The Politics of Practice.

Case-loading midwifery practice in New Zealand

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Certificate of Authorship/Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

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Table of Contents

Abstract

In their daily work case-loading midwives traverse place. They visit childbearing women or attend childbirth in women's homes and they may spend time in clinics or a variety of birthing facilities including smaller primary birthing units or larger obstetric hospitals. They spend their days engaging with childbearing women, their family or supporters and with obstetric, other professional or midwifery colleagues. As they move across place and between people, they traverse a variety of physical places and discursive spaces.

Midwives journey into the intimate space of the childbearing woman attempting to understand their subjective experience and the way that this pregnancy and childbirth is situated within the landscape of their life world. They travel with this understanding as they negotiate other spaces; the biomedical space of the maternity context and obstetric hospital and the spaces of their own constructions of childbirth. This movement points to the complexity of midwifery practice. As midwives traverse a variety of discursive frameworks they must negotiate multiple and sometimes competing meanings and interests. The obstetric hospital setting provides midwives with particular challenges as they work to create, maintain and protect the birthing space of the women in their care. Ultimately midwives work to create a space for birthing that is perhaps unique to each midwife/woman pairing.

Using a poststructural feminist approach, this thesis explores the discursive construction of case-loading midwifery in New Zealand. Midwives are often described as "guardians of normal birth" and this thesis argues that this is a constructed, strategic position rather than an ontological given. The practice of case-loading midwives within the obstetric hospital provides a focus, exposing the contested nature of maternity care and illustrating the way that midwives negotiate this contested terrain.

Chapter 1: Introduction

In New Zealand, legislative changes in 1990 ushered in a new era for midwifery. Midwives were no longer required to have a medical practitioner present at all births and were charged with the responsibility of caring for women under their own authority through pregnancy, labour and the postnatal period. Midwives now have direct access to government maternity funding and are able to establish themselves as self-employed practitioners. Midwives may prescribe pharmaceutical preparations, access the services of pathology and radiology, gain access to hospitals and birthing facilities and directly consult or refer to consultant obstetricians. By all accounts, midwifery in New Zealand has experienced a renaissance, and in so doing has attracted the interest of the international midwifery community.

This new midwifery emerged against a backdrop of increasing obstetric intervention in childbirth and feminist and natural childbirth critiques of this. Midwifery was constructed in opposition to obstetrics. Everything obstetrics was, midwifery wasn't. Where obstetrics was interventionist, midwifery was non-interventionist. Where obstetrics was masculinist, midwifery was feminist. Where obstetrics was "high tech", midwifery was "low tech". Where obstetrics was reductionist, midwifery was holistic. Midwifery and medicine cohered around opposing poles on a midwifery/medical continuum.

This midwifery promised much and had much expected of it. I expected, perhaps naively, that midwifery would turn the tide on medicalised childbirth and that childbirth intervention rates would decline. In the care of midwives I expected that childbearing[1] women would embrace natural childbirth and choose to birth their babies at home or in primary[2] maternity facilities. Midwives are "guardians of normal childbirth" after all, aren't they? This maxim has been a part of the rhetoric of midwifery and a cornerstone

[1] The term "childbearing woman" is used throughout this thesis to describe a woman who is pregnant, in labour, giving birth or is up to six weeks postpartum. This terminology enables me to clearly differentiate between the midwife (who is most often also a woman) and the woman for whom she is providing care.
[2] Primary maternity facilities may provide in-patient labour, birth and immediate postnatal care but do not offer on-site medical or obstetric care (Pairman & Guilliland, 2003).

of midwifery's professionalising strategy in New Zealand. I believed that if we achieved midwifery autonomy things would be different. Life was simple then.

In 2003, 78.1% of childbearing women in New Zealand elected a midwife to be her lead maternity carer[3] (New Zealand Health Information Service [NZHIS], 2006[4]). Intervention rates in childbirth continue to rise, the vast majority of babies (84%) are born in secondary or tertiary level hospitals[5] (Ministry of Health, 2004) and normal childbirth seems to be a relic of the past. Things are not so simple anymore.

More than fifteen years have passed since the 1990 Amendment to the Nurses Act 1977. A minor change to the wording of the Act produced major change to New Zealand's maternity system and the fortunes of midwifery. Yet this legislative change did not wipe the slate clean of the social, cultural, political and historical influences that continually shape the constructs of woman, midwifery and childbirth and consequently the practice of midwifery. These are complex processes and gaining an insight into them requires a detailed exploration of midwifery and the context in which it is embedded. It is here that this thesis makes a contribution.

This thesis aims to explore the discursive construction of case-loading midwifery in New Zealand through analysis of relevant professional, regulatory and government documents and the texts generated by interviewing 48 case-loading midwives. Case-loading midwives are those who carry a caseload of childbearing women and constitute part of the midwifery lead maternity carer group from which 78.1% of childbearing women (in 2003) chose their caregiver. These midwives provide continuity of care to a group of childbearing women from early pregnancy, through labour and birth and up to six weeks postpartum. They may be employed or self-employed. As lead maternity carers they may provide all the care that a childbearing woman requires or they may access the advice and expertise of other health professionals (such as obstetricians and

[3] A Lead Maternity Carer (LMC) is a "general practitioner, midwife or obstetric specialist who has been selected by the woman to co-ordinate and provide comprehensive maternity care, including the management of labour and birth" (Ministry of Health, 2003, p.145).

[4] At the time of writing the New Zealand Health Information Service (2006) summary document reporting on childbirth occurring in 2003 was the most recent available. This document reports a few select statistics only with the more comprehensive report due for publication in June 2006.

[5] Secondary and tertiary level hospitals provide in-patient maternity and neonatal care and on-site access to specialists including obstetric, neonatal and anaesthetic. Tertiary and secondary level maternity hospitals are referred to throughout this thesis as "obstetric hospitals".

paediatricians) working to coordinate the woman's care and ensuring that it is appropriate to her needs. Whatever their role, these midwives have a great deal of influence over the experience of the childbearing woman and it is here, at the level of day-to-day practice with the caregiver who may be most influential in the woman's experience, that I wanted to focus this study.

The section of the thesis titled, "Mapping the landscape" provides a brief overview of the historical, social and political context in which midwifery in New Zealand has evolved. This section also presents a critical review of some of the research literature relevant to the topic area. The next section, "Charting the course" introduces the theoretical constructs that frame this research (in particular the work of Foucault and select feminists such as Bordo, Grosz and Braidotti), and the methods by which this research was conducted. A more detailed exploration of some theoretical concepts and schemas as they apply to particular aspects of the analysis will be presented in the relevant analysis chapters. This approach allows for a more gradual elaboration of the theoretical concepts guiding the conduct of this research and the analysis of text, and also for particular theoretical concepts to be elaborated nearer to their point of application.

Exploration of the discursive construction of case-loading midwifery has given rise to the chapters in the section "Exploring the terrain", that is, 4.1 "Body politics and the biomedical discourse of childbirth", 4.2 "Body politics and the natural childbirth discourse" and 4.3 "Body politics and the neo-liberal discourse of childbirth". The professional midwifery discourse is addressed in the chapter 5 titled, "A place to stand". I have identified four major discourses constructing case-loading midwifery in New Zealand. These are the biomedical, natural, neo-liberal and professional. These differing discourses construct women, childbirth and midwifery in varying ways. Each of these discourses is addressed in discrete chapters but in doing so I do not mean to suggest that they are clearly distinct from each other or easily dissociated from the complexity of the whole of midwifery and maternity care. I see case-loading midwifery as constructed by a matrix of intersecting discourses (positioned by power). This construction shifts and changes within the community of midwifery, within any one midwife and within varying maternity care contexts, resulting in midwifery that is fluid and dynamic though also contradictory and highly complex.

In each of these chapters I describe the discourse and situate this within the socio-political and historical contexts that both shape the discourse and constitute the conditions of possibility, enabling the emergence of the particular discourse. In so doing, the reader is provided with significant background and historical information relating to each discourse, enabling an understanding of the development of midwifery in New Zealand and the way that this has shaped the profession of midwifery and contemporary midwifery practice.

The feminist poststructural approach to this study means that my analysis focuses on issues relating to gender and this invariably leads to a focus on the body. The chapters in these sections explore the way that these discourses construct childbirth and the bodies of childbearing women. It must be acknowledged that midwives' bodies are frequently women's bodies too; therefore the bodies of midwives are also implicated in this exploration. Midwifery and midwifery practice are fashioned by the prevailing constructions of childbirth and women's bodies, making the exploration of body politics key to understanding the discursive construction of case-loading midwifery in New Zealand.

In each chapter the text that comprises the data for this study is used to illustrate the discursive construction of childbirth, women and midwifery. These discourses are deconstructed to illustrate the way that the major concepts and "truths" of the discourse are constructed, situated and contingent, rather than natural and fixed. As constructions, there is nothing essentially good or bad about these truths but they do create varying effects. The chapters comprising the sections "Exploring the terrain" and "A place to stand" interrogate these discourses for their effects on childbirth, women and midwifery. This includes midwifery's own "truths" as these do not and should not stand beyond this interrogation and critique.

New Zealand society like many other western nations is highly influenced by the powerful biomedical discourse. Many aspects of our daily lives have become medicalised, and nowhere is this more evident than in the area of childbirth. The biomedical discourse of childbirth continues to predominate and, as this thesis will explore, the mechanisms by which childbirth is becoming increasingly medicalised are ubiquitous and subtle yet highly effective. Midwifery cannot help but engage with the

biomedical discourse of childbirth; it is at once constructed by it, and resistant to it. There is no one place where biomedicine resides but an exploration of midwifery practice within the obstetric hospital offers a unique insight into the way that case-loading midwives engage with the technologies of biomedicine and negotiate the complexity of the contemporary maternity care context.

Chapter 6.1 "The politics of place" focuses on the obstetric hospital. The concepts of space and place are examined and the obstetric hospital is explored in terms of its physicality (the building, layout, rooms and equipment) and also in terms of its discursive spatiality. The obstetric hospital is described as a technology of biomedicine as the design, furniture, equipment and culture presume (and work to construct), a passive maternal body that is inscribed as a site of risk. Midwives and childbearing women are disciplined in this place as technologies of biomedicine attempt to bring their behaviour, choices and midwifery practices in line with obstetric norms. While these are powerful technologies constructing and disciplining midwifery practice this does not mean that midwives do not engage in practices of resistance. These are explored in the following chapter, "The politics of practice".

Chapter 6.2 "The politics of practice" focuses on midwifery practice and midwives' negotiations within the obstetric hospital. Midwives participating in this study demonstrate a profound awareness of the way in which the technologies of biomedicine influence the birthing experience. In this chapter I conceptualise midwifery practice as concerned with the creation of space. Within the obstetric hospital midwives work to create an always unique, and often alternate, birthing space. The space created is unique to the individual midwife/childbearing woman pairing and, whether the birthing space is one accepting of biomedicine and birthing technologies or resistant to it, midwives attempt to create a space that at least holds the childbearing woman at the centre of the experience. This in itself often challenges the norms of obstetrics. Midwives often work to create a space in which alternate subjectivities, constructions of childbirth and agency, can be engendered. I describe how case-loading midwives create this space, patrol the borders and work the margins of this space, as they attempt to protect the birthing space of the childbearing woman.

The rhetoric of "midwives as expert in normal birth" has been a cornerstone of the professionalising strategy of midwifery in New Zealand. However the centrality of the concept "woman-centred care" in midwives' construction of case-loading midwifery means that these midwives care for women having childbirth experiences that sometimes stray far from what we would describe as "normal birth". The final chapter of this thesis "With an eye on the horizon. Nomadic midwives? Where to from here?" describes the way that midwives traverse and transgress varying physical and discursive spaces *with* the childbearing woman. It is "with woman" rather than "normal birth" that is the most important strategic connection. Braidotti's (1994) figuration of the nomad is used to explore a feminist politics of midwifery, one that may serve the childbearing woman well and also provide midwives with the flexibility to both challenge the dominant biomedical discourse of childbirth and remain relevant in contemporary society.

In many ways this thesis is concerned with geography. Geography is the study of the landscape, exploring the inter-relationships between elements (such as people, soil and water). Conceptualising maternity care as geography recognises that it is constituted by complex inter-relations between "natural" and "man-made" (sic) structures and phenomenon. Understanding the geography of maternity care requires exploration of the inter-relationships between bodies, spaces and places. These interrelationships are at the heart of this research inquiry. Geographical imagery is used throughout the thesis as I discuss place and space, and midwives as nomads, traversing and transgressing physical and conceptual landscapes. Geographical metaphors are also used to describe sections of this thesis. "Mapping the landscape" follows the introduction and provides the reader with relevant background information, situating this study within the context of other relevant research work. "Charting the course," describes the methodological approach and methods, whilst the section "Exploring the terrain" begins the analysis chapters presenting the major discourses constructing midwifery in New Zealand. "A place to stand" examines the professional midwifery discourse and details the development and role, of the New Zealand College of Midwives (NZCOM) in the re-making of midwifery in New Zealand. "Landscapes of practice" examines midwifery as it is em(placed) in the obstetric hospital. The concluding section "With an eye on the horizon. Nomadic midwives? Where to from here?" considers the relevance of this study for the future of midwifery in New Zealand.

Chapter 2: Mapping the Landscape

This chapter presents a brief outline of the historical and contextual factors influencing the development of midwifery in New Zealand. Discussion of relevant research studies is integrated throughout, providing the reader with an overview of the research-knowledge landscape and the place of this thesis within it.

Introduction

Midwifery is a product of the times and societies in which it develops. Midwifery in New Zealand has been shaped by our particular history and context, though in many ways, this mirrors the development of midwifery in other western nations.

This chapter briefly describes the historical development of midwifery in New Zealand from early European settlement, to the increasing medicalisation and hospitalisation of childbirth and the subsequent consumer backlash against this medicalisation. The discussion will then focus on place of birth, drawing specifically on literature that addresses the impact of place on midwifery practice.

Colonising New Zealand

Despite the promises contained within the Treaty of Waitangi[6], European colonisation has meant that European childbirth customs and practices have largely subsumed those of Maori. It must be remembered that Maori had been successfully reproducing for centuries prior to colonisation and the introduction of western, European health and childbirth practices. The midwifery of mainstream New Zealand today however is largely a product of a white, European people and it is this midwifery, which is the focus of this study.

[6] The Treaty of Waitangi is the agreement entered into by representatives of the Crown and Maori, in 1840. There are in effect two treaties, one in English and one in Maori. Issues relating to culture and translation have resulted in differing claims concerning the exact nature of the agreement (State Services Commission, n.d.).

European midwifery practices began in New Zealand with the first European immigrants. Some educated or experienced midwives and doctors emigrated from Great Britain though the isolation of many settlements meant that women in childbirth were assisted by whoever was available to assist them, including lay midwives. Lay midwives (or handywomen) learned their craft through experience, practice or apprenticeship type arrangements with experienced midwives or doctors (Donley, 1998). For many, their career in midwifery began with their own birthing experiences or their involvement with other birthing women of the family or community.

Early State involvement in health care arose by necessity with the increasing health problems associated with a growing urban, industrial society and health scares such as the plague and influenza (Fraser, 1984). Governor Grey established the first hospitals in New Zealand, providing charitable care to the "deserving poor" (Hay, 1999). As early as 1881, two hospitals provided for general and lying-in patients, both in the Otago region of New Zealand. Dunedin provided three beds in two wards that were annexed and managed independently of the main hospital. Dunstan hospital provided four beds in a female "sleeping-ward" (Cooper, 1998). Given the context of the time it is likely that these beds catered to the most destitute of women. Most women would have birthed at home. With the increasing European population and urbanisation however, some midwives began to set up their own private maternity homes. These mostly consisted of one room within the midwife's own home (Donley, 1998).

Colonising childbirth: The rise of medical intervention in New Zealand

Throughout the 19th century (on the tail of the Enlightenment), the western world began embracing positivist science. Positivism asserts that knowledge should be developed through rational and rigorous scientific processes rather than through speculation or metaphysical means (Crotty, 1998). The field of medicine, which had hitherto been constituted by practices arising through custom and tradition, began to align with positivist science. As chapter 4.1 ("Body politics and the biomedical discourse of childbirth") explains, it is positivist science that underpins modern medicine and which gives rise to the biomedical discourse of childbirth.

The growing acceptance of medical care by the public at large was facilitated by advances in medical practices such as the discovery of antibiotics, the antisepsis of Joseph Lister in 1865, and surgical and medical practices developed through experiences with the First World War and the influenza epidemic of 1918 (Dow, 1991). These factors not only contributed to a growing acceptance of medical practices but also shifted focus from community-based, palliative and primary care to the public hospital and acute care. In 1851 a total of four hospitals served the New Zealand community and by 1910 there were fifty-six (Dow, 1991). Where the hospital had once been a place of last resort for the poorest of society, societal views began to change and hospitalisation began to be seen as a valid and desirable health care intervention.

Midwifery was legislated in New Zealand in 1904, driven by concern at declining birth rates and high maternal and infant mortality rates of British citizens (Donley, 1998). Within a patriarchal context in which scientific and biomedical discourses were increasingly influential, the "ignorant" lay midwife was identified as the problem (Donley, 1998; Papps & Olssen, 1997). The popular and long-standing myth of the "Sarah Gamp" of Victorian England was revived in arguments endorsing midwifery registration. Richard Seddon (premier of New Zealand) argued in 1904,

> It is unnecessary to point out that there are some [midwives] who indulge a little too freely, and I think the sooner we have legislation which will ensure competent midwives – sober and especially clean midwives – the sooner you will prevent loss of life. (Seddon cited in Parkes, 1991, p. 166)

1904 can be seen as the beginning of the professionalisation of midwifery in New Zealand, effectively "sound[ing] the death knell" for the traditional midwife (Banks, 2000). With the predominance of the biomedical discourse, childbirth became increasingly medicalised and centred in public hospitals rather than the home or small, midwife-owned maternity homes.

Where childbirth had once been a part of life's processes for women (like menstruation and menopause) occurring at home within the cultural and social context of the woman's life, throughout the 1900s it became defined as a condition requiring medical treatment, moving from home to hospital (Katz-Rothman, 1991). This shifting meaning

was associated with changing practices relating to childbirth that included a shift from care by midwife (lay or trained) to care by medical practitioner. As Katz Rothman (1991, p. 50) succinctly states, "The rise in obstetrics was the fall of midwifery". Mein Smith's (1986) investigation into the maternity system in New Zealand from 1920 to 1939 suggests that the transition of care by midwife to doctor was accomplished by 1924 and that this transition preceded the move from home to hospital which occurred from 1920 to 1930.

In New Zealand, two factors have been identified as aiding the medicalisation of childbirth; the availability of pain relief in labour and puerperal sepsis (Donley, 1998). The introduction of the use of anaesthetics in childbirth was constructed from the start as the role of specialist medical practitioners. Chloroform and ether were frequently used and this was replaced by morphine and scopolamine; a cocktail known as inducing "twilight sleep" (Donley, 1998; Lewis, 1990). This drug combination provided analgesia which erased women's memories of the childbirth experience and also brought with it significant risks to the women and baby (Lewis, 1990). With the use of these drugs came the necessity for an environment with adequately prepared staff and equipment for administering the anaesthesia and managing an unconscious woman. Women in New Zealand (Donley, 1998) and abroad (for example in the United Kingdom [UK], see Lewis 1990) actively lobbied for access to hospitalisation and anaesthesia during childbirth. This illustrates the complex relationship that women have had, and continue to have, with medicine and the inadequacy of analyses that describe medicalisation or the relationship between medicine and women in oppressor/oppressed terms Lupton, 1997a).

Puerperal sepsis was the subject of a number of government inquiries in New Zealand. The last inquiry, the Kelvin Commission in 1923, was instigated following the deaths of five women from puerperal sepsis at the Kelvin Private Hospital in Auckland in 1923 (Parkes, 1991). The commission resulted in the recommendation that an inspector of private hospitals be appointed who would be responsible for drawing up procedures to reduce maternal and infant mortality through aseptic midwifery techniques. These techniques were developed (becoming known as the H. Mt. 20 regulations) and were to dominate maternity practice in New Zealand for the next thirty years. While successful in decreasing mortality rates for women, these regulations resulted in childbirth being

managed in the same way as a surgical event. Regulations associated with this inquiry made it difficult for smaller maternity homes or private hospitals to operate thus encouraging the move to larger public hospital facilities.

New Zealand's first labour government was elected in 1935, bringing with it a dramatic change in the philosophical underpinnings of health care provision in New Zealand. The aim of this government was to introduce a national health scheme that would provide free health and hospital services to all its citizens. While this was never fully realised, the Social Security Act of 1938 provided women with free access to the doctor of their choice, medical and hospital services (Fraser, 1984). This Act helped secure the position of doctors and public hospitals within the provision of maternity services in New Zealand and, by 1951, ninety-five percent of births were occurring in hospitals under the care of doctors (Donley, 1998).

Childbirth Knowledges

Papps' (1992) Foucauldian analysis of midwifery regulation in New Zealand draws attention to the way that the hospitalisation of childbearing women facilitated the development and rise to dominance of the biomedical discourse of childbirth. Gender relations within a patriarchal society, the authority of medical men and the hospitalisation of childbirth allowed women to be used as "clinical material" for doctors and medical students. A particular knowledge of childbirth was engendered through these processes and the dynamics of power and gender relations positioned this knowledge as "truth". Murphy Lawless (1998) reveals obstetric knowledge to be one of many knowledges, and she is concerned both with the way that this knowledge developed, and the processes by which it has become accepted as the most valid, relevant and important knowledge. Exploring the history of childbirth in Ireland, Murphy Lawless (1998) traces the rise of obstetrics and the obstetric discourse of childbirth. Murphy-Lawless presents a detailed critique of obstetrics' claim to superiority and safety, highlighting the way that the obstetric discourse constructs the female body and prevents women from exercising personal agency.

Papps (1992) describes how the power relations within the obstetric hospital shaped

midwifery practice, implicating midwives in the disciplining of childbearing women. Murphy-Lawless (1998) commenting on more contemporary times, identifies the difficulties that midwives encounter within the obstetric hospital in attempting to work within models of care or norms not supported by obstetrics. These works make a valuable contribution in deconstructing the medical and obstetric discourses of childbirth and exposing the relations of power that shape maternity practices. My thesis draws on the work of these authors as the biomedical and obstetric discourse of childbirth is critiqued in chapter 4.1 ("Body politics and the biomedical discourse of childbirth") and the complexities of practice are explored in the section titled "Landscapes of practice" (chapter 6.1 "The politics of place" and 6.2 "The politics of practice"). This thesis focuses more specifically on discourses constructing case-loading midwifery in New Zealand of which the biomedical is one among several. It also explores in a more detailed way the day-to-day practices of midwives within the obstetric hospital setting.

The dominance of the biomedical discourse of childbirth and the resultant medicalised childbirth practices are an important part of the context that gave rise to a discourse of resistance: natural childbirth. In New Zealand the 1960s and 1970s witnessed a growing tide of discontent with maternity care evidenced by escalating campaigning by childbirth activists and feminists. These groups promoted midwifery as an alternative to medicalised childbirth, thus aligning midwifery with natural childbirth and being a model of care that challenged the oppressive and paternalistic models constructed by the biomedical discourse of childbirth.

The consumer/midwife backlash

With the feminist and anti-establishment movements of the 1960s and 70s there was a groundswell of consumer discontent with maternity services in New Zealand (Donley, 1998). Feminists and childbirth activists began to highlight the paternalistic and oppressive ways that childbirth was managed within medical approaches to childbirth (Oakley, 1980). Women were critical of the strict routines of hospitalised care brought about by the H. Mt. 20 regulations and the processes necessary for the management of childbirth within large hierarchical and bureaucratic institutions. The medical model of

health was accused of being reductionist in its exclusive focus on the biophysical aspects of illness and health activists fought for a more holistic approach; one that was inclusive of the individual's emotional, spiritual and social experiences. Women sought to regain control of their bodies in childbirth, reconstructing their bodies as competent bodies and the childbirth experience as natural.

With the increasing medicalisation of childbirth the role of the midwife had been gradually eroded and by 1971 legislation was enacted removing their legal right to practice independently, by requiring midwives to work under the supervision of a medical practitioner. As Tully (1999, p. 87) indicates, this move "ratified the status quo whereby the majority of midwives worked in hospitals as specialist nurses under the supervision of obstetricians".

The Maternity Services Standards Committee was established (in 1960) to advise the minister on all aspects of maternity care. The membership consisted of six specialist obstetricians, four medical practitioners, and four nurses who also had midwifery qualifications (Papps & Olssen, 1997). This committee was influential in policy issues regarding maternity services, their general philosophical orientation resting on the assumption that birth was only safe in large regional hospitals under the care of a medical practitioner (Papps & Olssen, 1997). In 1979 the Maternity Services Standards Committee published a policy statement responding to the growing tide of discontent within the community with the explicit intention of discouraging the trend toward homebirth. The report condemned many of the ritualised hospital practices and recommended a more flexible, consumer friendly approach to the management of childbirth within hospitals (Papps & Olssen, 1997).

In 1980 the New Zealand Nurses Association (NZNA) produced their "Policy Statement on Home Confinement" stating that they did not support the demand for home confinement (cited in Donley, 1998, p. 104). In 1981 they developed another policy proposing the introduction of stringent "criteria governing the preparation and employment of domiciliary midwives" (cited in Donley, 1998, p.105). In 1983 a Bill was introduced to parliament which would limit the practice of midwives who were not nurses to hospital-based practice and make the Advanced Diploma of Nursing course available only to nurses trained at technical institutions rather than hospitals. The New

Zealand Nurses Association supported the Bill, causing a rupture between the parent body and the Midwives Section. The New Zealand Nurses Association urged unity within its ranks in order to progress as a profession but there was concern that "…progress for the nursing profession was to be brought at the expense of midwifery as a profession" (Donley, 1998, p.108).

This disagreement eventually led some members of the Midwives Section of the New Zealand Nurses Association to split from the parent body and form the New Zealand College of Midwives in 1989. Dissatisfaction with maternity services, threats to domiciliary practice, and dissatisfaction with midwifery education were issues that mobilised midwives and women as users of maternity services. At the second National midwifery conference in August of 1988, domiciliary midwife and activist Joan Donley presented a paper "Midwives or Moas". She predicted the demise of midwifery (just as the moa had become extinct) if midwives remained a part of the NZNA and she challenged midwives to form their own professional organisation. Apparently this was met with enthusiasm and a working party was established that included members of the Home Birth Association, Maternity Action Alliance and the Save the Midwife Campaign (Guilliland, Pairman, & Hasson, 1989). The midwives' campaign for autonomy and the consumer's desire for a childbirth service that would provide them with greater control and choice were seen as complementary aims (Pairman, 1998). In April of 1989 the New Zealand College of Midwives held its inaugural annual general meeting where its constitution was formally accepted.

Neo-liberal politics

New Zealand underwent a program of radical state restructuring based on neo-liberal politics with the election of the fourth Labour government in 1984 (Walsh & Boston, 1991). Where the United States of America had "Reaganomics" and Britain had "Thatcherism" in New Zealand the neo-liberal inspired policies of the Labour government became known as "Rogernomics", named after Roger Douglas, finance minister until 1988. These policies included the privatisation of state assets, a reduction in top tax rates from 66% to 33%, reduction of company taxes, the introduction of goods and services taxes and restrictions on the right to strike. The policies also

resulted in a reduction in welfare benefits and a generalised downsizing of the welfare state (Geddis & Morgan, 1997).

The National government of the 1990s continued the neo-liberal project with major health restructuring. This restructuring was based on a market approach to health care where health care is seen as a commodity, those providing health care as "service providers" and those experiencing care as "consumers". Health care in this context is considered in the same way as any other commodity that can be bought and sold. Mason (1995, p. 836) comments on this approach,

> Common buzzwords and phrases are 'customer', 'product quality', 'consumer rights', 'commodity', 'lifestyle' and 'freedom of individual choice'. Widespread, exclusive deployment and acceptance of the imagery associated with this language reflects profound changes in the working relationships in the health service.

Where previously providers of health care (such as hospitals) were allocated a budget within which they should operate their service, in this reformed health service a separation between purchaser and provider of health care was created. Purchasers were to purchase in a competitive market (Barnett & Barnett, 1999). The theory of the market model is that the competitive environment generates providers who can provide efficient services of high quality as they attempt to gain an advantage over their competitors. As a consequence those funding health care gain a superior product for less money and consumers are advantaged because they can choose between a variety of options and the quality of the service is enhanced. One of the main objectives of the health reforms was to improve consumer choice in regards to the provision of health services (Borren & Maynard, 1993).

It was into this health policy context that the joint consumer and midwifery push for midwifery autonomy found success. Abel's (1997) doctoral thesis documents the contextual factors contributing to the passage of the Nurses Amendment Act 1990 and the changes to midwifery and maternity services in Auckland from 1990 to 1996. Amendments to the Nurses Act 1977 in 1990 provided midwives with the legal permit to care for women through all phases of childbirth under their own authority. Under this legislation midwives could provide care on an equal footing (in competition with)

general practitioners. Within this policy framework, providers of maternity services were to comply with contractual specifications (Health Funding Authority, 1998) and those experiencing care could claim their rights as consumers by exercising individual choice.

Partnership and professionalisation

The New Zealand College of Midwives was formed just after the Cartwright Inquiry released its report on the management of women with cervical cancer at the National Women's hospital[7] (1988). The report recommended the establishment of a Health and Disability Commissioner whose functions would include the promotion and protection of consumer rights. The Cartwright Inquiry into the management of women with cervical cancer in the National Women's Hospital had a profound impact on New Zealand society. It brought issues such as the status of women and informed consent sharply into focus and added weight to the reconstruction of the patient as a consumer within the neo-liberal discourse of healthcare.

The influence of the Cartwright report is evidenced in the constitution of the New Zealand College of Midwives. As Guilliland (1989, p. 14) states, "the New Zealand College of Midwives has taken these recommendations [for greater consumer contribution and participation in health services] to heart with their commitment to consumer participation at the decision-making level of the professional body". The constitution of the New Zealand College of Midwives provided for consumer membership and participation at all levels of the organisation.

Building on work already undertaken in the development of the organisation's constitution, Midwifery Standards for Practice and Midwifery Code of Ethics, Guilliland and Pairman further developed the concept of partnership presenting the "The Midwifery Partnership: A Model of Practice" at the 1994 New Zealand College of Midwives conference (published in the October 1994 issue of the New Zealand College of Midwives Journal) and later published a monograph of the same name in 1995

[7] The Inquiry (led by Sylvia Cartwright) investigated the actions of Dr Green at the National Women's Hospital in Auckland. He conducted research into cervical cancer leaving some cancers untreated, without the consent of the women involved.

(Guilliland & Pairman, 1995a). Within this model midwifery is constructed as being primarily concerned with normal birth, as having "responsibilities as an emancipatory change agent" (p.8), as concerned with providing woman-centred care and developing a relationship between women and midwife that is not hierarchical in terms of power (described as partnership), that can only be developed through a continuity model of service delivery.

This idea of midwifery as a partnership with the woman (at individual and professional levels) arising from the particular social and cultural context within which midwifery emerged, has been a key element in midwifery's strategy to produce a "distinctive service" (Tully, 1999, p. 36) by constructing "… a collective professional identity which distinguishes midwives' philosophy, skills and services from those of other health professions" (Tully, 1999, p. 46). Tully's 1999 doctoral thesis "Doing professionalism 'differently': negotiating midwifery autonomy in Aotearoa/New Zealand" explores the professionalising strategies of midwifery since the 1990 Amendment to the Nurses Act 1977, highlighting some of the ways midwifery in New Zealand challenges accepted theories of the professions. Tully (1999) argues that in New Zealand patriarchal structures (those engendering medicalised childbirth and positioning women as subordinate to medicine) have been used as discursive resources enabling the professionalisation of midwifery rather than obstructing it. She also draws our attention to the way that midwifery has attempted to reposition itself as professional in partnership with women, challenging the prototypical professional/client relationship and thereby "doing professionalism differently" (Tully, 1999).

Sociological literature often presents professionalising process as proceeding from the ability of a group to establish "a distinctive product or service" (Tully, 1999, p. 36) which includes incorporation of training in a systematic body of knowledge, and gaining of credentials, leading to state sponsorship. Tully suggests that in New Zealand, State sponsorship (in the form of legislation providing for independent midwifery) occurred prior to the development of a distinctive midwifery service. This sequence pushed midwifery into "theoretical elaboration of its formerly tacit knowledge base" (Tully, 1999, p. 44) and, in so doing, demanded that midwifery leaders and educators construct a coherent midwifery out of "multiple possible ways of providing pregnancy/birthing care" (Tully, 1999, p, 45). In this thesis I suggest that a distinctive

midwifery service was already in existence, though it was the marginalised midwifery of the domiciliary, homebirth midwives. This was the midwifery that provided the foundation on which the new professional midwifery in New Zealand was modelled.

In describing "multiple possible ways of providing pregnancy/birthing care", Tully (1999) is suggesting that there are perhaps multiple "midwiferies" and that the midwifery, constructed post-1990 in New Zealand, is a particular midwifery rather than an essential one. Chapter 5 of this thesis ("Re-making midwifery and the professional midwifery discourse") continues this analysis, exploring in some detail the discourse of professional midwifery and the contextual and historical factors that have shaped the construction of contemporary case-loading midwifery in New Zealand.

Surtees (2003) thesis highlights not only the multiplicity in ways of doing midwifery, but also the way in which midwifery is constructed by multiple and often competing discourses. Surtees interviewed a broad range of midwives (case loading and core midwives in various areas) and other relevant people (such as midwifery managers, professional and legal advisors) and also conducted fieldwork in an obstetric hospital. Exploring the highly complex partnerships between midwives and childbearing women, Surtees focused on midwives' negotiations of risk/safety and their interface with technologies such as induction of labour and epidural anaesthesia. She cogently describes the way that subtle forms of governance normalise midwifery practice leading the midwife to construct herself as an "auditable subject" (p. 85). I am indebted to Surtees for many of the insights realised within my research, as I similarly explore the discursive construction of midwifery in New Zealand. In concentrating on case-loading midwifery my thesis is more narrowly focussed than Surtees and, while Surtees also hones in on midwifery practice within the obstetric hospital setting, the section "Landscapes of practice" provides a detailed account and exploration of the relations between place and practice.

Birthing places

Childbirth in most western countries has come to be situated primarily in the hospital setting and frequently in larger secondary or tertiary hospitals. These hospitals provide

obstetric, anaesthetic and paediatric services, are able to undertake emergency obstetric procedures such as caesarean section, provide care to compromised newborn babies and are supported by a host of support services and technologies such as cardiotocographic (CTG) machines, ultrasound scans, pathology and radiology services. Primary birthing units in contrast do not offer consultant obstetric, anaesthetic or paediatric services, frequently do not have any medical practitioners on site and are intended for the care of the woman expecting a normal labour and birth. A body of research (Campbell & MacFarlane, 1994; Department of Health, 1993; Olsen, 1997; Olsen & Jewell, 2000; Rooks, 1999; Zander & Chamberlain, 1999) supports the safety of primary, rural and home settings for women considered low risk yet this has had little impact on place of birth for the majority of women in western countries.

In 2002 New Zealand was serviced by six tertiary hospitals, eighteen secondary hospitals, and sixty-five primary hospitals. Of all hospital births occurring in 2002, approximately 44.5% occurred in tertiary hospitals, 40.2% in secondary and 15.2% in primary hospitals (0.1 % occurred in "other ") (Ministry of Health, 2004). It is difficult to establish the homebirth rate in New Zealand but it has been estimated at roughly 3.44% of all babies born in 2001. This situates the hospital and particularly the obstetric hospital overwhelming, as the most common (84.7%) place of birth in New Zealand. Midwifery, childbirth and feminist activists have been successful in securing midwifery a prominent role in New Zealand's maternity service and in providing women with greater choice in aspects of their maternity care. However, they seem to have made little inroads in regards to encouraging women to birth in places other than major obstetric hospitals. Murphy Lawless (1998, p. 39) comments,

> The cumulative inputs of the childbirth movement, the homebirth movement, the consumer movement and the feminist critiques of childbirth, which have all been influenced at some level by the notion of natural childbirth, have failed to dislodge the vast majority of women from going to hospital, the setting where the overall package of practices in labour and birth is still not in the hands of women.

