a differential in the care delivered to people who are not insured.

VMO’s have a lower threshold for intervention in private patients. They tend to put public patients off, leave it, leave it, but once they do come in its “OK lets do something now, since I’m here.”(Stephen SR 34).

(If there is a ) registrar on holiday – the junior can’t do forceps/caesars. If there’s a problem, it’s an issue of how long it’s left, whose going to do it - not interrupting their private list. (Julia MW 43).

The moral aspect to the tension between public and private care was spelled out by Nicki,

They’re probably more agreeable to let their private patients have epidurals than to let the public patients have them, to a degree...The logic behind that? Oh, I think they’re punishing them for not being privately insured (Nicki MW 152).

This is an echo of the system which existed between the 1950s and the introduction of Medibank (Australia’s first national health system) in 1975. At this time 60% of people held private health insurance, with the premiums subsidised by government, via tax rebate (Sax, 1984:Chapter 3). In such a two thirds/one third system, private health insurance is a mark of being respectable and thrifty. Consequently, the uninsured are seen as charity recipients, obliged to satisfy the doctors that they are not ‘rorting the system’ and getting something for nothing. This suspicion of public patients being unworthy in financial and other respects seems to persist and some VMOs were well known for trying to coerce or shame women because they had let their health insurance lapse. The antenatal clinic midwife had to deal with the patient’s distress, as the following comment shows,

We had a call from one of our shared care ladies - she’s 130Kg and she saw (VMO) and they had a real session on the weight and the private insurance. I said we can make sure she doesn’t see him again. (Notes 7A 5).

The antenatal clinic is in its own way a ritual to prove respectability by showing up early and regularly and it is not entirely free of judgement about people’s worth. However as an outpatient clinic funded by the state, it should not provide a legitimate opportunity for doctors to pressure people over their insurance status. However, the idea that people ought to have health insurance and are culpable if they do not, is a persistent one.

I think that's how (the VMOs) look at (public patients) a lot of the times...you know, you hear comments that - and I have, I've had a big argument with one of them about the fact that - well he may not have realised it, the rest of the working world have to really struggle to pay health insurance and people are pulling out, they've got to put shoes on their children before they pay private health insurance, because there's an option (Medicare). And really, it's a very good option - I'm a great believer in public health, but they feel that they don't pay more so they're not entitled to the best, (Nicki MW 156).

I heard one of the registrars put this view quite clearly, "for most things in our society if you pay more you get something better, like a \$20,000 car is better than a \$10,000 one" (Notes 33 27). From the specialists point of view, the differential between private and public care is what provides the incentive for people to take out health insurance and this is undermined if public patients are entitled to receive continuity of care, equal access to epidural pain relief or if the emphasis shifts from the need for specialist attention to the quality of midwifery care in labour. One of the junior doctors told me that his wife didn't care what midwives were on as long as she could rely on her doctor if things went wrong (Notes 33 29). There is a conflict between the philosophies of the two co-existing systems, the private, which suggests that there is one level of care for the insured and a satisfactory but less convenient one for the uninsured, those relying on the Medicare system, which is based on the idea of universal access to quality services. It is difficult for these to co-exist because the existence of a free service undermines the incentive for people to take out health insurance and the right to a uniform standard of care is undermined if the people who are providing it have an interest in two standards of care.

The interviews show that women and their families were beginning to perceive a shift in the balance of attractiveness between traditional private and public obstetrics. The comments in Table 7.14 and 7.15 agree with the findings of Brown et al. (Brown, Lumley, Small et al., 1994) that women are happy with private obstetrics antenatally but not so satisfied with care in labour. This is likely to be because the doctor they have got to know does not make it to the labour. Some women reported experiences of this kind, which meant that public care was seen as at least as satisfactory as private care, after all, if the VMO is going to 'leave it all to the midwives' anyway, then what is the point of paying and developing a relationship with him or her?

Table 7.14. Equity dialogue Deirdre and partner.

Deirdre: I'd recommend the clinic. Better than Dr. ... -very thorough. A lot of people are going through the clinic now, every second person goes through. The private patients, they're delivering them at City Private Hospital now.

Partner. Dr Michelle didn't just come in at the end, like Dr ... He left it all to the midwives.

Deirdre. He came in at the last minute. Except for E when I was induced, he checked me then, he didn't make it at all for G, and then he came in while I was pushing, but Michelle, she was wonderful. And she talked to me.

Partner. You couldn't have got better care - that's the thing you're getting the same care when you're a public patient as when you're private, better if anything.

Deirdre: .And when you go to the ward, the nurses checking you, you couldn't have got better treatment. A girlfriend of mine she just had a baby and she had to pay \$330 gap - she couldn't believe it - it was \$120 when I had the others.

Partner: . You get the same treatment on the ward

Deirdre. I don't know, if you had complications, it might be better.....(PN2 31...42)

These tables demonstrate a reflection on whether the care was inferior and the conclusion was that ‘you couldn’t have got better care’, the hospital is the same anyway and the ‘gap’ payment for private patients can be unexpectedly high. Deirdre does wonder whether it might be better to have a private obstetrician if something went wrong, and as we have seen, this intuition may be accurate as public patients with problems suffered from continually changing advice.

Table 7.15. Public medicine and continuity of care.

Angela	Well after I had L. I thought - not that I planned to have any more but if I ever had another baby I’d go privately, I wouldn’t go back through the ante-natal clinic, simply because - Well, my body didn’t heal from having the operation and I was sick all the time and I was seeing a different doctor all the time and I was sort of getting told different things all the time – just different opinions - but because we’re not covered by private health I’ll go through the ante-natal clinic again. But when I went to - I went for my first visit last week, it’s all changed, they seem to be much more organised now, so hopefully it will be a lot better (Intervention AN1 918).
Sheila	S (partner) was there the whole time except when he’d, you know, go out for a cup of tea or something, and there was a midwife who would come in and come out again, and - I don’t know - yeah, I think it was just the midwife and I felt - I was feeling the urge to push, and I think she went and got the doctor. By this time it was a different doctor because we were public patients this time, too (PN1 422) If you’re a public patient - if you have a good rapport with your G.P., which I did, go with them and then just visit the clinic, because the clinic is wonderful – they were really good. And I had all the care that I needed. I had my ultrasound because when I was overdue I had an ECG - yeah, one of those - which was good and that was fine – and you just had all the care that you needed anyway, so - And then you went to the hospital that you’d go to if you were a private patient anyway. And with the boys I was privately insured and the obstetrician wasn’t there to deliver them anyway, so it was the same care. And the after-care ... was great. And I’d recommend going to Town. (Conventional PN1 894)

### *The future of private obstetrics*

The obstetricians argue that their care is the best quality and that women should have a private obstetrician. Nicki, challenges this from a midwifery point of view, she observes that private obstetricians see a very large number of patients, meaning that they can only spend a very short time with each of them, though the patients take it for granted.

I actually have just started work for one of them as his ante-natal midwife in his rooms. I’ve never done anything like this before and I’m almost struggling with my conscience as I do it. He’s been really nice - couldn’t have been nicer to actually work for - and he’s nice to the ladies in his rooms - certainly pushes them through, sees a huge number of them, but ... I don’t know that they feel rushed, because that’s all they’ve ever had, probably, for the great majority of them (Nicki MW 80).

Not only that, she questions whether it is actually preferable for a woman to have only one opinion about her care

that’s how they see themselves, as the best. Whereas I would argue that a public patient in a public hospital has really got a much better chance than a private patient because they’ve got a greater review panel (Nicki MW156).

Although the midwives and the junior doctors are practicing in a more egalitarian way, even ‘subverting’ the opposition between public and private care while they are

training, the registrars plans for the future are to offer private practice, whether in a conventional mode or a progressive one. Robert, the more conventional SR sees himself continuing the traditional private practice with public care as a public service. I asked him if he thought it would continue to be viable,

Well, that's a very political question - I believe that Medicare is in crisis, that the public hospitals are under-funded and the government is going have to do something. Obviously from the doctor's point of view the best option is to ensure that people with anything over a moderate income have an incentive to take out health insurance, for instance by having a graded increase in the Medicare levy, so if you haven't got private insurance you really get hit. That's the way most doctors see it. (Robert SR 85).

Table 7.16 shows comments about the future kinds of obstetric work the doctors envisage. Interviews with the doctors reflected their concern about the waning differential between public and private care and the possibility of a change to midwifery care for public patients. Michelle is working as a CMO as a preparation for GP obstetrics. Like the British general practitioners who in 1902 opposed the Midwifery Act, she is worried that midwife only care will undermine the viability of her family practice. Peter and Ian, the VMOs differ on how they see the future. Ian regrets the passing of traditional obstetrics whereas Peter would be prepared to back up midwives and juniors and concentrate on gynaecological surgery.

Table 7.16 The future of private obstetrics.

Michelle CMO	Women don't necessarily need doctors - but I'd be disappointed if - and its becoming likely - that all normal pregnancies are cared for by midwives - the GP is left with nobody and loses skills, which is a shame. Many GP obs have good skills and you can lose them so quickly. Its a nice continuity for a real family practice (69)
Peter VMO	My personal preference would be for the end of private obstetrics - I would like to be specialist on call for labour ward, one twenty-four hour stretch per week, and do more gynae. Normal delivery would be done by midwife and juniors. Complications handled by registrars with sufficient experience and specialist obstetricians Some people still want the obstetric model. Most people now they don't have health insurance, its economic necessity to go to clinic. I think they're generally happy with public obstets. Choice of shared care depends on if they are out of pocket - depends on gap for GP and also the skill of the GP - some GPs are not perceived as having good ante-natal skills. Don't know about the demand for the midwives clinic. Probably going to be a combination (52)
Ian VMO	Peripheral and country hospitals have a problem. Increasingly only gynae surgery available in regional towns, the only private obstetrics will be in the Capital and regional cities which will market their services widely, but there is a sense of discrimination - the private patients are made to travel (40) The VMO is labelled as conservative, capitalistic - they're not the ones who have to spend their lives there. You would never get staff specialists in peripheral areas. In most country areas the government couldn't afford salaries, sabbatical leave, superannuation. VMOs are important in peripheral areas but you get the impression it's a nasty word (59)
Margaret NUM	[Private obstetricians]They're notorious throughout the area...Mind you they've taken out every uterus in the Town - that's an in joke. There was all this hoo ha about the midwives clinic - they hated the idea - now they're saying they don't want to see any normal women. You get this huge battle over everything - they're just averse to change in case it encroaches on the good life they have here. I reckon they take a quarter of a million dollars each out of this hospital and they only have to roll up every bank holiday. Private patients - that's just a waste of resources by rich people. They do what they're told (53)



Stephen's plans are innovative, though still aimed at the privately insured or those who can afford to pay 'out of pocket' for maternity care. He intends to form a combined obstetric/midwife service with at least two female obstetricians, where women could also take exercise classes. He acknowledged that it would be expensive, but "it's my observation that women can charge more"(60), which introduces gender in a way very different to the 'natural' critique which saw female practitioners as 'the people's healers'. Stephen's plans should provide a very attractive service for women who are in a position to pay for them but they do not address the issue of equity for the women whose obstetric needs are almost certainly going to be the greatest, the young and the most materially marginalised.