Midwives spend many hours attending women during labour in the obstetric hospital, they may care for women who have been admitted antenatally and those who choose to spend time there during the initial postnatal period. Obstetric consultation frequently

occurs in the obstetric hospital, either antenatally or during labour. Midwives are required to hold access agreements with these facilities[8] and they may also be required to complete other "credentialing" exercises such as gaining certificates in resuscitation or intravenous medication administration.

The obstetric hospital is more than bricks and mortar; it is the "centrepiece of modern medicine" (Davis, 1981, p.5) and a place in which powerful patriarchal and biomedical discourses dominate. It is also the place in which many midwives carry out their day-to-day work. As such, a focus on practice in this setting has the potential to contribute to our understanding of the complexity of case-loading midwifery practice in the contemporary health care context of New Zealand.

The influence of place on midwifery practice is something that has perhaps been understood by many in the midwifery community (Katz Rothman, 1991; Kirkham, 2000) but has attracted little direct research attention. Much of the literature focussing on the influence of place or birth setting does so from the experience of the childbearing woman rather than the midwife (Abel & Kearns, 1991; Davis, 1995; Edwards, 2000; Lock & Gibb, 2003; Morison, Hauck, Percival & McMurray, 1998). The influence of place on midwifery practice is acknowledged (though sometimes peripherally) in several New Zealand studies (Crabtree, 2002; De Vore, 1995; Fleming, 1995; Hunter, 2000; Moloney, 1992, Surtees 2003) and by Lock (1999) and Griffith (1996) in Australia.

Lock (1999) studied the postnatal experiences of mothers in Australia taking early discharge from hospital. In agreement with much of the literature focussing on birth environment, Lock found that the women interviewed experienced greater comfort in the home setting, more control over their environment and greater autonomy in terms of developing their own style of parenting and baby care. Lock also recognised that place influenced the practice of the midwife, commenting,

[8] Midwives are required to hold a current access agreement with a hospital if they choose to provide midwifery care to women admitted to that hospital. One homebirth midwife interviewed for this study did not hold an access agreement with the obstetric hospital and chose to relinquish the Lead Maternity Carer role when a woman was transferred from an intended home birth. In this situation she remained present in a supporting rather than professional role.

> The professional assistance offered was altered by place. In the environment of home the attention of the midwives became completely different. In contrast to the professional assistance that was offered in the strange place, attention to the specific needs of the individual mother being visited became its defining characteristic. (Lock, 1999, p. 112)

It was the change in place, the transition from home to hospital that illuminated the influence of place on both the childbearing woman and her perspective of midwifery practice.

Case-loading midwives in New Zealand practice in a variety of settings. They are not necessarily fixed in one place; that is, employed to work in one environment such as the hospital. Midwives may access a variety of settings (including private, public, primary, tertiary, home and hospital), and commonly spend much of their time in the community visiting women at home or in their own clinic rooms. Hunter's (2000) research focused on New Zealand midwives' experiences of providing care in small primary maternity units compared with large obstetric hospitals. While midwives in the smaller maternity units felt a greater sense of responsibility they also experienced greater autonomy and clinical freedom. Less reliance on technologies associated with the large obstetric hospitals and more clinical freedom equated with "real midwifery" for the midwives participating in Hunter's study (2000, p. 72). Midwives in Fleming's (1995) study, felt invisible and powerless in the hospital setting. They were not differentiated from nurses and were made to feel lazy or negligent if their practice did not conform to obstetric norms.

The obstetric hospital has been described as a battleground as midwifery meets medicine, creating a discursive or philosophical collision (Crabtree, 2002; De Vore, 1995; Moloney, 1992). Crabtree (2002) identifies the hospital setting as a "contested context" in her New Zealand study on midwives' construction of normal birth. Crabtree highlights the way that the midwifery and medical models of childbirth meet in the context of the hospital, creating a contested space. She concludes that,

> Midwifery practice and women's birthing experiences occur in a contested context that remains firmly entrenched in a medically dominated model of care. There is

> increased normalisation of intervention and technology leading to ongoing medicalisation of the physiological processes of labour and birth. (Crabtree, 2002, p. iv)

Moloney's study published in 1992 was conducted during the lead-up to and enactment of the Nurses Amendment Act 1990 in New Zealand and explored the experiences of five new graduate midwives working in teaching hospitals. Moloney's analysis focuses on the theory and practice gap experienced by these midwives, as the rhetoric of their education (embracing the midwifery model of childbirth) was not borne out by the reality of their day-to-day practice: the context pressed them to privilege bureaucratic processes and a medically dominated (authoritarian) approach to care. Griffith's (1996) Australian study similarly comments on the dissonance experienced by midwives due to the incongruence of their espoused beliefs and the reality of their practice as directed by the work environment; the hospital. Drawing on interviews with midwives practising in a variety of contexts (categorised as overly to minimally medicalised) Griffith describes a number of themes; "culture of birthing and clientele", "authority to speak", "levels of visibility and the form it takes" and "cheating or fudging, collusion and co-option", comparing and contrasting these across various contexts. Griffith is interested in midwives' competing claims to knowledge and truth and the way that the birthing context impacts on the authority of this knowledge.

De Vore's 1995 New Zealand study is concerned with the social and political context of the practices of four independent midwives. Like me and others cited here (Crabtree, 2002; Crabtree, 2005; Griffith, 1996) she is intrigued with the question of how a practice espousing a midwifery philosophy can exist within a setting that is so powerfully dominated by a medical one. De Vore found that in the hospital setting "…midwives were constantly reminded of the powerful dominant medical discourse which impinged on and constrained their ability to work within the midwifery model" (p. 129). De Vore's analysis of the influence of setting begins to delve deeper than many of the other studies, alluding to the way that the hospital space may work to construct more than the midwife's practice but her comportment and demeanour. In a fascinating anecdote (De Vore, 1995, p. 83) one of the participants, a homebirth midwife, described her experience of transferring a woman to an obstetric hospital after a planned homebirth. Following the birth the woman was in the shower whilst the

midwife went to fetch something for her. On her return she called out "how are you doing?" to the woman in the shower. The woman didn't recognise the midwife's voice although she had been caring for her throughout her pregnancy. She commented, "Is that you Sue? ... Oh you sound like a real nurse". The midwife insightfully reflected,

> That's what puts me off working in that environment because so quickly, for me personally… you get that nurse walk and you get that nurse tone in your voice … you're different to the midwife you are when you're not there. (De Vore, 1995, p. 83)

De Vore's analysis is informed by critical social theory and she suggests that this scenario demonstrates the way in which body language expresses power and control, perpetuating the hierarchical structures of the hospital system. A postmodern feminist analysis of this scenario may direct one to examine the way that discourse works to construct (and gender) the individual and the way that space can be conceived of as an expression and technology of discourse, a line of inquiry that is extended in this thesis.

What is refreshing about many of these studies is that they do not necessarily present midwives as dupes of hegemonic structures (Crabtree, 2002; De Vore, 1995) or as victims of medical dominance (Griffith, 1996; Hunter, 2000). They do paint a picture of the profound complexity of practice, drawing attention to midwives' counter-hegemonic practices (Crabtree, 2002; De Vore, 1995) or resistances (Griffith, 1996; Surtees, 2003).

Theorising midwifery practice

Katz Rothman's (1991) midwifery model of care, social models of childbirth and indeed the partnership model of practice (Guilliland & Pairman, 1995a) contribute significantly to the profession and practice of midwifery. They may provide midwifery with important discursive resources that support midwifery in challenging obstetric practices or biomedical constructions of childbirth. We do need to consider, however, to what degree these models are reflective of practice or strategic in their intentions, prescribing rather than describing midwifery practice. However midwifery is theorised, it is

important that we explore midwifery as midwives construct it. It is also important to explore the practice of midwifery as it is practiced on a day-to-day basis. In seeking to understand how case-loading midwives construct midwifery and in exploring the day-to-day level of practice focussing on the obstetric hospital, this thesis makes a contribution to this understanding.

Elaborating the practice of midwifery has become neglected as midwifery has worked to draw attention to the central role of the childbearing woman and her experience in a "woman centred" model of care, minimising their own part in the experience. For example, acknowledging the role of language in constructing a passive childbearing woman many midwives and childbirth activists have begun to use the term "catching" a baby rather than the terminology "delivering a baby". While I am sympathetic to the rationale underpinning this change in language the new terminology grossly understates the role of midwives in this event. It denies the work that midwives undertake in facilitating the process of childbirth and the work they do in providing women with safe and satisfying childbirth experiences. Midwives do much more than "catch" babies, yet exactly what they do and how they do it is rarely addressed.

My master's thesis (Davis, 1995) explored homebirth midwifery in Australia from the perspective of the childbearing woman. The women involved in the study described this midwifery as concerned with the facilitation of childbearing. This was achieved through the establishment of a trusting relationship between the midwife and childbearing woman (see also Flint, 1986). The midwife invested time and energy in gaining a holistic understanding of the woman, acknowledging her emotional, social and cultural context. They affirmed childbirth as a natural process and the practices involved in monitoring the wellbeing of mother and baby did not take centre stage. These were integrated into the experience, sometimes seeming secondary to the work of establishing a relationship and gaining understanding, and sometimes providing an opportunity for the midwife to affirm the naturalness of childbearing and the woman's contribution to her own and her baby's wellbeing. From the perspective of the childbearing woman, it seemed that these midwives actively worked toward building their confidence in natural birth through the establishment of a trusting relationship and a holistic understanding of the childbearing woman and her needs.

Powell Kennedy, Shannon, Chualhorm and Kravetz (2004, p.18) in their study exploring midwifery practice and women's experience of midwifery care in the United States of America (USA), describe the way that midwives work to orchestrate an environment of care.

> Orchestration was chosen to describe the midwives "art" in creating an environment in which the woman's desires were met, where she was kept safe along the way, and where normalcy was preserved. It included an awareness of the women's context and care setting and creating space where the woman's physical and emotional needs could be met.

In this study, midwives created this environment by advocating for the woman and acting as a "conduit". A conduit was explained in terms of a channel conducting the flow of water. Midwifery work was described as the channel; it prepared the way and supported the flow of water while the woman was described as the flow of water. One notices the movement of the water but not necessarily the conduit or channel and for this reason the midwifery work of orchestrating the environment often went unnoticed. An important element contributing to midwives' work here was the contextual understanding they had of both the woman and the birth setting. Midwives here, as they do in my study, use this contextual understanding and commitment to serving the childbearing woman's needs, to orchestrate the environment or (in my terms) create a unique birthing space.

In chapter 6.2 "The politics of practice" I further explore the active role of midwives in facilitating childbirth. This is work that often goes unnoticed by the childbearing woman and others. I describe the way that midwives create space for birthing and how this space is often unique to each midwife/childbearing woman pairing.

Conclusion

This chapter has described the development of midwifery in New Zealand, highlighting some of contextual factors that have shaped the development of midwifery, as we know it today. This establishes the foundation for an understanding of multiple "midwiferies"

that will be elaborated in the chapters to follow. The significance of birthing places was then explored in relation to midwifery practice. Few researchers have addressed this issue directly though a number have done so peripherally. In a maternity care context that has drawn attention to the central role of the childbearing woman in the childbirth experience, I suggest that midwives have tended to minimise the active role that they play in the facilitation of childbearing processes and experiences. Literature that addresses this more explicitly was presented, foreshadowing the theme of chapter 6.2 "The politics of practice".

This chapter introduced a number of theoretical concepts such as multiple subjectivities, discourse and the constuctedness of phenomena such as midwifery or childbirth. The theoretical and methodological underpinnings of this thesis and the methods will be elaborated in the next section, "Charting the course".

Chapter 3: Charting the Course

3.1. A feminist, poststructural approach to research

Feminist and poststructural theories inform this study. This chapter presents the major theoretical concepts that inform the methods and analysis of this research.

Introduction

This chapter presents the major theoretical concepts informing this research project. The methodological approach draws from the work of Foucault and feminists such as Bordo (1993a, 1993b), Grosz (1994, 1995) and Braidotti (1994). Whilst there continues to be controversy and debate concerning the utility or theoretical propriety of combining poststructuralist and feminist approaches (Bartky, 1988; Fahy, 1996; Flax, 1987; Fraser & Nicholson, 1990; Hartsock, 1996; Lloyd, 1993a; Lloyd, 1993b; Lurie, Cvetkovick, Gallop, Modleski & Spillers, 2001; Martin, 1988; McNay, 2000; Rolf, 2000), it is argued here that poststructuralist theories and in particular the work of Foucault, have made a valuable contribution to many feminist projects. I have looked to the work of various feminists (such as those mentioned above), for guidance and inspiration in using the work of Foucault and also for their own theorising, particularly in relation to the body and feminist politics.

Foucault and Feminism

Following Crotty (1998) I situate Foucault as a poststructuralist theorist who explores the making of meaning, as meaning is constituted within relations of power. Foucault's ideas form the basis of the analysis undertaken in this thesis. Some of these ideas will be elaborated in this chapter, with further development (as they relate to the analysis) presented in the chapters that follow.

In this thesis I wanted to focus specifically, though not exclusively, on issues of gender and I have looked to a range of feminist theorists to compensate for the "gender

blindness" of Foucault (Bartky, 1988) and to suggest ways that Foucault's ideas can be utilised (or extended) fruitfully for a feminist politics. Foucault is critical of emancipatory theories and certainly does not offer an emancipatory theory of his own. Feminist theories are based on emancipatory politics and this makes the coupling of feminism and Foucault a problematic one (Francis, 2000). As a feminist I certainly wanted this thesis to contribute to feminist emancipatory goals (in whatever small way it could) and have turned to a number of feminist theorists, who have suggested ways that feminism and Foucault can work together toward this aim for inspiration. In this chapter I present some of the ideas of these feminist theorists (alongside those of Foucault), explore the tensions between feminism and Foucault and, in chapter 3.2 "A feminist research design", turn attention to the methods through which this research was conducted.

Foucault's genealogy

On one level Foucault's body of work demonstrates a process of inquiry that problematises the social sciences, institutions and our understanding of concepts such as discipline (1995), madness (1965), medicine (1973) and sexuality (1990, 1992). On another level, Foucault's approach is profoundly political as his critique attacks the very foundations from which these concepts are built and on which they rest. By not accepting the meaning or present-day understanding of these concepts, by "get[ting] rid of the subject itself" (Foucault, 1980, p.117), Foucault is able to analyse the processes that account for the constitution of the subject within a historical framework (Foucault, 1980, p. 117). Using Nietzsche's terminology, Foucault called this the genealogical approach (Foucault, 1980, p, 117). Building on Nietzschean philosophy, Foucault's historical analysis opposes the search for origins as this implies that there is an "original" something or "primordial truth" that existed in pure form and "precedes the external world of accident and succession" (Foucault, 1971 in Rabinow, 1984, p. 76). Foucault challenges the whole concept of an a priori truth, perceiving that social and cultural processes create "truth". These processes reify this 'truth' over time; "truth is undoubtedly the sort of error that cannot be refuted because it was hardened into unalterable form in the long baking process of history" (Foucault, 1971 in Rabinow 1984, p. 79).

Foucault's genealogical method, then, does not aim to reveal the truth once and for all, to identify the origin or to map the evolution of a movement or concept. It aims to demonstrate that truth as we conceive it, is a construction that happens by way of accident, deviation, and error as much as anything; "…truth or being does not lie at the root of what we know and what we are, but the exteriority of accidents" (Foucault 1971 in Rabinow, 1984, p. 81). Foucault's method investigates the conditions of possibility that allowed for the emergence of a particular discourse and, rather than establish truth or falsity, he is interested in elaborating the effects of discourse.

Discourse

'Discourse' is a somewhat nebulous concept (Lupton, 1992) encompassing a variety of definitions and shades of meaning. Most broadly, discourse can be understood as "…any system of signs, whether spoken, written or otherwise" (Traynor, 2003, p. 137). These systems of signs include written text, verbal communication, body language, artwork, advertising and architecture, to give just a few examples. In this thesis for example, chapter 6.1 "The politics of place", explores the architecture of the hospital and spatial design of the obstetric birthing room as discourse. The architecture and design of this space communicates a meaning as surely as does any written text. Foucault uses the term 'discourse' to describe bodies of knowledge and, for him, these systems of signs are not reflective of a separate truth or reality but rather work to construct a subject or phenomena in a particular (historically, socially and politically situated) way.

Lupton (1992, p. 145) defines 'discourse' as "…a patterned system of texts, messages, talk, dialogue or conversations which can both be identified in these communications and located in social structures". What is of interest to Foucault is not so much the content of these communications, what they 'say', but how they come to 'say' it and the effects of this 'saying'. How did a particular perspective or understanding come into being? What were the historical and social processes and workings of knowledge and power that enabled this understanding to emerge and not another? What are the effects of the discourse and whom does it serve?

If we begin to think of childbirth and midwifery in terms of Foucault's thesis then we are directed to explore these phenomena not as "truths" embodying a certain natural or essential character, but as constructions, forged by particular historical, social and political contexts. Chapters 4.1 to 4.3 of this thesis explore the way that case-loading midwives participating in this study discursively construct childbirth. Biomedical, natural and neo-liberal discourses are implicated in this construction and in chapters dedicated to each discourse, I describe the context or "conditions of possibility" enabling the discourse and the effects of the discourse for the childbearing woman and the midwife. The chapter titled "(Re)-Making midwifery and the professional midwifery discourse" in the following section explores the construction of midwifery in New Zealand, and similarly describes the contextual factors shaping this midwifery and some of the effects of this construction.

Power, knowledge nexus

Foucault (1995) conceptualises power not as an entity in itself to be held by one person or group, to be wielded (or not) as the case may be (the sovereign conceptualisation of power), but as a relational phenomena (1980).

> Power must be analysed as something, which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application. (Foucault, 1980, p. 98)

Power is understood as a multiplicity of force relations that exist within our social world. It is the matrix of interrelationships through which power operates (the mechanisms of power), which is of particular interest to Foucault.

The sovereign conceptualisation of power suggests that power is a repressive force whilst Foucault's thesis examines power as productive. Foucault makes an essential link between power relations and their capacity to produce truths. In this, power and knowledge are inextricably linked. As Foucault (1980, p. 93) comments, "We are subjected to the production of truth through power and we cannot exercise power except through the production of truth". These truths not only govern our social world but also inscribe our bodies through mechanisms of subjection. This thesis will be further explored in the pages to follow.

Power always co-exists with counter-power or resistance. Resistance though, is not something external to the exercise of power. Resistance is intrinsic to power. It is because of the possibilities of resistance that power is incited. For Foucault (1980) the most effective understanding of power is to be found in the study of the "capillary" points of power or the extremities rather than at its central points. It is at these points that power is exercised and resisted.

Foucault's thesis on power and knowledge requires that we move beyond thinking about midwifery and medicine in terms of the dichotomies oppressor/ oppressed or bad and good. It means that we need to consider the discursive construction of these phenomena (chapters 4 to 5) and the relations of power that work to produce and communicate meaning. By focusing on the discursive construction of midwifery (and midwives) and the day-to-day practice of midwifery (in particular midwifery practice in the obstetric hospital), I am exploring the capillaries in the circulation of power. It is here that power is experienced, exercised, and resisted and it is here that midwifery and midwives are constructed.

Body politics

We have inherited certain western philosophical traditions that frame our understanding of concepts such as the subject and the body. We think of the subject for example, in terms of the humanist notion of a coherent, unified and rational self. The humanist notion of the subject suggests that there is a centre or a core in which the real or true self resides. Similarly the body is considered a well-differentiated, biological body.

There are male and female bodies, characterised by natural and essential features. This essentialism may also be expressed as a natural or given propensity for certain psychological characteristics (such as empathy), phenomena (such as intuition) or activities (such as helping) (Grosz, 1995). Poststructural theories not only problematise these concepts but call into question the very structures through which we think and understand them.

The poststructuralist approach to the subject does not subscribe to the humanist notion that the subject is coherent, unified, or rational. It does not consider that the subject has inherent, essential meaning independent of consciousness, a subject in which meaning and truth resides. The subject for poststructuralists is constituted through language and discourse and, as discourses (positioned by relations of power) are multiple, they give rise to subjectivities that are multiple, fragmented and contradictory (Gavey, 1989; Weedon, 1987).

The body in poststructuralism similarly, is not conceived of as a purely biological or essential body. Poststructural theories problematise the binary thinking that characterises western philosophy (such as female/male, nature/culture, body/mind) and the way this thinking defines the body in terms of biology and either/or categories. Within western philosophical traditions, the body is either male or female, it is a product of nature (and is therefore natural and has essential characteristics) and it is a different and separate entity to the mind. Feminist poststructural theorists (for example Bordo, 1993a, 1993b; Grosz 1994, 1995) draw attention to the way that these western, philosophical traditions are in fact masculinist constructions, which serve to denigrate and oppress women.

The biological and essential body

Biologism is a particular form of essentialism that focuses on women's biology, especially that related to reproduction. Biologism is ubiquitous in medical literature especially in relation to reproduction. Examples of biologism include the assertion that women's biology is the basis for a natural and inherent weakness. Grosz (1994, p.13) states,

> Misogynist thought has commonly found a convenient self-justification for women's secondary social positions by containing them within bodies that are represented, even constructed, as frail, imperfect, unruly, and unreliable, subject to various intrusions which are not under conscious control.

Some feminists agree (for example De Beauvoir 1989, cited in Wallace, 2001), suggesting that the control of, or freedom from the "tyranny" of reproduction is an important route to emancipation (Firestone 1978, cited in Wallace, 2001)[9]. The rhetoric of natural childbirth also promotes a form of essentialism as it often asserts that women have innate, natural qualities that enable them to birth and mother appropriately. This point is further explored in the chapter titled "Body politics and the natural childbirth discourse".

A feminist politics promoting essentialist notions of woman is problematic in that it collapses the cultural and social into the biological and is complicit with masculinist assumptions as it firmly establishes fault within women's unalterable biology. Essentialism is also problematic in that it assumes homogeneity within categories as all women are assumed to be essentially the same. Oppression may arise from multiple sources and the homogenous, "universal" woman as a basis for feminist politics has been accused of promoting the interests of white, heterosexual, middle class, educated, western women, alienating those who do not identify with this group (Bailey, 1993).

Feminists have sought to resolve the issue of biologism and essentialism by delimiting the concepts of sex and gender; referring to biological characteristics as sex and gender as constituted by socially and culturally constructed traits (Bailey, 1993). As a social and cultural construction, gender is amenable to change while biology is not, making gender and the constructed body a more useful concept for feminist politics.

[9] First wave feminism for example focussed on issues arising for women especially in regards to control over reproduction, abortion, maternity care and rape (Bailey, 1993; Wallace, 2001) with some success. While focussing on women's biology their major concern was the promotion of self-determination for women especially as it related to issues concerning their body.

Foucault's bodies; the first wave

Feminists have long conceptualised the body as a central site of political struggle. Bordo (1993a) for example credits Wollstonecraft (1792) as one of the first to conceptualise subjectivity as a product or construct of social and cultural practices, an insight that moved feminists beyond thinking about the body in simple biological terms. Wollstonecraft's (1792) 'docile body' is a theme that has been explored in feminist writing and in more recent times, the work of Foucault has been particularly influential. While not the first to describe a body inscribed by social and cultural values and practices, Foucault's thesis on power (particularly bio-power), resistance and his later work on subjectivity have provided feminists with useful frameworks through which to theorise and act on a variety of feminist issues.

Feminists have used Foucault's work in a variety of ways and authors such as Bordo (1993a) and Deveaux (1996) have described bodies of Foucauldian inspired feminist work that form different waves. Deveaux (1996) for example identifies three distinct waves, the first using Foucault's theories of bio-power and the docile body, the second, focussing on power/resistance relationships and the third, subjectivity and identity. Similarly for Bordo (1993a, p. 193), a first wave was concerned with Foucault's concepts of 'discipline', 'normalisation' and 'bio-power'. The first wave continued the thesis of the colonised and inscribed body and a second "more postmodern" wave problematised this construction and its determinism, focussing on 'resistance', 'contestation' and 'subversion'.

In 'Discipline and punish' Foucault (1995) describes a historical transition in the workings of power from one based on the authority of a sovereign and public displays of power enacted on the body of the subject, to the modern workings of power that involve a more subtle yet omnipresent and ultimately more efficient 'master'. In the sovereign model of power, power is conceptualised as something that can be wielded by the sovereign or possessed, and the subordinate is conceived as power-less. Foucault's modern workings of power describe a power that is diffuse and circulating, unable to be held or owned. Power works on bodies through discourse and every body is enmeshed and implicated in its workings. Dominant discourses create norms and we both discipline ourselves and are disciplined to align with these norms. Foucault refers to

this process as normalisation (1995). Foucault (1995) used Bentham's Panopticon to illustrate his point. The Panopticon is a ring shaped building, which may operate as a school, prison, workhouse, hospital or asylum for example. At its centre is a tower housing a supervisor that has large windows opening toward the encircling outer building. The peripheral building is made up of cells, each one with two windows, one open to the inner circle and tower and the other to the outside of the circle. The cells hold inmates who are highly visible from the tower due to the backlighting effect of the windows.

> They are like so many cages, so many small theatres in which each actor is alone, perfectly individualized and constantly visible. (Foucault, 1995, p. 200)

The inmate is never quite sure if the supervisor is in fact observing them, all they know is that they are highly visible. Foucault's point is that it is the unrelenting and continual potential for observation that ensures an automatic functioning of power and leads the inmates to discipline themselves.

> The efficiency of power, its constraining force, have in a sense, passed over to the other side – to the side of its surface of application. He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection[10]. (Foucault, 1995, p. 202)

Foucault describes the way mechanisms of discipline spread through the seventeenth and eighteenth centuries, transforming from a schema of exemplary discipline (public display of discipline exacted on a few individuals by a sovereign), to one involving generalised surveillance.

'Discipline and punish' (1995) details the way a new political anatomy developed in the 17th and 18th centuries that involved the development of a set of regulations and methods (relating to and diffusing from army, school and hospital) for controlling or

[10] I would like to draw attention to Foucault's use of the universal "he" in this footnote rather than disrupt the reading of his text with (sic).

correcting the operations of the body. A disciplined and docile body emerges from these technologies "…that may be subjected, used, transformed and improved" (Foucault, 1995, p. 136). Bodies are disciplined to conform to norms. Discipline at once increases the force of bodies in terms of economic utility and diminishes the force of these same bodies in terms of self-determination. The body thus becomes a political canvas that is constituted and inscribed by power (Deveaux, 1996), a work always unfinished and one we (as individuals), conspire in creating. Foucault's conceptualisation of power has been useful to feminists including, for example, Bartky (1988) and Bordo (1993a, 1993b) who use his thesis to account for women's complicity in their own subjugation.

Bartky (1988, p.71) for example explores the "disciplinary project of femininity" identifying the projects of transformation in which women are compelled to engage, in their pursuit of femininity; diet and exercise regimes to achieve the ideal body, attention to comportment, gestures, movements and adornment. For Bartky the unrelenting gaze that women endure is a generalised male gaze. This gaze and the disciplinary practices of femininity work not just at the level of the body but also at the level of women's consciousness. Bartky (1988, p. 74) draws on Foucault's (1995) concept of "micro power" to explain that the disciplinarian in this situation is "…everywhere and it is nowhere; the disciplinarian is everyone and yet no one in particular". This diffusion obfuscates the workings of power, giving the impression that women's feminine behaviour and disciplinary practices in relation to femininity are natural and voluntary. Bordo (1993a, p. 197) comments that a normalised image (of the ideal or appropriate woman, for example) acts as a standard against which women will "…measure, judge, discipline and 'correct' themselves". The rhetoric of self-determination and choice serves to conceal the mechanism of this normalising process. This is an important point that will be taken up in my analysis of "informed choice" within the contemporary maternity service of New Zealand.

Bordo (1993b) similarly describes the social construction of femininity and the way this inscribes and disciplines women's bodies. Bordo's analysis of anorexia nervosa and bulimia describes how they arise out of and reproduce normative feminine practices (Bordo, 1993b). Bordo (1993b, p. 188) however offers a more complex analysis than Bartky. By acknowledging that women are in fact aware of the social system of

rewards and punishments that shape their desires and actions, she rejects a conceptualisation of women as "cultural dopes". In her analysis of anorexia nervosa and bulimia Bordo (1993b) explores the way these practices paradoxically discipline the body and also leave the woman feeling 'in control' and powerful. Bordo thus highlights the way that power relations are shifting and unstable.

Foucault's (1995) "docile body" has been accused of being over-determined and passive; a construction that fails to acknowledge women (or men) as creative, active agents capable of resistance and subversion (Bordo, 1993a; Deveaux, 1996). This points to Bordo's (1993a) second wave of feminist, Foucauldian analysis that utilised Foucault's conceptualisations of power. This emphasised the productive rather than repressive aspects of power and the concomitant potential for resistance.

Foucault's bodies; the second wave

While disciplinary technologies and the construction of docile bodies was the focus of "Discipline and punish", and to some extent "The history of sexuality Volume 1, The will to knowledge" (1990), Foucault's later works; "The history of sexuality Volume 2, The use of pleasure" (1992) and Volume 3, "The care of the self" (1986) and "Power/Knowledge" (1980), contributed to a thesis on power that emphasised productivity rather than repression and a thesis on subjectivity that introduced an active agent. Foucault explains the changing focus of his ideas from his earlier work as development (1992, p. 6), while others describe the change as a "rupture" accusing him of inconsistency and contradiction (Dews, 1984, 1989 cited in McLaren, 1997).

In "The history of sexuality, Volume 1, The will to knowledge" (1990), Foucault uses his genealogical approach to explore sexuality, reiterating his point that power cannot be conceived of in terms of ownership or within a dominator/dominated binary. He criticises the repressive hypothesis of power emphasising the way that it is productive. By exploring the history of sexuality from the 17th century Foucault demonstrates that attempts at censorship or repression of sex resulted in (at the level of discourse) a "discursive explosion" (p. 17), a proliferation of discourses and institutional incitement to speak of, explore, know and investigate sexuality. Foucault links sex, truth and the

subject, demonstrating how confession became a valued technique for producing truth. He draws attention to the way the practice of confession assumes that truth resides in a deep, inner and secret self, waiting to be liberated through confession. The practice spread from the Church and concern for penance through to many other aspects of our lives.

> We have since become a confessing society. The confession has spread its effects far and wide, it plays an part in justice, medicine education family relationships and love relations, the most ordinary affairs of everyday life and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling with the greatest of precision whatever is most difficult to tell. (Foucault, 1990, p. 59)

He goes on to explain that where there is power there is resistance and as power is omnipresent and diffuse so too is resistance. Rather than a centre of revolt Foucault describes a plurality of resistances that are,

> Distributed in irregular fashion: the points, knots, or focuses of resistance are spread over time and space at varying densities, at times mobilising groups or individuals in a definitive way, inflaming certain points of the body, certain moments in life, certain types of behaviour…more often one is dealing with mobile and transitory points of resistance, producing cleavages in a society that shift about, fracturing unities and effecting regroupings, furrowing across individuals themselves cutting them up and remoulding them, marking off irreducible regions in them, in their bodies and minds. (Foucault, 1990, p. 96)

Foucault also elaborates his theory of "bio power" in this volume. He describes the way power over life evolved into two forms from the 17th century. One form centred on the discipline and regulation of individual bodies and the other on populations. Together these forms constitute two poles; "the administration of bodies and the calculated management of life" (1990, p. 140) around which power over life is deployed.

Foucault's body in this volume remains constructed and somewhat docile but his elaboration of the nature and workings of power and resistance offered feminists

opportunities that were not apparent with the focus of his earlier work (for example "Discipline and punish"). Feminist work using Foucault's ideas as they are elaborated in this volume, highlight the complexity and instability of power relations and draw attention to instances of, or opportunities for, specific and particular resistances, especially those occurring at micro rather than macro levels. Deveaux (1996) comments that feminist writing using Foucault's earlier work creates a false sense of feminist politics and that stories of oppression must be balanced by stories of resistance because this is the reality of feminism; there is both oppression and resistance. Bordo (1993a) on the other hand warns that a focus on resistance may lead us to overlook the reality which for her, is one where women are increasingly pressed to normalise their looks and behaviour (she cites the rise in cosmetic surgery as evidence).

In Foucault's later works (Faubion, 1998; Foucault, 1986, 1992) he focuses on the formation of identity and his subject becomes less docile. In these later works the subject is acknowledged as playing an active role in the development of identity through "technologies of the self". The self emerges through "…a game of truth, relations of power, and forms of relation to oneself and to others" (Faubion, 1998, p.117). Foucault's account of subjectification is inadequate for McNay (2000, 2004) who considers that it fails to properly explain human agency. While Foucault acknowledges that the subject is constituted through practices of subjection and freedom, McNay (2000, 2004) considers that recent theoretical works on identity have focussed on subjection rather than freedom, thus creating a negative paradigm. Within this paradigm a passive subject is discursively or symbolically constructed by repressive practices. McNay (2000, p. 5) calls for a more nuanced understanding of identity formation that explains "how women have acted autonomously in the past despite constricting social sanctions" and "how, when faced with complexity and difference, individuals may respond in unanticipated and innovative ways…". Therefore, McNay is calling for a theory of the subject that accounts for agency.

Foucault has also been criticised by feminists (see Braidotti, 1994 cited in McLaren, 1997; Ransom, 1993) for what they conceive of as his rejection of the subject[11]. For

[11] McLaren (1997) argues that Foucault does not reject the subject per se but rather refuses to begin analysis from an a priori theory of the subject

these feminists a subject is necessary for feminist politics. As Deveaux (1996, p. 240) questions,

> And how does a group or an individual simultaneously resist an identity and mobilize around it for the purposes of empowerment and political action?

This is a valid criticism and indeed raises a parallel issue for a feminist poststructuralist analysis of midwifery; if we fracture and destabilise the concepts of midwife and midwifery, how does that impact on midwifery politics? How can the profession move into the future without the benefit of a stable construct around which the profession and political action coheres? In resolving what seems to be a theoretical and political impasse many feminists working within a Foucauldian framework adopt or advocate some form of "strategic essentialism" (Braidotti, 1994; Spivak in Harasym, 1990; Butler, 1992 cited in Deveaux, 1996; Bailey, 1993; Grosz, 1995). This involves political action that is based on a notional subject, (one that is acknowledged as unstable, shifting and plural) but is fixed for strategic purposes. This is not without its difficulties as Butler (1992 cited in Deveaux, 1996, p. 239) questions,

> There is a political necessity to use some sign now, and we do, but how to use it in such a way that its futural significations are not foreclosed? How to use the sign and avow its temporal contingency at once?

Even though this fracturing of the subject can lead one into uncertain terrain in terms of grounding for political action, Butler (drawing on the work of Foucault and others such as Derrida) endorses Foucault's strategy and suggests that a feminist politics without a subject is not only possible but is also desirable. Butler contests the idea that an identity is a prerequisite for political action and that a constructed subject is historically determined. In "Gender trouble" Butler (1990) describes how the subject is constituted by discursive possibilities and is always in process. Identity is a self-representation that is a fiction created through performance. Butler thus points to the contingency of sexual identity and situates the possibility for agency in this contingency, "construction is not opposed to agency; it is the necessary scene of agency" (1990, p. 147).

Focussing on the cultural construction of identity is problematic for some. McNay (2000, 2004) for example draws attention to the main points of critique. Firstly, the approach reduces all forms of gender oppression into positionality within language. Secondly, cultural feminists (as McNay describes them) tend to underestimate the effect of structural and systematic forms of oppression and over estimate the potential for change brought about by cultural identity politics. McNay contrasts cultural feminists with material feminists, who focus on economic and other material conditions of oppression and gender inequalities. Material feminists however are criticised for this focus and the way that it can lend itself to a determinist analysis that does not adequately explain the effects of structural factors on subject formation and human agency (McNay, 2000). According to McNay, contemporary feminist debate has cohered around the two poles of the cultural and material, each focussing on the shortcomings of the other without advancing the case of feminism in a meaningful way. Drawing on the work of Habermas and Bourdieu, McNay suggests a way forward that integrates the material and cultural feminists perspectives, which she calls "situated intersubjectivity".

Situated intersubjectivity is described by McNay (2004) as an analytic tool that offers new insights into the social theory of gender. It brings together the cultural and material feminist perspectives by exploring the way that identity formation and the material conditions of our lives may be linked. McNay draws on Bourdieu's concepts of habitus and the field to develop this idea. Habitus refers to the "the physical and psychological dispositions of the individual" and the field, to the "social structure" (McNay 2004, p. 181). Individuals are not locked into social positions but move across varying fields. For midwives, there may be fields in which midwifery and midwifery knowledges are dominant (a small primary birthing unit for example) and fields where it is not (a tertiary hospital for example). Therefore, social positioning is not constant but encompasses contradiction and dissonance. The field also represents a complex interplay of material practices and symbolic relations that may act on the body (in terms of disposition) and importantly, disposition can also impact on behaviour within the field. Thus, identity is understood as developing not only from cultural and symbolic factors, but also through the interplay of the material and cultural with the physical and psychological self.

Knowledgeable bodies / bodies of knowledge

Within the binary and aligned pairing of body/ mind and female/ male, western philosophical traditions connect women closely to the body while men are connected to the mind. Western philosophical traditions also associate truth and knowledge with the mind and reason while the body, is denied epistemic status. Indeed the body is conceptualised as a potential obstruction to the pure operation of the mind as its passions and irrationalities demand control, and its connection with nature and animality demand transcendence (Grosz, 1994). Grosz therefore (1994, p. 4) considers that western philosophy has established itself through a rejection of the body (the male body) and an elevation of a "disembodied" mind. If knowledge and truth are connected to the male mind it follows that the body and therefore women, cannot be understood as knowing subjects. This knowledge is (re)presented as a universal and objective truth or knowledge, (one that simply describes or reflects truth or knowledge) rather than as a product of a phallocentric framework that may in fact, manipulate and distort the object under study. Grosz (1994, p. 20) comments,

> Knowledges, like all other forms of social production are at least partially effects of the sexualised positioning of their producers and users; knowledges must themselves be acknowledged as sexually determinate, limited, finite.

It is important to ask then, not "What is truth?" but "How does this knowledge, this method, this technique, constitute its object?" (Grosz, 1995, p. 27). These are exactly the sorts of questions that have driven the work of Foucault. Foucault (1980, p. 52) details the way that power and knowledge are inextricably linked (power/knowledge) and comments, "It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power". Power is productive rather than repressive in that,

> … the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information. (Foucault, 1980, p. 51)

The body is the principal target of power for Foucault, constituting bodies through discourse. Rather than knowledge of the body being conceptualised as pure or

objective, Foucault highlights the way that the discursive frameworks available to us shape our knowledge of bodies. For example, it is important to understand how the biomedical discourse constitutes the childbearing woman as an object of knowledge. Within this discursive frame certain masculinist presuppositions underpin knowledges, including the assumption that women's bodies are inherently faulty and that bodies function in a mechanistic way. Obstetric and midwifery practices based on the biomedical discourse are therefore concerned with correcting the faulty body and monitoring its mechanical functioning. Information is extracted from the body (measurements of progress such as cervical dilatation), which often does demonstrate a body not functioning as required, when judged by the criterion established by the discourse. This represents "discursive formation" which McNay (1992, p. 148) explains as consisting "of practices and institutions that produce knowledge claims that the system of power finds useful". Thus power is productive, it extracts specific knowledges from bodies and in turn, these knowledges inscribe the body in specific ways (Grosz, 1995).

Foucault's (1980) politics is concerned with illustrating the way that knowledges are products of power, thereby demonstrating their contingency, historicity and partiality. He comments in Power\Knowledge (1980) that he is interested in subjugated knowledges, which are those that are considered inadequate or disqualified by dominant discourses. Foucault (1980, p.82) cites the knowledges of the delinquent, psychiatric patient and nurse as examples and equally the knowledges of midwives and women could be considered subjugated and marginalised. Foucault believes "that it is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges that criticism performs its work" (p. 82). Feminists are particularly concerned with the reappearance of the subjugated knowledges of women and in this thesis I suggest some strategies that may facilitate the surfacing of the marginalised knowledges of midwifery.

Feminists however warn that adding women's knowledges to our body of knowledge does not alter the relations of power and the western philosophical traditions that govern the way we understand and use knowledge. Foucault (1980, p. 86) also cautions, that once subjugated knowledges are brought to light and circulated, they run the risk of being recodified and colonised by the unitary discourses that first disqualified them. As

the subjugated knowledges of midwifery are circulated with the mainstreaming of midwifery in New Zealand, these knowledges are subject to the same medico-legal apparatus that shape obstetrics and medicine. Under the influence of these dominant discourses midwifery may be at risk of developing in ways that make it more like the medicine it set out to challenge.

The body reborn as a different body

While feminists continue to debate and work through the issues that arise from the challenges posed by Foucault and poststructuralist theories, it seems that until recently, there continued to be reluctance on the part of feminists to grapple with the corporeal body. Ramazanoğlu (1993, p. 7) comments that this disinclination to deal with the materiality of the body or women's bodily experiences occurred due to feminist's fear of being tainted with the "odour" of biological essentialism. Shildrick and Price (1999) label this aversion, somatophobia. Foucault and poststructuralism have been accused of offering feminists a tidy escape from grappling with the corporeal body and Shildrick and Price (1999) claim that in the hands of some poststructural and postmodern feminists, the body as it is lived, has been emptied of its organs leaving only an inscribed surface. Several feminists, while influenced by Foucault and poststructuralism, have been concerned to include the corporeal body within their theorising, most notably Luce Irigaray (1985), Judith Butler (1990) and Elizabeth Grosz (1994).

Western philosophy depicts knowledge as emanating from the mind, disavowing the role of the body in its development. Grosz (1995) conceives of knowledge as active and productive, implicating the body (specific bodies) inextricably in the production of knowledges. Grosz (1995, p. 37) comments that, "Knowledges are products of bodily impulses and forces that have mistaken themselves for products of the mind". As a disembodied product of reason, knowledge is deemed to be sexually indifferent, a strategy that operates to obfuscate the masculinist interests that produced them. It is power rather than reason that plays the pivotal role in knowledge development. In addressing feminist concerns, it is not enough to attempt to introduce and affirm women and the feminine as objects of knowledge (correcting a historical oversight) because this

strategy leaves the structures and values governing knowledges unchallenged. Grosz (1994, 1995) advocates rather that we reconceptualise knowledges as products of sexually specific bodies and to do this we must theorise the body and sexual difference.

Feminist theorists focussing on sexual difference (for example Judith Butler, Luce Irigaray and Elizabeth Grosz) emerged in the 1980s. Rather than accept the binary concepts and normative ideal (of man) made available by western masculinist knowledge systems, these theorists conceptualised difference as a 'pure' difference. Within this conceptualisation women do not align with the negative pole of the familiar binaries, the white male is not held as the ideal norm to which all other bodies are judged; they are not different as measured against men. A focus on this 'pure' difference provides feminists with an opportunity to reject existing masculinist conceptual structures and define themselves in different terms (Grosz, 1995).

Feminists focussing on sexual difference problematised the sex/gender distinction pointing to the impossibility of eliminating the effects of culture to isolate sex. This dichotomy is undermined as they theorise the body in ways that represent an interweaving of gender and sex, culture and nature, interior and exterior (Grosz, 1994). In "Volatile bodies. Toward a corporeal feminism" Elizabeth Grosz (1994) for example, uses the metaphor of the Möbius strip (a two dimensional ribbon-like strip that twists and turns to form a three dimensional shape) to illustrate her conceptualisation of the body. If one traces the outside of the strip at some point and in a seamless way, it becomes the inside and vice-versa. The model of the Möbius strip is invoked to demonstrate the way that a subject's exterior is presented and lived by the subject (the inside out) and the way that social inscriptions produce effects on the interior of the body (the outside in)[12]. The distinctions between gender and sex, culture and nature, outside and inside, mind and body break down, as Grosz demonstrates how each concept is constitutive of the other. In this way Grosz is able to suggest a way forward for feminists that avoids a biological materialism that disregards the effect of culture and a cultural determinism that neglects the corporeal body.

[12] Grosz (1995) uses the same schema to explore the relations between space and body in a paper titled "Architecture from the outside". The "outside in" describes the influence of space on bodies and the "inside out" describes the influence of bodies on space. I have used Grosz's schema in my exploration of bodies and space in the chapter entitled "The politics of place".

Not unexpectedly, theorists of difference have been accused of essentialism and biologism leading Grosz (1995) to repeat the perennial dilemma of feminism. Either feminists avoid the theoretical pitfalls of essentialism and biologism by avoiding the category of woman (but accepting that this problematises feminist politics) or we use the category of woman, accepting the limitations of a patriarchal conceptual framework, but securing a foundation for feminist politics. For Grosz (1995) this dilemma can be conceptualised as an issue of intellectual rigor versus one of feminist politics. Grosz highlights the way that both these options are bound by constraints and suggests that we refuse to adopt an either/or position and approach the situation in a less than 'pure' but more pragmatic way. Here she draws on Spivak's (cited in Harasym, 1990; Spivak, 1984-85) 'strategic essentialism', a strategy that promotes the use of theoretical concepts and principles as tools for a feminist politics rather than rigid dogma.

For Braidotti (1994) the issue of difference is one of the most important issues confronting western feminists and she is concerned by what she describes as the "anti-sexual difference" feminist approach that embraces "a 'beyond gender' or a 'post gender' kind of subjectivity" (p. 149). Braidotti suggests that a focus on difference provides the means to redefine female subjectivity in all of its complexity. Her nomadic political project presents a schema representing three levels of difference; the difference between men and women, the differences amongst women and the differences within each woman. Braidotti's nomad embraces difference in and between women, acknowledging that identities are multiple, fluid and transitory. Like Grosz (1995), (following Spivak) Braidotti (1994) suggests that essentialism may be a necessary feminist strategy. The nomad may create temporary, strategic identities and connections.

> Being nomad, living in transition, does not mean that one cannot or is unwilling to create those necessarily stable and reassuring bases for identity that allow one to function in a community. Rather, nomadic consciousness consists in not taking any kind of identity as permanent. The nomad is only passing through; s/he makes those necessarily situated connections that can help her/him to survive but s/he never takes on fully the limits on one national, fixed identity. (Braidotti, 1994, p. 33)

A unitary identity or foundation is not required for political agency as the nomad's political effectiveness is situated in her/his transitory nature. The final section of this thesis, "An eye on the horizon" draws on the work of Braidotti (1994) to suggest what might be a fruitful way forward for midwifery; one that accommodates multiplicity in midwifery identities and practices and makes the necessary connections that provide for political agency.

Conclusion

Poststructuralist and feminist theories represent a large body of diverse work. This chapter presented the major theoretical concepts (derived from this body of work) that have broadly guided the methodological approach and methods of this research. The work of Foucault has been influential in the critique of western philosophy and has contributed significantly to an understanding of phenomena as products of the social and cultural milieu from which they arise. Understanding the body as a social and cultural construction has allowed feminists to think about the category of "woman" in ways that free it from the limitations of the natural body.

The category of "woman" and the concept of the body are of fundamental importance to midwifery. Women overwhelmingly constitute our profession and it is as women and through the bodies of midwives that the work of midwifery is conducted. Our work is primary focussed on childbearing women. Every day we engage with a variety of discourses that construct women, maternal bodies and mothers and with this, we construct ourselves as midwives. Chapters 4 to 5 of this thesis draw on the work presented in this chapter as I examine the prevailing discourses constructing the maternal body, childbearing and midwifery.

The next chapter of this thesis details the feminist research design of this project and discusses several pertinent issues relating to the conduct of feminist research.

Charting the Course

3.2. A feminist research design

Feminist issues as they relate to the design and conduct of research are discussed in this chapter. The research design, relevant ethical issues and the methods employed in the conduct of this research are then presented.

Introduction

The research process for me began with a broad area of interest and a set of (sometimes unarticulated) philosophical beliefs and assumptions. As the project evolved through reading, thinking and planning, a mix of theoretical understandings, design decisions, pragmatic concerns and sometimes compromises dialectically shaped the research design.

In this chapter I describe in some detail the methods of recruitment, engagement with participants and processes involved in the analysis of the research texts. A total of 48 case-loading midwives were involved in the focus group individual or group interviews which were audiotaped and transcribed. Along with relevant professional, regulatory and contractual documents these transcripts constitute the "text" or data, which were analysed for this research project. In this section I also discuss the issues that arise in conducting feminist research, suggesting that there are many ways of doing feminist research and that all research is constituted by a series of choices and often pragmatic decisions.

(Re)presenting the research process

The work of Foucault and poststructural feminists that I have used in this study represent a large and diverse body of work with which I have engaged and developed understanding of, over a number of years. From the outset, my ideas were not clearly formed and my understanding of the theories informing the research processes and

analysis was not highly developed. These developed together dialectically, as the research progressed. The development of my ideas over time is reflected for example in the changing title of the work and in the explanations provided in the participant information and consent forms. Early in the project (2001) I wrote that the purpose of the study was to "gain an understanding of the factors that constrain or enable midwives to work within a midwifery model of care, particularly the influence of the hospital setting" (see "participant consent form", Appendix A). As my understanding of poststructuralism developed (throughout the time that I was interviewing participants) I came to appreciate that I had to problematise the notion of "midwifery model". Rather than ask participants about the "midwifery model" (or presume any common understanding or alignment with the concept) I asked them rather, about midwifery. The questions that I asked participants probed their understanding of midwifery, their philosophy and what they were trying to achieve in their midwifery care. Indeed many of the concepts that I thought I understood had to be deconstructed. These included; midwifery, normal birth, midwifery and medical models of care, independent, autonomous, woman and the body.

The way that I conceived of this project at the time of advertising and recruiting participants did influence the type of midwife participating in this study. The midwives participating here are more likely to align with the midwifery model of care and therefore represent a less heterogenous group than the total group of case-loading New Zealand midwives.

When reading other theses I have often been left with the impression that they progressed in a very linear and orderly fashion and felt somewhat perturbed by the disorder and "mess" of the research process that I was experiencing. It was not until I turned my attention to the presentation of the work as a whole; the production of the thesis, that I came to appreciate the way that presentation conventions work to construct the research process as a linear and orderly process. In truth, the experience of doing research is perhaps more disorderly and messy than we are led to believe by our reading of the well crafted and honed, finished product of the research report or thesis.

I have given some thought to ways in which a poststructural thesis could be presented that more genuinely reflects the process, but the imperative to present something

readable, succinct and comprehensible has exceeded the desire to more closely reflect the process. So it is with relief and some frustration that I present this thesis in a conventional form; one that belies the complexity, discontinuity, fragmentation, upset, disorder and mess that characterised the research journey.

The analysis chapters of this thesis however should not be read as if they represent a chronological process. At times for example, the theoretical or contextual information presented in the analysis chapters precedes the voices of the midwives participating in this study. This approach to presentation is not intended to suggest that theoretical categories were applied or agreed to, prior to the interrogation of text. As this chapter will explain, analysis proceeded in a dialectical way and these chapters represent a weaving together of theory and text.

Ethics Approval

Ethical approval for this study was gained from the University of Technology, Sydney (UTS), Human Research Ethics Committee in December of 2000 (see Appendix B) and by the Otago Polytechnic Ethics Committee in March of 2001 (see Appendix C). The original research recruitment strategy involved advertisements placed in the New Zealand College of Midwives journal and newsletter and letters of invitation being sent to midwives locally. Whilst these strategies resulted in some interest it was not sufficient and an application was made to the University of Technology, Sydney (UTS), Human Research Ethics Committee in July 2001 to amend the recruitment strategy. The new strategy involved making contact with midwives over the telephone using published midwifery advertising material (such as practice advertising brochures and the yellow pages in the telephone book) and my network of professional midwifery contacts. This telephone contact was followed up by written material. The UTS Human Research Ethics Committee approved this amended strategy in August 2001 (see Appendix D).

A number of ethical issues were confronted through the conduct of this research and these are addressed in the paragraphs to follow.

Focus groups and interviews

The original proposal and ethics application for this project outlined a process of inquiry that was to begin with the conduct of three focus groups. One group would be composed of midwives who practiced within the hospital setting only, another group those who practiced in the homebirth setting only, and the other of midwives who practiced in both. It was anticipated that these focus groups would raise broad issues of interest and that more focussed, in-depth interviews with individuals would follow. I was not able to recruit sufficient participants at this point to conduct these three focus groups.

Since case-loading midwives have an unpredictable work schedule and a relatively limited interest in the study, I realised that I would have to take a more pragmatic approach to the collection of information than indicated in the original proposal. I therefore began the study with a small-group practice interview with homebirth midwives and a large focus group of local midwives (providing home and hospital midwifery care). Thereafter, I conducted a mix of individual and group interviews with midwives throughout New Zealand. Many midwives belong to group practices[13] and frequently these groups meet on a regular basis. It was relatively easy for me to arrange to interview group practices and for this to coincide with their regular group meetings. The group interviews conducted after the first focus group were with these group practices. Because these groups often meet regularly to discuss business or practice issues they seemed comfortable with each other and confident in expressing their sometimes divergent ideas within the group. In total, 48 midwives participated in 21 group or individual interviews conducted in 8 towns or cities (Dunedin, Oamaru, Nelson, Christchurch, Wellington, Hamilton, Rotorua, Auckland) throughout New Zealand (see Appendix E and F for geographical spread of participants and interview schedule). There was a break in interviewing through 2002, which was due to work and family pressures. During this time I continued to read relevant literature and transcribe interview material.

[13] Group practices can range from loose, informal agreements between midwives to provide back up and perhaps share advertising costs or clinic premises to formal, contracted business partnerships.

Interviews were audiotape recorded with the participant's permission. I offered to turn off the tape recorder if the participant requested for any particular reason (this was never requested) and I also turned the tape recorder off if the participant needed to answer a mobile phone call or page (this occurred many times). A transcriber (who signed a confidentiality agreement) and I transcribed the audiotapes in full.

Interviews began by reiterating that participants could ask to have the tape recorder turned off at any time and that they would have an opportunity to review the transcript in full and ask to have any comments they made removed from the transcript. I also reassured them that any identifying information they provided (for example mention of place names) would not be recorded on the transcript and that the information they provided would be anonymous. All names (including person, place or hospital names) in the transcripts and quotations used in this thesis have been replaced with [name of place] or [name of hospital]. To help ensure the anonymity of participants the schedule of interviews (Appendix F) contains only very general information about participants and this has been separated from the information about their geographical location (Appendix E).

In group interviews I requested that participants try not to talk over one another (to facilitate transcribing) though at times I had to balance this need with the desire to allow for an uninhibited, natural flow of discussion. Participants were asked to introduce themselves on tape and to explain a little about their practice; for example what midwifery services they offer, where they practice, the size of their caseload. For the purposes of transcribing the group interview data I had hoped that this introduction would allow me to match participant comments with particular participants but this was only possible where I knew the participants well (for example local midwives) and could therefore identify their voice on the audio tape recording of the interview. Some original transcriptions therefore include a name (pseudonym) beside each entry and others only identify whether it is the interviewer or a participant speaking. Quotations presented in this thesis identify the text as belonging to the interviewer or a participant. In quotations arising from group interviews I have numbered participants (always beginning with participant 1, followed by participant 2) so as to indicate that comments are being made by different participants. Quotations used in this thesis are also

identified by the interview date and text unit/s that were attributed by the software analysis programme QRS N5.

I asked the participants some very general questions to begin and this seemed to allow for a time of settling-in and gaining comfort in the process for all concerned. The interviews were semi-structured and I tried to allow the interview/discussion to flow naturally, making very brief notes throughout to prompt me to return to points participants made but had moved away from as their conversation proceeded.

Transcripts were returned to participants. They were invited to make notations directly on the transcript, make corrections, comments, add information or delete any of their own comments. A stamped, self-addressed return envelope was included and they were asked to return the transcripts to me. Several participants made corrections to words incorrectly transcribed and one asked that a comment be removed. This was attended to. I offered to supply participants with personal copies of the transcript if requested and several participants did request copies.

One participant was particularly concerned that she may be identifiable and I reiterated to her that I would make every attempt to ensure that the information supplied in regards to participants would not include information that would identify them. I also promised this participant that I would seek her permission before incorporating any of her quotations in this thesis. In May 2006 I contacted this participant and explained the contents of the table and map included as Appendices E and F of this thesis, and also discussed several quotations from our interview that I wanted to include. The participant was happy with the way participants were described in the table and gave permission for me to incorporate the quotations from our interview.

Official texts

The focus group and interviews were not the only source of information for this research. As I explored these transcripts I was able to identify several major discourses constructing midwifery in New Zealand. The professional midwifery discourse was one of these and much of the official text constituting this discourse emanated from the New

Zealand College of Midwives. I wanted to explore the genealogy of this discourse in some depth and so searched all of the New Zealand College of Midwives journals, newsletters, conference proceedings and publications. I was particularly interested in the early years of the college's work, as they were central to the transformation of New Zealand's maternity service and the midwifery role following the introduction of the Nurses Amendment Act 1990. These public documents formed the basis of the information that midwives were privy to (as opposed to minutes of meetings or less accessible or public information) and were therefore pertinent as they were influential in constituting the professional discourse of midwifery that constructs contemporary midwifery in New Zealand. I also searched the New Zealand Nurse's Organisation Journal, Kai Tiaki, for comment on the formation of the New Zealand College of Midwives and the New Zealand parliamentary Hansard to gain an understanding of the rhetoric that was used to gain support for the proposed amendment to the Nurses Act 1977.

The New Zealand College of Midwives was influential in several other official forums including the Nursing Council of New Zealand, who retained regulatory control of midwifery until 2004, and the Ministry of Health, who established the payment schedule and detailed the role of the primary maternity provider in contract documents commonly known as Section 51 (Health Funding Authority, 1998) and (under new legislation) Section 88 (Ministry of Health, 2002a). Pertinent documents from these groups therefore also constitute the information or texts, which are explored in this research.

Feminist research

In deciding on the design of the research I had to grapple with the question; what makes feminist research feminist? I knew that I wanted to focus on issues of gender in the analysis but does this focus alone make the research feminist? Does feminist research require that the process is also feminist? If so, what is a feminist research process?

Like poststructuralism, there is no universal agreement on what is meant by feminism or feminist research. Some suggest that feminist research must serve the interests of

women; it is research conducted not just on women but also for women (Alice, 1999; Cook & Fonow, 1986; MacDonald & Bourgeault, 2000). MacDonald and Bourgeault (2000) remind us however, that research is a political act and feminist researchers must manage complex and competing interests. How do we decide what is in the interests of women and who are represented (or left out) by the category of "woman" whom we endeavour to serve in our research?

Any research study consists of a series of decisions and choices. For Brayton (1997), feminist research occurs when those choices and decisions are guided by feminist beliefs and concerns. Characteristics of feminist research often include that it; is politically motivated (Brayton, 1997; De Marco, Campbell & Wuest, 1993; King, 1994) begins with and addresses the experience of women (Brayton, 1997; King, 1994; Lather, 1988) and addresses the power imbalance between researcher and researched (Brayton, 1997; De Marco, Campbell & Wuest, 1993; King, 1994; Lather, 1988).

Politically motivated and interested research

Feminist research agendas vary widely. Politically motivated research may have an emancipatory intent and/or seek to give voice to, or illuminate the experiences, of women (Cook & Fonow, 1990; Olesen, 2003). Olesen (2003) identifies that "feminist research in its many variants, …centres and makes problematic women's diverse situations as well as the institutions that frame those situations" (p. 333). This thesis makes problematic the phenomena of childbirth and midwifery. It examines the ways in which patriarchal interests construct childbirth and the maternity care context, exploring the consequences of this for midwifery. Whilst this research does not claim to have an emancipatory objective, it illuminates the distortions (in the midwifery experience) brought about by the dominance of patriarchal interests and constructions based on masculinist assumptions and foundations that structure our thinking. Appreciating the constuctedness of concepts such as childbirth and midwifery may be emancipatory to some and disturbing to others.

Feminist research is often concerned with addressing the invisibility of women's experiences and in particular, with telling stories that serve to counter hegemonic belief

systems (MacDonald & Bourgeault, 2000). This is not without risk, as MacDonald and Bourgeault, explain, that, in making women's experiences more visible, the researcher may also be making them more vulnerable. This is particularly so for midwifery, as midwifery in many cases, provides a counterpoint to dominant patriarchal and masculinist constructions. MacDonald and Bourgeault recognise that some feminist researchers are engaged in research in which they have a particular interest. As feminists, feminist researchers are likely to be supportive of feminist agendas and are therefore "interested" participants/researchers in the research they are conducting. We cannot assume however, that the interests of midwives and childbearing women are always the same (Benoit, 1987). This challenges the traditional construct of the researcher as objective and makes the research process a complex one for the feminist or interested researcher.

I have been a midwife for many years, advocating for a more autonomous role for midwives in maternity services, involved in midwifery education and active in the homebirth movement as a homebirth midwife and consumer. No doubt, I am an interested researcher/participant and my own experiences have impacted on this study, from its inception and the sorts of questions that captured my imagination through to the analysis and presentation of the thesis. This study is unique and indelibly stamped with my history and experiences; it is my construction or my "fiction" as Foucault would describe it. This "interested" positioning brings benefits and challenges. The "interested" positioning provides access to participants and brings a heightened sense of responsibility to them and the midwifery agenda. It provides insight into the complexity of the issues under investigation and empathy for the experiences of other midwives and women. But it also constrains, as my understandings and socialisation as a midwife have hardened over time, making other ways of conceptualising and envisaging midwifery more difficult (Acker, 2000).

The interested researcher must attend to the quality of their research processes and product, be accountable and responsible to their participants and be aware of the social and political consequences of their research. Researchers have little control over the way their research is read, interpreted or used and feminist researchers may be wary of the ways in which their research may be used against a movement or feminist agenda (in which they are interested) leading them to approach the process with a cautious

mindset (MacDonald & Bourgeault, 2000). For me, our vulnerability as midwives or women does not mean that we should not explore midwifery, childbirth or feminist issues for fear of exposing ourselves. Nor does it mean that we should not interrogate our own beliefs, practices and constructions for fear of destabilising or fracturing something that presents as stable and unified. I would find this position untenable, as it would close off exploration of all the interests that shape the constructs and practices under investigation and limit our scholarly and practical development. In the feminist movement, it was critique from within, in the form of challenges to the dominant Euro-centric models of feminism, that led to the development of other feminisms (for example, critical race feminisms and queer theory) leading eventually to a more inclusive and richer understanding of feminist issues. This is what I hope for midwifery: that critique and understanding inform our development in ways that are inclusive of difference and diversity. For me this means that we cannot stand beyond critique or prohibit certain areas of research; rather we must proceed with awareness and sensitivity to the issues.

Researcher and the researched

Acknowledging the researcher's interest and influence in the research study shatters any illusion of research as an objective, non-biased process. Research is acknowledged as a subjective process and within this conceptualisation the researcher is as much the subject of inquiry, as the inquirer. The researcher's reading, interpretation and analysis of the research texts (re)present the text (creating truths) in a particular way and this construction is acknowledged as one of many truths. Accounts of feminist research often acknowledge the researcher's influence and explore this in a reflexive way (Cook & Fonow, 1986; Marx, 2001; Lather, 1991; Olesen, 2000).

Historically, research has developed from elitist and patriarchal institutions in which women (or other subjects of research) have been exploited in oppressive researcher/researched relations. Feminist research introduced research methods that sought to redress the power imbalance between researcher and researched and involved a more active role for the participant. For some feminist researchers (for example Brayton, 1997; Lather, 1991) this means including participants in all levels of the

research process (for example active research methodologies) and for others, it means redressing the power relationships on a one-to-one level by for example, utilising interview techniques that are more mutually respectful and less intimidating. MacDonald and Bourgeault (2000) remind us however, that the idealised egalitarian relationship in feminist research may be elusive. This is particularly problematic in interested research where the insider position of the researcher has the potential to create a more exploitive relationship. The debate concerning power relations between the researcher and researched often fails to acknowledge the active role of the participant in the creation of research information (MacDonald & Bourgeault, 2000; Mishler, 1991). Participants frequently reinterpret stories as they speak (or write) them, and this process is influenced by a multiplicity of contextual factors (Fontana & Frey, 2000). Participants make choices about what to declare, leave out, highlight and what to minimise. In a sense they fabricate their story and it is a story that may be unique to that telling. Mishler (1991, p. 52) suggests that interviews are jointly constructed,

> … interviewers reformulate questions and …respondents frame answers in terms of their reciprocal understanding as meanings emerge during the course of an interview.

Meaning is contextual and jointly constructed by interviewer and interviewee. At this level, the researcher and researched are both active in the processes that create the research text.

I am indebted to the generosity of the midwives participating in this study. We met in a variety of places; their homes, my work place or their work place, together exploring the topic under investigation. Interviews were between one hour and three hours in duration, typically the larger group interviews being longer than the individual interviews. While I use the word "interview" I was more interested in facilitating a focussed discussion with the participants. My role in the discussions varied. I asked questions and generally attempted to maintain the focus of discussion on the research area. I used active listening techniques, sought clarification and asked participants to expand on or explain points further and at times I proffered opinions, participated in the discussion or responded to questions if they were directed to me. An "interview" suggests that a participant is asked a series of questions to which they respond. This

process may limit the breadth and depth of information obtained in the interview as it is constrained by the interviewer's questions. I wanted to facilitate a process that was more dynamic, exploratory and interactive than that, one that engaged the researcher and participant in dialogue.

While a number of participants expressed gratitude for the opportunity to explore and reflect on the issues raised in the discussion, my intention was not to emancipate or educate the participant through this process. I wanted to approach the topic as a naïve inquirer and allow for as much breadth and depth as possible to emerge from the discussions, though I do acknowledge that my own history and experiences will undoubtedly have an influence. I was also concerned to position myself as an interested equal rather than as an objective authority, and my participation in the discussions helped establish this (Oakley, 1993). Whilst this move reflects how I genuinely perceive my role I am mindful that it can also be useful as a strategy for engaging participants and gaining a level of trust and participation that might not otherwise be achieved (MacDonald & Bourgeault, 2000).

I am also mindful of the responsibility that comes with being entrusted with the participants' stories particularly as the re(presentation) of this information has been a task that I have undertaken alone. While some feminist researchers advocate involving participants in all areas of the research process, suggesting that to do otherwise is to be exploitive, I decided that this would not be appropriate for this particular research project. Ideas and concepts derived from Foucault and feminist, poststructural theorists guide the analysis of the research text. This theoretical field may not be familiar to many of the participants, making their participation in the analysis problematic. This does not mean that such an analysis is beyond the comprehension of midwives or that insights gained from a poststructural and Foucauldian analysis are not useful to midwives. It does mean that the analysis is my work and following Rolfe (1997, p. 442) the writing of this research is acknowledged "…as a creative act in which knowledge is produced as part of the process of writing". In this I am privileged, as the participants have had no control over the product to which they contributed the raw material. I have in a sense taken their text and given back little in terms of benefit from the experience or input into the analysis. I do hope however, that the participants see some value in participating in this research. By illuminating the constuctedness of midwifery and the

factors that shape this construction, in exposing the micro-politics of power as it circulates around and through the midwife and in describing the midwifery response to the maternity care context, I hope that this thesis will contribute to our understanding of contemporary midwifery practice. At times, the language and theoretical concepts constituting poststructuralism are complex and I have attempted to present these ideas and the analysis of the midwifery text in a way that is clear and readable to a midwifery audience.

Analysis

The analysis progressed in a dialectical way as I conducted interviews, transcribed some interviews, continued to read feminist and poststructural literature and discussed issues of interest that emerged from my work with my colleagues. I made marginal comments on interview transcripts that were read and re-read numerous times.

The software program QRS N5 was used to facilitate analysis of the interview transcripts. This program allows for parts of the transcript to be divided into text units and coded according to categories or subcategories of the researcher's choosing. A text unit may be a word, line or sentence in the transcript and the researcher establishes this. The first few transcripts coded for this project used lines as the text unit but I soon moved to sentences as this proved to be more useful. Each transcript represents an interview or focus group and is identified by the interview date (for example "interview 060501" represents an interview that was conducted on the 6th of May 2001). Where more than one interview was conducted on a particular day this is identified by the letters a, b, c or d following the date).

The attribution of quotations has proved to be somewhat problematic as I have been unable to consistently identify individual participants within some of the larger group interviews. In the interview transcript I was able to identify that it was a participant speaking (rather than the interviewer) but could not identify which participant. I have chosen therefore not to attribute pseudonyms to participants but to represent quotations presented in this thesis by their QRS N5 identification. Each quotation presented is followed by the interview code (identifying the interview date) and the text unit/s

attributed to that text (eg text units 5-10). I have however, indicated where the interviewer makes a comment or asks a question and where different midwives make comments in a group interview.

Each interview was coded using broad codes that did not necessarily represent theoretical categories but simply grouped some of the text into like group. This included the codes: characteristics of participants (where participants described themselves for example, their personal history, education, employment status), midwifery (where participants described their understanding of midwifery), pregnancy and childbirth (where participants described their understanding of pregnancy and childbirth), enacting midwifery (where participants described how they enacted midwifery). Within these broad codes, sub-codes were developed for example; the code "pregnancy and childbirth" was divided into sub codes "normal/natural", "empowerment" and "medical/risk". These sub codes were derived from the data. Some of the codes represent issues that emerged (during the time that I was engaged in interviews) as concepts of interest because of the frequency with which participants raised them for example, "informed choice" and "being watched". The codes developed were not mutually exclusive and some of the text was coded into more than one category.

As I sought to gain an understanding of the discourses constructing midwifery for example, I was able to use QRS N5 to generate (and print off) reports representing all sections of the text from all interviews that were coded "midwifery". I read and re-read these reports, making margin comments throughout. I expected that natural childbirth and biomedical discourses would form part of the construction of midwifery because this is well-documented in midwifery literature. Similarly, I was not surprised at the influence of the professional midwifery discourse because of the prominent role that the New Zealand College of Midwives has had in constructing midwifery in New Zealand since 1990. I was however, surprised by the predominance of the neo-liberal discourse. Within QRS I was also able to "jump" from quotations in these reports to the original transcript (from which the excerpt originated) easily. This allowed me to (re)contextualise the quotations so that (as much as possible) their meaning could be understood within the context of the discussion from which they arose.

Each interview was also coded according to the main setting of practice; home, primary facility, obstetric hospital or mix. I further coded obstetric hospital into those with obstetric registrar training and those without. This arose following interviews with midwives accessing a secondary hospital that did not offer obstetric training where I noticed that their focus seemed to be slightly different to that of other midwives. Coding according to practice setting allowed me to make some comparisons across these groups. For example, I was surprised by the fact that 'normal' birth did not seem to be a central concept for all the midwives participating but only for some of them. I wanted to make some comparisons across groups and within QRS N5 generated several reports; all material coded "normal/natural" for each of the interviews classified as; home, primary facilities, obstetric hospitals (with and without training scheme) and mix. I was able to see that there was much more text dealing with "natural/normal" birth in the interviews with midwives practising mainly at home, in primary birthing facilities and in obstetric hospitals without obstetric registrar training. This issue is discussed in the chapters to follow.

In general the coding allowed me to group all text that related to constructions of midwifery and childbirth, the influence of the obstetric hospital on midwifery practice and midwifery strategies or response to this influence and the context of maternity care. These groupings form the basis of the analysis chapters that follow.

Conclusion

Theoretical and analytical understanding developed as the research progressed in a dialectical way and in this section I have described the research process as it was experienced by me, as somewhat more disorderly and less linear than some research reports or texts would suggest. Ethical concerns, the ethical approval process and the research processes used in the conduct of this research have been described in detail. I have discussed some of the issues that arise in the conduct of feminist research, illustrating the way that feminist theoretical concerns have been considered alongside pragmatic issues in the design of this research project.

The next section of this thesis "Exploring the terrain" begins the section that presents the analysis of the research texts. "Exploring the terrain" is in three parts, each representing a major discourse contributing to the construction of midwifery in New Zealand: the biomedical, natural childbirth, and neo-liberal discourses.

Chapter 4: Exploring the Terrain

4.1. Body politics and the biomedical discourse of childbirth

This chapter describes the biomedical discourse of childbirth as it is evidenced in the talk of midwives participating in this study and explores the implications for childbirth and midwifery practice.

Introduction

The biomedical discourse of childbirth predominates in many western countries including New Zealand. This discourse constructs childbirth as a risky process and the bodies of women as faulty and passive. The biomedical discourse of childbirth underpinned by these gendered assumptions and epistemologies, gives rise to obstetrics and obstetric practices.

This chapter begins by exploring the epistemological foundation of medicine and obstetrics; scientific rationality. I argue that scientific rationality is a social and patriarchal construction that works to oppress women as it provides justification for women's subordination to men. The knowledges created by scientific rationality and positivist science are gendered knowledges that construct (rather than represent) their object of study.