Even though Peter would have been prepared to see the midwives take on the care of low risk pregnancies, he said that he could not give up obstetrics because that would be seen as not "pulling your weight" and the GPs would stop referring gynaecology cases to him, so that he would be unable to make a living. Friedson's classic formulation in *Professional Dominance* is that the profession regulates itself by its referral networks (Friedson, 1970). It seems that these referral networks discipline practitioners over their social and economic practices, as much or possibly even more than over their professional standards. A specialist who does not conform to the traditional pattern will be excluded unless he or she is operating in an environment in which they can build alternative referral patterns.

Margaret, the Nurse Unit Manager is somewhat cynical about the motivation of the VMOs who "take out a quarter of a million dollars each out of this hospital" (57), especially from gynaecological surgery. Her concern is about the welfare of babies who go home to abusive families and she feels that money would be better spent on midwives and social workers.

There is in these interviews a reflection of the dual nature of the Australian health system, in that at the time of this research it was a universal free public system grafted on to a two tier, majority private but public safety net one. The women I interviewed represented traditional public hospital users and those who had 'drifted out' of the private health system and who were discovering that, in fact, the care was as good if not better in the public system. The group, who are in the most need of care because they have the least resources, are seen as the most problematic.

### *The role of the maternity unit in addressing disadvantage*

As observed in the discussion of the 'natural critique', the social class characteristics of the women who come for care at the hospital are relevant to the work of both doctors and midwives. Private practitioners, whether they are doctors or independent and alternative midwives have a selected clientele who would tend to share their values. If they do not like the care offered, they can go elsewhere (though as Margaret, the NUM, observed, they tend to "do what they're told"). Traditional obstetric practice in which the majority of women had their own obstetrician for low risk childbirth meant that obstetricians spent most of their time taking care of women who were easy to relate to,

This is your life – it's nice to see thoughtful, affluent, intelligent people. Some public (patients) are difficult, high risk, unhappy. They can be hard work. Well motivated

women with husbands and families – they are pleasant and rewarding. There's a great sadness about losing this [care of low risk women] (Ian VMO 34).

There is a perfectly understandable preference to work with people who are like yourself rather than people who are 'difficult', 'hard work', just as it is understandable that alternative midwives in private practice like to work with women who are prepared to change their diet or to undertake particular kinds of exercise or confidential counselling to prepare for birth (Peterson, 1984; Peterson, 1983). The public hospital however does not have the option of selecting its clientele, the most needy of whom have no alternative services. It is well acknowledged that social disadvantage adds to reproductive risk (Black, Townsend, Davidson et al., 1982; Oakley, 1992b). So the women who are at the most risk of low birth-weight babies, difficulty in labour and problems with parenting are the ones who are seen as the least desirable patients partly because they are 'difficult' and partly because they suffer from social stigma, due to unemployment, social security dependency, having children by different fathers and becoming pregnant very young. The local community has a very clear picture of 'people like that'. In Table 7.15 Tess explains that she is careful about the people she associates with and eloquently expresses the local view of certain kinds of women and families.

Table 7.15 Community view of undesirable families as characterised by Tess.

We've got a select handful of people that we actually invite to the house, for a few reasons - because of the - Well, because of the kids - we only want a certain influence around the kids. And there are just so many - It's hard to say it without being judgmental

There are so many deadbeats around here and working up at the shop you see them all the time and you just - And it's any hour of the day. I had one woman come in and she'd been cut - she'd been actually stitched up by the hospital, and the night before I hadn't realised it was her son, eight year old - he came in about three o'clock in the morning and said "Can I ring the police, someone's been stabbed and such and such is beating upon Mummy" and it was her, she'd come in for cigarettes and something else, I can't remember what it was, with the boyfriend in tow, again at two or three o'clock in the morning..... You know, that sort of thing, I see a lot of that, and I can't - I can't bring myself to sort of go out of my way for people like that.

I think it's a lot of people just don't care any more, whether they're working or not. Half of my family - half of my aunts and uncles and cousins, they won't work because they've been living in a Commission home for so many years, they've been getting the dole or sole parent pension or something like that for so many years, and they just can't be bothered, and their kids are getting the same

But I mean I know if D (son) and I and the baby had to move into a Commission home, we would still be - the house would still be clean, they'd still be fed and all of that sort of thing, and I wouldn't resort to cigarette smoking and drinking and all of that. It's the type of person that you are. You know, if you're prepared to go out and work sort of thing. But a lot of them have just been so stuck in what they've been doing for so many years and their kids see that so they're not prepared - they're just not prepared - One of (son's) school friends is one of seven children and his biggest - his eldest sister is fourteen and she's just had a little girl of her own... It's really sad - I mean, not just for her because she's only a kid herself, but for the baby - that baby is going to get dragged up. Again, it's being judgmental, too (AN2 852)

Tess's concern is to quarantine her family from people who she perceives as living violent and disorganised lives, living on social security benefits and never looking for work. People she thinks are likely to have babies very young and 'drag them up'. She knows she is being judgemental but feels that some of her own family are very close to this edge and she doesn't want to join them. She is puzzled about why other people behave so differently from her. The staff of the hospital come from the same community

and share many of the same prejudices so it is worth recording her comments and concerns at some length.

Although Tess may be unusually frank in describing the boundary between the 'respectable' and the reprehensible, issues like these appear in the casual conversation of staff and receptionists in the ante-natal clinic and the maternity unit and are a form of 'lay knowledge' which informs everyday practice (Becker, Geer, Hughes, & Strauss, 1961:Chapter 16). These comments, taken from my notes, are to some extent gossip but tinged with genuine concern. These casual comments show how views expressed in the hospital reflect the more explicit comments held by community members like Tess. It is important to note that these comments are not just a selection from a range of 'gossipy' conversations about patients which just happen to be about welfare mothers. The staff did not discuss the characteristics of 'mainstream' patients, the numbers of their marriages or children, their childrearing practices or their medical or behavioural problems in the same way. Such details really should be covered by patient confidentiality.

She had all these boys, then a girl which was a cot death, then another girl.

How many has she got with her then?

A boy and the girl - they're both his (current partner) and she wants another one. (VMO) spent hours on a (reversed sterilisation) yesterday - took up the theatre for a whole afternoon.

Well last time she used to bring the kiddies in the middle of winter with no shoes, they looked like they'd just got out of bed, hair all sticking out, mind you she did have the sense - Dr. (GP) gave her a script for (drug name) And she must have read the warning on the box because she called us and we said come in and she said "poor old Dr., he does his best".

She says she'll go on having kids until DOCS [Department of Community Services] gives her back the first lot.

Seven in the morning and she was out there, puffing away- Yes, she's a fagger that one.

She's a diabetic, she can't drink coke so she had to drink the bourbon straight, drank the whole bottle. The baby's very jumpy ... Probably got nicotine and alcohol withdrawal. Scrawny little thing.

This girl rang, she had a new baby and no formula or money for it. DOCS said "there's nobody here, I can't go" and (Domiciliary midwife) said, "she's not the sort who's going to hit you over the head, she only wants money for formula"(Notes 51 7-18).

The sensational nature of some problems, and their rather soap opera like character as well as the frustration of dealing with intractable issues which are on the boundaries of what the maternity unit can actually affect means that they spill over into the normal topics of workplace conversation which more frequently cover organisational frustration and personal celebrations. It is understandable that members of staff feel at a loss as to

how to help in difficult cases, but it is also the case that their casual discussion of 'welfare mothers' demonstrates that these women have forfeited the rights to privacy granted to everyone else and their behaviour is subjected to heightened scrutiny. The fact that the hospital was in a small town meant that staff, including the receptionists, recognised women when they were out shopping and reported on their children's appearance and the number of partners they appeared to have. Although none of the women I interviewed had such extreme problems, several did live on government benefits and have children by more than one father, so they would fall into the area of suspicion. Beth had started her family as a teenager, Cindy complained about unsympathetic public scrutiny of her children's behaviour, Julie had reversed her sterilisation to have another baby with her current partner and Roxanne was having trouble coping with her four children who ranged from newborn to fourteen.

The issue of the kind of people the maternity unit is working with and what the midwives and doctors can reasonably be expected to do for them appears in many of the interviews. The equity critique suggests that midwifery is traditionally a kind of health care accessible to the disadvantaged, because it is affordable and sympathetic to their needs, where as obstetrics is elitist and expensive. As discussed in the previous section the specialists and the registrars discuss social disadvantage in the context of the public and private finance of their practice. For the hospital midwives who are on salary it is a matter of work satisfaction. In Table 7.16, Nicki reflects on her experiences with what she calls 'social welfare culture' and ponders what to do to help teenage mothers. She makes an effort to understand things from a different point of view and to point out exceptions to her generalisations.

Table 7.16 Social welfare culture and difference

Nicki MW	<p>There's a large social welfare culture who are very prolific producers of children – multi-generational, so that you might have the mother and daughter or two all at once, and their expectations are just to get in and get out, from what I can see, get this kid born, get in and get out, and it doesn't seem to me that they think much about that, and I don't mean that as a criticism - that just is how it strikes me - and we actually got one of the daughters from exactly one of those situations to come through the midwives' clinic last time - She still didn't attend - she still didn't have her children immunised by the end of the process, and we'd done our darnedest to make that occur ... They just go from day to day, I think. There's not a plan of action, very much, and perhaps that relates to their financial security, or lack of, as much as anything else (272)</p> <p>... They have very different values to what we have, and they don't see that it's important to breast-feed or that it's important to be particularly clean with new babies, or pay extra attention to how warm they are and that sort of thing, and yet, I can think of one family in particular, one woman's got five kids, I think - they wouldn't have a pair of shoes between them and yet her seventeen-year-old sister would just turn herself inside out to do what she could do, with limited resources that she had she really tried hard for her baby, and it was her first, but it was a very amazingly different attitude towards it (280)</p> <p>The Family Care centre have done their darndest - pulled the records and sent invitations to everybody to set up a young parent support programme - I believe that we have the second highest teenage pregnancy in the State (695)</p>
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Although the obstetricians are preoccupied with maintaining private practice and tend to see public care as a safety net, or charity, they are not completely unsympathetic to those who are more needy.

They come from up the coast or from the country and end up in labour ward. Caravan park occupants - single mothers, with little family support, drug addicts. Some of them respond well to care, it can be nice. (Ian VMO 123).

There's a lack of preparation, it can be frustrating - sometimes women don't seem to care what happens to them. Though that's a generalisation - lots of women are not like that. (Robert SR 23).

Michelle, the CMO who described herself as 'right wing' was committed to becoming a GP obstetrician in a rural area, even though many of her colleagues thought she was crazy.

People say to me only an idiot would do obstets but I like dealing with healthy patients and babies - its the fear of litigation - women have very high expectations that everything will be beautiful, but babies still die, it will always happen...My fear is - I'm always frightened that, because everyone makes mistakes and you just own up and take what's coming - in obstets there's always room to lay blame that may not be just, but its foisted on you just because you were there. It scares people away, they think it's not worth the hassle. And someone will always say you're not an expert. (Michelle CMO 71).

John, the GP was on attachment to get experience because he had decided to stay with country obstetrics. He would have preferred not to but he perceived an extreme need for GP obstetrics in the country (5). Both of these can be seen as somewhat altruistic, against the stereotype which Ian complains of, that all obstetricians are selfish capitalists. However, their solution is the traditional one of encouraging more people into private health insurance. Even Margaret the NUM who was critical of private medical practice recalled working in an expensive private hospital interstate, where the needy were cross subsidised by charging wealthy women "\$450 a day to mind the baby and change the nappies. It supported the whole unit, including those who couldn't pay"(34). For most of the doctors, this model of provision for those who can't pay is preferable to a universal system, ideologically and because the public system is under funded.