Midwives participating in this study describe the way that obstetric knowledge and obstetricians remain the authority on childbearing matters. In consulting with obstetricians it is obstetric knowledge and obstetric practices that are privileged, subordinating the knowledges of the midwife and the childbearing woman. While midwives may resist the constructs of biomedicine or the practices of obstetrics, this chapter (and the chapters to follow) describe a complex relationship in which midwives are at once constructed by and resistant to the biomedical discourse of childbirth.

This chapter and those to follow do not begin with the voices of the midwives participating in this study. Rather, this chapter begins with an exploration of the epistemic basis of medical and obstetric knowledge and an outline of the historical

context in which it developed in New Zealand. With this foundational understanding established, the voices of midwives and the construction of midwifery arising from their text, is introduced and discussed. The decision to present the analysis in this way does not mean that analytical concepts were decided in advance. As chapter 3.2 ("A feminist research design") describes, analytical concepts arose through a dialectical engagement with research data, midwifery, sociological and theoretical literature.

Scientific rationality

Positivist science has played an important role in the Modernist project and epitomises western philosophy's exaltation of mind over the body. Modernism holds that there is truth and freedom to be discovered and that more science, more technology, more knowledge and increased rationality will inexorably lead humankind to this truth (Alvesson & Deetz, 1996). From the Enlightenment, scientific and biomedical discourses have combined to form a powerful discursive field in which medical practitioners are positioned as arbiters of truth and authorative knowers. Scientific and biomedical discourses offer facts and promise certainty. They credit their methods with progressing humanity closer to Modernity's goals and this is posited as the justification for the increasing medicalisation of childbirth. We have witnessed improvements in maternal and neonatal morbidity and mortality throughout the 18th and 19th centuries and perhaps coincidentally, this was the same time period that the profession of medicine was established and became involved in childbirth. Researchers such as Marjory Tew (1990, 1995) and Pascall (1997, cited in Brooks and Lomax, 1997) have credited these improved maternal and neonatal morbidity and mortality rates with improved social and economic conditions rather than the involvement of medicine in childbirth, as many have assumed. However, in criticising the medicalisation of childbirth we cannot dismiss the advances that medical science has brought to modern health care (Lupton, 1997b). Childbirth for many is safer because of treatments such as blood transfusions, caesarean sections and antibiotics. On the other hand, it must also be acknowledged that not all medical treatments in childbirth have been a success, that treatments have often been applied routinely without adequate evaluation and that some have resulted in serious iatrogenic effects. The assumption that increasing medical involvement, scientific research and development of medical technologies is equivalent

to progress is an assumption that continues to support various arguments for the maintenance and increase of medical involvement and intervention in childbirth.

As women are aligned to the body in the mind/body binary, knowledge production as a reasoned and higher order activity of the mind becomes the realm of men rather than women. The body, bodily sensations and experiences are discounted as sources of knowledge and women are discounted as knowers. Within maternity care, obstetric knowledge usurps any other knowledges of the female body and childbirth, including those of the childbearing woman or midwife. For midwives in this study the assertion that obstetric knowledge is superior knowledge (indeed, the only knowledge that matters) is highlighted when they consulted with obstetric or other medical practitioners. In this case (though there were some exceptions), the childbearing woman or the midwife's knowledge is frequently discounted. One midwife participant comments on the certainty of medical knowledge and the expectation of compliance,

> Well it's because the obstetricians think that they know what the answer is and expect the woman to fall in with that. Yeah, they just don't doubt themselves, they don't see that there is any grey, it's just black and white.
>
> (Interview 061101, text units 302-303)

In the field of maternity, medicine (and later the speciality of obstetrics) aligned with science to produce a discursive field positioning medical and obstetric practitioners as authorities in matters of childbirth. Obstetrics presents itself as a superior model of rationality and as such its constructs (of the body and childbirth processes), are presented as fact. I will argue, following Grosz (1994, 1995; also Martin 1997, 1999 and Murphy-Lawless, 1998) in the following pages that knowledges are products of sexualised bodies and patriarchal contexts and as such, are saturated with gendered assumptions. These assumptions are not benign as they work to construct the female body and direct the contemporary management of childbirth.

Gendered knowledge

Chapter 3.1 ("A feminist, poststructural approach to research") described the way that knowledges can be conceived of as products of power (Foucault, 1980; Grosz, 1995) rather than as objective and de-contextualised "truths". Feminists (such as Grosz 1994, 1995; Martin, 1997, 1999; Bordo, 1993a, 1993b) have highlighted the way that knowledges are products of a patriarchal and masculinist culture. Knowledge and knowledge production are not neutral, disinterested products or activities. "Truth" does not wait in pure form to be discovered or described and the processes of knowledge production are not neutral or disinterested. Knowledge generation is a gendered activity that produces "truth" or constructs the object of knowledge in a particular way.

Women and childbirth as objects of knowledge have been constructed by the biomedical discourse in ways that reflect the sexualised positioning of women in our society. Our knowledge of anatomy, reproduction and childbirth has been constructed within the frame provided by western philosophical traditions and so serve to support and reify the assumptions underpinning these traditions. For example Martin (1999) describes how texts and popular writing frequently describe human fertilisation in ways that reflect the active/passive and male/female binaries. Spermatozoa are described in heroic and individualistic terms. Among millions of competitors the single-minded spermatozoa races energetically to its goal, the ovum. Once reaching the ovum the competition remains heated, as one sperm must beat all others to fertilise the ovum. It does this by battering the wall of the ova until it triumphantly breaches its boundaries and fertilisation takes place. The ovum by contrast is depicted as a lumbering, bloated ball, bobbing aimlessly, in the fallopian tube where it is unwittingly attacked by the spirited sperm. The woman or the ovum's role in fertilisation is described in passive terms whilst the sperm and male participation is described as active. This conceptualisation clearly reflects western masculinist constructs of male and female relations re-creating a romance that depicts the male as the suitor and the female as the vanquished maiden.

Feminist theorists (such as Bordo, 1993b; Fox Keller, 1996; Grosz, 1995) have described how the female body is defined as "other" within the dominant western philosophical traditions. The male body is held as the archetype or normal body and

women's bodies, which clearly function differently to the male body, are considered abnormal or aberrant. Biological functioning specific to women (such as menstruation, childbearing and menopause) are problematised within the biomedical discourse and this results in these processes being pathologised. Indeed historically, specific female organs such as the ovaries or uterus were deemed to be the cause of certain pathologies such as hysteria (Diedrich, 1998). Martin (1999) for example has demonstrated the way that medical texts describe women's biological processes in negative terms compared to that of male processes. In exploring the way that women's reproductive cycles are described, Martin (1999) identifies the themes of waste and degeneration.

With fertilisation and implantation firmly established as the raison d'être for women's reproductive cycles, menstruation represents a failure of conception. Martin explains how medical texts describe menstruation as the *failure* of conception and the *shedding* of *debris* following *necrosis* of the ripened uterine lining. These terms represent failure, loss and waste. Women are born with approximately one million ovarian follicles of which approximately four hundred will reach full maturity during their lifetime. Martin reports on how medical texts have described the stockpile of ova as wasteful, highlighting the way the follicles degenerate over time. The spectre of ova degenerating in the ovaries day after day, underpins the pressure that many women experience as they are reminded of the "ticking of the biological clock" and urged to reproduce before their ova pass their use-by date. The themes of waste and degeneration do not carry through to descriptions of male spermatogenesis even though trillions of sperm are produced (rather than *shed*) and perhaps only a few of those will participate in fertilisation, the rest of course degenerating. To counter these negative representations Martin (1997) highlights research that has been conducted on menstruation, which suggests that the process may have an important protective function for women. As bacteria can be introduced into the female genital tract through sexual intercourse, menstruation provides a mechanism by which the female genital tract can flush out bacteria and the uterus can renew its lining regularly, thus protecting women from infection.

Medical texts and the biomedical discourse have played a major role in producing truths about the female body and work such as Martin's (1999, see also Murphy-Lawless, 1998) highlight the way that the biomedical discourse constructs a knowledge that is

saturated with gendered assumptions. Within biomedical and scientific discourses these knowledges are not understood as constructed, partial or limited knowledges but as undistorted "truths" (Grosz, 1995). The products or constructs of scientific rationality and biomedical discourses are permeated with gendered and other cultural assumptions.

The biomedical discourse of reproduction frequently draws on metaphors of the machine and production to explain the workings of the human body (Davis Floyd, 1987; Katz Rothman, 1991; Martin, 1997; Oakley, 1979).

> All this imagery depicts a body that belongs to the late industrial machine age, especially the post-World War 2 era, of mass production dominated by orderly assembly-line production on a rigid time schedule, run by machinery divided into parts, each with a separate function. (Martin, 1997, p. 18)

Within this discursive framework women's biological functioning is associated with production; menstruation is depicted in terms of lack (failure of production) and menopause is described in terms of a breakdown not only of production possibilities but in a woman's physical and emotional functioning. These mechanical metaphors celebrate order, consistency, regularity and predictability. These are characteristics that more closely describe the male body as the female body is in a constant state of flux brought about by hormonal changes associated with the menstrual cycle. When regularity, predictability and order are imposed on a woman's body, phenomena such as irregular menstruation or menopause are defined as abnormal and so fall within the remit of the medical profession.

The biomedical discourse of the body constructs firm and closed boundaries so that what is body and what is alien to the body is clearly delineated. This is evident in some popular media advertisements regarding medicines for the common cold. The external body is depicted as a fortress or warrior, fending off the invasion of germs (Martin, 1997). While this metaphor does not hold true for all aspects of biological functioning, the state of pregnancy presents a glaring challenge. Martin (1997, p. 19) comments on pregnancy,

> When they are pregnant, they are truly hybrid, uneasily "tolerating" the foreign fetus deep inside.

The biological state of pregnancy is an anomaly within the biomedical discourses and this factor (along with the growing tendency to individualise the fetus), demands vigilant surveillance of the woman for fear that her body may turn against the fetus inside her.

Women's bodies do not conform to the male norms established by the biomedical discourse and so their biological functioning is depicted as a deviation from the norm, prone to failure and inherently flawed. Women's bodies are clearly "other" than the male body or norm and nowhere are they more "other", more unpredictable more mysterious and more undisciplined than in pregnancy and childbirth (Martin, 1987, cited in Brooks and Lomax, 1997).

Rise of medicine in New Zealand

Throughout the 1900s childbirth in New Zealand gradually came under the responsibility of the medical profession and the place of birth shifted from the home or small maternity home to larger public hospitals. This occurred due to the development of the medical profession and medical practices, increased government involvement in public health care and the watershed legislation, the Social Security Act 1938, which provided New Zealand citizens with free public hospital care. Societal attitudes toward the hospital changed and it began to be accepted as a valid and desirable health care intervention. Medicine too had changed as it embraced the rationality of positivist science and aligned with the Modernist project of progress and modernisation.

In New Zealand the issue of pain relief in labour proved to be influential in the medicalisation of childbirth. Women lobbied for access to pain relief and the effects of the drugs used meant that childbearing women needed to birth in well-equipped hospitals with access to health professionals such as doctors, anaesthetists, nurses and midwives. Concern for puerperal sepsis and the introduction of the H. Mt. 20 regulations also changed the face of childbirth. These procedures required childbirth to

be managed in the same way as a sterile surgical procedure. Women were to be prepared for childbirth by having their perineum shaved and their bowel evacuated with the administration of an enema, to minimise the risk of faecal contamination during the "procedure". When birth became imminent women were moved to a surgical theatre for delivery where they were laid prone, draped in green sterile drapes and had their perineum douched in antiseptic solution. Birth attendants were clothed in sterile surgical gowns, hats, masks and gloves (Donley, 1998). Epitomising the construction of birth as a surgical event Bonney (1928 cited in Parkes, 1991, p. 168-169) argues,

> Supposing that instead of the operation being for the removal of a child through the vagina, it was for the removal of a large fibroid by the same route. The patient would be fully anaesthetised in the lithotomy position on an operating table … All but the entrance to the vagina would be heavily draped with aseptic cloths ... whist the surgeon, carefully gloved, gowned and masked, would operate, sitting in the best possible light. If this is the ideal for the removal of one neoplasm, it must surely be for the other.

Within this construction the woman is presented not only as a patient but a potentially harmful contaminant and an unwieldy vessel whose body must be manoeuvred (into the lithotomy position) so that the surgeon can comfortably gain access. Any active role the woman may have in the process is denied as she is rendered unconscious and the 'neoplasm' is extracted from her vagina.

As childbirth became medicalised in New Zealand the role of the midwife changed. All but a scarce few births nationally occurred inside the hospital and all but a few midwives practised inside of the hospital. Midwives were absorbed into roles within the hospital structure that reflected the patriarchal structures of society as large. Within this setting and with the increasing technological intervention in childbirth (the domain of the medical specialist or obstetrician) the role of midwifery changed from a relatively autonomous one; caring for women throughout the childbearing phases under their own authority, to one of dependency on the medical profession; assisting medical practitioners in the care of women. While it is important not to romanticise early midwifery or suggest that this represented a golden age (a point that will be explored in the next chapter), the midwife no doubt, moved from the place of an authoritative

"knower" to one subject to the knowledges and technologies of biomedicine.

The rise of scientific and biomedical discourses of childbirth in New Zealand have occurred within a patriarchal context that imbues the knowledges produced with gendered and other cultural assumptions. The biomedical discourse constructs female anatomy and functioning as defective and sometimes positions the woman and her body as adversary of the fetus (King, 1991). These assumptions underpin biomedical discourses of childbirth and dictate practices that focus on surveillance and attempts to manage risk.

Risk and surveillance

While technologies, practices and our maternity health care system have changed since childbirth first became medicalised, midwives participating in this research identify "childbirth as risk" as the dominant construction of childbirth today. Reflecting concern for both medico-legal risk and childbirth as risk one midwife comments,

> And it is drummed into us all the time, "document, document, document", "if you don't do this, this will happen, if you don't do that then that will happen". The whole thing is perceived as risky. I mean it's perceived as risky before it's perceived as normal. You know, you have to eliminate the risk and then it'll be OK. It's like safe in retrospect isn't it?
>
> (Interview 070801, text units 370, 375-378)

Various authors such as Beck (1999), Castel (1991) and Lupton (1995) suggest that we have become a society predominated by concern for risk. In health care in particular, the language of risk has become central. In occupational health we are exhorted to be ever alert to potential risk and to report these risks to the appropriate people. In the medico-legal arena we are interested in the legal risk to ourselves as health carers and engage in risk management strategies. In evidence-based health care we calculate risk and are concerned with the degree to which interventions reduce risk. In public health a new patient category has emerged; the "at risk" group. We are no longer interested in primarily focusing health care on those that are currently ill but increasingly focus on

those "at risk" of becoming ill. Kenen (1997) refers to this group as the PPD (Possibly Potentially Diseased) or DIW (Disease in Waiting). We are acutely aware of risk today though paradoxically, in many areas of life and certainly in childbirth, we have never been safer (Saxell, 2000).

Childbirth has certainly not escaped this concern for risk. In most western nations childbirth has come to be understood as a risky medical event (Treichler, 1990), one that is best managed by medical professionals. Rather than a normal physiological process, childbirth is constructed as a process fraught with potential danger and even a 'double medical emergency' (Treichler, 1990, p. 119) as two lives hang in the balance; that of mother and baby. Within this construction the processes involved should be carefully monitored and controlled in order to manage this risk. This requires the involvement of properly trained health professions and a birth environment that can provide the expertise and equipment needed: the hospital. This construct of risk is the pivotal notion around which arguments for place of birth, appropriate practices and caregiver have revolved. In 1982 in New Zealand, the Maternity Service Standards Committee released the document "Mother and Baby at Home; the Early Days". This report detailed fifty-five obstetric risk factors that would necessitate transfer of a woman's care from domiciliary midwife to a specialist obstetrician. The effect of these recommendations was to "sweep practically all women into the waiting arms of the O & Gs ensconced in their high-technology…hospitals" (Donley, 1998, p.111). Today the "Guidelines for consultation with obstetric and related specialist medical services" (Ministry of Health, 2002a) list no less than two hundred and twenty four conditions and their attendant level of referral[14].

Risk lists and risk scoring systems have developed alongside the specialist field of obstetrics. Obstetrics has taken the lead in defining pathology (and therefore normality) and in the development of risk scoring systems, the potential for pathology in childbearing. Various systems have evolved (Saxell, 2000) with the variety attesting to the subjective rather than objective nature of the exercise. Saxell notes that many of these scoring systems focus on physiological rather than social, psychological or

[14] The document prescribes three levels of referral; the midwife or other lead maternity carer *may* recommend consultation with obstetric or other specialist, *must* recommend consultation or must recommend *transfer* of care.

economic factors even though these latter factors play a significant role in determining the health of a woman and her pregnancy. In general, risk-scoring systems have poor specificity and low predictive values (Saxell, 2000) while their application has serious consequences for the woman labelled “high risk”.

For many of the midwives in this study, the referral guidelines mentioned above, have the same effect as Donley (1998) identified with the 1982 document.

> …when you do a referral you think, "oh well, that's that one down the drain sort of thing".
>
> (Interview 061101, text unit 494)

As Saxell (2000) notes, though pregnancies are dynamic, women are rarely moved down the ladder of risk or out of a high-risk categories, even if the factors causing risk disappear or prove to be erroneous. Once women are “swept into the waiting arms” (after Donley, 1998) of obstetricians through consultation, the midwives in this study describe how the full force of obstetrics and their concern for risk is brought to bear on women.

> I don't actually like having to consult because I feel the woman does lose control because so often they [obstetricians] will use fear tactics.
>
> And so it is taken out of her hands and the confidence she has in herself and her body and her baby and her supports, just get so undermined that she really has no choices left. And it takes a very strong woman to withstand that.
>
> … the women get swayed by the fear of "well your baby might die”, or “I can't promise you won't get a damaged baby if you do that". Its very powerful stuff and they'll use it very freely. They have no scruples about it. And most women haven't got the courage to actually question or challenge that.
>
> (Interview 061101, text units 295-297, 305-308)

A body of sociological work is emerging that describes risk management and risk screening practices in terms of social control (Castel, 1991; Kenen, 1997; Queniart,

1992; Vaz & Bruno, 2003) and this is a theme that will be explored further in chapter 4.3, "Body politics and the neo-liberal, consumer discourse of childbirth". Obstetrics is not an exact science and many practices cannot be supported by evidence (Smith, 1991), yet for the childbearing woman who may have limited medical or obstetric knowledge and who is subordinate to the medical profession, appeals to safety and "shroud waving" often results in their compliance (Rapp, 1988; Saxell, 2000).

Medical management and technological monitoring addresses the inadequacy of women's bodies and attempt to assuage or control what is perceived as the inherent risk of pregnancy and childbirth. Shorter (1991) contends that as the risk of maternal mortality diminished historically, medicine shifted its attention from mother to fetus. The rise in medical and technological interventions such as ultrasound imaging and fetal surgery has also facilitated the construction of the fetus as an individual with human rights. Within this construction, women are often depicted as the adversary of the fetus and medical specialists as the fetus' advocate (Murphy-Lawless, 1998; Saxell 2000).

The concern with creating optimal conditions for the fetus means that risk management may begin pre-conceptually. For example, women are urged to seek professional advice, undertake health screening activities and begin folate supplementation pre-conceptually. Risk management continues through the antenatal period as women are screened and scrutinised and frequently assigned a risk status. Midwives in this study describe the pressure they encounter from specialist medical practitioners to routinely screen women for conditions such as gestational diabetes or for the presence of Group B streptococcus even though there is little evidence to support their routine use (Enkin, Keirse, Neilson, Crowther, Duley, Hodnett & Hofmeyr, 2000; Gosling, Stone, & Grimwood, 2002; Grigg, 2002).

> Having to do a Strep. B swab at 36 weeks is something I disagree with but I'm not up enough on the literature yet to be able to say to women and to management, "look, I'm not going to suggest that women do this because I firmly believe that they don't have to". I would risk losing my job … if I did that.

> You're fighting with the obstetricians sometimes. If the woman comes in late in her gestation showing signs of gestational diabetes, the first thing they'll ask is "where's

> the Polycose[15] [test result]?" And if you haven't had one done, ooh your backs up against the wall right from the start. There's no perception of, "oh OK she didn't have to have one done. There are other signs of gestational diabetes and they're showing now so then we'll take this course of action". It's like, "you didn't do this test … we should have known … therefore the consequences are, because you didn't do the test!"
>
> (Interview 070801, text units 67-68, 72-77)

While these midwives may construct childbearing in terms other than risk or take a differing approach to the detection of disease in pregnancy they are implicated in the biomedical construction of childbirth. Whether they subscribe to the biomedical discourse of childbirth or not, their practice is scrutinised and judged in line with the practices, values and presumptions engendered by the discourse. This is felt most acutely when they seek obstetric consultation.

Anxiety over risk heightens during labour and birth, an event constructed as perilous and fraught with danger within the biomedical discourse of childbirth (Davis Floyd, 1987). Obstetrics asserts that all labour and births are potentially pathological and the declaration of normality can only be made in retrospect (Murphy-Lawless, 1998). The woman's body as inadequate and posing risk to the fetus and the woman as passive are themes that continue within this construction of childbirth. With the medicalisation of childbirth the "active management" of childbirth was proffered as the solution to controlling this high risk and unpredictable phenomena. "Active management" refers to the active involvement and intervention of the obstetrician in the labour and birth processes.

Control and efficiency

Active management of labour is associated closely with O'Driscoll who was Master of the National Maternity Hospital in Dublin from 1963 to 1969 and who wrote the text "Active management of labour" (O'Driscoll & Meagher, 1986). Active management involves a regime of intervention that assures that women's labours are accurately

[15] A Polycose test is a screening test for gestational diabetes.

"diagnosed" and conform to predetermined timeframes. As the process of labour and birth are considered high risk, then a shorter labour (it is argued) will help minimise risk. The obstetrician is the central player in this mode of management and every woman is brought under their intensive gaze within the hospital setting.

The first important phase of active management involves the accurate "diagnosis" of labour. For O'Driscoll (1986) this diagnosis can only be made by objective means; a vaginal examination determining the cervix to be fully effaced. Once the "fact" of labour is established, women's amniotic membranes are ruptured (if they weren't already) and their cervical dilatation (as objective evidence of progress), charted on a partogram. O'Driscoll's management thereafter was based on the work of Friedman who determined that in "normal" labour, cervical dilatation progressed at a rate of one centimetre per hour to full dilatation. Friedman determined that any labour falling outside of this pattern of progress carried an increased risk to the fetus and should be considered abnormal. O'Driscoll promised every woman that her labour would be brought to conclusion within twelve hours (Murphy-Lawless, 1998). For those women demonstrating *lack* of progress or *failure* to progress, Syntocinon was used to augment their uterine action and speed the rate of cervical dilatation, thereby bringing it in line with the established norm.

Midwives in this study contrast the medical approach to childbirth with their own understanding, often influenced by the natural childbirth discourse. Within the natural childbirth discourse, women may follow their own rhythms and progress may be far less predictable. The strength of their contractions may ebb and flow, they may even cease for a period and begin sometime later. These women's bodies may not demonstrate inexorable and measurable progress, may not conclude the event within twelve hours and may not conform to machine-like, process-line efficiency. Their journey to childbirth may take an individual and meandering path and may even stretch over several days. While many midwives in this study demonstrate an understanding of childbirth as constructed by the natural childbirth discourse, they also highlight how the biomedical constructions of childbirth are never far from their consciousness as this midwife illustrates.

> … I have said [to women] in the hospital "its OK if you feel like you need to have a sleep because your contractions have gone off, that's OK" … I say that but then I spend the whole time when she's sleeping worrying and questioning myself and thinking, "have I done the right thing, Jesus, oh my God, that baby! I should be in there monitoring. While the woman is sleeping, the baby is dying!
>
> (Interview 270503, text unit 601)

Within the biomedical discourse of childbirth this unpredictable rhythm of labour and childbirth is an example of the woman's flawed biological functioning and serves only to extend and amplify the risk in a process that is already fraught with danger for mother and child. The natural childbirth discourse proposes an alternate reading of such a labour, one that is based on the belief that a woman's body is capable and trustworthy. However, for these midwives the biomedical discourse of risk always co-constructs any clinical situation and this situates the midwife in a liminal place; betwixt and between biomedical and natural constructions of childbirth.

Murphy-Lawless (1998, p. 213) describes how O'Driscoll's statistics demonstrate that increasing numbers of Irish women required augmentation under his care (from 30% of primiparous women in 1986 to 45% in 1993) leaving her to wonder how, given improving general health, "… more rather than fewer women of a huge population of childbearing women can be designated faulty in the task of giving birth?"

While active management of childbirth is no longer openly advocated in New Zealand, the biomedical construction of childbirth continues to be highly influential, as evidenced by the increasing rates of medical intervention in childbirth. In 2002 almost one-third of New Zealand women experienced an operative delivery (caesarean section, vacuum extraction, forceps). Paradoxically, those with the lowest levels of general health (Maori and Pacific Island women) were less likely to experience this intervention and more likely to experience a normal birth (Ministry of Health, 2004). Also, in 2002, 19.7 per 100 babies were induced and again those with the lowest levels of general health (and so designated highest risk) were less likely to experience this intervention (Ministry of Health, 2004). It is generally believed that medical intervention in childbirth is aimed at addressing problems in childbirth and that those who are less advantaged are more likely to have morbidities impacting on pregnancy (for example

diabetes and addictions such as smoking). Several researchers have found, paradoxically, that rates of medical intervention are highest in advantaged rather than disadvantaged women (Gordon, Milberg, Daling, & Hickok, 1991: Hurst & Summey, 1984; Roberts, Algert, & March, 1994; Roberts, Tracy & Peat, 2000). In a large Australian study, Roberts, Tracy and Peat (2000) found for example that rates of caesarean section were highest in women who engaged private obstetricians and birthed in private hospitals. This group constitutes one of the most educated and economically privileged groups of Australian women. Gordon et al (1991) found an association between income and caesarean section noting that the rate of caesarean section increased with increasing income. Clearly, obstetric practice is complex but it seems that risk assessment and the desire to control childbearing (in the name of safety) is less objective science and more socially constructed than we are led to believe (Saxell, 2000).

Marking time

Within the biomedical discourse of childbirth the passing of time is highly significant and marked in various ways. The first marking occurs with the diagnosis of pregnancy and the documentation of the woman's last menstrual period. This date is highly significant as the length of pregnancy and the due date of the baby is calculated from this date. Interestingly, as this important date relies on the woman's subjective experience and recall of her last menstrual period, due dates established by ultrasound scanning (a more objective means) frequently replace the due date established by the woman's reported last menstrual period. A pregnancy of forty weeks is presumed from this date, an Estimated Date of Delivery (EDD) established, and the antenatal period is marked by a regime of health care and monitoring interventions. Routine prenatal visits usually begin monthly and increase in frequency toward the due date, reflecting a concern for increasing risk as the pregnancy progresses. Uterine size is measured regularly by establishing the height of the fundus (the top of the uterus) in relation to anatomic landmarks such as the pubic bone, umbilicus or xiphisternum. The passing of time is thus inscribed onto women's bodies as their fundal height compared to weeks gestation is assessed against norms that establish the normality or otherwise of fetal

growth. A midwife from a rural practice in this study reflects on the significance of the EDD in her midwifery practice.

> The EDD is a very medical notion…. But we do focus on it because [at every visit] you get the wheel[16] out… And we tell them how many weeks they are today and we feel their fundus and some of us measure their fundus … We focus on it as well … And we may have a scan, we then look at the scan and the due date and say "well are you sure? We will go with your dates. Oh no the scan [was] at 6 weeks, no we'd better go with the scan date because it's quite accurate". … You just do it, it's awful, it's constant. I don't know if there is any way out of that.
>
> (Interview 050603, text units, 341 - 349)

The significance of establishing an accurate EDD becomes clear as a woman's pregnancy reaches its final weeks. As a woman's body is perceived as an inadequate body, a body that may pose a risk to the fetus, leaving the fetus inside the mother's body for a prolonged period of time is perceived as risky. Within the biomedical discourse of childbirth, prolonged pregnancy has been established as a pathological condition requiring medical intervention (Chua & Arulkumaran, 1999). While many texts both medical and midwifery orientated, describe a normal pregnancy as lasting between thirty seven and forty two completed weeks of pregnancy, in practice there appears to be a diminishing tolerance for pregnancies that continue much beyond forty weeks. Midwives in this study report on the pressure they feel to refer women for induction of labour at gestations that vary with different hospital or obstetric policies.

For rural midwifery practices referral to secondary hospital services means that these women have to travel the distance to the secondary facility, to labour and birth away from their local support network of friends and family and midwives whom they have come to know. For many of these rural women an induction of labour represents the loss of the normal birth they desire. In response to the potential threat of transfer to the secondary facility, one rural midwifery practice developed a regime that attempts to ensure that women birth before the 40 weeks plus 10 days limit established by the policies of the secondary hospital. This involves recommending women take a "pre

[16] The "wheel" refers to a disc shaped tool that enables the practitioner to quickly calculate the woman's current gestation based on her EDD.

birth" homeopathic mixture at 38 weeks followed by "stretch and sweep[17]" of the cervix and membranes with administration of evening primrose oil at 40 weeks plus 7 days. I asked the group if this would be their practice if the secondary hospital did not have a policy of induction of labour at 40 weeks plus 10 days pregnancy.

> Participant 1: If there was no policy you mean, would we be doing it? Probably not.
>
> Participant 2: I would not be doing it. We are trying to beat the clock … we are focussing on the date as much as them [the obstetricians].
>
> ….
>
> Participant 3: It's because of the clock its true. I didn't know about stretch and sweep and evening primrose oil until I got here.
>
> (Interview 050603, text units 369-378)

While treatments such as homeopathy are often constructed as "natural" and not seen in the same light as medical or obstetric interventions, these are interventions nonetheless. With this regime women's bodies are being made to conform to "normal" pregnancy and labour patterns as defined within the biomedical discourse of childbirth.

Annandale's (1988) research into midwifery practice in a freestanding birth centre in the USA also found that midwives were engaged in practices that "standardized birth so that it did not come into conflict with explicit obstetric norms and implicit patient expectations" (p. 104). This included using caster oil and artificial rupture of the membranes to induce labour and avoiding admission to the birth centre until labour was well established. Women's bodies are disciplined by these intervention regimes in the same way that they are disciplined by medical interventions. What sets the midwifery and obstetric practices apart in this situation is the nature of the intervention. Both collude in constructing the woman's body as faulty, in setting the parameters of a normal gestation and constructing these (non-conforming) pregnancies as "non-normal".

[17] Stretch and sweep of the cervix involves a vaginal examination where the practitioner inserts one or two fingers into the woman's cervical os, stretching the cervix and sweeping their fingers between the cervix and the amniotic membranes. This procedure results in a release of prostaglandins, which can help to stimulate labour.

Within the biomedical discourse of childbirth, the marking of time intensifies during labour. Obstetric policies clearly delineate time specific norms against which labour progress is assessed and by which women's labours are classified as normal or abnormal (Simonds, 2002). The partogram is frequently used to provide a graphic illustration of a woman's progress as plotted against time. Prolonged rupture of membranes is another pathological condition constructed by the biomedical discourse, the exact definition and time period that is considered "prolonged" has varied over time and between doctors and institutions. Various stages of labour are constructed within the biomedical discourse of childbirth and each stage can be diagnosed with an objective finding. For example, the beginning of the first stage of labour is diagnosed by the regular and painful contractions that begin to dilate the cervix, the beginning of second stage is marked by full dilatation of the cervix, and the beginning of third stage with the expulsion of the fetus. Note that these criteria relate to objective physiological changes that require diagnosis and verification by a professional, rather than the subjective or self-reported experiences of the childbearing woman. Obstetric policies, (underpinned by the biomedical discourse of childbirth) specify an appropriate timeframe to each stage of labour, commonly; 10-12 hours for first stage, 1-2 hours for second stage and several minutes for third stage.

> They have timeframes don't they. There's the medical model, which is a time for everything. Virtually everything happens in a set amount of time where we know it will happen in its own time as long as the baby is fine and the mum is fine, it's progressing, it's going to happen.
>
> (Interview 270503, text units 311 - 313)

The timeframes of obstetrics continue to play a major role in maternity management today and are asserted in variety of ways, marking women's bodies as normal or abnormal and making midwives "conscious of time ticking by" (Interview 011101, text unit 248).

> Like I might think she's been fully [dilated]… for the last half hour … but I'm not going to tell them until she is really actively pushing and maybe got a peep [of the baby's head showing]. Because they're going to be setting their watches and I don't

want them knocking at the door saying “haven't you had that baby yet" or "where's the placenta" or whatever else.

Interviewer: Why do you think they do that?

Well I think that for them it's that safety thing, you've got to have the baby within an hour and you've got to have the placenta within five minutes …. Like if it's an hour and a half after the baby and there's no placenta "what are you going to do about it?" Like it's, their framework of normal and OK it’s very different from mine… So they have this need to be in control of what's happening.

(Interview 061101, text units 210- 214)

This quotation illustrates one of the ways that the timeframes associated with the biomedical discourse of childbirth is asserted (particularly in the hospital setting) and also alerts us to the way that midwives subvert or resist these biomedical constructions. This will be discussed more fully in chapter 6.2 “The politics of practice”. This research indicates that the timeframes of biomedicine remain a feature of contemporary maternity care in New Zealand and whether midwives embrace, subvert or resist it, the “ticking clock” is something with which they must engage.

Agency

The biomedical discourse of childbirth constructs the bodies of women as passive and their biological functioning as inherently pathological (Brooks & Lomax, 2000). The cultural construction of women as passive is evident in the way physiology is described in medical and popular texts (Martin, 1999) and in the way childbirth is described and managed (Murphy-Lawless, 1998). Lupton (1997a) reminds us of the way that dominant discourses operate to construct a “truth” that is aligned with these conceptualisations. For example, a body that is believed to contain humours will demonstrate humours and a body that is believed to be pathological and passive will demonstrate pathology and passivity. The rationality of medical knowledge is proffered as superior to that of other knowledges and this serves to marginalise women’s subjective experiences and knowledges and also those of the midwife (Pitt,

1997). As passive and un-knowledgeable bodies, women require the activity and higher order rationality of medical science to "deliver" them safely through childbirth.

The biomedical discourse of childbirth demands passivity and compliance from women. As Brooks and Lomax (2000, p. 125) comment,

> At best, women's own accounts, or situated knowledge of their embodied experience are viewed as a form of self-indulgence and, at worst they are reduced to an irrelevance.

In 1996 the Code of Health and Disability Consumer's Rights became law in New Zealand, providing users of health care with rights that include information on which to base choices and the right to make their own decision regarding health care (Health and Disability Commissioner, n.d). While "informed choice" works at one level to create a discursive space for women in their relations with maternity care (a point that will be discussed in the chapter 4.3 "Body politics and the neo-liberal discourse of childbirth"), on another level, the biomedical discourse continues to construct women as more appropriately passive within the health care encounter. Midwives in this study describe how this occurs within the context of consultation. The obstetric consultation is not always framed as an information-gathering exercise for the woman within an informed choice process. More often than not, midwives perceive that for the medical practitioner, a consultation is a process in which the medical practitioner will dictate management to which the childbearing woman and midwife are expected to comply.

> And if you've had a consultation or referral … then it's not so much that "this is the advice we give" but "this is what … you will do". And instead of saying "this is what we suggest would be a reasonable course of action" … "you will do this and you will do it our way".
>
> (Interview 220501, text unit 527)

Another midwife comments;

> I think too, that a lot of obstetricians do not believe that women have the right to turn down their advice.
>
> (Interview 010601, text units 74-75)

In some cases the displeasure of the obstetrician is expressed through their curt reaction and body language and in more extreme situations, through their refusal to provide any further advice or care to the woman.

> He said the same thing to a woman who was expecting a breech baby and she wanted to birth standing up, and he said, "If she comes in wanting that I shan't have anything to do with her". It's all bluster, it's all power play, it's to get you to do what he wants you to do.
>
> (Interview 010601, text units 800 - 805)

The biomedical discourse of childbirth requires a compliant and passive body. This body includes the body of the woman and the body of the midwife. As my midwifery text of 1981 informs me, midwives are "…an extension of his (sic) [the doctor's] eyes, ears and hands…" (Myles, 1981, p.10). Midwives were considered a type of "physician extender", a cheaper supplement that made a more precious commodity spread a little further. In recent history in New Zealand, midwives worked under the delegated authority of a medical practitioner. While maternity reform in New Zealand has certainly influenced power relations amongst maternity care providers and provided midwives with a more autonomous role, the midwife as an agent of obstetrics remains a common construction and something many of the midwives in this study are confronted by in practice.