While many of the midwives appear to share the popular disapproval of 'welfare mothers', there are moves by some of them to address systemic problems amongst the women they serve. Both Margaret, one of the managers, and Nicki one of the midwives who was enrolled in a Masters' programme, had altruistic aspirations about what midwifery could achieve with disadvantaged communities. Margaret had worked in the past with indigenous people both in Australia and overseas. Nicki and her husband had a long standing plan to work in the far north,

When I did (midwifery) I was intending to go and work on ... a little island up in the Gulf of Carpentaria - haven't got there yet. Well my husband had worked there before we were married and he'd actually been up there building houses and things like that and felt that we could do...real nitty gritty sort of stuff...So we have just been talking about it recently. With two children, now, it's more complicated...Whether we'll get there or not, I don't know. I'd like to do some coal-face work. (Nicki MW40).

For the time being she was planning an outreach for teenage mothers.

I want to do early intervention teenage pregnancy - teaching teenagers how to be healthy, not how to be pregnant; ...I can't help but feel - and this is probably a terrible thing to say - but these kids who are pregnant at fifteen are not going to hear me at school anyway, whether I'm there in front of them or not, they don't listen - It's not for them, school is not their bag, and that doesn't mean they're not intelligent, it just means school is not their bag ...so they leave school, they get pregnant and they either go up or down from there I reckon.(Nicki MW 635).

Although Margaret, one of the Nurse Unit Managers, expressed frustration with the behaviour of some women,

The problem with midwifery practice is that women range from really informed to the ones who couldn't give a rats, the baby means \$250 more from social security,... There are women in here getting more money than I earn. (Margaret NUM 47).

She had also taken imaginative steps to enrol young women in a sports programme which also gave them access to contraceptive advice. Her present principle concern was child abuse and domestic violence which she felt were threatening morale amongst the staff because they feel helpless to prevent abuse.

It's hard for me as head of the unit to maintain motivation amongst the staff. They have to battle with drunken husbands. And we all know what the children are going to streets ahead. There's a lot of sorrow in this practice. I've been thinking about palliative care - easier to say goodbye than to say hello - isn't that dreadful, but you don't know if they've got a hope in hell. We've had three babies born here who've been murdered (Margaret NUM 51).

She believed that there was a connection between the practices of the maternity unit and the outcomes for families. She reflected on that element of the critique of medicalised childbirth which attributes family breakdown to the separation of mothers and children at birth, the idea that when babies were put in the nursery 'behind glass', the family was not able to 'bond' by spending time with the new baby and that this made child abuse more likely. Margaret questions this received wisdom and suggests that by putting the onus back on the family and reducing the input of the professional staff, in other words by expecting 'bonding' and mothering to occur 'naturally', the new maternity unit practices had 'demystified' the fragility of the baby and made it easier for families to fall into abusive patterns.

Family breakdowns may have been our fault in the past - taking them away, putting them behind glass - but maybe we were making a treasure of them, maybe we've thrown away the protection now - when then we were saying, no you can't touch? (Margaret NUM 61).

The adoption of 'alternative' practices developed by highly motivated alternative childbirth advocates may not be the best way to address the needs of people who have fewer resources and who are difficult to reach. Even Caroline, the midwife who was most committed to such practices, suggested that staff might well be failing to reach the people who are in the most need.

I think that's the whole - I think that's a lot of the problem, really, that because they don't really know any thing at all about having a baby - not a thing, you know - they've never come across it, they've never read a book about it, every single thing that happens to them is totally alien, and we forget that, and to be honest I can't imagine it, not

knowing anything about it, so I find it difficult to know where - Where do you start to explain something to somebody when you know so much about it and they know nothing, you know. So I think that a lot of the time we just assume that they've understood what we've said because it's so obvious to us. (Caroline MW 192).

However, if there were more resources directed into providing midwifery services, so that the midwives could provide one to one care and better outreach programmes some of these problems might be addressed. Margaret commented on the enormous amount of public money being spent on private obstetrics and gynaecological surgery, the 'waste of resources on rich people' and 'they've taken out every uterus in the area',

When I think of all the things we need, midwives and social workers out in the community to see why these babies are being murdered. We're beginning to appreciate birth as the creation of the family - fathers, grandmothers there. But we need to ensure the child is fostered and nurtured in a safe environment. (Margaret NUM 59).

This section has demonstrated that the arrangement of public and private care in Town hospital has the most thoroughgoing effect on every aspect of its activities, affecting the level of choices public patients are offered and in some cases the timeliness and appropriateness of their care. It has also shown the tensions between two models of health care, a universal one and one based on private health insurance with a safety net for the uninsured, which operate to their mutual detriment. It has also made the point that there is considerable unmet need in the area for services which could be provided by midwives who are beginning to focus on the whole population, not just the individuals for whom they care, but that lay attitudes to disadvantage may interfere with this.

### *Conclusion*

The intention of this chapter has been to review the three strands of the feminist critique of medicalised childbirth with reference to the study hospital. This exercise has shown that some changes are in process, such as the introduction of 'alternative' birth practices and an increase in egalitarian communication styles by some of the younger doctors. The discourse of medical harm and of evidence-based practice have raised and reduced but not eliminated some medicalising contra-indicated practices, such as the use of pethidine and the automatic induction of labour for women with ruptured membranes. However, in neither case has the change been accompanied by the complete ideological changes which the 1970s critique would have demanded. As well, elements of alternative practices are used in many births, by practitioners with different philosophies. Women also are diverse in their knowledge and desire for intervention or natural birth or some combination. The discourse of intervention as harm is not thoroughly taken up; most practitioners appear to believe that social induction and early epidural are acceptable and safe options for women. However, this does not mean that women are automatically given the option to choose 'safe' practice or even to take on the risk of harm themselves. These options, as well as the ability of the junior staff to deliver the best possible care to public patients are impacted by the way in which the hospital is funded and connected to the system of private practice. Rather than a wholesale adoption of any one critical discourse, elements of them are circulating within an overall regime of risk management called, 'good care', which operates within

the tension between a universal and a two-tier system of health care. The final chapter addresses the implications of this situation for the boundaries between medical and midwifery practice.



## CHAPTER 8 MEDICAL AND MIDWIFERY BOUNDARIES.

The discussion of women's shaping of their own experience in Chapter 6 showed that there were intense relationships between women and practitioners which were not confined to one gender. Although these can be shaped in traditional gendered ways, with paternalism on the part of obstetricians and dependency on the part of women, this is not the only format (Reiger, 2001b). There are many different levels of autonomy and relationship between both male and female staff and women. Similarly, throughout the discussion of the three critiques, issues of the boundary between medicine and midwifery have constantly been in circulation. This section will pursue the issue of medical and midwifery boundaries based on the interviews, casual observations and observations from some more formal events, such as clinical meetings. The main issues which will be addressed are changing relationships between VMOs, junior doctors and midwives and different styles of formal presentation between medical and midwifery practitioners, especially in respect of formal knowledge and emotional care

### *Patterns of formal and informal persistence and change*

There are obvious differences between medicine and midwifery in their knowledge base, their daily practices and their style of relating to patients and to each other, but the opposition between male and female, medicine and midwifery is not completely fixed (Pringle, 1988: Chapter 3). There are possibilities for doctors and midwives to interact in a pragmatic way which contradicts the theoretical opposition between the two models of care (Foley, 2003:166). A close consideration of how the boundaries operate in practice can enhance understanding of the potential for positive change and suggest ways out of a technological/natural impasse. Michelle, the CMO who wanted to be a country GP obstetrician said,

Doctors equal intervention, midwives clinic equals natural birth, that's the perception but it doesn't always follow. Some obstetricians will deliver in all sorts of positions. It's gone the wrong way and we have to fight to bring it back. It's possible to make a big difference - to encourage them [women] to be in charge. I think it's different for women doctors - people perceive that a female obstetrician will intervene less (Michelle 42).

Caroline, the young midwife with the most commitment to 'natural birth' was not sure whether gender is the most important factor or whether it is outweighed by professional training.

I think women doctors are possibly better, but even then I think just because they've gone through the training - because they wanted to be a doctor, they wanted to help the sick - men or women - you know, they do want to take the pain away and make it all better. But I think women are better because - especially if they had children themselves - they know what to expect. They know that the woman looks as if she's falling to bits, but "I looked like that when I had a baby and I was alright" sort of thing, so - But there aren't many female obstetricians ... (Caroline MW 104).

Individual senior midwives were able to exert some authority, because of their position, their personality and the length of time they had been in the job.

As for the medical staff, I think I enjoy respect of the men who work here. I've had to work hard for that. I don't know if it's them changing or me - I couldn't possibly say (Margaret NUM 53).

The VMOs are described by the more junior midwives as quite chauvinist and as engaged in a power struggle with the midwives.

Table 8.1 Midwives' views of the obstetricians

June MW	Some of the obstetricians are still the old school - "I'm the doctor, you'll do as I say" (55)
Nicki MW	The male obstetricians are fairly traditional and highly, highly chauvinistic, and I think that's - that makes life difficult at times....They're very young men to be so entrenched in the power struggle. And actually that's another thing I've never been so aware of anywhere else. I have with one or two doctors of a larger group, but it's a power struggle between them and between them and the nursing staff in maternity up there, which is very interesting (72)
Caroline MW	You know, they're condescending ...and you can almost feel them patting you on the head you know. Or else they'll just be rude to you and, you know, if you don't call them - one of them, particularly, at the right time so he can get there for the delivery, then he can be abusive, you know. "Why did you call me too soon/too late?" For God sake, you know,...the kid doesn't have a watch on and know he's meant to come half-an-hour after I've telephoned you (104)

Formal clinical meetings were the place in which major differences between the medical and midwifery staff were most evident, particularly in the style of expression and the kinds of knowledge that were seen as relevant. The dominant medical style tended to be impersonal, factually based and the predominant midwifery style to be personal and anecdotal. Changes toward a more empathic style by some doctors and the more professional, research based style of some midwives did not come to the fore, rather there was a clash of 'cultures'.

I was told that these meetings were a forum for inter-professional education where the staff could debrief with respect to incidents which had occurred, such as perinatal deaths and where policy was set. Discussions about the deaths of babies are obviously difficult, as they involve apportioning blame and dealing with feelings of guilt. It is an area of maternity care which has sometimes not been well handled (Barclay & Jones, 1996). The clinical meeting seemed to be a rather political forum in which to do such a delicate task, but it was a good setting for observing communications between professional groups.

The meetings were at six o'clock in the evening in a large room with a high ceiling in the old part of the hospital. The clinical meeting was necessarily formal because participants were seated round a board-room table. The proceedings were chaired by and dominated by the obstetricians. Meetings were attended by VMOs, some junior medical staff, the senior midwives and some less senior midwives who were off duty. Most midwives, who work shifts, were not able to attend even if they had wanted to do so. The majority of the midwives who attended did not speak, and it does not seem that attendance would be very attractive to midwives in general, if there was no possibility of participation. The midwives had their own 'education meeting' between the morning and afternoon shifts which was not attended by doctors.

Although they interact in the everyday and may be seen as doing similar kinds of work (Foley, 2003:180), the professional groups had markedly different styles of self presentation. Doctors gave formal presentations. They presented standing with visual aids on an overhead projector, concentrated on rare conditions and tried to catch each other out by asking difficult questions. Their conversations were competitive and loud and passed over the heads of other people in the room who rarely contributed. Midwives who presented data on, for instance, breast feeding problems, read their papers sitting down and confined themselves to descriptive statistics, they seemed somewhat intimidated by the setting.

One clinical meeting addressed the recent birth of a baby with a serious malformation which had not been detected by pre-natal tests. As well as the issue of clinical judgement and responsibility, this meeting also brought up questions of the appropriate kinds of evidence and the handling of emotion. The initial discussion was of a technical nature in which randomised control trial evidence about prevention of this particular malformation was combined with a discussion of who had failed to detect the problem on the ultrasound. One of the registrars was blamed for this. He was not present at the meeting; I had seen him leaving the hospital and he remarked to me that he was going home to spend time with his wife, which I interpreted as meaning that he could not face the meeting and needed emotional support.

It was difficult in the context of the clinical meeting not to see the boundaries between midwifery and medicine in highly traditional gendered terms, in terms of personal style, body language, willingness to be confrontational and preoccupation with the abnormal. Doctors seemed to be portraying the dominant rational side of the dichotomy and midwives the emotional, submissive side.

### *Gender, professional boundaries and emotion*

The issue of emotion and gender could be seen even more clearly when a female paediatrician presented research about handling the grief of parents who have a handicapped baby. All the doctors present were male and all the other females present, except for me, were midwives. Even though this was a very relevant topic to the case under discussion, the paediatrician seemed to struggle to establish her credibility. She apologised for the 'airy fairy' nature of the topic and the lack of hard evidence, and constantly deferred to the obstetricians. One of the midwives told me later, "She rarely is called 'doctor'; you know, even patients don't know who she is, which is awful"(260). She presented research which argued that it was helpful for the parents to have a known doctor, that they needed a lot of time and information about the handicap, physical contact and a repeat interview after two days. This was possibly to build a case for more involvement of the paediatricians but primarily to support the suggestion, which the previous chapter depicted as highly controversial, that public patients needed improved continuity of care. At one point she referred to the recommendation that bereaved parents need physical contact and said, "Of course I don't touch my patients, except the babies, I just hand them the tissues and stand back "(Notes clinic1 78). One of the less senior midwives who did not usually contribute volunteered some additional information on this issue,

From what I've read and courses I've been on, they say that handing people a box of tissues is telling them to stop crying - that you can't handle it (Notes Clinic1 82).

This seemed to be a reasonable point but instead of taking it up and building an alliance with the midwives based on gender, the paediatrician took it as criticism. She snapped at the midwife who did not speak again. This embarrassing put down was covered up by silly conversation and people miming blowing their noses on their sleeves. As has already been noted, the VMO's argued strongly that continuity of care was impossible for public patients and one of them further argued that it was important for VMOs not to be emotionally involved, because they did long stretches on call.

You might be there for four days over a weekend - you can't get too emotional. I remember one week I had four still births, I was in pieces. You've got to keep something back for yourself. Midwives are only there for eight hours and then can go home - they are more available to get involved (Notes clinic 1 88).

The VMO here defined 'emotional work' as something that belonged to the midwives' domain, but he did not appear to give them credit for any greater expertise from which the doctors might learn. I was left with the impression that it was less important and valuable than the heroic work of being on call for very long hours and remaining impartial.

The other function of clinical meetings was to set policy on particular issues, such as antibiotic cover for particular classes of patients and here the issues of gender, rationality and power were evident in other ways. VMOs had different opinions on this topic, as reflected in my interview with one woman who had been upset when one specialist told her she did not need the antibiotics the other doctors had told her were essential (Deirdre PN2 38). The senior midwives entered the debate with the intention of getting some resolutions agreed between the senior doctors so that they would have uniformity in the treatment of public patients. The VMOs ask the most well informed Senior Registrar for the latest 'evidence', on which to base a protocol to guide the midwives and juniors. They jealously guarded their freedom to exercise their clinical judgement about their private patients, but the midwives were relieved when they could get them to agree on some aspect of public patient care. The decision they reached with some pressure from the most senior midwife and the 'evidence' from the SR, should prevent women like Deirdre having such a problem again. Other small 'victories' from the midwives point of view were decisions about calling in paediatricians for babies who had received pethidine and a decision about communicating with GPs (Notes Clinic1 97). The paediatrician's suggestion of continuity of care was vigorously refuted by all the VMOs present because it did not accord with their understanding of the boundaries between private and public care, but the senior midwives in alliance with the junior doctors achieved the evidence based guidelines they had been seeking.

As the clinical meeting scenario shows, on the formal level there are patterns of authority in which medicine is dominant and midwifery subordinate, but even here there is some room for midwives to achieve the decisions they want. On an informal level, the boundaries between the medical and midwifery staff have become more fluid. Backstage in the coffee room I gathered the impression of the collegial relationship of junior doctors and senior midwives as they negotiated the heavy but episodic workload and complex demands of public and private obstetrics. The junior doctors felt that they

should have a bigger say in the setting of policy, “Considering that we do three quarters of the public obstetrics, from the medical point of view, we should have a say”. The ante-natal clinic midwife said, “You’re just the meat in the sandwich” and they all joked about the impossibility of getting the VMOs to agree about anything (Notes 11 2).

The potential for cooperation between midwives and doctors is limited by the competition between the two occupations over patients, as Witz (1994) observed for the nineteenth century. There are also issues of the different cultures between medicine and midwifery (Foley, 2003). One JMO summed up the situation.

The boundaries [between medicine and midwifery] are blurred - getting more blurred and that’s OK. The problem is the professional issues – there are only so many patients, and people want to make a living. Medical people are not very nice to each other. They are used to success, highly motivated and competitive. They may say “What a pity” when someone didn’t get a job but really they’re thinking “better its him not me”. It’s a pyramid structure, much more competitive than at university (Notes 61 3).

One of the professional issues which creates tension between the midwives and the VMOs is potential litigation (Lane, 2001). As described in Chapter 7, this issues has become very salient for private practitioners. One of the midwives spoke about the tension such issues caused.

We raised some issues about litigation and the VMO said “What’s it got to do with you? We carry the can, what business is it of yours?” I was very glad to go home from that meeting (Notes 11 8).

The idea that the clinical meeting might be a good way of addressing the emotional needs of the people who work in the unit, as some of the doctors suggested, is rather bizarre. The midwives do in fact take responsibility for a lot of emotional work. Several midwives told me that they had particularly good protocols for meeting the needs of parents whose babies have died, that they cater for the parents needs to see the dead baby, to spend time as much time as they need, and they make up an album with photographs and handprints for the family to remember him or her (Nicki MW 468). While the emotional needs of parents may be catered for, the emotional impact on other patients and the staff may be less well addressed.

The girl next to me lost a baby on the Saturday, she’d been in for three weeks but something had happened, she was induced but the baby got crushed. On Sunday morning her husband came to tell us. She’d been put in a private room on Saturday. I felt so guilty. The girl across from me had known her for two weeks. We all had boys but she’d had a girl. The sisters were crying “We lost the baby”. Then I wanted to get out of hospital, the atmosphere was very sombre...I had the same bed with [both boys] next to the desk and I heard them saying, “you have to write down everything that happened”. The poor midwives have to go through it again and again. And poor Doctor ...It wasn’t a very nice place to be (Deirdre AN1 310).

There was no set procedure for handling the grief of the staff. Nicki (MW) felt that they comforted each other and that debriefing round the coffee room table was probably more effective than a formal protocol as it was immediate (478). It does not seem that anything was provided for the women in the shared room, wondering what had happened to the woman who went into labour and never came back.

The midwives form a supportive community for each other, particularly those who work in labour ward. One midwife was talking about her day off when she had celebrated her birthday with her family. She said that it had been very nice, but she would rather have been at work with her friends. There were usually birthday cakes to share in the tearooms (Notes 91 6). This contrasts with the JMOs view that the medical world is one of individualistic competition.

### *Changes in midwifery culture and responsibility*

The dichotomy between midwifery and medicine may be lessened in future because more women are becoming doctors and not all the male doctors are imitating the traditional paternalistic style. As described, midwives are also changing, some aiming at a more autonomous professional attitude and others leaning towards a more 'alternative' ideology. There is at least the possibility that the two groups will move more closely together so that patients will have 'the best of both worlds' (Foley, 2003; Smeenk & ten Have, 2003).

Relationships have changed over time, they vary between places and they depend on personalities. All these dimensions of change take place against the wider background of government policy and social change. There were specific changes at the hospital, such as the introduction of the midwives' ante-natal clinic as well as the influence of birth centres in neighbouring hospitals and a general climate of social and professional development.

The midwives clinic, we see our own patients. There is much more time. There's a lesser volume of patients even though there's a lesser volume of staff, but we allow ourselves double the time, so we still weigh them and do their blood-pressure and check their urine, but we very much talk to them about all the other issues that are going on in their life, and like their diet and their exercise and their sleep, and we try very hard to provide natural remedies like arching their back for their sciatica and all that sort of thing; we've got the time to tell them all of that and to give them opportunity to ask questions. We now do post-natal visits so we get mothers back at three weeks to show us their babies and talk about contraception and pap-smears and breast-feeding, mainly, and we pick three weeks because that's when they all fall out, that's when they get into strife, and that's lovely too. We don't - we don't offer (team) midwifery, we don't offer a total continuity of care, but the ladies really like the fact that they see one of us - ideally the same one of us - at every visit, and then again at their post-natal visit when they come back, (Nicki MW 400).

Margaret, one of the nurse unit managers, reflected on the transformation in midwifery medical relationships and notes the subtle difference between a traditional and rather patronising attitude to midwifery skills and a more co-operative relationship with younger doctors. The problem is still a power imbalance between the younger midwives and the most senior clinicians, in which the midwives have not got sufficient influence.

I suppose you were well respected (in the old days) "I'm so glad you're looking after so and so" but it was as long as you didn't have any opinion - just "how many cm is she? And "get me there on time". It seems so long ago.

Younger doctors are better with midwives. The midwives are less tolerant of arrogance from them. My girls fight with obstetricians about stupid things, they're not powerful enough to stand up to them over clinical issues. They come to me - that's what they're supposed to do (Margaret NUM 55).

Tables 8.2a and b show responses by doctors and midwives about the scope of decisions taken by the midwives. Although the factual content of the answers is similar, because the scope of midwifery practice is quite clearly defined by protocol, the mode of expression says a lot about the diverse views and relationships between medical and midwifery staff, which is why they are quoted at some length.

Table 8.2a Scope for Midwifery decision making according to doctors.