As an agent of medical authority midwives are mostly expected to enforce the medical plan.

> Interviewer: What do they think your role should be in that situation?
>
> Oh I guess to do as I'm told which means doing what they [the obstetric team] think is right.
>
> (Interview 061101, text units 292 – 293)

Where women sometimes made choices that resisted the biomedical discourse or medical advice, midwives in this study felt that their midwifery care was seen to be lacking. It was assumed that the midwife could not have provided the "right" information or "right" advice to the woman because if she had, the woman would acquiesce to the management plan dictated by the obstetrician. While the medical profession usually only becomes involved in a woman's care when they are directly consulted, referral guidelines, hospital policies or guidelines, a perceived litigious climate and practices within birthing areas (particularly those providing secondary services and obstetric training programmes) frequently draw women into the line of sight of the obstetrician or obstetric team. Once consulted, the authority of obstetric knowledge is exerted and the biomedical discourse works to construct the woman and her midwife as more appropriately passive within the medical encounter. Consultation is clearly an area that challenges midwifery practice and this point will be discussed further, later in this thesis.

Conclusion

The biomedical discourse of childbirth and respective technologies of power construct the pregnant and birthing woman as flawed and the processes of childbirth as risky. Medical and obstetric knowledges gain authority as scientific and rational knowledges and, in so doing, obfuscate the way they are socially and culturally embedded and constructed. These constructions are gendered, reflecting and reifying the sexualised positioning of women in our patriarchal society. While the 1990 amendment to the Nurses Act 1977 changed the landscape of maternity services in New Zealand and provided midwives with greater autonomy, midwives in this study illustrate the way that the biomedical discourse of childbirth continues to play a major role in constructing childbirth, maternity services and midwifery in New Zealand.

In analysing the biomedical discourse and its role in constructing childbirth and midwifery practice, I do not mean to establish a medical and midwifery binary in which medicine and midwifery inhabit polar ends of a spectrum. The construction of childbirth and midwifery is much more complex and involves a number of discourses. The biomedical discourse is not the precinct of medicine alone and, along with the other

discourses constructing childbirth and midwifery, this is a discourse that works on and through midwives by directing their practice and shaping their subjectivities. Midwives engage with this discourse in a variety of ways, sometimes colluding, sometimes resisting. The complexities of these relations will be elaborated further in the chapters to follow.

The next chapter describes the natural childbirth discourse, analysing the way this discourse works to construct the childbearing woman and midwifery practice.

Exploring the Terrain

4.2. Body politics and the natural childbirth discourse

This chapter explores the natural childbirth discourse. It problematises the concepts of "normal" and "natural", discussing the complex relationship that midwifery has to the concept of "normal" birth.

Introduction

This chapter describes the emergence of the natural discourse of childbirth as a discourse of resistance, arising in response to medicalised childbirth practices. In New Zealand and other western nations, natural childbirth and midwifery have been aligned in a discursive strategy that aims to further the agenda of both natural childbirth activists and midwives in their push for greater autonomy and professional recognition.

The natural childbirth discourse is evident in the talk of midwives participating in this study, co-producing midwifery in New Zealand along with other discourses described in this section of the thesis. The natural childbirth discourse constructs childbirth as natural, instinctive and individual. Greater ranges of experiences are constructed as "normal" within a natural approach to childbirth, than would be tolerated within a medical approach. Midwives participating in this study described the way that they sometimes "stretch the boundaries" of medical parameters of "normal" in practices that use the constructs of the natural childbirth discourse as resource. This leaves midwives feeling vulnerable and anxious in a context where the biomedical discourse dominates official readings of childbirth.

This chapter aims to demonstrate the constructedness of natural childbirth, problematising the concepts of natural, normal and abnormal. Unlike the biomedical construction, the natural childbirth discourse constructs the female body as a competent body but this construction frequently draws on essentialist notions of female embodiment. As such the natural childbirth discourse reifies the natural body of biomedicine and therefore fails to adequately theorise the female body or childbirth in a

way that acknowledges the diversity of women's embodied experiences of childbirth or the cultural and social nature of the phenomena.

As in the previous chapter, the voices of the midwives are introduced following discussion of the historical context, giving rise to the natural childbirth discourse in New Zealand and the alignment of midwifery with the concept of natural childbirth.

Emerging discourses of resistance: natural childbirth and feminism

The early to mid 1900s brought a dramatic change to New Zealand's maternity services, as childbirth shifted from domiciliary to hospital settings within an increasingly medicalised context. By the 1920s the H. Mt. 20 regulations had been introduced in a bid to reduce maternal and infant mortality rates. While successful in decreasing mortality rates for women of European descent, many of the procedures relating to the regulations were dehumanising for women and would later became of the focus of criticism by feminists and childbirth activists. Under these regulations, licensing requirements for private maternity homes became increasingly difficult to achieve, resulting in the closure of many private maternity homes and focussing care within public hospitals.

The introduction of pharmacological pain relief, particularly "twilight sleep" meant that childbirth needed to occur within settings that had the staff and equipment to manage the complications and sequelae of this treatment (Donley, 1998). Women actively lobbied for access to "twilight sleep" and the Social Security Act of 1938 provided such access, providing women with free access to the doctor of their choice, and medical and hospital services (Fraser, 1984). This Act secured the position of doctors and public hospitals within the provision of maternity services in New Zealand and by 1951, almost all births (95%) were occurring in hospitals under the care of doctors (Donley, 1998).

While many women in New Zealand accepted the medical approach to childbirth engendered by the dominant biomedical discourse, some did not. The natural childbirth movement had been gaining momentum internationally, facilitated by publications such

as Grantly Dick Read's "Child-birth without fear" (Dobbie, 1990) and later the Lamaze method of birthing without pain (Katz Rothman, 1991). In New Zealand the Natural Childbirth Group began in the 1950s with the intention of educating women about the benefits of natural childbirth. This conception of natural childbirth included giving birth without drugs, being supported by husbands during labour and birth, not being separated from the baby, breast-feeding the baby on demand and giving women some autonomy within the experience, e.g. the right to unwrap the baby and check its fingers and toes (Dobbie, 1990). This group was later to become Parents Centre New Zealand (Dobbie, 1990). According to Donley (1998) the new title reflected a less confrontational and somewhat attenuated political agenda.

Bogdan-Lovis (1996) describes the politics of groups such as Parent's Centre as liberal feminist because they attempt to work within the existing order and structures to effect change. Liberal feminist politics promote education as an important strategy for change, believing that a knowledgeable and informed woman can equalise the power dynamics within the health care relationship and that this will enhance her ability to exercise personal choice within the existing maternity system (Bogdan-Lovis, 1996). Indeed one of the main functions of Parent's Centre was to provide antenatal education to prospective parents. As I will discuss in chapter 5, the liberal feminist consumer is one that the partnership model of midwifery (Guilliland & Pairman, 1995a) constructs as the focus of midwifery care.

The feminist and anti-establishment movements of the 1960s and 70s gave momentum to childbirth activism in New Zealand. Feminist and childbirth activists were critical of medicalised childbirth practises. The H. Mt. 20 regulations in particular came under fire and these groups were highly critical of what had become a highly medicalised and institutionally focused childbearing experience. They were also concerned to humanise childbirth and reintegrate the process as a family and community, rather than a medical and institutional event. They fought for control over their bodies, to redefine their bodies as competent and to make childbirth a natural and holistic event.

In 1976 and 1978 Home Birth associations formed in Christchurch and Auckland respectively, and in 1980 the New Zealand National Homebirth Association (Donley, 1992) was founded. Within these groups a more radical feminism was expressed as

these women chose to remove themselves from the patriarchal and medicalised site of obstetric care in the hospital to birth their babies at home with domiciliary midwives. In "Herstory of N.Z. Homebirth Association", Donley (1992) describes the establishment of the Auckland home birth association by two "middle class feminist activists" (Donley, 1992, p. 3). Donley, (1992) who was a homebirth midwife in the Auckland area, was influential in the professionalising strategies of midwifery in New Zealand. While natural childbirth was initially associated with domiciliary midwives who provided homebirth services to women, this domiciliary model of care and the alignment of midwifery with natural childbirth was used as a strategy to advance the natural childbirth agenda and to construct a new professional midwifery in New Zealand. This is a point that will be explored further in chapter 5 of this thesis titled, "(Re)-Making midwifery and the professional midwifery discourse".

Natural discourse of childbirth

Other influential advocates of natural childbirth and critics of the medical approach to childbirth include; Sheila Kitzinger (1962, 1971, 1980, 1987), Janet Balaskas (1983), Michele Odent (1986), Anne Oakley (1980, 1984a, 1984b) and Barbara Katz Rothman (1991). The natural childbirth discourse emphasises the "naturalness" of childbirth. It constructs pregnancy as a state of wellness and the body as a competent body, highlighting the way that women's bodies are designed for the purpose of childbirth (Katz Rothman, 1991; Balaskas, 1983). This discourse encourages women to get "in tune" with their body and instincts (Kitzinger, 1980; Odent, 1986) and to remain active in labour (Balaskas, 1983; Kitzinger, 1980; Odent, 1986). Natural childbirth practitioners commonly eschew medical interventions or pharmacological analgesia, advocating "natural" interventions or support measures such as massage, use of water or herbal remedies (Odent, 1986; Kitzinger, 1980). Natural childbirth advocates highlight the individuality and uniqueness of each woman's experience, normalising a wider range of experiences than would be tolerated within the biomedical discourse of childbirth (for example longer labours and pregnancies). In contrast to medical approaches to childbirth focusing on the physiological aspects of pregnancy and birth, the natural childbirth approach emphasises the importance of the childbearing woman's emotional and psychological experiences. A mind-body unity is sometimes evoked to

explain the impact of emotions or psychological factors impacting on the start or progress of labour, for example (Odent, 1986).

Natural childbirth advocates exhort the childbearing woman to reclaim control of childbirth. Rather than allow the health professional to dictate management, women are urged to become well-informed, make prudent choices regarding their care and prepare well for the experience. For some such as Kitzinger (1980) and Balaskas (1983) education is the route to natural birth. In her book "Pregnancy and childbirth" (1980) Kitzinger for example, provides women with a detailed account of physiological processes, medical terminology, conditions of pregnancy and suggestions for preparing for childbirth. Balaskas (1983) focuses on physical and emotional preparation for childbirth, recommending an exercise and relaxation regime.

Somewhat paradoxically, for these natural childbirth advocates education and preparation are important prerequisites for reclaiming control and responding to childbirth in a natural and instinctive way. Odent (1986) suggests that structured antenatal education is antithetical to natural childbirth, commenting that "[T]he less a woman has learned about the "right" way to have a child, the easier it will be for her" (p.26), but goes on to describe how women are instructed on the benefits of an active labour and upright birthing positions in his maternity facility in France.

These authors position natural childbirth in opposition to medicalised childbirth and invariably align midwives with natural childbirth and medical practitioners with medicalised childbirth.

Aligning midwifery and natural childbirth

Barbara Katz Rothman in her book "In labour. Women and power in the birthplace" (first published in 1982 with a second edition in 1991), is credited with coining the phrase "midwifery model". In the prologue to her book Katz Rothman (1991) positions herself as a feminist middle class academic and describes her experience of homebirth with a medical practitioner in New York in 1973. The experience sparked her sociological interest and Katz Rothman began researching childbirth from this

perspective, becoming a well-known author and supporter of midwifery. Through her research Katz Rothman was able to clearly describe the medical approach to childbirth, which she calls the medical model. Her feminist politics are apparent as she highlights the way the medical model has emerged from a male-dominated profession in a patriarchal society. Within this, the male body is conceptualised as the norm and the female body, a deviation from the norm. Childbirth is therefore pathologised and, through the influence of the technological orientation of modern industrial society, the childbirth process is mechanised (Katz Rothman, 1991).

In contrast, through the "writings of eighteenth- century midwives … contemporary feminist activists … conservative, often religious mothers of large families and … lay midwives living on communes" (Katz Rothman, 1991, p 24), Katz Rothman found common themes that represent an alternative approach to childbirth. Within this approach the woman and her experience are central and childbirth is considered a natural, physiological function for which women's bodies are mostly well suited. After considering "alternative model" and "homebirth model" Katz Rothman (1991) settled on "midwifery model" to describe this approach "… out of respect for our foremothers who were midwives and to honour the work of our sisters who are now midwives" (Katz Rothman, 1991, p. 25). It is interesting that Katz Rothman's midwifery model arose not from mainstream, contemporary midwifery practice (which would have been highly medicalised and described more aptly by her medical model) but from the practices and beliefs of select and marginalised women. What is interesting here is the strategy employed and the way the concept has been mobilised in the discursive battle for professional midwifery that has seen Katz Rothman's midwifery model (and permutations of it) become the official currency of professional midwifery internationally. This is the same strategy that has been used in the development of "The midwifery partnership. A model for midwifery" (Guilliland & Pairman, 1995a) in New Zealand, a point I will return to in chapter 5. Midwifery and the midwifery model of care have come to symbolise the antithesis of medicalised childbirth and, as such, a discourse of resistance.

The aligning of midwifery with natural childbirth was an important professionalising strategy for midwives in New Zealand. In the Hansard of parliamentary debate on the Nurses Amendment Bill (1989) the then Minister of Health, Helen Clark, clearly

aligned midwifery with natural childbirth in arguing for a change to the legislation that would allow midwifery autonomy in New Zealand.

> In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a midwife deliver her baby without the need for a woman also to be under the care of a medical practitioner.
>
> …
>
> Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology there has been a trend towards treating pregnancy and labour as an illness. That has resulted in an increasing amount of medical intervention in the management of normal pregnancy, which has contributed to the erosion of the midwives' role and has proved to be both costly and, in many cases, inappropriate. Medical practitioners are trained to diagnose and treat people with illnesses and abnormalities. In pregnancy and childbirth their expertise is very necessary in high-risk, complicated, and abnormal cases.
>
> The focus of a midwife's expertise, however, is low-risk, uncomplicated, and normal pregnancy and childbirth. The great majority of births in New Zealand---that is, 85 percent---are normal and do not as a matter of course require medical intervention. It is appropriate that midwives are able to provide a low-technology childbirth service to meet the needs of low-risk women. This amendment will give women the choice to access the services of either a medical practitioner or a midwife when available.
>
> (Clark, 1989)

While natural childbirth was initially associated with marginalised groups; feminists, childbirth activists and domiciliary midwives, the natural childbirth discourse was used as a discursive resource to reconstruct mainstream midwifery in New Zealand and, as can be seen from the quotation above, an important rhetorical strategy in the professionalising of midwifery. As such, the natural childbirth discourse is implicit in the construction of contemporary midwifery in New Zealand and is evident in the talk of midwives interviewed for this study.

Natural midwives

Case-loading midwifery in New Zealand is a discursive construction constituted by several childbirth discourses, including the natural childbirth discourse. This is an influential discourse, constructing childbirth as a natural process and midwives as guardians or facilitators of this process. Some midwives participating in this study contrast themselves with "medical" or "medicalised" midwives. "Medical" midwives are those who do not ascribe to a natural childbirth approach. They may be case-loading midwives with high case-loads, epidural and intervention rates or they may be core midwives staffing obstetric hospitals that support an obstetric approach to childbirth. In contrast "normal birth" or "natural" midwives are those that work to achieve natural birth or minimise intervention in the childbirth process. The role of the midwife as constructed by the natural childbirth discourse is to facilitate the natural course of childbirth rather than manage or direct the process.

> Letting the process of nature call the shots …
>
> (Interview 28c0503, text unit 283)

For these midwives this means taking on a caseload that allows them to spend time with each woman, particularly in labour. They comment on the way that busy midwives are more inclined to allow intervention in the labour process because this allows these midwives to manage their workload. For example, induction of labour means that the midwife's workload can be more predictable, augmentation of labour avoids lengthy labours and epidural anaesthesia means that midwives do not have to spend as much time supporting women in labour and might be able to care for several women in labour simultaneously.

"Natural" midwives in contrast approach childbirth in a holistic way, appreciating that the process is natural and individual for each woman. They sometimes encourage women to avoid pharmacological pain relief and they may use "natural" remedies or interventions to facilitate the childbirth process.

Childbirth as holistic and embedded in a social context

The biomedical discourse of childbirth constructs the act of childbirth in purely physiological terms. Obstetric practices and hospital routines of the past have isolated the woman and the experience from her family and community, constructing the experience as a medical rather than community or family event.

The natural approach to childbirth attempts to integrate these aspects of childbirth, the mind with the body and the woman with her family and community.

> It's the expression of family and I guess my fundamental beliefs are that birth has to be in the context of our family lives and we don't go to hospital to do any other physiology or spiritual, emotional activities so why would you go and have a baby [there]?
>
> (Interview 27b0503, text unit 35)

This midwife not only expresses her belief in childbirth as embedded in the woman's social context but also recognises childbirth as more than a physiological event. For her and other midwives participating in this study, it is an emotional, spiritual, psychological and physiological process. For Ina May Gaskin (1990) in "Spiritual midwifery" (an influential text in the natural childbirth movement), the midwife must understand the energy of childbirth, "The spiritual midwife brings about states of consciousness in women that allow physical energy transformations of great power, great beauty and great utility" (Gaskin, 1990, p. 278).

Midwifery care is sometimes described by midwives participating in this study as "family centred". They often prefer to visit women in their own homes as this helps them to gain an understanding of the childbearing woman as she is embedded in her social context.

> I don't like clinics personally and I find for my own practice I've got a better sense of where that family is at, for planning whatever they want to be doing. So knowing that, when they go into labour, who is the support? Who's the transport? Who's looking after the other children if there are other children? And quite often I

might be midwife for, this might be their third or fourth child so, like I've been midwife for the other ones so I've got a fairly good sense of where that family is at.

(Interview 281101, text units 52-58)

Other family members such as partners and other children are often involved in the midwifery care and many midwives are careful not to usurp the supporting role that they see as more befitting partners, family or friends.

I would be talking to the woman about what was going on for her and how she is feeling. It does vary from client to client I mean we have got a lot of Maori clients who come in with a lot of whanau[18] and support people and generally what I do is just get ... make sure that the woman is okay and just kind of show her into the room to have a quick chat with them and dim the lights down and then go out and leave them to just kind of get used to the environment themselves and for their own family to support them and just come in within half an hour of them being there and just have another listen in to the baby and just kind of assessing things slowly …

(Interview 28c0503, text units 206-208)

Midwives explained that they shared the journey with the childbearing women for a short time only and it is the woman's family, partner or friends that provide the ongoing support and the social and cultural context from whence she came and to which she will return.

Some midwives in this study perceive midwifery care as a public health intervention. Through their care they are concerned to make a contribution to the woman and her family's overall health and wellbeing. They see midwifery as an opportunity to educate the woman about her body and other health issues such as diet, smoking and substance use. The opportunity for public health intervention provided by the midwife is something that the New Zealand government and midwifery's professional body have embraced as a number of public health promotion activities have been subsumed into routine midwifery care. These include screening for family violence, smoking cessation programmes and the promotion of childhood immunisation.

[18] Maori term for extended family.

For some midwives participating here, their focus is on assisting the woman to mobilise her own practical and emotional support for the impending birth and the changes this will bring to the woman and her family.

> Because this is their baby, their life. We don't know anything much about them and also really encouraging that they reach out and find their support people that are going to be there after the baby is born and carrying on supporting, whereas we're there definitely [for] such a short time in their pregnancy.
>
> (Interview 220501, text units 41-42)

Besides acknowledging childbirth as a social and community event this approach positions the childbearing woman in a more active role. The midwife does not assume responsibility for providing all the care and support the childbearing woman may need but, as a self-responsible and autonomous individual, the woman is encouraged to do so for herself.

Physiology rather than pathology

The natural childbirth discourse constructs childbearing as a physiological process, one for which the woman's body is fittingly designed.

> Well for me, my philosophy is that it is a very normal process, it's a natural process - if it ain't broke don't fix it. That the women have everything they need to do it. However, we have got a lot to offer them to help …
>
> (Interview 29b0503, text unit 34)

The belief in childbirth as a normal, physiological process is often described as the cornerstone of the midwifery philosophy (for example see Davis, 1992; Gaskin, 1990; Guilliland & Pairman, 1995a) and the key to the distinction between midwifery and medicine. The biomedical discourse constructs childbirth as pathological (that can only be diagnosed as normal in retrospect), and obstetric interventions are aimed at detecting pathology at the earliest moment, avoiding or correcting this pathology. The assumption from the outset is that the process is inherently pathological. The natural

childbirth discourse constructs childbirth as a natural function of a woman's body. While the midwife should be alert to signs of complication (Davis, 1992) their role is to facilitate the natural childbirth processes. For Davis (1992, p. 5) it is to "maintain balance and restore harmony".

Part of the midwife's role within the natural childbirth approach is to enable women to respond to childbirth instinctively. Women who are "in tune" with their body and who are encouraged to respond instinctively to labour, naturally adopt positions for example, that facilitate their birth. Discussing the environment of the obstetric hospital and contrasting this with their small primary maternity facility this midwife comments on one woman's instinctive response to labour.

> So [in the obstetric hospital] the ability to take up positions to potentiate their ability to have a baby is lessened … [At the primary maternity facility] this woman climbed her leg up the wall until she was almost doing the splits and then pushed out a ten pounder. … I'm sure she would have ended up with ventous in [name of secondary hospital] because she wouldn't have had the ability to do that sort of thing.
>
> (Interview 260503, text unit 700)

Working with the pain of labour can be part of this instinctive approach to childbirth. Pain is part of the physiological process of childbirth and natural childbirth advocates promote the avoidance of pharmacological anaesthesia or analgesia; a 'working with the pain' rather than an 'avoidance of pain' philosophy (Leap & Anderson, 2004). The natural functioning of the body during all phases of childbirth is recognised as complex and interrelated. Interference (especially pharmacological) has the potential to interrupt this finely-tuned but not well-understood balance of interrelationships. Avoidance of pharmacological pain relief (such as epidural, narcotic analgesia) also avoids their attendant side-effects or associated risks that further diminish the opportunity for normal birth (Leap & Anderson, 2004). Furthermore, advocates of natural childbirth suggest that fully experiencing childbirth and working with the pain of childbirth is empowering for women, having various short and long-term benefits (Kitzinger, 1991; Leap & Anderson, 2004).

Intervening – naturally

The "natural" midwife may introduce "natural" interventions and these are contrasted with "medical" interventions. "Medical" interventions are seen as interrupting the physiology of childbirth while "natural" interventions support it. These interventions include herbal, homeopathic or other complementary therapies, use of water or massage or interventions such as stretch and sweep of the cervix to induce labour.

> I think that I'm quite a natural practitioner, I like to keep things normal as much as possible which I think most midwives do … if intervention was necessary or a referral to secondary care was necessary then … at the same time, I would be talking about maybe natural ways of influencing what's going on as well as in looking at the diet, looking at life style, looking at all of those kinds of things too.
>
> (Interview 28c0503, text units 109, 130)

Many of the midwives interviewed have developed skills in a variety of alternative therapies and routinely use interventions such as homeopathy for example. The New Zealand College of Midwives consensus statement on the use of complementary therapies (2004) stresses that if midwives are using these therapies they should be trained in their use. Clearly some of the midwives participating here have gained qualifications in some therapies (such as naturopathy and homeopathy) though this issue was not directly explored with all of the participating midwives. Complementary or alternative therapies vary widely and it is perhaps unfair to group them all under one umbrella, though it is interesting that therapies or treatments falling under this umbrella are often perceived by midwives to be innocuous or "natural". This includes the administration of preparations such as evening primrose oil (for prolonged pregnancy) whose efficacy or even safety has not been established.

While "natural" interventions are constructed as innocuous by midwives or assigned a facilitative rather than intrusive role in the woman's childbearing experience, the midwifery use of natural interventions can reify the biomedical construct of the flawed maternal body. As the next paragraphs will explain, the natural body constructed by the natural childbirth discourse may not be as liberating for women as we might expect, as it too serves to reify the masculinist construction of the essential, feminine body.

Reclaiming the natural body

The natural body of biomedicine

As chapter 4.1 ("Body politics and the biomedical discourse of childbirth"), explains the biomedical discourse of childbirth aligns women with the natural, constructing their bodies as naturally frail and flawed. This discourse of childbirth represents an attempt to impose order and rationality on the imperfect functioning of the body on behalf of women (who are deemed incapable of such rational action). As Harold Francis (1985, cited in Kitzinger, 1987, p. 241) comments, "… the practice of medicine consists of the recognition and correction of the shortcomings of nature – nature is a bad midwife."

The hierarchical arrangement of binary pairs structuring western philosophy not only demonstrates masculinist but also Euro-centric biases. Women are aligned with the inferior body/nature/emotion/and subjective sides of the binary pairs, contrasting this with the superior mind/culture/reason and objective elements. Euro-centric biases are evident in the binaries of black/white, primitive/cultured, irrational/rational, body/mind and the alignments of black/primitive/irrational/body and their assignment as inferior when contrasted with the other side of the pairing. These assumptions suggest that women or persons from other than European cultures are more primitive, less cultured, less rational and, as they are associated with the body, that they are somehow more base or immoral than Europeans.

Within medicalised approaches to childbirth any features of the childbearing experience alluding to the primitive or natural are seen as repugnant and attempts are made to remove or control them. For example women have been sedated to prevent "uncontrolled" behaviour or "inappropriate" noises, and they may be discouraged from adopting undignified positions such as hands and knees, squatting or birthing on the floor (Kitzinger, 1991, p.22). Many midwives participating in this study commented on the way the noises of childbearing women are negatively received in the obstetric hospital. Midwives caring for women making use of noise are urged to provide them with pain relief implying that noise making is problematic and their midwifery care is lacking. An obstetrician in a study by Kerreen Reiger (2000, p. 4) commented on birth,

"We've spent 2000 years getting it out of the paddy fields….". Within the biomedical discourse of childbirth, culture and rationality is imposed over nature and irrationality.

The natural childbirth discourse constructs a more competent female body but in so doing frequently draws on essentialist notions of instinctive womanhood.

The natural body in the natural childbirth discourse

According to Murphy-Lawless (1998) the childbirth movement of the late 1950s was based on a naturalist thesis of childbirth. The naturalist thesis holds that childbirth is a natural attribute of women, that women's bodies are instinctive and can operate outside of the constraints imposed by culture. For many advocates of the natural childbirth thesis, culture has corrupted western woman's ability to birth naturally. What is required is a return to the natural body or a return to the primitive woman within.

Coslett (1994) suggests that the construct of "primitive woman" haunts western naturalist childbirth stories. "Primitive woman" is the non-European woman (frequently African or Asian) who gives birth in the paddy field or bushes without support or fear, throws the baby into a sling and returns to work barely missing a beat in the rhythm of her daily routine. Coslett (1994) claims that Grantly Dick Read introduced "Primitive woman" to obstetrics in his text "Natural childbirth" (1933) and to the natural childbirth movement in successive editions of the text titled "Revelation of childbirth" (1942) and "Childbirth without fear" (1954). Read describes "Primitive woman" as uncivilised and uncorrupted by the western culture of childbirth. She does not know to expect pain in childbirth and so she experiences a painless and joyful birth. Read's (1933) thesis suggests that civilised women have been corrupted by culture and taught to expect pain in childbirth. They require that this socialisation be un-done and this can be achieved through the teachings of the obstetrician who can instruct women on how to control their fear of childbirth. Coslett (1994) comments on the incongruity within Read's thesis; on the one hand describing primitive birth as instinctive and natural and on the other, writing himself into the process as a key player.

This notion of undoing socialisation and re-learning instinctive behaviour is a notion that influenced many childbirth activists such as Balaskas (1983) and Kitzinger (1987) and pervades the midwifery literature (Page, 2002) and the talk of many of the midwives participating in this study. The antenatal period is seen by many midwives participating here as a period in which midwives can attempt to re-educate or re-socialise women toward a more natural childbirth approach. Within the natural childbirth discourse an essential self resides under a layer of enculturation. The instinctive self is the real self (Coslett, 1994) and the emancipated woman is one who is able to cast off this layer of enculturation and respond to childbirth instinctively.

While suggesting an alternative understanding of feminine corporeal competence, the body within the natural childbirth discourse reifies the essential feminine body of biomedicine (Coslett, 1994: Murphy-Lawless, 1998). This conceptualisation fixes the bodies of women as homogenous, natural bodies and therefore fails to recognise that childbirth and women's response to childbirth is as much a cultural and social construction as a physiological one. All women may not experience childbirth as instinctive or natural. Where women are exhorted to recapture primitive birthing and are viewed as less than emancipated or less than real women if they fail to achieve a natural birth, the natural childbirth discourse can be seen to be as oppressive for women as the biomedical discourse. Brooks and Lomax (2000, p.128) comment on childbirth preparation classes that compel women to re-connect with instinctive behaviours.

> This time the construction of woman as instinctive primitive bearers of children requires all aspects of the performance of the labouring body to conform to a definition of the feminine as natural, sexual and instinctive being.

As with the biomedical discourse of childbirth this construction can also be problematic as it fails to represent the diversity of women's embodied experiences of childbirth.

Fluid fence lines

Within the natural approach to childbirth each woman's labour and birth experience is perceived as unique and individual, thus the time frames and boundaries imposed by

medical approaches are not necessarily seen as applicable. The group of midwives represented in the following excerpt work in a primary rural maternity unit one and a half hours by road from the nearest secondary maternity facility. They are discussing the influence of the primary maternity unit on their practice and in particular the absence of medical staff.

> Participant 1: Last night with the baby that was transferred down for ventous, like she pushed for two hours. Now if she had made progress we would probably have pushed that a bit further.
>
> Participant 2: Like you can actually do that and no one knows.
>
> Participant 3: Yeah, you haven't got a registrar sitting on the desk twiddling their thumbs, waiting for you.
>
> Participant 1: So you push that, but because there was no progress you knew you had to transfer. But you can actually push those, well its not limits but you allow women to do it the way they do it individually.
>
> Participant 2: You know that it's normal.
>
> Participant 3: You don't have to put a time on it.
>
> Participant 1: We don't put time limits on it and we don't do all the other things, it's more … individual.
>
> (Interview 050603, text units 286-293)

While in some instances these midwives are able to eschew the timeframes imposed by medical approaches to childbirth, this does not mean that they embrace all childbirth experiences as normal or natural. Like other midwives in this study they articulate measures of normality that relate to each individual situation and include the degree of progress being made in labour and factors that indicate the wellbeing of the mother and baby. These midwives and others in this study often include slow progress with the absence of signs of fetal distress as normal. Midwives refer to this as "stretching the

boundaries", referring to the way that they are challenging medical definitions or boundaries of normalcy, and normalising a wider range of pregnancy, labour and birth experiences - experiences that would have been pathologised by the biomedical discourse of childbirth.

Midwives participating in this study describe how, throughout their career (particularly since working in a case-loading and a more autonomous capacity), they gradually come to challenge definitions and understandings of childbirth constructed by the biomedical discourse, replacing these with constructions influenced by the natural childbirth discourse. For many of the midwives participating here, the childbearing woman herself acts as teacher and support to the midwife and frequently too, this alternate construction is made possible by the support of midwifery colleagues. In the following excerpt one midwife reflects on her transition from labour ward midwife to case-loading practice.

> We had to get used to the antenatal part because we hadn't done that before. … [T]he big thing about the birthing centre and about doing homebirth is actually getting used to working without medical support. In the beginning we were really a little nervous about it, but the more we did the more confident we became and we actually realised that it was just so good to be able to support each other and so we actually stopped doing a lot of things. We actually stood back a lot more and let nature take its course and we would say to each other, "oh I don't know. This woman's been two hours in second stage and we're an hour from the base hospital and should we call a doctor or should we send her up? Perhaps we should get the ambulance and get her up to [name of secondary service]". And then we'd say "well hang on a minute, there's nothing wrong with her recordings, she's a fit, strong, young woman, there's no problems, the fetal heart is fine, there's no meconium and there is actually progress. It's slow but things have moved".
>
> (Interview 260503, text units 155 - 158)

While this midwife challenged the obstetric definition of normal by "normalising" a labour that would have been constructed as non-normal by obstetrics, she demonstrates the application of alternate criteria for the establishment of normal. Here she is

considering the general health status of the childbearing woman, the absence of signs of fetal distress and the fact that there is slow but apparent progress.

In a study focusing on how midwives balance risk and manage women's expectations for natural birth in the United States of America, Annandale (1988) found that women's expectations for natural birth were never completely independent of obstetric definitions of risk. This is also true for the midwives participating in this study. Midwives perceive that the biomedical discourse dominates official readings of childbirth and so in stretching the boundaries, midwives are aware that they are moving into marginalised and contested terrain.

> And I think too that one of the things with independent work that I find, and I guess that other midwives do, I don't know, is that you're stretching the boundaries all the time. Like you're bouncing against … the medical circle and you're stretching that out and it's always a bit scary, how far you can safely stretch it…
>
> (Interview 061101, text unit 113)

Stretching the boundaries is a frequent source of anxiety for the midwives participating in this study.

> Because I know that pushing the boundaries at home, like for people when they first start it can be really frightening. Like we had a birth recently. I went to help another midwife, really slow progress, really erratic labour and had we been in hospital, look there would have been referral. … [T]his other midwife by this stage was like, "my God!" When I said, "we pushed the boundaries a bit" she said "no, we rolled the carpet right back to the corners. I was really sweating!"
>
> (Interview 291101, text units 649-656)

Whilst the natural childbirth approach directs midwives to approach each birth experience as unique there is no consensus or clear understanding of what constitutes a unique normal experience or what constitutes one that demonstrates pathology. As I will discuss further in the following paragraphs the boundaries and definitions of "natural" and "normal" as constructed within biomedical and natural discourses are not fixed or clear.

Constructing natural, normal and abnormal

The distinction between "natural" or "normal and abnormal" has been a critical organising principle in the development of obstetric knowledge and obstetrics as a discipline (Murphy-Lawless, 1998). Murphy-Lawless (1998, p.58) considers that obstetric science "turns on that moment of identification". Fundamental to obstetric thinking is the presumption that childbirth is first and foremost, a risky phenomenon for mother and baby. The actual identification of abnormality however, has proved to be elusive. As the field of obstetrics has grown (along with the technologies and sciences associated with the discipline), the endeavour to clearly distinguish the normal from the abnormal has caused the sphere of abnormality to increase.

The midwives participating in this study for example commented on the way that new prenatal investigations seem to be flourishing. These frequently centre on developments in ultrasound technologies such as anatomy screening of the fetus or screening to identify markers for Down's Syndrome (such as nuchal folds in the fetal neck). These screening tests create a new category of "abnormal", as women with dubious screening results are identified as high risk. At times these tests identify other factors such as fetal cardiac or cerebral foci, whose significance is not well understood yet can have a devastating impact on the woman as she endures a now "high risk" pregnancy, fearing that her baby may not be normal. The availability of these screening tests places midwives in the position of having to discuss them with women, drawing their focus toward the abnormal and highlighting the need to identify and label their risk status. The increasing "at risk" population of birthing women also serves to sweep women into the domain of obstetrics.

Shifting sands

Constructions of normal and natural are not fixed or clearly defined and change over time, between regions or amongst specific groups. Turner (2002, p. 659) comments, "The cultural value and legitimacy of the term *natural* has shifted across time as differing systems of belief have gained acceptance". Midwives participating in this study comment on the changing boundaries between normal and abnormal. The

domain of normal is described as diminishing in some areas as, for example, the time limits tolerated for factors such as length of gestation, pre labour rupture of membranes, and length of labour are decreasing. At other times these boundaries are extending. For example my midwifery text of 1981 (Myles, 1981) defines an "elderly primipara[19]" as a woman over thirty years of age. As society has changed and more women over thirty are experiencing childbirth, this definition has been modified. The term "elderly primipara" has disappeared from the latest edition of the Myles Textbook for Midwives though they advise that women over 35 years of age may require additional surveillance and advice (Fraser & Cooper, 2003).

The term "normal" can also mean usual or common (Gould, 2000). The midwives in the following excerpt reflect on both the definition of normality and the dynamic nature of this definition.