Robert SR	Well, its not really their decision, they can say what they think -especially about pain relief, "she isn't coping or she's coping quite well" - Different units have different policies, it goes on the protocol in the particular unit, whether to do an ARM. Syntocinon, that's not their area at all, they can suggest it, but that's not their decision. In this unit the midwives do ARM, scout clips, take blood, give anti-biotics and some of them can cannulate. Other units are beginning to do suturing - at the Teaching Hospital they can do a course in repairing 1st degree tears, but only 1st degree, not any others. (51)
Michelle CMO	That depends on who they are. The seniors will tell you – she needs ..... The juniors will say what do you think? If it's a junior resident they'll say "We did an ARM and she's going well..." The midwives do all the top-ups [of epidural anaesthesia] - they taught me how to do them - and epidural anaesthesia for post-operative pain - no midwives were accredited to do it - so we were in this situation that they taught me how to do it so that I could authorise them to do it. I don't know the legalities of suturing - I suppose if they've done the course, I'd be happy to teach them to suture; if they've done the episiotomy, they should be able to fix them up - and minor tears. (20)

The two responses in Table 8.2a epitomise a conservative and a progressive medical attitude. Robert's was the most conservative response. In his view midwives are not allowed to make decisions, though they can follow protocols and make suggestions. He admits that the scope of midwifery practice is expanding elsewhere, but only to a small degree. Robert's response preserves the traditional hierarchy between the two occupations and only reluctantly acknowledges change. Michelle's response was very much more cordial towards midwifery decision making and more realistic about the realities of life in the maternity unit. She distinguishes the senior midwives, who will tell junior staff what needs to be done from the junior midwives who will ask for an opinion. She acknowledges that if the doctor is very junior, the midwives will take action and tell the doctor afterwards

Michelle also points out the ridiculous situation that the midwives had to teach her how to do something, to top up epidurals for post-operative pain, so that she could officially authorise them to do it and she says that she is quite willing to teach midwives who are qualified how to suture [stitch tears], as opposed to Robert's more defensive answer. She is not sure though, whether all midwives want to expand their scope of practice, and says that she has encountered the attitude that the midwives have enough to do without taking on medical work as well, but this may be an attitude she has absorbed from the midwives she knows in her family, who she quotes as saying, "We've got more sense".

Table 8.2b Scope for Midwifery decision making according to midwives.

Peggy MW	If the baby's in trouble or the mother has severe IPH - we're on the spot, we have to pass it on but you know what these doctors are like - you have to be tactful, don't just say "this baby needs to get out" - they know that, they'll discuss it quite happily. So we don't physically do very much accelerating but to a large degree, we're the instigators. Mostly we rupture the membranes and put up a synto drip (44)
Nicki	Those sorts of things are fairly much suggested by the midwife and if they're reasonable,

MW	generally acted upon - that's not such a problem. Procuring an epidural sometimes is, but that, again, is a problem with the anaesthetist rather than someone agreeing that it needs to happen, basically. Yes, they'll agree that it needs to happen but then you've got to find someone to actually do it (132)
Caroline MW	Yeah, there is really, but because I'm still a junior I don't really - and I am, I probably too much I'm non-interventionist. You know, I would rather stray to the side of not intervening whereas some of the other midwives, yeah, I've seen midwives that are more senior say "I think she needs ....." and they'll just tell the doctor, really, "I think she needs ..." and the doctor will say "Yeah, rightio"....not so much the private patients, but the clinic patients, where you just have to deal with the resident or the registrar, they'll just say "I think that's what should be done" and the doctors will say "Yeah, OK" and they'll write it up and that will be it. So, yeah, there is that - they do make the decisions; well, definitely with the clinic patients. With the obstetricians, they would call them first and they would come in and say "Yes, I think they need ....", but the midwives wouldn't make that decision, but they would call them.(116)

The three midwifery responses in Table 8.2b characterise different approaches to midwifery work. Peggy relates the traditional midwifery view that they are 'on the spot' but that information has to be relayed tactfully to doctors so they don't feel threatened, Nicki, whose approach to midwifery is a professional one, feels that the midwives do have a reasonable ability to have their suggestions heard, except for organisational issues such as arranging epidurals, where they don't have the control. Caroline, the most alternative midwife, feels that she is too junior to have much decision making power, and that she would be reluctant to intervene anyway, but she points out the difference in power between the public and private patients, and the difference between dealing with junior doctors and specialists.

The junior doctors who had experience at several hospitals varied in their overall attitudes to midwifery, but they all expressed some concern about the increased role of midwives, even if, like Stephen, the more progressive Senior Registrar, the concern was expressed in sympathetic way

The midwives clinic is a really good idea to improve the continuity of care. The midwives are very well educated - very motivated, so they provide good education for the patients. The down-side is that they are very anti-interventionist which is OK because the clients are too, by and large, but it can get them into trouble. I have seen cases where they have waited too long with disastrous outcomes, they are potentially doing harm. That's experience of course, but also stubbornness - I've seen very experienced midwives involved in disastrous outcomes because they just wouldn't say 'I need some help'. It depends on the nursing medical relationship. It's not good at present at Town - there's a lot of tension (Stephen SR 43).

Stephen is critical of midwifery 'stubbornness' but he puts it down to a relationship between midwives and doctors, which encourages or discourages asking for help. Robert is also worried about the increasing scope of midwifery practice, its implications for patient care and for the training of junior doctors.

I think it [Active Birth] should be encouraged as long as there's continued team work - there's a tendency at the Teaching Hospital for the midwives to see the Birth Centre as their domain and they keep the doctors away from public patients - they're subtly kept away... In most cases nothing happens but things can get left - the midwives might not be as alert to changes in CTG [heart beat]- they tend to miss failure to progress, it could be eight hours before you pick it up, it would be identified much earlier in the main unit. The midwives tend not to do PV's[vaginal examinations] so often. It is bad for the juniors - they are supposed to see so many normal labours but it's often a case of "oops, we forgot to call the doctor in time"(Stephen SR 64).



He describes the problem as more technical than one of relationships. According to him, the midwives do not carry out procedures or interpret data competently and have a territorial attitude to their patients. Even though Michelle communicates well with the midwives, she agrees about the relationship with the birth centre.

You're much more excluded from the [Teaching Hospital] birth centre - I don't know if it's the personality of the midwives or the preference of the women but you feel as if you have to apologise as you walk in - its very uncomfortable. It's a little bit like that in the main part too (Michelle CMO 16).

But she feels that the relationship at Town hospital is more constructive, despite the structural tension over who is going to manage and who will deliver normal babies.

There are bigger numbers at Teaching Hospital - but you have a better relationship with the midwives here. It's difficult for residents and midwives to get on well. Some groups of midwives are less likely to want me to get involved, though it's more likely that they'll ask me than some male residents. Because of the title you're expected to waltz in and interfere, but if I'm not asked I don't interfere, I don't examine her or touch her (Michelle CMO10).

She also acknowledges the teaching role of the midwives, an aspect of midwifery practice which is not frequently noticed (Foley, 2003:181) and that they differ in their degree of desire for autonomy.

The midwives are less likely to be in charge of a woman's labour - here they involve the doctor and there has to be a doctor at each delivery. They like to teach and they know we're here to learn - they're more willing to involve you. It depends on the midwife. Some are more dependent on the resident - not for guidance but they'll ask for back up - what do you think about...? They bounce ideas off you. I suppose that means that they are less autonomous (Michelle CMO12).

Michelle's view is confirmed by Rose's account of midwifery work.

We have more responsibility here. In some places you can't even do a VE (vaginal examination) without a doctor's OK. It's a huge responsibility, but the staff are capable of it. If you wonder "Am I overstepping the mark?" you go to one of your peers and get a second opinion, some support and input. It's backup in case someone questions you. If someone's labouring away and there are no complications we let them know that they're there. Ring the doctor and they come in for the delivery. You ring and then arrange the care. Pain relief is liased with the doctors (Rose MW45).

Michelle describes a somewhat cooperative relationship with the midwives, who in turn find her easy to get on with, and are more likely to go to her than a male doctor because she does not 'interfere' without asking. She also behaves more like a midwife on occasions, up to the point of doing strictly nursing work "

Michelle's a dream. She's seen it from both sides [she has midwives in the family]. She'll give a pan if it's necessary. [The other woman medical officer] will be too when she's more experienced (Peggy MW 41).

The other registrars differed in their relationship to women and midwives. Nicki feels that their gender is part of the explanation, but personality and attitude are also responsible.

Two of the three have been wonderful; one of them was a fairly traditional male ... So he was a bit of a difficulty...to get him to do what you wanted him to do for the women was quite a psychological challenge.

We have two female residents job-sharing at the moment - I know that the ladies like having ladies, they really do - I should say women. But, they're great; they're very sensitive to women's needs and very easy to deal with. We tend to operate with them as women rather than as doctors and nurses, I feel.

We have, and have had another junior male resident - he's a real odd-bod at the moment. Normally - the one we had before him was excellent, so I don't think it's so much the fact that he's the junior position or that he's male - I think it's really just a...personality issue, yeah, exactly. And he's not - he's not unkind to the ladies - he's very nice to pregnant women, really, but he's just an unusual man (Nicki MW 88).

Caroline, the alternative midwife, finds the intervention of some doctors into midwifery care frustrating, because they observe the woman from the outside and tend to want to take action instead of relying on the midwives' knowledge of the woman.

God, why did you offer them [pain relief] - they were doing alright. So that's very frustrating. You don't want anybody else to interfere. You're managing this woman, you can see that she's coping well, the baby's coping well - just leave things alone. But they're doctors and they can't: because they started as looking after sick people, they just can't separate the pregnant woman from that 'sick person' thing; all people in hospital are sick, and that's it, you know, and we must stop the pain, we must make it better for them. So they want to do all these things which go against the natural flow of it, you know (Caroline MW 100).

While it might be expected that Caroline would find the doctors 'interfering' because of her commitment to low intervention, even Rose whose position is rather more conventional, gets annoyed on occasion.

When they do a VE (vaginal examination) "just to see how you're going" when we've done one five minutes before. If it's only to assess progress why do they do it? If we're good enough to care for them they should trust our judgement. It's an indignity for the women too. One day I'll get the guts to say, at the moment I just seethe (Rose MW 47).

Nicki, the professionalising midwife, feels that the degree of midwifery autonomy varies according to who is in charge,

Well I sit in labour ward to do my notes every day, so I listen to what happens. I think it depends very much on the staff members that are working. Some staff members will do exactly what they think the doctors want done and others won't, or won't so readily - they will question it. So it depends, really, on who's running the show, basically (Nicki MW108).

Stephanie, one of the unit managers, feels that midwives at Town already have higher level skills than at other places, but they are not recognised for their professionalism.

We provide a high standard of care and have more clinical expertise than the Teaching Hospital. Midwives here rupture membranes and put on scalp clips. Our clinical skills

are much greater - there you have to compete with students, residents, med. students. It gives us a better feel about our work. Margaret and I write the protocols, she has the expertise for the nursery ones. I've had registrars say, when I've offered to do something "Oh, can you do that?" Sometimes I feel frustrated; midwives need more recognition for their professionalism. A junior RMO is going to be educated by the midwives, not by the medical staff - but when they leave they won't realise that most of what they know has been taught by the midwives (Stephanie NUM 24).

Obviously there are changes taking place in the maternity unit. It seems quite obvious that people know what needs to be done. Stephen (SR) says that women need individualised care, even though that is difficult. Robert (SR) says that shared care between doctors and midwives is ideal, though he does not see how it is possible in the public system. The midwives say that they can give the best care if they have one to one staffing, but that makes them unpopular with the administration. Midwife Nicki says that the midwives want an expanded role, if only they can all agree on it and the obstetricians will not make problems for them, while doctors Michelle and Stephen agree that a good relationship between the doctors and the midwives encourages consultation. It thus seems that the gendered boundary between intellectual knowledge and emotional work is becoming less rigid. The political question is whether it is seen as important enough to fund maternity care properly and whether the interests of women take precedence over professional boundaries.

## Conclusion

The boundaries between medicine and midwifery that I found at Town hospital are permeable and becoming more fluid, both in terms of gender and of the work that is undertaken. But while there is considerable change at the junior level, the persistence of professional monopolies militates against swift change. There is still a persistence of traditional gender and power relationships, but the degree of changed gender identities found shows potential to allow a blurring of boundaries. Such change would not so much represent a radical alternative to the maternity care system as an acknowledgement of diversity rather than the historical enforcement of greater uniformity. Such change allows some genuine choices for women even while it is well acknowledged that both doctors and midwives are operating within a regime of risk. What is highly valued by the women is a freeing up which allows, genuinely communicative and warmly emotional relationships and access to a range of methods for dealing with the issues of childbirth in a manner which takes their choices seriously. What would be the worst option for birthing women would be for midwives to attach their professional identity to a doctrinaire version of 'natural childbirth' that becomes the default option. Choice and issues of support are central on the day, but crucial to this is that people who work in the hospital and for all those who will give birth that the services are available and are funded to allow a degree not only this choice and support, but also a capacity to celebrate this life transition with appropriate conviviality.

## Postscript. Birth and conviviality

One of my last visits to the maternity unit was on the day of the Christmas party, which was set up in the large empty nursery left by the change to rooming in. The nursery was

decorated with streamers and there was a Christmas tree. The tinsel looked strange against the clinical pastel paint and shiny linoleum. It was an incongruous setting but it was close to the delivery rooms and the working nursery, so that the midwives at the party could remain aware of what was happening. One of the first women who had been a patient of the new midwives' clinic went into labour and the birth was going to be handled by a midwife without a doctor present. The Christmas party seemed to be an appropriately festive occasion for celebrating a birth, especially one so significant for the expanded midwifery role. I went from the party to the delivery room to act as an extra birth supporter. The labouring woman was on the bed, with her partner holding her left hand. Things were getting rather hard for her to handle. I held her other hand and she gripped tightly, looking desperate as if she was having trouble coping. Just as Stephen (SR) had suggested, she was pushing on her back and nobody asked if she wanted to change position, which they would have done if she had been at home or in the birth centre. The midwife put on a gown for the delivery, and goggles in case she was splashed with blood. I had not been at a birth before where universal AIDS precautions were taken. I understand the need for them but they made the midwife look like an 'alien' and I had seen a lot of midwives deliver without them. We reassured the birthing woman as she struggled with pushing and with the discomfort of stretching to give birth, "breathe, keep looking, only a short time to go". The baby was born, the couple were very happy, and the midwife relieved. She wrapped the baby, and gave it to the mother, but was a bit concerned about its breathing. This is the day to day business of the maternity hospital, in one way very mundane and ordinary, but for each woman an experience of enormous physical and emotional intensity and for each staff member a heavy responsibility. Back in the nursery, the midwives gave each other presents, everyone drank champagne and ate party food. Periodically an alarm went off in the working end of the nursery and two or three midwives left to help another small baby who was having trouble breathing. The maternity unit operates at a pivotal point in the transition between life and death. As well as a great capacity to handle emotion, a requirement for complex technical knowledge and highly developed craft skills in surgery and the care of small babies, there is room for celebration.

## CONCLUSION

### *Introduction*

The problem that inspired this thesis was that feminist theorising about childbirth appeared to be static and not developing in parallel with other feminist theories of the body and subjectivity. A feminist critique of childbirth was widely assumed, as Annandale (Annandale & Clark, 1996) perceptively diagnosed, to be a single position. This formulation was inaccurate, because the feminist critique of childbirth was in fact, as I have shown in Chapter 1, extremely diverse. She also pointed out, and I have documented this, that second wave feminist theorising tended to universalise issues of women's desires and the functioning of the female body and to dichotomise issues of technology/nature, male/female, obstetrics and midwifery. In Chapter 3 I presented an account of the feminist poststructuralist concepts that I believe are useful in countering these problems and producing a re-imagined account of childbirth. I have attempted to demonstrate this by carrying out an empirical study into a particular maternity unit and using the accounts of women, midwives and doctors to rewrite the story of birth as a drama, to enter a dialogue with the diverse strands of feminist theory and to challenge the idea that alternative midwifery is the only form of practice important in feminist understandings of birth.

### *Post structuralism, power and embodiment.*

A valuable focus of post-structuralism for approaching reproduction is the way that power is not only seen in forms of domination, but as enacted in the practices of professionals and in different kinds of resistances and relationships. This presents more useful insights than any sweeping modernist assumptions of critical feminist theory that the overwhelming power of capitalism and/or patriarchy must be challenged in order to achieve liberation

Alternative forms of power can be seen in the increased regimes of surveillance operating in the maternity system. Schedules of ante-natal care and deadlines for ultrasounds, as well as the national surveillance of perinatal mortality rates are all forms of surveillance which bear on the women and the practitioners at the maternity unit. I query any reading of post-structuralism which finds these forms of governmentality intolerable but without any possibility of resistance. Rather I suggest that they entail both limitations and possibilities. The regime of risk management at the maternity unit does not stand alone and the power relationship is not just between the individual practitioner and the single patient. They are both involved in networks, in which different practices and levels of 'interference' are found to be justified. Practices of pain relief and alternative positions in labour percolate through the system and in most cases it does not take overwhelming force to shift the regime slightly away from narcotic analgesia or towards alternative birth positions. This is one positive side of the capillary nature of power. Slightly differently, there are points at which labours are defined as problematic and at this point the management regime is unlikely to allow any compromise in the direction of less technology, though as in Angela's case, it may make technological pain relief more accessible when it otherwise would not be. Another implication of the networking of power is that staffing is not under local control and unless the definition of childbirth can be changed, then only low intensity levels of staff are provided. Ironically, the promotion of childbirth as something 'normal' militates against this.

A second area of interest in post-structuralist writing has been particularly developed by feminist philosophers and scholars of psychoanalytic discourse. This is the idea of that the body is not a natural object, but one which is deeply affected by culture, embedded in individual subjectivity through language. Applying this body of thinking to birth discourages the idea that a pre-existing natural body can easily be accessed. The cultural shaping of the body is so pervasive that simply changing the external language, such as saying 'give birth' instead of 'delivered' or assuring women that birth is painless or normal is unlikely to affect the woman's embodied experience. This body of ideas suggests that a woman's relationship to the process of labour, to technology and to the people who care for her will be very diverse because she is responding to 'inscriptions' of which she is not fully aware. Thus for some people the internal sensations of labour will be absorbing and for others, they will be disgusting. Some women will want to labour alone, others will be highly dependent on particular staff with whom they have an intense emotional relationship.

Birth in this account is a highly culturally shaped, but individual, experience and not one which is simply amenable to more education on a cognitive level. The drama of birth plays out in very diverse ways and for each woman it is an intensely emotional and barely controllable event. This contrasts somewhat with the liberal emphasis on rational choice and the radical feminist idea of the ecstatic natural body available to everyone.

The women themselves showed considerable enthusiasm about explaining in detailing their experiences of their births and their reactions to the staff. At first, their response to the interviews were to evaluate the services they had received, which they did overwhelmingly positively, though consumer issues such as waiting times and the poor quality of hospital food were prominent. Their evaluation of the hospital showed that it was a significant institution for them and their families and they were tolerant of its deficiencies and grateful for its services.

The way in which women spoke of individual staff revealed the emotional importance of relationships with staff in labour, whether these were positive or negative. Significantly for the cultural feminist critique, such relationships appeared to be formed with carers on the basis of their friendly egalitarianism. Men and women, midwives and doctors appeared in these accounts as objects of positive transference. The carers had a vital role in mediating the difficulties of coping with such a personal and confronting experience in the institutional space of the hospital, though the constraints of the physical layout and the fact that the maternity unit was short staffed meant that they could not fulfil this role as fully as they might have wanted.

As they continued with narratives of their births, issues of the uncertainty of birth, situated as it is on the boundary of the emotional and physical came to the fore. The birth process unfolded as a drama in which the woman faced a challenging journey to the hospital, and the intense embodied experience of labour. This is an experience outside the boundaries of ordinary language and normal social behaviour. The birth experience reaches its climax at the moment when the newborn takes its first breath and the process of returning to the social world begins. For each woman this requires negotiating another embodied experience, that of breast-feeding and imagining her future life, involving diverse combinations of work, relationships and children.

I have described the birth in terms of the diversity of women's experience, broadly categorised as 'natural' birth, 'conventional birth' and birth with intervention. These are not fixed categories; 'natural birth' involves a changing selection of 'benign' technologies as well as the woman's own concentration and involvement. Conventional birth also changes over time in response to scientific evidence, local practice and the movement of staff from centre to centre. Birth with intervention is also a diverse category, some women did experience it as 'horrendous', but other women went through accelerated labours with pleasure. Some descriptions subverted the natural/technological opposition, like the woman who relied on the Electronic Monitor as a way of 'seeing' her own pain or another who considered a homebirth but became an advocate for epidural anaesthesia.

Cognitive learning was found not to be not the most important type of knowledge for women though some contact with the vocabulary of active birth seems to have been helpful. This may be because it gave strategies for behaviour in labour and a language for describing the sensations. Labour, like sexuality, is an area of life that is difficult to talk about. What seems to be more helpful than formal knowledge was for the women feel that there was an empathic relationship between them and their carers, both male and female. They spoke so warmly about being treated as equals, not just because they were given information but also because of the level of emotional contact. This was found to be preferable to the imposition of disciplinary knowledge by the professional staff, which in fact at times provoked resistance. This showed up particularly in relation to conflict over the issue of being allowed to sleep versus rooming in.

These data also show how close the different birth options are and the way in which any one woman's experience is to some extent contingent on the staff she encounters on the day. Although a drift away from pethidine was not actually acknowledged by staff, the interview data suggest that this is happening. The agenda of liberal feminism which promotes informed choice suggests here that more open discussion of options would be beneficial, except that the issues are emotional and embodied ones. The difference for the woman between low technology pain relief and low level pharmaceutical pain relief seems to be slight and really dependent on the cultural interpretation of the pain. This suggests at a practical level that a move towards less pharmaceutical pain relief could be readily promoted via better physical infrastructure, improved staffing regimes and better use of support people.

Recounting the drama of birth as one of embodied discourse and unconscious transference certainly highlights the limitations of rational choice in the birth situation. This is paradoxical for an institution which itself claims to be running on scientific rationality. Interviews with women show how choices are often made on a very contingent basis and heavily influenced by the emotional quality of relationships. The staff appeal to the idea of cognitive learning and in most cases oppose the discourse of the natural, but the ideal of open communication and free rational choice is contradicted when they invoke the discourses of harm to restrict women's choices.