> Participant 1: But for a primip with a breech baby a Caesar is normal.
>
> Participant 2: I suppose, yeah.
>
> Participant 3: I think we have to be really careful about things like [that] … because it used to not be normal and I think that a lot of , the shift of normal is getting wider or maybe narrower actually. So there is less and less, … things that are normal for midwives and more and more things that used to be normal for midwives that are becoming normal for secondary care.
>
> Interviewer: But on the other side of that, epidural is becoming normal, so normal is expanding as well, it's expanding and contracting.
>
> (Interview 270503, text units 223 - 229)

As these midwives note, there are many variations or conditions of childbirth that were once considered within the midwifery domain, such as caring for women with twins or whose babies present in the breech position. These and many other actual or potentially risky conditions have been pathologised and are now considered best managed by

[19] A primiparous woman is one having her first baby.

obstetrics. On the other hand, obstetric practices that may have been used in more exceptional circumstances (caesarean section, epidural anaesthesia, induction of labour) have become so commonplace that the practices have become normalised.

Normal or natural?

There is little agreement within the literature (Annandale, 1988; Gould, 2000) or amongst midwives participating in this study as to the meaning of normal or natural birth. The defining characteristics of normal birth are contested even within groups of like-minded midwives who work together in group practices. These midwives are discussing various forms of pain relief and their impact on what could be considered a normal birth.

> Participant 1: Well is pethidine still normal? Is gas still normal? I class those as normal.
> Participant 2: I wouldn't count pethidine but gas doesn't count.
> Participant 3: Neither would I.
> ….
> Participant 4: If they have no pain relief, then that's normal.
>
> (Interview 270503, text units 214 - 221)

Gould (2000) suggests that it is important that midwives define "normal labour" for themselves, arguing that it is the failure of midwives to define normality that has allowed the increasing medicalisation of childbirth. Gould's research found that midwives define normality in a variety of ways and that they also considered that the terms normal and natural meant different things. Gould (2000, p. 420) comments:

> Many midwives may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural.

Normal birth is often equated with vaginal birth and for the purposes of statistical collection a vaginal birth (excluding ventous or forceps) is considered a normal birth regardless of the analgesia, anaesthesia or interventions (such as induction or

augmentation of labour) used. These births however may not be considered natural births. Natural births are more likely to be defined as those births in which medical or pharmacological interventions are not used.

Whose normal?

In Gould's (2000) study some midwives suggested that normal should be defined by the woman, a stance also supported by a number of midwives participating in this study. Some midwives are reluctant to deny women the achievement of "normal birth" perhaps because of the way that normal birth within the natural childbirth discourse is aligned to essentialist notions of womanhood.

> Participant: So if a woman said to you; "Did I have a normal birth?" And she had gas and pethidine you'd say "no you didn't have a normal birth".
>
> Interviewer: Well that sounds a bit harsh doesn't it?
>
> (Interview 28a0503, text units 329 - 330)

Another midwife participant in this study relates the story of a woman who had a very complicated and highly medicalised childbirth experience but who was pleased to claim the achievement of normal birth at its completion.

> I had someone recently who had 29 week twins, you know she had had the most horrific pregnancy; she'd conceived using IVF … she'd got ovarian hyper stimulation syndrome so she was admitted to hospital, she was really sick. She was very, very nauseous, she already knew she had twins, really nauseated, she was admitted to hospital [again] … then she started bleeding reasonably heavily but got through that ... she had a few weeks where everything was okay, developed a severe nerve entrapment which meant that she could only sleep sitting up in a lazy boy and then she laboured at 29 weeks…. They tried to inhibit the labour so she laboured all day Friday, Saturday, Sunday you know on again off again … She pushed for quite a long time, the first was cephalic, came out reasonably easily and the second was a breech extraction. … and that baby, the second baby has a cleft palate … She was

still blown away by the fact that she had two normal births ... she kept saying "I am so pleased, I am so pleased it was all normal" and I am like "well if that's your definition of normal you know, I'd hate to see abnormal really".

(Interview 28b0503, text units 194-201)

Clearly the midwife and the childbearing woman in this situation were working from very different definitions of normality. This example highlights the contextual and fluid construction of normal or natural in relation to childbirth. It also highlights the way that the natural childbirth approach valorises normal birth which may result in childbearing women and midwives taking a more expansive approach to the definition so as not to deny the childbearing woman this achievement.

The desire to define and categorise normal and abnormal is a result of western, binary thinking. It has been important to midwifery because the midwifery scope of practice has been constructed by the concept of normal birth. Several midwives participating in this study, though, are beginning to problematise the binary of normal/abnormal, as we shall see in the following paragraphs.

Midwives and normal birth

While midwifery autonomy was gained using a strategy that aligned midwives with normal childbirth, midwifery practice in New Zealand has come to incorporate care for women who are not necessarily experiencing a low-risk or a normal childbirth. Two midwives participating in this study clearly see their role as focusing on normal childbirth and hand over lead maternity carer responsibility to secondary services when women required these services. For these midwives, this includes women who choose to have epidural anaesthesia in an otherwise normal childbirth experience. In my experience this would not be common practice among midwives in New Zealand. Most other midwives retain lead maternity carer status (and thus responsibility for coordinating the woman's care) no matter what complications arise or what interventions are introduced to the childbearing experience.

Interviewer: Are you handing over at that point or are you LMC?

> No, we are always LMC right through yeah. The only time you hand over LMC care to the hospital is for caesareans, emergency caesareans or whatever.
>
> (Interview 28a0503, text units 198-200)

The "Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000. Maternity services" (Ministry of Health, 2002a) or "Section 88" as it is commonly known, is the contract between lead maternity carer and Ministry of Health that specifies the role and responsibilities of the lead maternity carer. Both this contract and the National Access Agreement (the contract between District Health Boards and lead maternity carers that enables and specifies the conditions for hospital privileges) provide lead maternity carers with a level of discretion concerning lead maternity carer status and issues of consultation and referral to secondary services. Where midwives retain lead maternity carer status for women with pre-existing or emergent conditions or those requiring certain interventions this does not mean that these midwives take sole responsibility for their care. It does mean that these midwives are responsible for coordinating care and collaborating with other health professionals such as obstetricians, as deemed necessary.

This means that women in New Zealand frequently experience continuity of midwifery care no matter what their experience of childbirth; a factor that disrupts the normal/abnormal polarisations that are often used to categorise childbirth. As Banks (2001) states; "Childbirth is neither 'normal' nor 'abnormal'. It is, quite simply, a childbirth journey - a unique experience for each individual woman." The role of the "natural" midwife in situations where care becomes complex and other practitioners become involved becomes one of attempting to keep the interventions and interference to a minimum or maintaining the woman-centred focus of care.

> I can't remember if it was a doctor or a midwife but a goodly number of years ago [they] said something along the lines of "you are either a natural birth promoting midwife or you're an abnormal birth midwife". And I actually disagree with that. I think you can move between the two and make the abnormal as normal as possible.

> I remember having great arguments with [name] who was the paediatrician in charge of the unit for many years. She would get really het up about it if you have a section or a birth where you needed the paeds [paediatricians] there. If this babe was born in rip-roaring condition I'd say, "well you don't need to see this baby, look its fine". And she would get so het up about it. She had to assess this baby and like what do you need to do with a pink crying, vigorous, active baby? You don't need to take it over to a trolley and do all the bits and pieces. So even within the abnormal you can encourage the normal and normalise it as much as possible. So I think you can do both but it's the focus ….
>
> (Interview 061101, text units 457 – 463)

This midwife is articulating a continuum of care rather than an abnormal/normal dichotomy, where the midwife remains involved whatever the clinical situation. The midwife's role becomes one "normalising" the clinical situation in terms of minimising unwarranted medical intervention and thus disruption to mother and baby.

Skinner (2003) seems to support this approach when she cautions that delimiting the midwife's role to that of normal birth is precarious for midwives as it is obstetrics, not midwifery that is defining normality, a point also made by Hartley (1997). In the current health care context what is "normal" is rapidly diminishing as more and more women are constructed as "at risk". She suggests a broader reading of normality; one that includes the social and cultural experience of childbirth. A sense of social and cultural normality can still be maintained even when the physical experience of childbirth has become more complex than "normal". Hartley (1997) on the other hand, advocates an extended role for the midwife, one in which the midwife would replace the doctor in conducting procedures such as ultrasound and instrumental births. The midwife's ability to provide continuity of care for women through primary and secondary care services probably enhances the experience for the childbearing woman (Hodnett, 2000) and helps disrupt the normal/abnormal childbirth polarisations. In this study the concepts of woman-centred care and continuity of care feature prominently in the talk of midwives with relatively little emphasis overall on normal or natural childbirth. The exception to this is in the transcripts of midwives who primarily care for women birthing at home or in primary birthing facilities. For many of these midwives, anything other than normal birth requires a transfer to an obstetric hospital.

For them, normal birth is particularly important and the interviews generated much more text discussing this issue. Another exception to this is in the transcripts of midwives who access one secondary hospital that does not offer obstetric training. In addition, anaesthetists in this area are reluctant to provide epidural services to women experiencing normal labour. Unlike midwives who routinely provided care in other obstetric hospitals, these midwives discuss normal birth more often and cite normal birth as the aim of their midwifery care. By contrast, other midwives interviewed, who primarily provide obstetric hospital care, did not. For many midwives working in obstetric hospitals there seems to be little incentive to keep birth normal, particularly if this is not an aim of the childbearing woman.

A more fluid reading of normality and a more fluid understanding of the role of the midwife may be beneficial to the childbearing woman and midwives. The idea (and the reality in New Zealand) of midwives and women together moving seamlessly from the community through to secondary or tertiary care and back to community, is attractive. However, it is also a reality that childbirth is becoming increasingly medicalised and more and more women are pressed into obstetric care or medicalised childbirth practices. Contemporary midwifery in many western nations has been constructed as a counterpoint to the medical approach to childbirth and we need to consider carefully the consequences of relinquishing our connection to the concept of normal birth. This is an important issue for midwifery and it will be revisited in the final chapters of this thesis.

Conclusion

The natural childbirth discourse emerged in response to medicalised childbirth practices. This discourse constructs childbirth as a normal physiological event and the maternal body as a competent one. The focus of midwifery care within this construction is on facilitating the natural functioning of the maternal body and very often playing a part in the empowerment of the childbearing woman through the experience (and pain) of childbirth.

The maternal body within the natural childbirth discourse however may not be so different from the biomedical one. Both essentialise femininity and maternal

functioning, failing to address the ways in which culture and socialisation play a part in the experience of childbirth.

Midwives' relationship to the concept of normal birth is complex yet highly significant. As Helen Clarke's (1989) parliamentary speech indicates, midwifery autonomy in New Zealand was predicated on midwifery's claim to expertise in "normal birth". Many midwives participating in this study however, problematise the dichotomy of normal/abnormal, placing greater emphasis on a woman-centred or humanised birthing experience, continuing to care for women throughout the spectrum of childbirth experiences. The natural childbirth discourse does provide midwives with an alternative construction of childbirth that allows them to challenge obstetric assumptions, practices and routines. Stretching the boundaries of medical constructions of normal and approaching the female body as a competent body are legitimised by the natural discourse of childbirth.

The next chapter explores the neo-liberal discourse of childbirth, focusing on the way this discourse constitutes the maternity consumer and midwifery vis-à-vis the consumer construct.

Exploring the Terrain

4.3. Body politics and the neo-liberal discourse of childbirth

This chapter explores the neo-liberal discourse of childbirth. Within this, the constructions of "consumer" and" informed choice" and the midwifery role in relation to these constructions, is discussed.

Introduction

Over the last century, in many parts of the western world the concept of health, and our expectations of health care and health professionals have changed dramatically. Within the context of a patriarchal society we have seen the rise of the medical profession along with discourses of science and technology. This has resulted in the medicalisation of many aspects of the human condition (Crawford, 1977; Germov, 1998; Turner, 1987).

Medical care throughout the nineteenth and twentieth centuries was characterised by a paternalistic approach. From the mid-twentieth century there was a shift in the way health was conceptualised and health care was approached. The medical conception of health was accused of being too narrow and reductionist, giving rise to a broader definition and a holistic approach to health. Along with this and facilitated by social movements of the time, individuals demanded more control over their experiences and this encouraged a shift from paternalism to an approach encouraging individual choice and responsibility (Crawford, 1980; Richards, 1997: Woodward, 1998). This push from feminist and popular health reformists aligned with a neo-liberal political climate in the 1980s to secure the place of the consumer in New Zealand's healthcare system. The language of the neo-liberal consumer discourse of health was one of rights, self-determination, empowerment and autonomy (Mason, 1995).

The neo-liberal consumer is one that midwives have embraced in their efforts to provide maternity care to women in a way that responds to the critique of the medicalised childbirth experience. While many authors have commented on the consequences of the biomedical discourse of childbirth for women and midwifery practice (Katz Rothman, 1991; Kitzinger, 1979; Oakley, 1980), few have considered the

implications of the neo-liberal consumer discourse that has emerged in New Zealand and many other western societies.

This chapter outlines the emergence of the neo-liberal, consumer discourse of childbirth in New Zealand and also demonstrates the way that midwives work to construct childbearing women as consumers, using the construct as a discursive resource. I then move away from the immediacy of the voices of the midwives participating in this study, as I problematise the neo-liberal discourse and use Foucault's (Burchell, Gordon & Miller, 1991) notion of governmentality to support the assertion that the consumer is less empowered than the neo-liberal, consumerist rhetoric would have us believe. I suggest that informed choice is more illusion than reality as childbearing women are pressed to discipline their choices in line with the dominant biomedical discourse of childbirth.

Waning welfare and neo-liberal politics

Liberalism can be understood as a political philosophy and tradition that concerns itself generally with individual freedom. The word "liberal" derives from the Latin, "liber" meaning "free" (Wikipedia Foundation, 2005). As a political philosophy liberalism holds that the purpose of government is to facilitate individual liberty. Individual liberty is perceived as a natural right which precedes and should direct laws of governance. To this end liberalism generally espouses commercial freedom, a circumscribed role for government, self-determination and support for individal rights. Liberal politics generally stand in oppositon to those of socialism and communism. The latter frequently advocate a greater role for government in shaping the polity and an emphasis on collective rather than individual rights and welfare.

Neo-liberalism refers to a resurgence in liberal-inspired political and economic philosophies that became influential in the 1980s. Neo-liberalism opposes government intervention in the economy, suggesting that this intervention produces economic inefficiences. Economic and social progress, it is argued, can best be achieved by lifting restrictions on business and encouraging a free market. Neo-liberal policies typically encourage private enterprise, entrepreneurial activities and consumer choice.

> Neo-liberalism is underpinned by beliefs in the efficacy of the free market and the adoption of policies that prioritise deregulaton, foreign debt reduction, privatisation of the public sector ... and a (new) orthodoxy of individual responsibility and the "emergency" safey net, thus replacing collective provision through a more residualist welfare state. (Hancock, 1999, p. 5)

In 1984, New Zealand's fourth Labour government embarked on a project of radical state restructuring based on neo-liberal politics (Walsh & Boston, 1991). These reforms resulted in a general downsizing of the welfare state (Geddis & Morgan, 1997) and continued into the 1990s with major health restructuring under the National government. This government embraced a market approach to health care that saw those receiving health care re-constructed as "consumers" and those providing health care as "service providers". A competitive health care market was created in which service providers would compete for custom and consumers would exercise choice (Borren & Maynard, 1993). Health care in this context is likened to any other commodity that can be bought and sold.

This is the political context into which the new midwifery in New Zealand was delivered in 1990. Amendments to the Nurses Act 1977 allowed midwives to practice under their own authority and claim directly from the government purse for their services. Midwives were contracted to provide primary maternity services on the same contract (today known as Section 88) as general practitioners. This contract prevented midwives or general practitioners from charging any additional cost for primary maternity care, though general practitioners retained the ability to do so for any service other than maternity care.

From employment to enterprise

The ability to claim directly from the public purse for the provision of primary maternity care meant that midwives were able to leave employed situations and set up small businesses as self-employed practitioners. Some hospitals also set up case-loading practices, employing midwives to provide the service, working within the "Section 88" contract (formerly known as "Section 51" [Health Funding Authority, 1998]) and claiming from the primary maternity budget. Many midwives today work in

group practices though the nature of their practice relationships vary widely. Most of the group practices interviewed for this study consist of informal relationships where the group provides backup and leave cover, personal and practice support and sometimes shared advertising. These midwives usually attend their own administrative duties, provide their own equipment, attract their own clientele and claim payment individually for the women in their care. One group employ an assistant to manage first-line inquiries about the practice and one midwife within a group practice employs a practice manager to arrange her appointments and run her clinic. Within this new maternity care system more midwives have had to consider not only the practice of midwifery but also the business of midwifery.

Midwives in this study acknowledge that in the early years post-1990, or as they entered the workforce as new self-employed practitioners, the client-centred focus of their practice was pursued with a certain amount of zeal. For example, midwives provided antenatal and postnatal care in the comfort of the woman's home, perhaps in the evening if this was convenient to her. They remained on call and available to the woman twenty-four hours a day, seven days a week. This was driven by philosophical and commercial imperatives. Offering a service that would be attractive to women would provide these midwives with a competitive edge, as compared to the services provided by general practitioners or some other midwives.

Participant 1: I think that's probably why some women do choose us. Midwives who work like we do. I'm sure. It's got nothing to do with how nice and smiley and how good we are; it's the fact that they don't have to come from [suburb outside of town] into town. It's as simple as that.

Participant 2: And they can reach us at all hours, you can't ring up your doctor at half past seven and say is it all right for me to drink Power Aid.

Participant 3: And you drop everything don't you. You go around and see them at ten o'clock at night. Whereas the GP won't do it.

….

Participant 2: I think some midwives always do that. Always want to meet everybody's needs.

(Interview 010601, text units 161– 191)

As they gained in experience and midwifery care became more commonplace, the impulse to focus so keenly on women's needs gave way to what they describe as a more balanced approach, one that recognises that the midwives themselves have needs that should be addressed.

> It took me a long time to realise that it was OK for me to have expectations of women. It was always what the woman's expectations were of me and what I could provide for women. And it took me a long time to give myself permission to say, "Well actually, I've got expectations of you. You have got responsibilities towards me". And the way I dealt with that was to very clearly say right at the beginning when I first met the woman or spoke to her on the phone even, was that I did my routine work between nine and three, I didn't do visits in the evening, I only did what I had to do at the weekends because I had two small children to look after and so on and so forth. It didn't always work mind you but on the whole I felt quite good about that and I had a leaflet that I printed all this out on and I'd give it to women and I take the view that if women don't like that then they need to find another midwife. Although of course that's easier said than done, because if you're relying on a certain number of births.
>
> (Interview 010601, text units 215– 229)

Several midwives have reconsidered the decision to provide care in the woman's own home and have set up clinics. For these midwives, the benefit of providing a home-based service is outweighed by the cost and time involved in travel.

> We all got better at looking at the business side of independent practice as well, being self-employed. Whereas, to start with it was probably, well we probably made a bit of a rod for our own back with being very available, and you know trying to meet their [women's] needs. Just working from, "oh we're giving a service" … but you've actually got to now look at it and say, "Well is that actually cost-effective to travel that far? … Using the time and the car when you could be taking somebody

> that's living much closer. And you don't have the stress of getting there and back and fitting it into your day." So, we really had to look at the business side of it …
>
> (Interview 240801, text units 107-110)

Midwifery as "with woman" is a central tenet of natural childbirth and (as the next chapter will describe), the professional discourse of midwifery. This focus also provides midwifery with a claim to a distinctive service and so a competitive edge within the market-driven maternity system. However, midwives have had to grapple with the sometimes competing demands of midwifery as "with woman" and midwifery as a business.

The new maternity marketplace constructed by the neo-liberal discourse not only reconstructed the midwife as a businesswoman but also the recipient of health care as a consumer. As a consumer, choice is all-important.

From patient to consumer

Throughout the nineteenth century the medical profession rose to a privileged position in society and was afforded a great deal of status and power. In childbirth and other areas of health care, women submitted to the care of health professionals, asking few questions and being provided with little information. Routine practices such as perineal shaving, administration of enemas, and episiotomy dominated women's experiences. Babies were kept in hospital nurseries and delivered to the mother in line with a strict feeding regime. Women were expected to comply with and acquiesce in the greater knowledge and skills of the medical professionals.

As the women's and anti-government/establishment movements of the 1960s gained momentum, women began to speak out against this paternalistic model of health care and attempted to wrest control of their personal health responsibility from the medical profession. Women expressed concern over paternalistic approaches to health care and questioned the motivation and judgement of the medical profession in determining their care and choices. Their language was one of "rights", "empowerment" and "self determination" (Cox White & Zimbelman, 1998). This reflects a concern for individual autonomy and a move away from an implicit reliance on the beneficent action of a

respected authority. In New Zealand, community groups such as Parents Centre, the Homebirth Association and later the "Save the Midwife" campaign were particularly vocal in the area of childbirth (Donley, 1998). In 1987 events at National Women's Hospital in Auckland served to fuel the fire by providing a poignant illustration of some of the problems arising from the authority of the medical profession and reliance on a paternalistic approach to health care.

Dr Herbert Green at National Women's hospital in Auckland conducted a clinical trial concerning the treatment of cervical cancer. Some women in the trial were denied adequate treatment for their cervical cancer and tragically for some of these women, their cancers became invasive. Several women in the trial also died as a consequence (Bunkle, 1998). The Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital (Cartwright, 1988) found that women had been used in research at the National Women's Hospital without consent and were not adequately informed of the treatment options available to them (Cartwright, 1988).

The disregard shown to these women was breathtaking but it also highlighted a number of fundamental problems associated with the power imbalance between providers and recipients of health care. The ensuing inquiry resulted in a number of recommendations that aimed to address some of these issues. The report recommended the establishment of a Health and Disability Commissioner whose functions would include the promotion and protection of consumer rights. In 1996 the Code of Health and Disability Consumer's Rights became law in New Zealand providing consumers of health care rights to: respect and privacy, fair treatment, dignity and independence, proper standards of care, effective communication, information on which to base choices, make their own decision, support, make decisions about whether to participate in teaching or research, and the right to complain (Health and Disability Commissioner, n.d.).

It is important to note that the patient has now become a consumer in the language of public policy in New Zealand. The consumer is a construction of the neo-liberal political discourse of health care. Consumers are free to choose among various caregivers and treatments, they have the right to consent or refuse consent, and they have the right to self-determination. This discourse focuses on individuals and rights

and constructs empowerment as the exercising of these rights. As the midwives participating in this study demonstrate, the rights accorded the consumer also come with responsibilities.

Empowerment and responsibility

The neo-liberal, consumer discourse features in the talk of midwives participating in this study. This discourse constructs childbearing women as consumers who are empowered by their ability to control their experiences and make their own health care decisions. While the natural childbirth discourse frequently associates empowerment with the achievement of natural birth, most midwives participating here associate empowerment with this personal control and decision-making capacity. When asked what she was trying to achieve with her midwifery care a midwife responds,

> That the woman feels happy with each step of the way. So that regardless, even if she may have planned to have had a birth on her own … vaginally and ended up with a prolapsed cord and a caesarean, well that's a bit extreme, but you know. [If she] can still feel all right about it and feel involved with each step of the way. Or that she's had a major driving say in it really.
>
> (Interview 010601, text units 71 - 75)

Whatever the birth outcome, the most important factor for midwives participating in this study is that the woman considers that she remained in control of the experience.

> I had very few women that were actually unhappy because they felt they had been kept in control. So even though it can get really annoying for them and for me having to give all that information and make them make decisions, in the long run it paid off and I would say "its up to you to make decisions, its up to me to support your decision, its up to me to give you the information to make the decision on". And that worked well.
>
> (Interview 260503, text units 534 - 536)

To appropriately take up the consumer position women require information on which to base their decision-making. Decisions have to be made on a vast array of topics that

include; choice of caregiver, attendance at antenatal education classes, early neonatal screening for chromosomal anomalies, ultrasound scanning for anatomical anomalies, antenatal screening tests for HIV, diabetes, Group B Streptococcus infection, place of birth, type of birth (eg water birth), monitoring in labour, pain relief in labour, support and facilitation practices in labour and birth, management of third stage, suturing of the perineum and vitamin K administration to the neonate. These are numerous and complex topics and, in an environment that is perceived by midwives as increasingly litigious and directed by the ethos of evidence-based practice, this places a heavy onus on midwives to provide information. It is not surprising then that midwives participating here describe the midwifery role as largely providing women with information or access to information.

> Well, for me it comes down to being with women and for me it's very important that the woman is actually the lead person. But I am there to give her information to help her make her choices but it is up to her to make the choices. And it's my job to give the information and then if she makes a choice its my job to make that choice as safe as possible but still working with her.
>
> (Interview 260503, text units 194 – 196)

> Participant 1: I think that we are really clear about the way we work, that we want to work with people and encourage them to find their way and that we share information, we'll find information, we'll help them find information. We're not going to tell them what to do and that is about them taking responsibility. … And we also talk about the way we want to work with that sort of information sharing, that its partnership stuff. That it's reliant on their participation as well and without that it doesn't work.
>
> Participant 2: And we're really clear with some people that you know often think, "Well I want you to make a decision that will be OK". We're really clear that if you ask us our personal opinion that we won't give it, so that won't influence their decision-making.
>
> (Interview 220501, text units 34 – 40)

As this excerpt above illustrates, the midwife's role is constructed as one of neutral conduit of information. These midwives are eager to provide women with neutral or unbiased information and prefer to distance their own personal or professional opinions from woman's decision-making processes. While this seems to be the majority position it was not one held by all midwives participating in this study. The following exchange was part of a group interview and demonstrates one midwife's response to another's assertion that her practice in regards to routine Cardiotocograph (CTG) monitoring was directed by the woman's informed choice.

> Participant 1: What I mean by squeaky clean is in terms of standing up to the registrar that's what I mean. Like if somebody comes in and says, "Have you done a CTG?" I'll either say "yes I've done it because the woman said yes", or I'll say "no I haven't because one, she had decided she didn't want it or two, because she was in full labour and it was impossible". That's what I mean about being squeaky clean.
>
> Participant 2: That makes it sound like you've got no values or views as a midwife, it's all the woman.
>
> (Interview 010601, text units 543-550)

This exchange illustrates the differing ways that midwives understand and enact "informed choice". The first midwife in the exchange above constructs the midwife as neutral conduit of information and establishes her role as supporting whatever the woman chooses, while for the other, the midwife's professional values should play a part in directing practice. This exchange also demonstrates the power of the neo-liberal, consumer discourse and the technology of "informed choice" in New Zealand. Because it is influential, midwives utilise "informed choice" as a resource to challenge medical interventions and sometimes to advocate a more natural childbirth approach. "Informed choice" may be an unreliable strategy for achieving natural childbirth however, as women may also choose a more medicalised approach, and frequently do. The rising interest in elective caesarean section without medical indication attests to this (Gamble & Creedy, 2000; Robinson, 1998; Young, 2000).

An important element of "informed choice" for midwives participating in this study is the responsibility that is constructed as allied with the right to choose. The act of choosing is described as empowering but with this comes a high level of responsibility that the woman (as chooser) has to bear. This is a significant shift from the construct of patient who handed over responsibility to an authoritative other. These midwives acknowledge that not all women welcome the responsibility of choosing or have the skills to make well-informed choices. Midwives participating here took up various positions in regards to this. Some, like the midwives below are adamant that this is a responsibility of the woman or parents and press toward that end.

> Participant 1: … you know that these women for whatever reason either aren't prepared to take responsibility or their idea of a partnership is where you do all the work and I'll just cruise.
>
> Participant 2: Well its not even that, they actually come from a socialisation where the doctor makes the decisions and they think midwives are going to do that too. So it's trying to get them into that form that they have to make decisions that they don't want to make. They don't know how to make them.
>
> Participant 1: And then when things don't go quite as they thought.
>
> Participant 3: And they want somebody to blame.
>
> Participant 1: It's very much the midwife's fault. They don't want to take self-responsibility.
>
> (Interview 050603, text units 486 – 493)

For these midwives, women who are perceived as not taking responsibility are not taking up their role within the partnership and this is problematic. Other midwives took a more laissez-faire approach, accepting that some women or parents might abdicate responsibility for some choices. Several midwives also problematise the notion of choice recognising that they in fact have a significant part to play in the choices that women make, a point that will be explored further in the chapters to follow.

Midwives participating in this study construct childbearing women as neo-liberal consumers of maternity services. Within this construction self-determination and thus empowerment is achieved through the act of choosing. The act of choosing and particularly making appropriately informed choices, however, is laden with responsibility for the childbearing women. Women demonstrated their willingness to take on this responsibility by engaging seriously in the informed choice process. According to these midwives this forms a significant part of their role as constructed by the partnership model of practice (Guilliland & Pairman, 1995a). The neo-liberal consumer positions midwives as information brokers. A large proportion of their role is taken up with providing information, providing access to information or interpreting information on a vast array of topics on which childbearing women are pressed to make choices.

Within the neo-liberal discourse of childbirth the individual is seen as the focus of care. The childbearing woman is required to take up her role as an active agent in the health care partnership, becoming empowered through informed decision-making and the appropriate assumption of responsibility. In focussing on the individual this discourse also serves to depoliticise health and apportion blame for ill health to the individual. Health becomes much more than the absence of disease but a moral imperative. The neo-liberal discourse creates the illusion of empowerment and free choice (Anderson, 2004; Kirkham & Stapleton, 2004) which (in the context of an increasingly medicalised society) turns out to be less empowered or free than the rhetoric would have us believe.

Consumer choices: market driven or disciplined?

Individualising health

The profession of medicine has come to situate ill health or disease at the level of the individual body. With the aid of autopsy and a knowledge of anatomy, medicine came to understand that disease as an entity caused real anatomical, observable changes in the body. Along with this conceptualisation came the understanding of single pathogenic causative agents. The domination of this way of perceiving disease and ill health has excluded the development of alternate ideas such as those emphasising multiplicity of causation or social determinants of health (Crawford, 1980). Medicine within the

dominant biomedical discourse represents a science of the individual.

The 1960s and 1970s saw the emergence of phenomena like the women's movement and a holistic, popular health culture that sought to shift control and responsibility for personal health from the professional to the individual. From paternalism and trust in the beneficent intent and actions of the professional, society moved toward placing greater value on autonomy and self-determination.

The holistic health movement was heralded as a radical break away from the dominant discourse of biomedicine with its reductionist methods and paternalistic approach. Holistic health philosophy asserted the need to understand health in a more whole and inclusive way and many proponents of this approach have espoused the importance of claiming responsibility for one's own health rather than relying on an authoritative other. With the popularising of this movement the control of individual health has been brought into the realms of individual responsibility. We no longer rely on the authoritative other to solve our health problems. We now claim responsibility for our own health. On the surface this new conceptualisation of health seems like an enlightened one. It is holistic, it acknowledges a connectedness between mind and body, and it recognises personal responsibility. However, Crawford (1980) considers that it encompasses and so acts to reinforce some of the fundamental elements of the biomedical discourse.

This new approach continues to individualise health. It suggests that we can prevent ill health through modifications to our lifestyle, implying that our lifestyle choices are the root of ill health. When the individual is seen as the cause of disease then the cure is also situated in the individual. Personal health is located within the sphere of personal control. If we make the right choices, eat the right foods, lead the right lifestyle with the right attitude; we can experience optimal well-being. Hence the proliferation of personal health strategies aimed at modifying lifestyles, behaviours and attitudes contributing to health.

This individualised approach to health has been embraced by health policy and health promotion professionals and also by other groups as we are encouraged and supported in our efforts to embrace healthy living and associated activities (Nettleton, 1998). The

problem with this approach to understanding health is that it fails to acknowledge some of the other determinants of health such as genetics, or those that are social or economically related. In New Zealand, women disadvantaged in terms of education, economic and social resources are more likely to have health issues that result in poorer pregnancy and childbirth outcomes. The ability to draw on health resources and make the kind of individual lifestyle and behavioural adjustments advocated by neo-liberal inspired policies has been said to be a luxury only white, middle-class members of society can afford (Crawford, 1980). By focusing on the individual and individual lifestyle choices, the rhetoric of personal choice and responsibility depoliticises health by steering the focus away from social, cultural, political and economic factors associated with health.

In today's society health has come to represent much more than the absence of disease. Health has become a virtue and, as such, the individual imperative to strive for wellness has become more pronounced.

Wellness as a virtue

Within the popular health movement, health is understood as more than a physiological or biological state. Part of the popular health movement has been the rise in "healthism", defined by Crawford (1980, p. 368) as:

> … the preoccupation in personal health as a primary – often the primary –focus for the definition and achievement of wellbeing; a goal which is to be attained primarily through the modification of lifestyles, with or without therapeutic help.

Crawford (1980) describes this preoccupation with personal health as pervading USA culture (and I would suggest equally, New Zealand culture), as evidenced by the growing interest and burgeoning industries in; exercise, health clubs, dietary supplements, weight loss and stress management. Optimal personal health is the goal and this is defined as more than the absence of disease. This is reflected in the World Health Organisation's (2003) definition of health.

> Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease of infirmity.

No longer are we as a society content to be free of disease but we are struggling to achieve a new "high level wellness" that is inclusive of; high self-esteem, happiness, a sense of purpose in life, a feeling of joy, achievement of self realisation and a commitment to and motivation for living (Crawford, 1980, p. 380). Personal health is seen to lie within the sphere of personal control. For Crawford (1980, p. 378), this new approach to health encompasses "…an ideology of self-improvement which insists that change and health derive from individual choice".

Personal choice and individual responsibility are seen as the mechanism for achieving health and wellbeing and this belief demands that the recipient of health care becomes an active agent in the quest for health and self-determination. In healthism, Crawford (1980, p. 380) sees healthy behaviour becoming a "paradigm for good living". Within this approach an array of experiences collapse under the umbrella of health and an array of values collapse in health values.

In an argument similar to Crawford's, Rose (1994, p. 67) contends that "health" has replaced other virtues or values within our society and has become one of the central concerns around which we "compose a style of life for ourselves". With this the remit of medicine has extended beyond the limits of illness to include wellness or normality. Drawing on the work of Foucault, Rose (1994, p. 68) suggests that this "new regime of the self" was made possible by a reorganisation of our relationship to individuality. This is the focus of Foucault's (1973) work in "The birth of the clinic". In this, Foucault describes the role of the clinic and the "mutations" in the way that medicine understood disease and the individual. The anatomo-clinical method and clinical experience made possible a positive knowledge and a science of the individual. As illness was clearly located in the individual body, medical rationalities gradually eliminated other understandings of suffering (such as spiritual) in favour of a focus on health and happiness (Rose, 1994). As Rose (1994, p. 68) comments;

> Thus we should not be surprised that health has replaced salvation in our ethical systems, that the doctor has supplanted the priest, that the discourse of medicine has

become saturated with questions concerning the meaning of life.

The doctor has become an expert in the art of living (Rose, 1994) and medical and moral values have become conflated as individuals are exhorted to transform, improve and discipline themselves in a quest for health or as insurance against illness (Crawford, 1977; Rose 1994). Health and wellness as concepts in our society have become charged with moral overtones.

The moral overtones influencing expectations around health behaviour of the pregnant woman are even more pronounced and so is the propensity toward blame. Women are blamed for any perceived imperfections in their baby, whether they are physical or otherwise (Gregg, 1993). Women have begun to censure not just their physical behaviour but their very thoughts and emotions in fear that these may have a negative psychological or emotional impact on their baby (Gregg, 1993). There are so many choices for women to make and it seems everyone is watching and waiting to make judgements.

The consumer mirage

The construct of the consumer features prominently in public health policy and health literature. Is health care really a commodity like any other and do we really treat it as such? Irvine (2002) suggests that it isn't well-established as a practice for recipients of health care.

> In the concrete world of living actors, it appears that people continue to think and act in a manner consonant with traditional models of patienthood.
>
> (Irvine 2002, p. 31)

Lupton's research (1997b) suggests that those more likely to engage in consumerist-type behaviours are younger, well educated, professionals. Even so, their approach and behaviours are not fully driven by consumer imperatives because health care, unlike other commodities, entails a high level of emotional investment and is not undertaken as a "purely rationalist response to the perception of a need" (Lupton, 1997b, p. 379). While health care choices are constructed in this new environment as an "outcome of an

individualised calculation" (Lupton, 1997b, p. 379) they are in fact much more complex.

A number of authors and researchers in health and sociology view the emergence of the consumer construct in health care sceptically. Irvine (2002) considers that the concept began as a grassroots resistance to medical authority but has since been appropriated for other ends. The last decades of the 20th century in many western nations, have witnessed a changing political, social and economic landscape. There has been a trend to privatisation, deregulation, economic rationalism and the embracing of a new managerialism with a shift to more market-driven economies. The medical profession has enjoyed considerable power and status within our society, clinging protectively to what is described as their right as professionals to be autonomous and to make independent clinical decisions. Direct threats to this autonomy are translated as threats to the quality of patient care.