The ideology of the 'natural birth' is treated with some suspicion in the maternity unit, while many practices absorbed from alternative childbirth milieux are combined with different levels of technology. The notion that natural childbirth is an ideal that is desired by and achievable by all women is demonstrably a serious over-simplification. The force of my critique is that 'natural birth' is a cultural practice not a pre-existing

entity that emerges by itself when oppression is removed. Unlike village societies, which have a 'doxa' (Bourdieu, 1977) (an unquestioned level of taken for granted knowledge and practices), there is considerable heterodoxy within all groups in contemporary societies including women, midwives and doctors as the study has shown. Individual practitioners have different attitudes and philosophies and the women themselves bring different levels of conscious and unconscious knowledge to the birth process. Theorising the body as inscribed by culture and shaped by language in subtle ways implies that there will be considerable diversity in the way women experience their bodies and labour. On the other hand, low tech innovations and the stress on social support developed within a cultural feminist, alternative birth framework, are still relevant and demonstrate the diversity of practice possible within the maternity unit.

Issues of equity have been central to materialist and liberal feminists' position on childbirth and the notion that parenthood is not and should not be means tested and that it should be available as a festive event for everyone, not just the prosperous, would be very widely supported. While giving birth in the semi-public space of the hospital is challenging for all women, it is even more an alien place for the most disadvantaged women, who have a substantial social distance from the midwives who are likely to see as suspect, their health behaviours and child care skills. 'Lay' attitudes to disadvantaged groups filtered into the conversations about such patients and this was combined with the frustrations of the professionals towards women it was hard to help. Domiciliary visiting might be better for this group, as one of the midwives suggested, but this requires good interpersonal skills as some midwives felt uncomfortable going to people's homes and complained that women kept the TV on and refused to let them in to the bedroom to be examined. While an expanded role for midwifery would increase the possibility that the marginalized are ever more heavily supervised, the positive side of surveillance would mean that young women and struggling families would be less likely to sink into invisibility.

The study showed the tension in the Australian system between the ideal of a universal public system and the adherence to a two tier one. As consumerism and free market principles become more and more salient and health insurance more expensive, it is hard to see people staying with public maternity care. More people will want to use private hospitals because they have nicer décor and better food and ultimately may have more responsive care. This would fragment the work of obstetricians between hospitals and make continuity of care problems for public patients even greater. As it is a well-recognised and respected institution, a public maternity hospital is in an ideal situation to give parents and children a convivial start to life and to act as a place of refuge for families who have problems. Such collective maternity provision could be something in which the Australian people might with profit choose to invest more extensively.

### ***The importance of female practitioners associated with birth, especially midwives.***

One of the assumptions of the second wave critique was that midwifery is in itself a form of 'feminist praxis' (Rothman, 1990). This really referred to independent midwifery and implied that the only birth practices which are seen as progressive are very alternative and involve individual arrangements between clients and midwives, rather than systemic changes. To arrange such birth attendance for the majority of



women in Australia would require a formidable political upheaval and a complete revising of the health system. This idea rests on a modernist concept of power and in terms of a post-modern world, the idea of an emancipatory movement which could demand change on a massive scale was overtaken in the 1980s and 1990s by the reality of increased 'governmentality', a focus on collecting information about the population and of intensified techniques for managing resources, especially on the population level.

The increase in governmentality has not been entirely negative. As described in Chapter 2 childbirth was taken up as an issue by the British Parliament and this produced the *Changing Childbirth* report which gave at least the promise of an expanded role for midwives as primary carers, including birth at home (Department of Health (UK), 1993). Admittedly the problems of the under-funded National Health Service and coordination with General Practitioners continue to make progress towards this expanded role for midwives slow, but the professional base of British midwifery was relatively strong in any case.

If Britain is afflicted with bureaucratic inertia, the problem in the USA is one of a lack of coordination or ability to get anything done in the area of health policy (Rothman, 2000), though there remain opportunities for midwives in the private sector. The absence of affordable health care in the USA means that small-scale alternative midwifery schemes play a useful role, while discussing systemic solutions that are unlikely to eventuate is rather futile. The 'liberal' climate of the USA, in the sense of free market and anti-state, means that its privatised solutions, such as certified lay midwifery, are not very relevant in the UK and Australia where midwifery is already an essential part of the public health system.

In Australia in the 1980s, elements of the alternative birth agenda had been carried by femocrats within government and this resulted in funding for Alternative Birthing Services. However, this increased interest by governments did not produce the backing for alternative, de-professionalised midwifery services, which many activists expected, largely because the late 1980s and early 1990s were an era of increased governmental activity, such as the production of the Homebirth guidelines. The alternative childbirth movement splintered at the prospect of cooperating with government regimes, along the lines of the disparate philosophical influences from Britain and the USA.

Many alternative childbirth advocates argued that the failure to gain government backing for alternative forms of midwifery was because of repressive over-surveillance of midwives. It was, as in Britain in the 1950s, partly because of increased surveillance of perinatal mortality rates (Bastian, Lancaster, Homebirth Australia., & National Perinatal Statistics Unit (Australia), 1990; Bastian, Lancaster, National Perinatal Statistics Unit (Australia) et al., 1992). Increasing knowledge and technological practice has altered subjectivity and what has increased is not just medical technology, but also the expectations that babies will survive. Thus understanding this as entirely repressive overlooks the positive opportunities within the situation. At this point, the Labor government was favouring midwifery to save money (Schofield, 1995) and while it was unlikely to subscribe to the libertarian philosophy of lay midwifery, the possibility was that it might be persuaded to back an expanded role for registered midwives in the public system. This opportunity is likely to be overlooked however if the models proposed for an expanded midwifery role involve de-professionalised practice or a fee-for-service based private practice.

Like van Krieken (van Krieken, 1996), I argue that 'governmentality' is not always negative. The idea that all forms of surveillance in relation to childbirth should be resisted is a libertarian agenda based on the idea of a pre-existing natural body that should not be subjected to interference. If on the other hand, the productive nature of power is appreciated, this means that either strategies of self-government, or subscribing to wider schemes of surveillance can produce an effect that is widely approved, such as lower perinatal mortality, competent professionals or better coordinated care. As historical analysis of the medical profession has established, the gender and class position of obstetrics, as established during the twentieth century meant that obstetricians tended to be paternalistic males with midwives subordinated by virtue of gender conventions and their lack of professional autonomy. The study shows that while there have certainly been changes and a weakening of gender and class power structures within the hospital, obvious remnants of the attitudes of medical dominance are still evident. In the interviews with the obstetricians and the midwives, for example, it was found that midwives were patronised or shouted at, and women were humiliated, for example, for not having private insurance.

However, the picture is more complicated than just the persistence of these older professional boundaries and private financial interests which still at times interfere with positive changes in regimes of care. There are possibilities for change in the complexity of the interaction between midwives and doctors. Even though there are tensions between junior doctors and midwives over access to patients and responsibility for decision making, the junior doctors and the senior midwives worked well as a team. Together they reorganised the ante-natal clinic to give greater continuity of care and their relationship was such that at least some doctors acknowledged the potential to learn from the midwives. This progressive philosophy was evident in the work of some doctors, both male and female, who seem to have egalitarian attitudes to each other and to the women they care for.

Findings from the study could be used to re-imagine the type of professional autonomy that Australian midwives could aspire to. As the interviews show, the financial insecurity that goes with practice in the private sector, is enough to alienate most midwives from the idea of an independent professional role, and the medical indemnity situation prohibits it at present anyway, but hospital midwives are salaried and covered by the vicarious liability of their employer. The alternative, of low risk midwifery based care in hospital, or in domiciliary outreach programmes, like in Britain, would be a very attractive situation for practising midwifery if it were properly funded. Necessarily it would have to operate within a regime of 'risk management', what the staff call 'giving good care', but I see this not as excessive medicalisation or oppressive surveillance but a form of positive governmentality.

Midwifery may not need to be an independent fee-for-service profession to compete with the obstetricians, an aim that has never had government support. Rather it could be a research based occupation concerned for the whole population, as envisaged by Nicki, the midwife who was planning an outreach programme for school leavers in the hope that they would not get pregnant so young. Although there are moves towards a separate midwifery register in New South Wales, the absence of a midwifery identity, may not actually be the main problem for Australian midwifery. In so far as midwifery was

subordinated as part of nursing, it may also benefit from moves to decrease nursing subordination. The NSW Nurse Practitioner Act was passed in 1998 and this is a highly significant development in respect of widening nursing's scope of practice. While its implementation is very slow, the symbolic professional boundary has been crossed with the backing of the state government. The possibility of increased autonomy for nurses is there and midwives could take advantage of that route.

***Final reflection -The significance of birth as a cultural phenomenon.***

Women's lives have changed considerably since the 1970s and birth and early parenting take up less time in a woman's lifespan than in previous generations, but it remains an extremely significant event for the majority of women who have a child at some time in their lives. The problem for feminist theorising is to account theoretically for the experience of childbirth without falling into the assumption that birth constitutes the primary meaning of a woman's life and that she can only be thought of in terms of one or other version of the 'reproductive metaphor' (Haraway & Randolph, 1997).

In my study, the practices of the maternity unit were viewed through the diverse critiques of modernist feminism to see how they were invoked in contemporary childbirth. While my study is of a single site in New South Wales and was limited in the number of women and midwives involved, I hope that its depiction of the practices of a mainstream hospital will be found capable of generalisation on a theoretical level, to question the idea of a universal theory of women's experiences and dichotomous understanding of good and bad births, natural and technological, male and female, obstetrics and midwifery. Seeing the maternity unit through all three lenses in turn serves to produce a more nuanced understanding of the issues of childbirth, reflecting the way in which the different feminist critiques have become circulating discourses. I have also explored the way in which the birth process is shaped by cultural influences, including the location of the hospital, its special layout and the language and images that women have of birth. Women's diversity is an important issue, both theoretically and in the practical regard of providing appropriate care in childbirth. An approach that explores diversity is preferable to one that focuses on a single dimension of natural or technological birth and could be used to explore childbirth at different sites in future.

While the body was a fashionable topic of theorising in the 1990s, the body giving birth has not been the focus of theoretical attention. My empirical research and theoretical discussion have aimed to address this, not through joining one or other side of any polarised debate, but by applying a post-structuralist approach to re-imagine the complexities of birth in this particular maternity unit, seen through women's narratives of their births and the staff's stories about their work. These accounts expose the role of language, emotion and transference in the social construction of birth, which in turn allows a more vivid retelling of birth as the social drama that it is.

## APPENDICES

### *Appendix 1. Interview Schedules.*

#### *Medical Interview*

Interview to take approximately one hour. Explain ethnographic research and semi-structured interviewing. Consent form. Note taking or taping. Study is concentrated on the role of midwives in hospital birth - aim of this interview is to explore this issue from the point of view of medical staff.

Experience of Town hospital obstetric unit.

How long worked here.

Compares with other units.

Describe a typical day for a registrar.

How would you describe the women who come in as public patients?

How does their care compare to women with private obstetricians?

What kinds of attitudes to pain relief have you found amongst women in Maitland?

If a 27 yr old woman having a second baby with no medical complications phoned to say she was having contractions 5 mins apart what would happen when she arrived in the unit?

What if she was determined to have a 'natural' labour, would that make any difference?

What if she asked for an epidural straight away?

How would decisions about rupturing the membranes, using continuous fetal monitoring or syntocinon to accelerate labour be made?

What would the midwives role be in that?

Do midwives top up epidurals or do suturing in any circumstances?

Have you seen any changes in the responsibilities of midwives?

Do you think change is desirable - in what way?

How would you like obstetric services to be organised in future?

How do you envisage yourself practicing in the future?

What was it that attracted you to obstetrics?

What is the best thing about it? What is the worst?

*Medical interview Part 2. Case studies adapted from Oakley and Houd (1990).*

If you imagine yourself in the position of an obstetric specialist, would you tell me how you would treat the following patients?

A twenty-eight year old woman is having her second child. She's 12 days overdue according to dates and ultrasound and the baby is estimated to weigh 3600g. Her estriol levels are normal. Her first child weighed 3500g and was delivered eight days after term. She had four and a half to five weeks between her periods. What would you do?

A twenty six year old woman is unmarried, living with a student and having her first baby. She's been trying to get pregnant for 2 1/2 years. She is twelve weeks now and everything is normal - how would you treat her?

A thirty-one year old married teacher is having her first baby and she wants a home delivery. No significant medical history, regular periods, certain about dates, planned pregnancy, non-smoker, normal height and weight. Has had a normal pregnancy so far. Would you agree to a home delivery?

What about antenatal care?

A woman is having her first baby and she's certain of her dates. Obstetric conditions are favourable and she asks for induction three days before her due date. There's no medical indication but she wants the baby to be born before her mother has to go back to Italy. What would you do in that situation?

A thirty one year old primipara who goes in to labour a few days past term. The delivery starts at home with ruptured membranes at six o'clock at night and at eight o'clock she's in the hospital 2cm dilated, clear fluid, good heartbeat and no contractions. What would you do?

A thirty-five year old woman having her third child. The dates are a bit unsure. She's in labour now, maybe two to four weeks early, although the midwife thinks she's at term. She's had three scans that show she's early. She's a smoker. She's in heavy labour when she comes in. The dilatation is 6cm and the membranes haven't ruptured. How would you treat her?

Do you use risk categories?

What about the woman's own definition of risk?

Do you think routine continuous fetal monitoring reduces the perinatal mortality rate ?

Do you think women have the right to choose the kind of care they get?

Do you think women have an automatic right to abortion?

*Midwifery Interview Schedule.*



*Schedule for interviews with women.*





## ***Appendix 2. Women who took part in the study***

Appendix 2 lists the women who took part in the study against a pseudonym with some brief details about their education and employment history and intentions, the same for their partner, whether they owned a home and where their other children were born. This information is summarised in Table 5.2. Each brief biographical sketch includes some details from the interviews which characterise their individual situation and illuminate their experiences.

**Angela** finished year 12 and used to work in telephone sales while her husband was studying nursing at university. She doesn't expect to be a full time mother permanently – she and her partner have discussed him staying at home so she can study. He is working now and they are thinking of buying their own home. This is their third child together.

Angela lived the furthest away from Town hospital, in the City. They chose to go to Town because she had her first two children there and her family live nearby and can look after the children. She didn't plan to have a family at this point in her life, her first pregnancy was unexpected. The second pregnancy was unpleasant because she was unwell and this time she discovered she was pregnant when she went to have her 'tubes tied'. She said that she had changed her ideal of motherhood from a very 'natural' and ideological one to a much more pragmatic understanding.

**Beth** finished year 10 and works in a factory, like her partner. She went back to work as soon as possible after the study birth and her mother and a friend look after the children. The family moved house during her pregnancy and live in an older style rented house on the rural fringe of the town. Beth was 23 and her partner 28.

Beth was the youngest woman I spoke to, she had her first child, a boy when she was 18 and this is her second. She gets lots of support from friends, who were at the labour and at the house when I visited. Beth had no intervention in her labour at all, but she was very emotional and fortunately received individual attention from a midwife.

**Cindy** did year 10 and found an interesting job in the media, which she had to give up when she moved away from the Capital city. She and her partner live in a rented house on a new estate. He wants to do an apprenticeship and they would like to buy a house. She would like to work but her experience is very specialised and she finds childcare too expensive. Her first child was born in Capital City. Cindy was 28 and her partner 25.

Cindy was finding motherhood difficult, especially because she felt that people disapproved of her older son's behaviour and that she was always under scrutiny. She said that the midwife who looked after her in her first pregnancy had bullied her into walking through the labour, when she just wanted to lie down and cope with labour that way.

**Deirdre** and her partner left school after year 10 – she went to TAFE, he did an apprenticeship. Neither of them liked their original training so she did secretarial work, he changed to truck driving and is employed full time. She tried part-time work, but prefers to be a full time mother. They own their house on one of the new estates, which they had recently extended. They already had a boy and a girl and were having their third child, all born at Town hospital. Deirdre was 31 and her partner 33.

Deirdre was very committed to motherhood, to her home and her garden. She had been to ante-natal classes with an independent midwife and had been very disappointed not to be able to breastfeed. In fact she had got quite depressed, but had asked for help after her most recent birth and was feeling much better.

**Julie** left school in year 10 and did a secretarial course at TAFE. She travelled around Australia with her first husband. Her present partner also left school in year 10 and worked as a storeman but is now on a disability pension because of a back injury. She is thinking of doing an open access course so that she can study nursing at university. They rent their house near the Town hospital, where she was born herself. She has two daughters, the eldest born in interstate, the second one at Town. Julie was 31 and her partner 38.

Julie has many friends who were often at the house and who act as support people. The house is full of books, in particular new age literature since this is an interest of her partner's, they devised a New Age ceremony for their recent wedding. Julie is a great raconteur and tells her life as a series of lively and dramatic stories.

**Kate** did year 10 and worked as a nurses' aide and in telephone sales. She was going to do further training but didn't continue with it. She was proud of her working history and would like to go back to work if she could find childcare. Her husband left school in year 9 and was a labourer but he has health problems and is on a disability pension. They live in a rented house on a new estate. Her first two children were born elsewhere in the State, near her family. Kate was 30 and her partner 31.

Kate's family was the most materially disadvantaged of those I talked to, they had no telephone and did not have a car during her pregnancy. They bought a series of second hand cars after the baby was born. She has a lively way of talking and uses many homely expressions for labour and childbirth, she is close to her family who, she says, all have quick labours, with no fuss. They moved to Town for her partner to find work but this has not been successful.

**Laura** has a permanent part time job in the finance industry and does one or two other extra jobs. She will go back to work after her maternity leave. Her partner is a managerial employee and spends a lot of time away on business. They were on the point of selling one house and building another one. His daughter from a previous marriage is coming to the birth. They have one daughter together and this was their second baby. Laura was 31.

Laura had the most highly pressured job amongst the women I interviewed, she was always very busy and had to fit interviews in at lunch hours. She had a lot of intervention in her birth, partly because she had been found to have gestational diabetes.

**Roxanne** left school after year 10 and did unskilled work, she does not envisage working again in the foreseeable future. She has a de facto partner who does labouring work. They are paying off the house that she bought from her family. Her two older children were born at Town hospital. Roxanne was 32 and her partner 23.

Roxanne was discontented with her life and motherhood, regretting the loss of her single social life. She was unusual in not complaining about the food at the hospital, she seemed to enjoy being looked after.

**Sheila** did the Higher School Certificate (HSC) in Year 12 and was trained as a nurse but doesn't want to work as a nurse again, she intends to do more voluntary work at her children's school. Her partner also did the HSC and had a period of unemployment after being made redundant. He has recently been to University to get additional qualifications and now has work. They own their own house in a country village. This is her third baby born at Town hospital. Sheila is 32 and her partner 37.

Sheila likes simple living. She says that living on a low income was a good experience because now they feel quite well off. They have a big garden with chickens and a vegetable patch. She likes the community feel in the village, though she says it can get rather intrusive.

**Tess** left school after Year 9. Recently she has been working night shift in a fast food place. Her de facto partner is in sales and plays in a band. They live in his house, which is near the hospital, with her son from a previous marriage. His children from his first marriage visit at weekends. Tess is 26 and her partner 47.

Tess read a lot and thought a great deal about diet, exercise and active birth. Paradoxically, she also talked about using amphetamines to lose weight and says that she might again, but not until she has finished breastfeeding. She was quite interested in social issues, and was critical of the medical profession and welfare mothers.

*Appendix 3 Summary of previous and study births.*

Table A 3. Past experiences of labour, expectations and study birth events

Previous (P) and Study(S) birth types	Previous birth experience(s)	Expectations of the study birth	Actual experience of the study birth
Angela 2 P - Intervention  S - intervention	Induction for first “Enjoyable labour”. No pain relief, “nothing to it”. Considered homebirth the second time – but haemorrhage after. Second - “horrible pregnancy”, induction and epidural.	Apprehensive  Husband believes in alternatives - ‘raspberry leaf tea’ -  Wants an epidural straight away	‘Wonderful epidural’  Pushed baby out herself, felt much better.  Less haemorrhage, helped bath baby
BETH P – Intervention  S - natural	Labour stopped after five hours - Oxytocin drip to re-start labour. ‘like period pain’ -easy to cope with.	Expecting a natural birth, this time	Massage, no stitches or pain relief “Came by herself” Very emotional –constant support from midwife
DEIRDRE 2 P - intervention 1 P -Conventional  S - conventional	Natural childbirth classes, Induction for first two Post-natal depression, Distress about inability to breastfeed. Third one better.	Early release if everything OK.  Expects pain relief: “Don’t be a martyr”	Quick labour, gas and air only – “could have done without anything”
JULIE 1 P - Intervention 1 P - Natural  S - induced	Water broke, Induction, pethidine, haemorrhage  Water broke, waited, no induction or analgesia, but tears and haemorrhage	‘Hope it’ll be quick, on my side’  Wants lots of supporters Partner wanted water birth – as natural as possible	Induction, ‘much better – wish they’d all been like that’ Refused Pethidine “The bath made the difference, and the support team”.
KATE 2 P - Natural  S - conventional,	Waters broke - short labours, both drug free. Disliked being ‘strapped down’ Family has quick, ‘silent labours’	‘Quick, I hope’ Freedom of movement  “Glad when its all over and done with”	Unexpectedly long labour, ‘sucked the gas bottle dry’. Waters broke late –then born quickly.
LAURA  P - Intervention  S - intervention,	Stayed in hospital after ante-natal visit, labour started slowly. Broke water and put on scalp monitor. “Stuck to bed.” Gas, pethidine, acceleration ? foetal distress Episiotomy Shaky, left alone.	‘Don’t want to be tethered like last time’  ‘If it has to be, it has’  ‘Will know more whether it’s going well or not’	? gestational diabetes Induced – “no warm up, it was awful” Only 3 hours Gas, pethidine “begged for a Caesar” “lost it”, Used monitor to cope with contractions
ROXANNE 2 P conventional 1 P natural S - conventional	Two births at City: Gas and Pethidine One born at Town: Hot towels for pain Fast labours.	Hopes for an early, fast labour. ‘you have to have something’. Wants doctor, not just midwives	Water broke, labour started early morning. born 9am. “pretty good really”.

Previous (P) and Study(S) birth types	Previous birth experience(s)	Expectations of the study birth	Actual experience of the study birth
SHEILA 2 P - intervention S- intervention	Inductions both times 'never gone into labour by ourselves'	Would like to go into labour naturally - but expects to be induced	'went into labour by ourselves this time' augmented by drip 'went on a long time'
TESS 1 P - natural S - natural	Very quick labour – 'ecstatic, a lot easier than I thought'	Wanted to try birthing stool	Short labour, no drugs, baby fine

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