The economic rationalisation of the managerial imperative comes head-to-head with professional authority and autonomy. Consumer discourses are a convenient ally for the managerialist approach as it confronts professional authority while seemingly providing the consumer with an improved service. Irvine (2002 p.38) states;

> …at the level of everyday practice, the language of the health consumer is a vehicle which transports unpopular managerial reforms into health care institutions. It is also a useful instrument which legitimates the penetration of the state into the professional domain; through an appeal to higher principles of 'consumer interests'.

The notion of the consumer is problematic in that it harbours potential for disorder. So while on the one hand the construct is encouraged there are processes in place that act to constrain true choice and consumerist behaviours toward health care. Irvine (2002) says that health institutions develop strategies, which limit the potential for disorder by disciplining subjects in a variety of ways to mange the risk of non-compliance. There is a range of techniques that "undermine resistance and instil self discipline" (Irvine, 2002, p.41). Foucault's (Burchell, Gordon, & Miller, 1991) elaboration of the concept of governmentality is useful to understanding the way that populations are controlled and true choice (and thus consumerist behaviour) is limited.

Governmentality

Foucault (1995, 1990, 1992) draws together two important themes in his concept of governmentality: the disciplined social body and care of the self. In his earlier works (for example "Discipline and punish. The birth of the prison", "Madness and civilization. A history of insanity in the age of reason"), Foucault (1995, 1965) focuses on institutions of social control such as education, medicine and the penal system. These institutions produce, and are produced by, discourses that function to construct and thus define normality. Those not conforming to a certain construction of normality are labelled deviant. Within these discourses regimes of truth operate to discipline individuals and thus bring them in line with normalised patterns of behaviour. Foucault's elaboration of Bentham's panopticon as a disciplinary technique alludes to the thesis of self-surveillance or governance that he develops in his later works (such as "The history of sexuality"). Technologies of the self describe the way that individuals work to construct a self or subjectivity in line with the moral and ethical values predominant within a society (Foucault, 1992; 1986)

Governmentality is achieved through the diffused operation of powers; a subtle and ubiquitous form rather than a heavy-handed power that can be located in any one authority. In governmentality populations are controlled one person at a time as individuals monitor and discipline themselves in line with norms established through prevalent discourses. Those remaining deviants may be disciplined by the more heavy-handed approach of an authority.

Biomedical and neo-liberal discourses unite at certain points to construct powerful norms to which childbearing women are expected to comply. These discourses construct health as an individual project and wellness as a virtue. Self-care practices and lifestyle choices are featured as the central determinants of health and the appropriately responsible individual is one who makes socially sanctioned self-care and lifestyle choices that maximise their potential for health.

Governing choices

While the consumer enjoys certain rights within the health policy and social context,

these rights are accompanied by a set of responsibilities. We function in a society that has expectations of "normal", correct, behaviour. These normative discourses establish correct modes of thought and set the standards, boundaries and ground rules of acceptable and competent conduct. They act to ensure that individuals in taking up their rights as consumers

> … take charge of their conduct by actively monitoring their behaviour for its acceptability and competence, to ensure that they use their autonomy "correctly". (Irvine 2002, p. 41)

Kirkham and Stapleton (2004) report on research into the use of the MIDIRS (Midwives Information and Resource Service) informed choice leaflets in the UK. They describe a culture within the National Health System that supports and encourages certain consumer decisions over others, thereby sanctioning "right" decisions and "correct" consumer and midwifery behaviour.

There have also been many examples both locally and internationally where women's rights to choice and self-determination have been constrained because they have been seen to be making irresponsible choices. Examples at the extreme end of the spectrum include enforced caesarean section or blood transfusions (Ratcliff, 2002). There are some subtle and not so subtle forces shaping our choices. Women are not free to make any choice but only those that are considered to be within the realms of what is normal and responsible (Anderson, 2004; Katz Rothman 1990). Interestingly, choices that support the dominant medical and scientific discourses such as elective caesarean section without medical indication are often not considered irresponsible or irrational. They are rationalised and normalised with recourse to the biomedical construction of normal childbirth as a risky event.

The biomedical discourse of health and childbirth continues to be highly influential, socialising women long before they enter the childbirth services "market place". When childbirth is understood as a risky event and medical technology and intervention as key to moderating this risk, then many options will not be considered choices at all. This is evidenced by the fact that so many women choose to birth in hospitals despite the evidence supporting the safety of homebirth (Leap, 1996).

Our medicalised health context and feto-centric medical and legal environment (Gregg, 1993) combine to put women in an invidious position in regard to choice in childbirth. They are pressed to demonstrate that they are being responsible and they are doing everything possible to ensure a healthy outcome for their baby. Often this is understood as taking advantage of medical "advances" and technologies. Those women declining to take advantage of these services are viewed with suspicion. Women are driven toward medical and technological monitoring and intervention by our social and cultural contexts, so many of the "choices" we suggest women have, are not really choices at all.

Advances in technology have extended the gaze of medicine beyond the childbearing women to that of her growing baby. Ultrasound scanning technologies, for instance, not only scrutinise the gross anatomy of the fetus but also reveal the sex of the fetus and demonstrate breathing, thumb sucking and hiccoughs. Three-dimensional images further show us the facial features and rounded body of the fetus, perhaps highlighting family resemblances; bringing the fetus to life long before it has drawn its first breath. Surgical and other interventions (such as blood transfusions) can now be applied directly to the fetus. Few will forget the powerful image from Life Magazine (Hollandsworth, 1999) of the tiny fetal hand grasping the gloved hand of the surgeon in a photograph of one of the first fetal surgeries. The photograph depicted fetus and surgeon united in an emotive and powerful alliance, but (significantly) the baby's mother did not feature in the photograph. Paradoxically, as these technologies personalise the fetus they objectify (and sometimes vilify) the mother. She is looked past and through to access the newly-constructed patient and citizen, the fetus.

As "patient" the fetus is accorded the rights of citizenship; rights that are frequently advocated for by Christian, "right to life" and medical groups. The biomedical discourse of childbirth constructs the mother's body as inherently flawed and as representing a potential threat to the fetus. As such, a host of monitoring and screening technologies have been developed and introduced into routine maternity care. These monitoring and screening technologies include; amniocentesis, ultrasound scanning, various blood tests, blood pressure, palpations, cardiotocographs, urinalysis, and vaginal swabbing. As a group of midwives participating in this study complained, because these technologies have become routine midwives feel pressed to offer them but in

doing so, this makes midwives complicit in the biomedical construction of the flawed maternal body and the risk-laden pregnancy.

Women are exhorted to take advantage of the technologies associated with childbirth with the implicit promise that they will be ensured a safe journey through pregnancy and a positive outcome. As society has become increasingly medicalised, and as the fetus has become a citizen or patient within the biomedical discourse of childbirth, the mother is morally obliged to do everything humanly possible to ensure a healthy outcome for her baby (Gregg, 1993). This includes not only making use of available technologies but also in disciplining her own behaviour, diet (Markens, 1997) lifestyle choices and sometimes even her thoughts and emotions (Gregg, 1993).

In taking up the subject position of responsible consumer, most women willingly comply with the norms constructed by the biomedical discourse of childbirth. To do otherwise is to be deviant and this brings great risk. The empowered consumer that the neo-liberal discourse constructs is not as empowered and not as free as the rhetoric would have us believe. We find that in health care and particularly in childbirth women are heavily circumscribed in their choices.

Conclusion

In 1990, neo-liberal politics provided the context into which the midwife was reborn as an autonomous service provider. The neo-liberal consumer is a powerful construct in New Zealand's health care system with consumer rights protected by law. For feminists and holistic, popular health advocates the right to choose represents a shift in the power balance from health professional to the recipients of health care. The act of choosing is associated with empowerment; an idea that has been taken up by midwives. Midwives interviewed for this study, construct childbearing women as consumers who are required to make a number of important choices throughout the childbearing period. Most midwives participating represent the act of choosing as a maternal responsibility and prefer to distance their own professional or personal values from the woman's decision-making. The childbearing woman's role in the midwife/woman partnership includes making informed choices and the midwife's role for the most part, is perceived as providing information from which these choices will be made.

While the rhetoric of individual, free choice suggests that women and other consumers are empowered by the consumer experience, the biomedical discourse engenders a variety of techniques that serve to discipline consumer choices. The fetus has emerged as a new citizen within the biomedical discourse and the rights accorded the fetus serve to burden women with heavy responsibilities vis-à-vis the welfare of the fetus. The biomedical discourse constructs the woman's body as a potential adversary to the fetus and therefore advocates medical monitoring and surveillance of the woman throughout pregnancy. In taking up the position of responsible consumer, women willingly comply with the monitoring and surveillance technologies because to do otherwise is to risk much.

As the biomedical discourse predominates, midwives participating here find themselves in a precarious position regarding informed choice. They construct the provision of information as an important role of the midwife and the increasing array of technological and monitoring technologies as choices. In doing so they are at once supporting the construction of the neo-liberal consumer and also the faulty maternal body of the biomedical discourse. Some midwives also acknowledge the influential role they play in directing women's choices. This point will be discussed further in the chapters to follow.

The neo-liberal social and political climate has been particularly influential in allowing the emergence of a more autonomous midwifery in New Zealand. The next section of this thesis explores the way that contemporary midwifery emerged in New Zealand from the 1980s to 90s, constituting a new professional midwifery.

Chapter 5: A Place to Stand

(Re)-Making midwifery and the professional midwifery discourse

This chapter describes the context that engendered the professional midwifery discourse and the strategies that authorised and legitimised this construction as the official midwifery in New Zealand.

Introduction

Though women in childbirth have always sought the support of others, midwifery is not a natural phenomenon that transcends context, time and place. Rather, midwifery emerges out of a social, political, economic and cultural context and it is this context that gives midwifery its shape: a midwifery that will be different to midwifery of other contexts, times and places. Therefore, what it means to be a midwife and what the practice of midwifery entails cannot be seen as essential, stable or coherent.

This chapter describes the social and political context, which shaped the "new" midwifery in New Zealand. This "new" midwifery emerged in the late 1980s as a result of childbirth and feminist activism. The New Zealand College of Midwives has been a key player in constructing and professionalising midwifery in New Zealand, moving it from the margins to the mainstream. The professional midwifery discourse is embedded in professional, contractual and regulatory frameworks thereby reifying this construct of midwifery by directing (disciplining and regulating in a literal and Foucauldian sense) the practice of midwifery and constituting the subject position midwife. Midwives participating in this study are constituted by the professional midwifery discourse, which highlights the primacy of independence and autonomy, woman-centredness and continuity of care. Their voices are introduced later in the chapter following exploration of the influences giving shape to contemporary midwifery in New Zealand.

Marginalised midwifery

Midwifery in New Zealand was first legislated in 1904, providing for the training and

registration of midwives and the establishment of St. Helens Maternity hospitals, which were to function as training hospitals for midwives. Nightingale's "notes on lying-in institutions" influenced this midwifery-training programme and traditional modes of care were replaced with a "modern" medical focus. Medical practitioners and hospital matrons taught these programmes (Cooper, 1998) and although doctors were called into the St. Helens hospitals for emergencies, these maternity hospitals were managed and staffed by midwives.

As early as 1925 midwives and nurses were represented under the one Act in New Zealand: the Nurses and Midwives Act 1925, and throughout the 1900s midwifery as a profession distinct from nursing was eroded. From 1957 maternity education had become a part of the three-year general nursing training and those nurses wishing to specialise in midwifery could undertake further six-month training at a St. Helens hospital. Direct entry midwifery training was phased out (Tully, 1999). In 1971 legislation further eroded the role of the midwife by removing their legal right to practice independently[20]. Midwives were required to work under the supervision of a medical practitioner, ratifying what had become the status quo (Tully, 1999). Some midwives did continue to provide domiciliary (homebirth) midwifery care though the payment available for this was minimal and these midwives were reliant on obtaining the support of a sympathetic medical practitioner. Mainstream doctors and midwives, however, marginalised these midwives as they were considered "mavericks" and the women choosing homebirth as the "lunatic fringe" (Donley, 1989, p. 7).

By 1979 recommendations of an influential report; the Carpenter report, began to impact on midwifery education as training programmes at the St. Helens hospitals were phased out and the only route left to midwifery was through the postgraduate Advanced Diploma in Nursing. This programme entailed just eight to nine weeks of obstetric theory and practice (Donley, 1998). Many midwives throughout this period sought midwifery training overseas (Donley, 1998). Nursing had subsumed midwifery; midwives were regulated by Nursing Council and represented professionally by the Midwives Section of the New Zealand Nurses Association. Further threats to domiciliary practice loomed. Midwifery at this time was at its lowest ebb.

[20] Independent midwifery previously referred to midwives working independent of hospital or other employment, referring mostly to domiciliary midwives providing continuity and homebirth services. The term now frequently includes any midwife carrying a caseload as Lead Maternity Carer whether employed or self-employed.

Coinciding with the discontent of midwives (and for many of the same reasons), childbearing women began to express their dissatisfaction with maternity services. They considered that the experience had become too medicalised and the feminist and consumer health activists of the 1970s and 1980s sought to wrest control of their personal health from the medical profession. Their language was one of "rights" and "self determination", and concern for personal autonomy (Cox White & Zimbelman, 1998) reflecting liberal and liberal-feminist political ideology (Annandale, 1998). Within liberal feminist politics the focus is not so much on structural reform but on the right of individuals to make autonomous, rational choices (Annandale, 1998). As Irvine (2002, p. 35) comments,

> With their cognitive competence taken as given, health consumers are understood to be self-actualising, self-activated, autonomous social agents who cannot be subordinated to the professionals, and are capable, with adequate information, of formulating their own intentions, deciding their own preferences and wants, and making rational choices about their fate.

For some women this meant choosing homebirth supported by domiciliary midwives (reflecting a more radical political orientation) or general practitioners who were sympathetic to, or in agreement with their political and philosophical agenda. Women choosing homebirth and domiciliary midwives probably represented a more homogenous group than midwives and their clientele today. Domiciliary midwifery care promised equality within the midwife-childbearing woman relationship and control for the woman over her childbirth experience. They also embraced a more holistic approach to the childbirth experience and a non-interventionist or natural birth philosophy (Auckland Homebirth Association, 1993). As we will see in the following pages, the feminist politics of the homebirth movement was influential in constituting the new professional midwifery that was to emerge in New Zealand.

In challenging the medicalisation of childbirth, women began to petition for choices in childbirth and their right to control what happened to them. As in the United Kingdom (for example Kitzinger, 1979, 1991) and USA (for example Katz Rothman, 1991) a more autonomous midwifery was constructed as the alternative to medicalised childbirth. In New Zealand feminists, homebirth and consumer activists and midwives

have together constituted midwifery as a vehicle for challenging medicalised childbirth.

Aligning midwifery with women

Midwives often allude to a golden era of midwifery where "real" midwifery was practiced before its conquest by medicine. Midwifery and maternity services in New Zealand have undergone dramatic changes since the 1990 amendment to the Nurses Act 1977 with literature describing the re-birth (Surtees, 2003), re-constitution (Surtees, 2003), renaissance, re-creation, re-instatement (Guilliland, 1991) and re-emergence (Guilliland & Pairman, 1995a) of midwifery. The prefix "re" would suggest repetition or re-appearance (Delbridge, Bernard, Blair, Peters, & Butler, 1991), yet it would be erroneous to believe that midwifery has or could return to some golden era of midwifery as if it had lain in wait for times more opportune, to re –emerge; its essential meaning intact.

In 1990 legislation was passed that changed the landscape of maternity services in New Zealand and ushered in a new era for midwifery. Whilst the Nursing Council of New Zealand continued to regulate midwifery under this legislation, this changed in 2003 when the Health Practitioner's Competence Assurance Act (2003) was passed, providing for the establishment of the Midwifery Council of New Zealand. In September 2004 this council assumed regulatory authority for midwifery, thereby separating the professions of midwifery and nursing at the regulatory level. Today the New Zealand College of Midwives is undoubtedly the professional body with the authority to represent midwifery and it enjoys a membership of over 80% of the midwifery workforce (N. MacLean, personal communication, May 24, 2006). Many midwives are self-employed, accessing public funding and public and private hospitals to carry out their care. Midwives are able to prescribe pharmaceutical drugs, order laboratory tests and ultrasound examinations and can refer directly to an obstetric consultant when required (Ministry of Health, 2002a). 78.1% of women now elect a midwife as their lead maternity carer (New Zealand Health Information Service, 2006), and women enjoy continuity of care as the predominant model of maternity care.

Maternity care and midwifery in New Zealand have undergone a transformation since

1990 and throughout this period different groups have hotly contested the meaning of midwifery (and childbirth as a consequence of this debate). In the face of fierce opposition from the medical fraternity, midwifery has established itself as the foundation of New Zealand's maternity service. Midwifery in New Zealand today, is not the midwifery of yesteryear, nor is it midwifery born anew and 'pure'. It is a midwifery that is a product of the discursive framework through which it emerged and by which it is fashioned.

Midwifery is constructed by discourse and as Treichler (1990, p. 132) comments; we cannot "look *through* discourse to determine what childbirth [or midwifery] 'really' is, for discourse itself is the site where such determination is inscribed". What is the shape of this midwifery? What is the meaning that midwives ascribe to midwifery in New Zealand today? How did this meaning and not another emerge as the "truth" or dominant meaning? Again from Treichler (1990, p. 126), "… cultural and semantic work are required to amass linguistic capital; the political, social, discursive, and economic weight required to transform a given meaning into an official definition". The 'cultural and semantic work' and the professionalising processes that have constructed midwifery in New Zealand are explored in this section of the thesis.

One meaning of midwifery that is frequently drawn on today is that arising from its old English definition "mid wyf" meaning "with woman" (Wickham, n.d). In an interpretation that may be somewhat removed from its original meaning, this is taken to mean more than "with" in a literal sense but "with" in an existential sense (Hunter, 2002; Wickham, n.d.). "With woman" is an ill-defined concept and within the current midwifery literature has been interpreted variously as physically and emotionally supporting the woman, understanding the woman and her values, providing care that is centred on the woman and her needs, advocating for the woman and supporting her choices on an individual level and, for women in general, on a political level (Hunter, 2002; Katz Rothman, 1989; Powell Kennedy, 2002; Thompson, 2004; Walsh, 1999). The discourse of midwifery as "with woman" assumes that the interests of childbearing women and midwives are one and the same. Whilst domiciliary midwives and their homebirth clientele may have shared a similar philosophy for childbirth this is not necessarily true for midwives and the diverse group of childbearing women for whom they provide care today. As we shall see in the following chapters, midwives are in fact

negotiating complex situations in which a variety of competing interests shape their practice.

The practice of midwifery has come to be understood as concerned with the support and promotion of natural birth (Banks, 2001; Downe, 2004; Foureur, 2005; Katz Rothman, 1991,1999; New Zealand College of Midwives, 2002; Rooks, 1999). When did midwifery come to be understood thus? Accounts of midwifery practices within the St. Helens hospitals (which were midwife-managed and staffed) in New Zealand reflect a midwifery that was highly medicalised, interventionist, based on routine and ritual, and taking little account of the woman and the quality of her experience (Parkes, 1991). Even in the early days of the St. Helens hospitals when mothers were not medicated, their childbirth experiences would not evoke the concept of 'natural' as we hold it today. This midwifery was inscribed with the dominant discourse of the day in the same way that midwifery throughout history has been. Yet midwifery has come to be constructed as something other than medical and this is perhaps best illustrated by the concepts of the medical and midwifery models of care that are set in opposition to each other.

As chapter 4.2 ("Body politics and natural childbirth discourse") describes, Barbara Katz Rothman (1991) is credited with coining the phrase "midwifery model". Katz Rothman drew on the beliefs and practices of select and marginalised women to construct the midwifery model and posit it as an alternative to the medical model of childbirth. This is not to suggest that Katz Rothman single-handedly transformed midwifery or maternity care throughout the western world. Rather Katz Rothman (1991) was the first to coin the phrase "midwifery model" and in polarising the midwifery and medical models, joined others (for example Kitzinger, 1991) in positioning midwives and medical men[21] on opposite sides of the contested ground that is childbirth. A similar oppositional politics was used in New Zealand to construct the new midwifery post in 1990. The New Zealand College of Midwives has been a key player in this construction, moving midwifery from the margins to mainstream maternity care.

[21] The gender specific term "men" is used here alluding to Jean Donnison's (1977) book "Midwives and medical men: A history of inter-professional rivalries". The differences between the midwifery and medical approach to childbirth are frequently conceptualised as divided along gender lines (see Katz Rothman 1991; Kitzinger 1991)

New Zealand College of Midwives: moving midwifery from the margins to mainstream

At the 1988 National Midwifery Conference a working party of childbirth activists and midwives was established to develop a professional association for midwives (Guilliland, Pairman, & Hasson, 1989). In April 1989 the New Zealand College of Midwives was born. The formation of the New Zealand College of Midwives coincided with the Cartwright Inquiry into the management of women with cervical cancer in the National Women's Hospital (1988). The report highlighted issues related to the status of women within health services and recommended the establishment of a Health and Disability Commissioner whose functions would include the promotion and protection of consumer rights. The development of the New Zealand College of Midwives was largely driven by radical and liberal feminist imperatives that emphasised personal choice and control, and the Cartwright Inquiry served to propel these concerns to the fore.

The constitution of the New Zealand College of Midwives provided for consumer membership and participation at all levels of the organisation. The New Zealand College of Midwives presented the structure of the organisation to its membership in the September 1989 journal issue. Significantly, the organisational chart is inverted and presents individual members at the top of the tree, flowing to the board of management at the bottom of the chart. The New Zealand College of Midwives was divided into ten regional committees each contributing one member to the National Committee. These ten regional representatives, along with three consumer representatives and the board of management, constituted the National Committee. The board of management consisted of six members elected from the regional committees, at least four being midwives (Guilliland, 1989, p. 15).

Formed just prior to the 1990 amendment to the Nurses Act 1977, the New Zealand College of Midwives rapidly became the "official" voice of midwifery, invested with the authority to speak the 'truth' for midwifery. Not only did this organisation speak for midwifery it spoke *of* midwifery and in so doing, began the cultural and semantic work that transformed a given meaning of midwifery to the official meaning (Treichler, 1990).

Codifying the midwifery of the mavericks

The feminist movement of the 1970s gave rise to feminist and childbirth activists whose critique of medicalised childbirth focused on a concern for greater individual choice and control. The role of these feminists and childbirth activists (constructed as consumers within the professionalising rhetoric) in the emerging midwifery profession and in lobbying for changes to the maternity system was profound. They had a significant influence on the shape of the new midwifery to emerge in New Zealand. The political climate of the 1980s and the health reforms influenced by neo-liberal politics, also helped to ensure that the midwifery that developed in the 1990s would be an independent one, independent of the medical profession at least.

The midwifery to emerge as a result of these social, political and historical processes was one that highlighted midwifery's autonomy and independence. In response to the feminist critique of medicalised childbirth practices, the new midwifery was to be "other than" what this represented. Where scientific and masculinist discourse constructed women and their doctor in a hierarchical relationship, midwifery would construct the midwife-woman relationship as an equal partnership. Where biomedicine constructed women's subjective knowledge and experiences, and their emotional needs or desires as subordinate to a narrowly defined concern for physical outcomes, midwifery would do otherwise. Midwifery would appreciate the woman in a holistic sense and seek to provide her with an experience that was rewarding in a broader sense than encompassed by physical outcomes. Where care within the medically dominated childbirth services was fragmented (that didn't allow for knowledge of the woman holistically), midwifery care would be based on a continuity model that allowed the midwife and woman to establish a relationship of trust and understanding. Where the biomedicine determined treatment options based on scientific, biophysical knowledge and intervention, midwifery would include a more "alternative" conceptualisation of health and health interventions.

This model of midwifery already existed in domiciliary midwifery practice, the midwifery of the "mavericks" (Donley, 1989, p. 7), who practiced independently of hospital employment prior to 1990. Constituted by natural childbirth and feminist discourse, domiciliary midwives represented a marginalised group, who were resistant

to the dominant biomedical, scientific and patriarchal constructions of childbirth. As the New Zealand College of Midwives set about constructing New Zealand's "new" midwifery the midwifery of the domiciliary midwives became codified (Daellenbach, 1999). This codification occurs as official definitions are established, declarations are made (such as consensus statements), standards of practice, codes of ethics, and competencies are developed, and these provide the basis for regulatory practices such as those developed by the Nursing Council, the Midwifery Council and the New Zealand College of Midwives. In this way, a discursive framework emerges which works to construct midwifery as a profession, the subject position of midwife and the practices of midwives. This construction however, derives its meaning from its binary opposite, "medicine".

Oppositional politics

Chapter 3.1 ("A feminist, poststructural approach to research") describes the binary logic that underpins western philosophy and the patriarchal (and Euro-centric) interests that construct hierarchical relationships between polarised concepts. The privileged side of the binary is often inscribed as masculine. Annandale and Clark (1996) remind us that concepts such as man and woman, black and white, medicine and midwifery are "…discursive categories created through the use of binary logic" (p. 21). Midwives, feminists and childbirth activists have embarked on a strategy of constructing midwifery in opposition to medicine but in so doing have profoundly linked midwifery to its antagonist, medicine. Midwifery derives its meaning from medicine. Annandale and Clark (1996, p. 30) suggest that this results in a poor understanding of midwifery.

> The demarcation between obstetrics and midwifery begins to explain why we have an extremely poorly drawn picture of 'alternatives' (be it in childbirth or any other area) – they exist in opposition to dominant practice 'A' but they do not appear as 'B', but as 'not A'.

This oppositional approach has two problematic effects. Firstly, it means that if we embrace or valorise one side of the binary we unwittingly reinforce this polarisation and women's alignment with the negative pole. As Cocks (1984 in Annandale and Clark, 1996, p. 28) writes;

> What both feminists and phallocentrists see as hegemony based on masculine perceptions of domination, performance hierarchy, abstraction, and rationality finds its antipode in a woman's community proclaiming itself as naturally nurturant, receptive, cooperative, intimate and exulting in the emotions….[feminists] assume that such principles exist and that they have been fixed and dichotomous since the dawn of patriarchal history…. Thus it is that the dominant culture and the counterculture engage in a curious collusion in which, a rebellious feminism takes up its assigned position at the negative pole.

Secondly, securing a definition by cohering around a polarity presses us toward a narrow definition of midwifery (or natural birth for example) and may obscure what could be multiple ways of being a midwife or doing midwifery. This narrowed definition might not accommodate all those who are being spoken for, serving to alienate some and (as in the wider feminist movement), raising the issue of who is speaking for whom. Whose meaning of midwifery is privileged and what or who is marginalised as a result?

Clearly a coherent and universalising, though oppositional, construction of midwifery has been successful in professionalising midwifery in New Zealand. Many feminists argue that a coherent and stable sign (such as woman or midwifery) is in fact necessary for a feminist politics. How can we advance the cause of women or midwives if we cannot agree on what in fact constitutes the category of woman or midwife? What sort of understanding could accommodate the multiplicity and fluidity that exists in these subjectivities and how could this act as a basis for political activity? These are complex issues that continue to engender heated debate and controversy within the wider feminist movement (Braidotti, 1994; Hartsock, 1996; Martin, 1988; McLaren, 1997; Ransom, 1993; Sawicki, 1996) and are issues with which midwifery must engage. The final chapter of this thesis returns to this discussion.

NZCOM: Speaking for and of midwifery

The formation of the New Zealand College of Midwives in 1989 was a watershed moment for midwifery in New Zealand, for many reasons. NZCOM was the only national body concerned specifically with midwifery and quickly became the

recognised and authorised voice of midwifery, playing an important role in constructing the profession, as we know it.

NZCOM represented midwifery before Select Committee hearings as the Bill proposing Amendments to the Nurses Act 1977, progressed through parliament. Before the Bill was passed a supplementary order was added which nominated NZCOM "…as the body with the authority to negotiate fees for independent midwives with the Minister" (Donley, 1990, p. 7). In 1993 NZCOM represented midwifery at the Maternity Benefit Tribunal that was to review the basis for funding of maternity services in New Zealand. The medical profession sought to have midwives funded from a separate schedule to medical practitioners, a move that would remove the parity of midwives and the medical profession in terms of funding for maternity services. By this time NZCOM's position as the authoritative voice for the midwifery profession was well established. Their representation of midwifery continued into negotiations concerning health reforms and health service restructuring in 1993.

The Amendment to the Nurses Act 1977 also allowed the New Zealand College of Midwives to nominate a member to the Nursing Council of New Zealand, which continued in its role as regulatory body for midwifery in New Zealand. Karen Guilliland as president of NZCOM was the first ministerial midwifery appointment to the Nursing Council of New Zealand (Guilliland, 1991). Among other functions, the Nursing Council was responsible for setting the standards for midwifery registration and also for approving midwifery education (including the new 'direct entry') programmes that would lead to registration. The New Zealand College of Midwives' membership on Nursing Council was important as it provided the college with an important vehicle for securing a particular construction of midwifery through the practices associated with the sphere of influence of the Nursing Council.

In 1992 Karen Guilliland, president of the New Zealand College of Midwives, took up the position of part time co-coordinator of the college. Sally Pairman was elected as president. These two midwifery leaders have continued to play an important role in shaping midwifery in New Zealand. Both have served for periods on the Nursing Council of New Zealand and Sally Pairman was recently appointed to the inaugural Midwifery Council (elected as chairperson). Guilliland and Pairman published "The

Midwifery Partnership. A Model of Practice" in 1995 (Guilliland & Pairman, 1995a). This model draws heavily on domiciliary midwifery practice or 'the midwifery of the mavericks' as Donley described in 1989. Midwifery as partnership is central to the professional midwifery discourse and is constituted by the concepts of midwifery autonomy, woman-centred care, continuity of care and normal birth.

Midwifery as partnership

The New Zealand College of Midwives constructed the midwife/childbearing woman relationship as one of partnership from its beginnings, through its constitution and organisational structure. This idea of midwifery as a partnership with the lay woman (at individual and professional levels) arising from the particular social and cultural context within which midwifery emerged, has been a key element in midwifery's strategy to produce a "distinctive service" (Tully, 1999, p. 36), by constructing "… a collective professional identity which distinguishes midwives' philosophy, skills and services from those of other health professions" (Tully, 1999, p. 46). This construction is reified as it becomes embodied in "official" texts such as the Midwifery Code of Ethics and Standards of Midwifery Practice (New Zealand College of Midwives, 2002), the Nursing Council of New Zealand's Competencies for Practice (Nursing Council of New Zealand, 2000) and, ministerial documents such as the "Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000" (Ministry of Health, 2002).

The June 1992 issue of the New Zealand College of Midwives journal reports on an NZCOM workshop at Victoria University where thirty-nine people came together to develop the Code of Ethics. The Code of Ethics and the Standards of Midwifery Practice were published in 1993 (and updated in 2002) by NZCOM as the "Midwives Handbook for Practice" (New Zealand College of Midwives, 1993). The introduction states that the document "…identifies the beliefs that Midwives hold about Midwifery" and that it " …sets in place a system for the profession and the public to be able to judge both individual practitioners and the Midwifery Service" (NZCOM, 1993, p. 5). The philosophy states that midwifery; is concerned with the promotion of wellness, that its epistemological base reflects both arts and sciences, it is collaborative, approaches the woman in a holistic way, is empowering, takes place in partnership with women,

and, finally, that continuity of care "enhances and protects the normal process of childbirth" (New Zealand College of Midwives, 1993, p. 7). Bronwyn Pelvin (1992, p. 7) wrote an article in the December 1992 issue of the journal commenting on the production of the "Midwives Handbook for Practice" and exploring the ethical principles underpinning midwifery stating, "Midwifery *must* be done in relationship with the woman,…".

For Pelvin this relationship can only be established through continuity of care and,

> If you as a midwife don't have that knowledge of the woman … you are unable to *be* her midwife…. You will be able to care for her, you will be able to give her good care but you are not able to be *"with woman"* in any significant way… But let us not mistake providing excellent care with *being* a midwife.

In taking a strong stand on the importance of continuity of care, the New Zealand College of Midwives isolated some midwives who did not see themselves within this construction (for example shift-working, hospital-employed midwives). The first published evidence of this discontent is to be found in the April 1993 issue of the journal, as Henderson (1993, p. 4) writes in a letter to the editor;

> How dare B. Pelvin presume to choose in which way midwifery should be practiced for me, the consumer, by stating that continuity of care should be THE midwifery model. She belittles the vast majority of her midwifery peers by damning fragmented care.

The Code of Ethics and Standards of Practice were published in 1993 (New Zealand College of Midwives, 1993). The first points of the code of ethics read:

> Responsibilities to Clients
> a) Midwives work in partnership with the woman
> b) Midwives accept the right of each woman to control her pregnancy and birthing experience
> c) Midwives accept that the woman is responsible for decisions, which affect herself, her baby and her family/whanau.

d) Midwives uphold each woman's right to free informed choice and consent throughout her childbirth experience.

(NZCOM, 1993, p. 10).

The Standards of Midwifery practice follow. There are ten standards, each with more detailed criteria:

1. The Midwife works in partnership with the woman.
2. The midwife upholds each woman's right to free and informed choice and consent through the childbirth experience.
3. The midwife collates and documents comprehensive assessments of the woman and /or baby's health and well-being.
4. The Midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.
5. Midwifery care is planned with the woman.
6. Midwifery actions are prioritised and implemented appropriately with no Midwifery action or omission placing the woman at risk.
7. The Midwife is accountable to the woman, to herself, the Midwifery profession and the wider community for her practice.
8. The Midwife evaluates her practice.
9. The Midwife dissolves the Midwifery partnership.
10. The midwife develops and shares midwifery knowledge and initiates and promotes research.

The Code of Ethics and Standards of Practice clearly reflect a feminist (and neo-liberal) re-visioning of midwifery and require the midwife to work in collaboration or partnership with the childbearing woman. While there has been some debate as to whether the standards represent ideal or expected practices, they are nonetheless important because, in setting out the profession's expectations for practice, they function as a benchmark against which midwifery practice can be assessed in a variety of contexts, including the legal and disciplinary. As such they form part of the regulatory framework in which midwives function.

The concept of partnership and midwifery practice was further developed by Guilliland

and Pairman as the "The Midwifery Partnership: A Model of Practice" published as a monograph (Guilliland & Pairman, 1995a). Within this model midwifery is constructed as; being primarily concerned with normal birth, having emancipatory potential, and concerned with providing woman-centred care. Midwifery care is provided within the context of a relationship between the childbearing woman and midwife that is not hierarchical in terms of power (described as partnership) that can only be developed through a continuity model of service delivery. They are emphatic that midwifery is defined by continuity of care stating:

> When midwives practice in an environment which excludes continuity of care, they cannot be described as practising midwifery under our definition because they rely on another discipline to provide aspects of the total service. As midwives they will be bringing to their service elements of the midwifery philosophy …but they will not be practising midwifery in its full tradition.
>
> (Guilliland & Pairman, 1994, p. 6)

And

> Ultimately, midwives who for whatever reason, choose to provide fragmented care such as labour care only or delegated care, are acting as midwives but are not independent in their practice and therefore are not practising midwifery.
>
> (Guilliland & Pairman, 1994, p. 7)

The authors state "This monograph presents a descriptive model of midwifery as a partnership between the woman and the midwife, derived from 'research' in practice, and reflection on our personal experiences and practice as midwives" (1995, p. 7). They also comment that the concept of partnership as described in the New Zealand College of Midwives Code of Ethics and Standards of Practice were "…generated from practice and from women's experiences, and documented by practitioners, consumers and educators over a period of two years from 1988 to 1990, culminating in the publication, "Midwives' handbook for practice in 1993" (1995, p. 8-9).

I would suggest that the dominant model of care in the time leading up to the publication of the Code of Ethics and Standards of Practice would have been highly

medicalised and hospital-based and would not, in the main, have reflected a partnership approach to the woman and midwifery relationship. This partnership model was more reflective of domiciliary midwifery practice, which was a small and marginalised group rather than mainstream. So, rather than the partnership model being descriptive of the mainstream midwifery practice of the time and rather than the concept of partnership (within the Code of Ethics and Standards of Practice) being generated from the majority of women's experiences or midwifery practice, the experiences and practices informing these documents (or philosophical positioning) were of a select group of midwives and women with a particular vision or concept of what midwifery could and should be. This strategy is reminiscent of that used by Katz Rothman (1991), in the development of her midwifery model. Katz Rothman's vision of what midwifery 'should be' was fashioned from the practices of marginalised groups who presented an alternative to mainstream medicalised childbirth. New Zealand has been particularly successful in moving this construction from the margins to mainstream and in so doing, staking a claim for a particular area of expertise or distinctive service (Tully, 1999).

Karen Guilliland and Sally Pairman have been key players within the professionalising project of midwifery in New Zealand. Their work has been highly political, with an eye to the future of the profession of midwifery as a whole in New Zealand. Their partnership model of practice, conceiving of continuity and independence as necessary to midwifery, can be conceptualised as an important political strategy. Their comment from the monograph is telling in this respect and justifies their stance on independent practice and continuity of care.

> For midwifery to be a profession relies on the majority of midwives practising independently in partnership. In the years leading to the 1990 Amendment midwifery clearly understood the need for autonomy in order to have a professional identity. … Without independent practice provided throughout the whole maternity experience, midwifery reverts to an occupation, midwives lose their 'with women' status, and women lose the opportunity for an alternative childbirth service. (Guilliland & Pairman, 1994, p. 7)

Guilliland and Pairman (Guilliland & Pairman, 1995b) in responding to criticisms of the model, comment:

> In order to be a profession we must offer a service that is unique otherwise we cannot describe midwifery as a profession. Continuous total care throughout the normal experience of pregnancy, birth and the postpartum is only provided by midwives. … Continuity of care is therefore required in order to fulfil the demands of professional status (p.6).

In Tully's (1999, p. 52) words, this construction

> … provides a framework of practice which can be used by one group to construct its work in a particular way in order to make claims over it vis a vis another group/ profession. In this sense the reformed model of professionalism, with its different constitution of 'expertise' is strategic rather than 'new'.

One of the effects of this construction has been to alienate midwives whose practice is not supported by this construction, for example employed midwives or those who do not provide continuity of care. This has created a perception that the New Zealand College of Midwives is an organisation that focuses on the needs of independent midwives rather than those in employed situations. The April 1995 issue of the journal published several letters to the editor reflecting these concerns.

> For the College of Midwives to support a paper that suggest midwives in hospital settings are not practising midwifery is at best irresponsible and at worst downright dangerous. It encourages divisiveness within the midwifery profession. …. This paper serves to reaffirm the opinions expressed in the Wellington NZCOM conference, that the College is focussed on the interests of the independent practitioner. (Rose, 1995, p. 4)

> This division has been intensified by the publication … when Karen and Sally speak of political activity leading to a greater understanding of the relationship between women and midwives, they must be aware they are speaking of *some* women and *some* midwives. If NZCOM is to be truly representative of midwives, then some definitions must be broadened. (Churcher, 1995, p. 5)

To some degree this polarisation is still felt within the midwifery community, as

evidenced by the following dialogue in one of the interviews for this study.

> … well, a lot of the core midwives of course they're all members of the Nurses Organisation who never actually joined the College [of midwives] and regard the College with suspicion because they feel as though it's trying to run their lives. And the focus of the College had been on independent midwifery, on continuity of care. This was very threatening to them and they felt un-included because they weren't providing continuity of care, so they therefore felt that people who were members of the College did not regard them as midwives. But there were people in the College who felt that you had to be doing independent, offering continuity of care to be a midwife. … it's taken quite a while to get over that I think, and to get core midwives joining the College and realising that really most of us are just midwives. … yeah there is a lot of suspicion of the College by core midwives and it's still there, to an extent, not as much as it used to be.
>
> (Interview 260503, text units 429- 445)

Continuity of care and independent, autonomous practice were not just constructed as important concepts to midwifery but as essential to the identity of midwifery and the survival of the profession. Understanding the recent social and political history of midwifery and the debates that have occurred help explain the important place that continuity and independence holds for the midwives in this study. One case-loading employed midwife in this study comments on a sense of a hierarchy within midwifery where independent self-employed midwives are considered "real midwives" and employed core midwives are situated on the lowest level of the hierarchy.

> I don't know what the restrictions of being hospital-employed are. There is definitely a mental one because all your colleagues are independent midwives and see you slightly differently. …. I hate that, like even when [name of midwife] rings me and says you [the researcher] want to talk to a hospital-employed midwife and I think "oh you're just a hospital-employed midwife". I hate that.
>
> Interviewer: How do see yourself in comparison to a self-employed midwife?

> Oh lower, definitely lower. No, independent midwives are like the real midwives and then we are OK, we come in just a little under. That's how I perceive it and then you work on the ward well, you know, you're a ward midwife.
>
> Interviewer: That's lower again?
>
> That could be me, but it probably isn't. I think it's probably a bit of a perception because that's what our training as direct entry midwives… I mean we trained to be independent midwives, so if you're not really doing that then you're not really cutting it. Everyone accepts that yes some people just can't do on-call work and you do need midwives working on the wards and in hospital, of course we do (inaudible). But yeah it's like it just doesn't have quite the same mana, being a hospital-employed midwife.
>
> (Interview 301101, text units 376 - 389)

As this quotation demonstrates the construction of midwifery being codified and established by the New Zealand College of Midwives has been influential in constructing midwifery subject positions. The professional midwifery discourse has been so influential that the subject positions of midwives prior to 1990 (that would have privileged those midwives working in higher technological environments such as delivery suite, secondary or tertiary hospital settings) has been inverted so that those midwives who are self-employed and community-based are now privileged. When midwives talk of "real midwifery" they construct a midwifery that is discursively produced by the professional discourse of midwifery. This discourse has been useful as a resource for the professionalising of midwifery in New Zealand but another effect of this has been to alienate midwives who do not identify with this construction.

Continuity of care and partnership are not only important concepts within the professional midwifery arena but also they have become embedded in contractual and regulatory frameworks. The embedding of these concepts serves to reify the professional midwifery discourse and to regulate and discipline midwifery practice in a literal and Foucauldian sense.

Contracting and regulating partnership

Maternity funding in New Zealand was re-visioned in 1993, resulting in maternity providers receiving a set, capped budget for each primary maternity case, and divided into several modular payments. Midwifery faced a significant challenge as the New Zealand Medical Association took the opportunity to attempt to win back a different (and superior) payment schedule from midwives, a venture that was ultimately unsuccessful. The New Zealand College of Midwives was involved in the negotiations concerning the maternity contract, which was finally agreed to in 1996. The contract was developed around the concept of the lead maternity carer who centres the woman as the focus of care and provides continuity of care to the woman throughout her childbirth experience (Health Funding Authority, 1998). Under new legislation the maternity care contract resurfaced as Section 88 of the Health and Disability Act 2000 (Ministry of Health, 2002a), this time stating the vision for the service as follows,

> Each woman, and her whanau and family will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on *partnership, information and choice* [italics added]. Pregnancy and childbirth are a normal life-state for most women, with appropriate additional care available to those women who require it. A Maternity Carer chosen by the woman with responsibility for assessment of her needs, planning her care with her and the care of her baby and being responsible for ensuring provision of Maternity Services, is the cornerstone of maternity care in New Zealand. (Ministry of Health, 2002a, p. 11)

This means that midwives and other primary health care providers are contractually required to provide care in partnership with women. This document makes more explicit the intention that women receive continuity of care from one lead maternity carer. This continuity is to continue wherever possible when women transfer to secondary maternity services. It is evident then that the professional midwifery construction of the partnership relationship and feminist concern for the provision of information and choice has emerged as significant in government policy on maternity services.

While legislation in 1990 provided midwives with a degree of professional autonomy, the regulation of midwifery remained under the auspices of the Nursing Council of New Zealand. The Nursing Council of New Zealand functioned under the 1977 Nurses Act and its amendments and "govern[ed] the practice of midwives by setting and monitoring standards of registration which ensures safe and competent care for the public of New Zealand (Nursing Council of New Zealand, 2000, p. 23). The competencies for entry to the register of midwives (Nursing Council of New Zealand, 2000, p.33) were re-written in 1991 (and updated in 1996 and 1999) and describe four midwifery competencies, each with several performance criteria.

1.0 The applicant works in *partnership with the woman* [italics added] throughout the maternity experience.
2.0 The applicant applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.
3.0 The applicant promotes practices that enhance the health of the woman and her family/whanau and which encourage their participation in her health care.
4.0 The applicant uses professional judgment as a reflective and critical practitioner when providing midwifery care.

There are thirteen performance criteria under the first competency, which highlight the responsibility of midwives to centre on the childbearing woman as the focus of care, to promote her self-determination and empowerment through informed decision-making (Nursing Council of New Zealand, 2000, p.33-34). The professional midwifery discourse of the New Zealand College of Midwives is evident in these competencies and this is important because it works to create legitimacy for this construction of midwifery. The standards for registration and competencies of the regulatory body carry significant power in the disciplining of midwifery in both a literal and Foucauldian sense.

When the interviews for this project were being conducted, the Nursing Council of New Zealand functioned as the regulatory body for midwives. In September of 2004, (under new legislation, the Health Practitioners Competence Assurance Act 2003) the

inaugural Midwifery Council of New Zealand assumed regulatory responsibility for midwifery. With some wording changes and a more explicit statement regarding the Treaty of Waitangi, the Midwifery Competencies and Scope of Practice statement remain largely unchanged.

The professional midwifery discourse constructs midwifery as a partnership with women emphasising midwifery independence and autonomy, the provision of woman centred and continuity of care. The professional midwifery discourse as it is evidenced in the talk of midwives participating in this study is explored in the following paragraphs.

Midwives talking midwifery

Independence and autonomy

With the Amendment to the Nurses Act 1977 in 1990 there was no longer any legal inhibition to midwives providing care under their own authority. Midwives were no longer dependent on hospital employment to receive remuneration for their services and they were no longer dependent on medical practitioners to provide practice directives. Midwives could become self-employed, claim directly from the maternity benefit for their services, order the required pathology tests or ultrasonography, prescribe medications, access hospital facilities and hospital-based services such as publicly funded obstetric or paediatric consultants. Midwives were on a par with general practitioners in terms of payment for services and their ability to access related health services such as pathology services.

Midwives in this study acknowledge that it took some time for both midwives and New Zealand women to become comfortable and confident in independent midwifery practice. In the early days of midwifery independence many midwives worked in shared care arrangements with general practitioners. The general practitioner was able to act as gatekeeper to maternity services, as most women used their services for pregnancy testing. In many instances, the hierarchical and gendered relationships of the previous system were reproduced in this working relationship and rather than "shared" care, the general practitioner dictated the terms of the relationship and the care of the

woman. Many of the midwives in this study elected not to work within the "shared care" model but to provide midwifery-only care to women.

> Initially, we did some shared care with the doctor and we kind of knew in our hearts that that wasn't the direction that we wanted to go and it was probably a couple of years later that we made a decision that if women wanted our care that we'd do midwife-only care.
>
> (Interview 290503, text units 15- 18)

New Zealand women have increasingly taken up the option of midwifery care only (Ministry of Health, 2004). Some of the midwives in the study noted that one of the benefits of providing shared care to a woman electing this option was that she frequently chose midwifery-only care as a return client. Shared care was seen as an opportunity then to expose women to midwifery care. The early years of independent practice were also seen as a proving ground for some of the midwives in the study. They needed to claim their independence and this meant demonstrating it to women.

> ... it was a time also when I think midwives were out to prove just how good they could be at this job and anything a doctor could do, we could do better. And we did, but to our own detriment and there wasn't always great support for us from a professional point of view.
>
> (Interview 28b0503, text units 39-40)

Being independent also means being in control of one's workload and daily work schedule, particularly for those who are self-employed. While the demands of on-call practice are onerous, many of the midwives participating here state that they enjoy the flexibility that comes with self-employment.

Autonomy for these midwives is concerned with making their own decisions rather than having them dictated to them. It is also concerned with taking responsibility for their actions.

> … but the thing is you've got to be accountable for your own practice at the end of the day no matter whether you work in a team and are hospital employed or you are an independent. Once you're a lead maternity caregiver, that's the way I see it,

you're totally responsible and accountable.

(Interview 301101, text units 258-259)

An important element to autonomy and independence is the midwife's responsibility to acknowledge her own boundaries, whether these relate to her practice skills and knowledge or her ability to practice safely if she becomes tired.

I believe I'm a professional, I'm accountable, I'm a big girl, I can say whether I think I want to look after that or not look after that.

(Interview 29b1101, text unit 389)

Midwives in this study discussed "boundaries" sometimes referring to the line between home and work and sometimes referring to their scope of practice. The midwifery scope of practice is a somewhat nebulous concept in New Zealand with different midwives taking a different stand on what this means for them. For example some midwives construct a narrow scope, highlighting their specialist skills in normal birth, believing that their scope of practice does not extend to caring for women with epidural anaesthesia for example. These midwives hand over care to secondary services if a woman requests or requires this intervention. Other midwives construct a broader scope, remaining lead maternity carer when the woman's care becomes highly complex and complicated by medical or other obstetric conditions. Many midwives in this study identify their scope of practice in a fluid rather than static way. For these midwives it is something that is negotiated within each midwife/childbearing woman dyad and within the particular circumstances at the time. The powerful technologies of continuity and woman-centred care shape midwifery in regards to scope of practice.

Woman-centred care

Modern midwifery in New Zealand emerged from a system of care that was dominated by the biomedical discourse of childbirth. Within this discourse, the doctor was the authoritative decision-maker and the woman was expected to comply with the doctor's decisions. The woman's subjective knowledge and her needs, wishes and desires were subjugated by imperatives dictated by the biomedical discourse, which focused on routinised procedures and the physical condition of the mother and baby. The

midwifery to emerge from this discursive framework, (indeed which was made possible by it), was one that would centre the woman as the focus of care. The woman's wishes and her needs as she identified them were to be paramount. Midwifery is strongly constructed by the midwives in this study as being concerned with the individual woman's needs and desires. When I asked midwives what they wanted to achieve with their midwifery care, most mentioned aims that are defined by the woman.

> It's a bit like supporting them to achieve what they want to, you know.
>
> (Interview 220501, text unit 16)

> Well for me it comes down to being with women and for me it's very important that the woman is actually the lead person.
>
> (Interview 260503, text unit 194)

Woman-centred care is an important element of the professional discourse of midwifery. Midwives interviewed for this research reflected on the way that this concept has influenced their practice over time, many acknowledging that concern for woman-centred care perhaps overshadowed other elements in the early years of independent practice. As lead maternity care by midwives has become more commonplace, or the midwives have sought to redress the balance between their professional and personal lives, they have revisited and re-negotiated the meaning of woman-centred care. Woman-centred care however continues to be a hallmark of midwifery practice or the midwifery model of care. Woman-centred care for many midwives participating here is the benchmark against which they judge their midwifery care. Undoubtedly they aspire to a safe outcome for mother and baby but it is not a normal birth or a birth with minimal intervention that defines success for many midwives, it is a birth that the woman feels satisfied with. It is her experience that is central.

Continuity of care

Maternity services in New Zealand prior to 1990 were based on a model of care that was fragmented. While women may have established a relationship with their general practitioner, the midwives who were based in the hospital provided most of the labour

and postnatal care. Typically, women arrived in labour to a birthing area and were allocated to a midwife who was previously unknown to them. Similarly for the postnatal component of the woman's care. Women who laboured for longer than one shift were cared for by more than one midwife and with postnatal stays of up to ten days those in the postnatal area were cared for by many different midwives. Few domiciliary midwives were available and these midwives did not have the ability to care for women in the hospital setting. Women could access a form of continuity of care but this would entail choosing a homebirth, finding a midwife to provide this service and a medical practitioner willing to support this choice. This was a radical choice for many and one that was difficult to arrange. Therefore most women experienced a fragmented form of maternity care and it was in response to women's criticisms of this service model that the new midwifery in New Zealand was fashioned.

Continuity of care was constructed as a defining feature of the new midwifery in New Zealand and it is not surprising then that continuity of care emerges as a significant element in the professional midwifery discourse of the midwives in this study.

Participant 1: What's important to us in midwifery?
Participant 2: Continuity, continuity.
Participant 1: Continuity.
Participant 4: Continuity is the one thing we've been adamant in maintaining.

(Interview 240801, text units 95-98)

I think that it all hinges around continuity of care … providing that experience no matter where a woman is birthing.

(Interview 220501, text unit 151)

Continuity of care for many of these midwives provides them with the opportunity to develop the relationship with the woman that is seen as important for both understanding her wants and needs, her social and cultural context and for building a level of trust. Continuity of care is seen as not just important to the woman but also as important to the midwives' satisfaction with their job.

But what really makes it still enjoyable is the continuity of care isn't it. You see

them from woe to go and when you then get the repeats, they have their second third fourth baby with you, and you think "yeah, great" and you see the family grow and either come together or fall apart and new partnerships form ….

(Interview 240801, text units 115-116)

The concept of continuity of care also plays an important part in shaping the case-loading midwives role in caring for women whose childbirth experiences become complicated by medical, anaesthetic or obstetric conditions. Many of the midwives participating in this study continue to provide lead maternity care to these women, transferring care to secondary obstetric services only for caesarean section. This means that these midwives continue to provide lead maternity care for women experiencing hypertension, diabetes, and induction of labour, for example.

Interviewer: Are you handing over at that point or do you remain LMC?

No, we are always LMC right through yeah. The only time you hand over LMC care to the hospital is for caesareans, emergency caesareans or whatever.

(Interview 28a0503, text units 192 - 200)

This is not to say that these midwives are caring for these women without any input from specialist obstetricians. The role that each practitioner plays in the care of these women varies from place to place and also may be individually negotiated with each clinical situation. Remaining as lead maternity caregiver however carries significant responsibility. The "Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000" sets out the service specifications for maternity care and include explanation of the lead maternity carer role;

The Lead Maternity Carer will take responsibility for the care provided to the woman throughout her pregnancy and postpartum period including management of Labour and Birth. It is expected that, from the time of Registration, all Modules of Lead Maternity Care will be the responsibility of one Lead Maternity Carer who has been chosen by the woman in order to achieve continuity of caregiver. (Ministry of Health, 2002a, p. 11)

While this document does not specify the role of various practitioners it urges practitioners to "exercise wise clinical judgment about the services s/he provides, taking into account the limits of her or his own competency and the Referral Guidelines" (p. 12). Referral guidelines set out a list of health or pregnancy-related disorders or situations and recommend various practitioner actions in relation to these; may recommend consultation with specialist, must recommend consultation with specialist and must recommend transfer of responsibility to specialist.

For many of the midwives participating in this study the technologies of continuity and woman-centred care predominant within the professional discourse of midwifery press them toward remaining as lead maternity carers for women whose experiences clearly fall outside of the scope of normal childbirth. Women who require obstetric input still require midwifery care and the midwives participating in this study describe how these women should not be disadvantaged in terms of their access to continuity of care. In this situation midwives position themselves as advocates of the woman, attempting to maintain the woman-centredness of the childbirth experience.

For some rural midwives their scope of practice was stretched beyond their comfort levels but the provision of a woman-centred service and commitment to maintaining a rural maternity service means that they continue to provide care in situations they would rather not.

Participant 1: We tend to end up carrying on the care for a lot of these secondary-care women … and it has been our experience … that we are getting to do tests and different things that step outside the normal because of this. …

Participant 2: We get a lot of secondary care, to keep women in the community, we do a lot of secondary care.

Participant 1: To keep them home, just stop them having to travel so often.

Participant 2: To keep them with their families.

Participant 3: And the cost.

Participant 1: The cost is phenomenal. Particularly for people who aren't on benefits, low-income families that aren't entitled [to benefits]. [Name of tertiary hospital] don't want them sitting down there.

> Because it's a cost to them. But the women don't [want that either], it doesn't suit their families and their other children ….
>
> (Interview 050603, text units 569 - 583)

The inscribing of risk status upon pregnant bodies is a modern phenomenon that functions as a technology of the biomedical discourse of childbirth. Since men began their foray into the field of maternity care they have focused their practice on the more complex cases, developing instruments, interventions and bodies of knowledge, which were hidden from women. Within a patriarchal social context that privileged masculinist and biomedical discourses, midwives have been aligned with the low risk side of the low/high risk polarisation. In embracing this delimited practice arena midwifery has constructed itself as "expert" or "guardian" of normal childbirth. This positioning has been an important element in the strategies used to gain midwifery autonomy in New Zealand. When the Nurses Amendment Act was introduced to parliament, Helen Clark (then Minister of Health) argued,

> I see the main skill of midwives as being in recognising the limits of their professionalism, and in recognising that their role is with the low-risk births and with healthy mothers who are likely to experience normal births. When a birth seems as though it will have complications that is the time for referral (Clark, 1989).

Within this rhetoric the midwifery role was clearly envisaged as focusing on low-risk, normal childbirth. This alignment of normal childbirth and midwifery was an important strategy for the professionalisation of midwifery in New Zealand. However, the pre-eminence of continuity of care within the professional discourse of midwifery has perhaps attenuated the focus on normal or low-risk childbirth, leading midwives to construct their role as "with women" whatever and wherever their experience may be. In this study, midwives providing exclusive primary, rural or homebirth services tend to construct their role more definitively as, first and foremost, practitioners in normal or low-risk birth. Practical issues for example often prevent rural midwives from providing continuity of care through to the secondary or tertiary setting. They often transport clients to secondary or tertiary hospital by ambulance and need to return with the ambulance or they are left in the urban setting without transport. They may also be leaving the rural area without adequate midwifery cover for the period they are away.

The homebirth midwives participating in this study take varying positions in regards to their role once a woman transfers to a secondary or tertiary hospital. Several remain in the lead maternity carer role while one chooses not to maintain an access agreement and therefore, is unable to continue in a lead maternity carer or midwifery role. This means that this midwife will transfer care to the secondary facility team (employed obstetricians and core midwives) though she can continue to be involved in a support role or as advocate for the woman. For this midwife, her perception is that having an access agreement means that she is expected by hospital staff to behave in a certain way.

> … And then I got an access agreement and then I found that there was an expectation of me to behave in the same way that other people behaved in that environment [the hospital].
>
> Interviewer: Other employed staff?
>
> Yes and that was the very reason why I left there. … I had it said to me recently that it is the expectation that the midwife will support; get the women to understand why the doctor wants this to happen. So, I got rid of the access agreement because every time there was a conflict, I had to explain why a woman chose this and why a woman chose that.
>
> (Interview 27b0503, text units 140 - 147)

In choosing to provide homebirth services only, this group constructs midwifery as focused on normal birth. However the differences between these homebirth midwives demonstrate varied philosophies regarding their role when women require or choose obstetric or technological intervention in childbirth. Most midwives in this study provide care to women choosing to birth in hospitals or at home (some choose not to support women for homebirth). Most of those accessing secondary care facilities continue to care for women choosing epidural anaesthesia or undergoing induction or augmentation of labour. However, one midwife in the study was notable in that, while she did support women as LMC birthing in the hospital environment, she did not continue to provide care to women requiring secondary care services, which she includes as caring for women following epidural anaesthetic.

… I only provide basic midwifery care, I don't provide secondary care and therefore, I usually need to hand over care for those services if they're required.

Interviewer: And does that include epidural?

Secondary care is epidurals included, yep. So I hand over for that reason as well.

(Interview 281101, text units 7 - 14)

Interviewer: So tell me about that, why don't you provide that?

Because it is a secondary care skill and I prefer to be working at a community level. I offer a range of homeopathic remedies for women in labour, I also encourage the use of water, because I think water is awesome, in labour and massage and things

like that. That generally, in a normal way, pregnancy is normal, so labour is normal.

(Interview 281101, text units 95 - 98)

This midwife's understanding of midwifery is primarily constructed by the natural childbirth discourse and for her, continuity of care is a secondary concern to this normal birth focus.

The importance of continuity and woman-centred care within the professional midwifery discourse is sometimes problematic for midwives particularly in regards to self-care.

Negotiating continuity

The demands of independent midwifery are great as midwives commit to ensuring that women have access to care seven days a week, twenty-four hours a day. Midwives need to be on-call for significant periods of time, carrying a pager or cellular phone to remain accessible. The unpredictable nature of the work means that when midwives are on-call they cannot commit (with surety) to other engagements or activities (including sleep) that may be associated with their social or family life or even other work

commitments. This carries a significant burden in the lives of some midwives and it was not until 1999 that the first murmurs acknowledging the issue of self-care appeared in the New Zealand College of Midwives Journal (Rolsten, 1999). Since 1999 a couple of articles have been published (Engel, 2003; Miller, 2002) and a number of presentations have focussed on this issue at the New Zealand College of Midwives Conferences (Auckland Midwives Collective, 2000; Browne, 2004; McLardy, 2002).

All midwives must have back-up arrangements (in case of illness or other unavailability) and midwives throughout New Zealand manage their practice and on-call commitments in varying ways. Some midwives remain on call indefinitely, and this is more or less a burden depending on the size of their caseload. Some midwives arrange structured days off but all struggle with providing continuity of care and meeting their own personal needs.

> I really, really enjoy the continuity of care and for me it's really important …, the trouble with that is that every year we as a group get together and think "now how are we going to structure weekends off?" I mean it just doesn't work for me, because I feel when I sign a woman up and I am talking about the role and continuity of care and everything and I am making a commitment to her to attend her birth…
>
> (Interview 29c0503, text units 37 - 38)

> And we do technically, it never seems to happen that way but technically, we do have every second weekend off. But some of us stay on call for somebody. I try to be really strong and not do that but it's very hard sometimes to turn the pager off.
>
> (Interview 301101, text units 47 – 49)

Continuity of care remains a powerful technology within the professional midwifery discourse, influencing the way that the midwives participating here negotiate the balance between self-care and the provision of continuity of care. Some midwives have re-negotiated the concept of continuity of care to encompass care by colleagues who are of a similar philosophy; 'continuity of care philosophy' rather than 'continuity of carer'.

> And people say "but that's no good because you're not providing continuity" and I

> say "well, you are providing continuity of midwifery care but not by the same midwife". In our practice we are all very similar. We all have very similar philosophies. I suppose we have the same philosophy because if we didn't we couldn't work together. And like I've looked after, been to homebirths with the other midwives on the weekend if their partners have been off and it's like, you're just moving in and out of this very liquid relationship with the woman and the midwife.
>
> (Interview 071101, text units 156 – 160)

Some midwives participating here emphasise the importance of the partnerships they have with other midwives rather than with the childbearing women. It is this partnership that first and foremost has to be developed and nurtured because it is through this partnership that these midwives are able to gain the personal and professional support they require to continue in their role as case-loading midwives.

> Participant 1: It's that relationship building, I think why our partnerships work so well because we have similar philosophies and so its important to us to provide continuity of care but it is also important for us to have some self preservation and time off. So what we've found is the provision of two faces, merging like we are one person and women appear to be pretty content with that. So even though they are seeing two midwives it's like they have the same philosophy so they don't have, generally speaking, conflicting things so what am I trying to say?
>
> Participant 2 We want to form a partnership with the woman but we also have a very important partnership with midwives as well to help make it work for women.
>
> (Interview 050603, text units 97 - 100)

This is an interesting shift in the use of the concept of partnership. While partnership and woman-centred care was once pursued zealously (often to the detriment of midwives themselves) these midwives are drawing on the powerful technology of partnership to legitimise self-care practices.

The concept of continuity of care is fundamental to the construction of the new

professional midwifery in New Zealand and as such forms an important part of the professional midwifery discourse. Continuity of care is not only seen as an important part of these midwives' service but also it plays a role in shaping their identity as midwives and their standing within the midwifery community.

Conclusion

This chapter began by suggesting that midwifery is not a fixed, essential or coherent phenomenon but rather is one that is constructed by discourse. Midwifery in New Zealand has been re-made since 1990 and the liberal feminist concerns of feminist and childbirth activists have been central to the way this midwifery has been constructed. I suggest that a midwifery constructed in opposition to medicine is not a useful strategy for midwifery as it serves to reinforce the gendered binary divisions that underpin this polarising schema.

This (re)construction has become the official midwifery of New Zealand with the New Zealand College of Midwives. Several midwifery leaders have played an important role in this construction and have moved midwifery from the margins to mainstream maternity care. The professional midwifery discourse constructs midwifery as a partnership between childbearing women and midwife, emphasising the importance of midwifery autonomy and independence, woman-centredness and continuity of care. The professional midwifery discourse works to construct the practice and subject position of midwife through the effects of discourse (as it constructs the subjectivity of midwives). It works also through regulatory and disciplinary technologies, most overtly, through government contract and policy documents, legislation and the regulatory bodies (Nursing Council and Midwifery Council) governing midwifery. The professional midwifery discourse therefore regulates and disciplines midwifery practice in a literal and Foucauldian sense.

The sections of this thesis titled "Exploring the terrain" and "A place to stand", have explored several major discourses working to construct case-loading midwifery in New Zealand. These multiple discourses sometimes converge and often compete, making midwifery a complex and dynamic phenomenon. With this understanding, the next

section of the thesis “Landscapes of practice” turns attention to midwifery practice as it is emplaced within the obstetric hospital.

Chapter 6: Landscapes of Practice

6.1. The politics of place

This chapter explores the discursive space of biomedicine as it operates through place (the obstetric hospital), impacting on the childbearing woman and disciplining midwifery practice.

Introduction

Most childbearing women in New Zealand give birth in obstetric hospitals (Ministry of Health, 2004). Place of birth is important because place is not a benign concept. Place communicates and creates meaning as surely as any written or verbal text. As this chapter demonstrates, place is a product of the social and conversely also plays a role in constructing the social. Therefore, place in regards to childbirth and midwifery practice, is profoundly important because it plays an important part in constructing childbirth and midwifery practice.

In this chapter I explore the interrelations between the obstetric hospital and midwifery and childbirth from two perspectives; the inside out and the outside in, following Grosz (1995). I describe the way that the obstetric hospital has developed as an expression of scientific and masculinist interests and functions as a technology of the biomedical discourse of childbirth (the inside out). I also describe the way that discourse operates through place. In the obstetric hospital the biomedical discourse of childbirth dominates, constructing the corporeal experience of the maternal body "confined" within and also disciplining the practice of midwives (the outside in).

This chapter begins with a brief theoretical exploration of the concepts of space and place and a discussion of the often polarised concepts of home and hospital. The section titled "The inside out" begins with a brief historical overview that describes the shift from home to the obstetric hospital as the usual place of birth and then moves on to explore the voices of the midwives participating in this study. The section titled "The outside in" introduces midwives' understanding of place as it impacts on the childbirth experience and investigates the role of place in the construction of midwifery practice.

Theorising space and place

Geographers (such as Massey, 1993,1994) are both celebrating and expressing concern with the ways in which the social sciences have recently become more concerned with concepts that are at the heart of geography, such as space. My brief foray into the realms of geographical literature would suggest also that geographers are similarly exploring those fields more traditionally situated within the social sciences (such as feminist issues or health) (for example see Bondi & Rose, 2003; Dyck, 2003; Kearns, 1993) including pregnancy and childbirth (Abel and Kearns, 1991; Fannin 2003; Longhurst 1997). While many authors are now interested in space, Massey (1994) notes that they frequently fail to clearly define what they mean by the term. Understanding of the concepts of space and place may vary between disciplines and have evolved over time. Massey (1994) traces the developments in the theorisation of space in geography as it moved from positivist "spatial science" to the understanding of space as a social construct.

Positivist spatial science reflects the Newtonian concept of "absolute space" which conceptualises space as an area between geometric coordinates and has been the predominant representation of space into the nineteenth century.

> 'Absolute space' refers to a conception of space as a field, container, a co-ordinate system of discrete and mutually exclusive locations. Absolute space is the space that is broadly taken for granted in Western societies – our naively assumed sense of space as emptiness…(Smith & Katz, 1993, p. 75)

This space is an inert or dead space, representing the area between co-ordinates or objects. This spatial science was challenged in the 1970s by a generation of Marxist geographers who focused on the way that social relations constitute space. Thus, "space as a social construction" emerged as an important geographical understanding (Massey, 1993, p. 145). This understanding emphasised geography (geographical forms and distributions) as an end product or outcome of social relations. This was a one-sided formulation that was soon challenged as the social-spatial dialectic developed further.

Mirroring the trajectory of the theorisation of other concepts (such as the body) in other

disciplines (such as feminism) this somewhat one-sided understanding has given way to an appreciation that space plays an active role in the social; the social is constructed by the spatial.

> Society is necessarily constructed spatially, and that fact – the spatial organization of society – makes a difference to how it works". (Massey, 1994, p. 254)

Similarly Grosz (1995) whilst not a geographer, encourages us to think about the body and space in terms other than the traditional which focuses on a one-way relation; space as a container for or expression/product of the body. She suggests that our relations to space are not passive but that the body and space represent two interests that are reciprocally defined. We perceive space (and time) through our bodies and bodies are understood in a spatial (and temporal) context. Characteristically, Grosz is interested both in the way that bodies make spaces; how these spaces reflect the bodies that make them, and also in the way that spaces make bodies. Grosz draws on the work of French sociologist Caillois to illustrate the way that the environment is not as clearly distinct from the organism as Modernist thinking would have us believe. In the insect world for example some insects mimic the natural environment so that their environment becomes very much a part of their organic self and an active component of their identity.

Foucault (1995) also disrupts the dichotomies of body and space, inside and outside as he demonstrates the relations between the body/subjectivity and architectural space in his analysis of Bentham's panopticon. The architectural design of the panopticon allowed for the continuous observation of individuals and under this (potentially) unrelenting gaze, individuals self correct their behaviour in line with established norms.

The panopticon thereby functions as a disciplining technology and space is established as much more than an inert geometric concept. In describing the effects of the panopticon Foucault illustrates the way that space functions as a technology of power, directly working on the individual to shape their behaviour and construct their subjectivity.

In "The birth of the clinic" Foucault also explores the relations between body and place as the hospital is implicated in the development and methods of medical knowledge.

Foucault explores the role of the clinical gaze in the development of medicine. Through the gaze "the abyss beneath illness, which was the illness itself, has emerged into the light of language." (1973, p. 195). In the first instance this gaze refrains from intervention or experimentation and requires a neutral and homogenous space in which cases can be apprehended, unadulterated by extrinsic factors. The hospital provided such a space. What is more, the accumulation of cases within the hospital provided the opportunity for repeated observation, teaching and learning of medical knowledge in this setting.

> For clinical experience to become possible as a form of knowledge, a reorganisation of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge became necessary; the patient has to be enveloped in a collective, homogenous space. (p. 196).

The hospital for Foucault was much more than a building but represented a network of relations that made possible new forms of visibility and therefore new forms of understanding. In short, medicine's (the knowledges, methods and practices) emergence from the 18th century was made possible by the re-invention of the hospital. The hospital therefore is not just an expression of medicine but is implicated in the construction of medicine.

Space, the body and the social cannot be understood as dichotomous and distinct, singular concepts. Following Massey (1994) space must be understood "as constructed out of interrelations, as the simultaneous coexistence of social interrelations and interactions at all spatial scales" (p. 264). Space is dynamic and productive rather than static and inert.

Dichotomous Spaces/Places

Western thought is underpinned by dualisms as discussed in chapter 3.1 ("A feminist, poststructural approach to research"). These dualisms are arranged in hierarchies that are divided along gendered lines. For example, in the dualisms nature/culture, body/mind, irrational/rational, emotion/thought women are aligned with the sides that

are negatively valued; nature, body, irrational and emotional. This is also true for the dualisms space/time and space/place.

Massey (1994) draws attention to the way that space and time are positioned as polarising concepts. Time is the valued concept in the binary as it represents progression, dynamism, reason, civilisation, masculinity and history. On the other hand, space is the less valued concept that is associated with stasis, emptiness, inertia, passivity and the feminine. Similarly space and place are positioned as binary opposites.

> 'Space' has often been seen as abstract whereas 'place' is concrete, space open but place is enclosed, space is barren whereas place is peopled, space is general whereas place is particular, space is sterile while place has *genius loci*, space is big whereas place is small. (Bale, 2005)

This trans-coding (the alignment of the feminine with a negative concept within a binary pairing) is not enacted in a consistent way. When space for example is paired with the concept of place rather than time, space becomes the masculine and place, the feminine. Here space comes to represent the abstract workings of the mind, expansiveness, objectivity and independence, the spaces of business, industry and the wider world. In contrast place (and the feminine) is associated with domicile (home and hearth), locality, narrowness, domesticity, belonging, and mothering (for example, the term "mother country").

Acknowledging that the terms space and place are loaded with gendered connotations, I nonetheless use the term space in this chapter to refer to conceptual spaces such as the discursive fields constituting medicine or the obstetric hospital. Place refers to physical locations such as the home or hospital. Thus the hospital or home can be represented by both the terms place and space, as they are physical locations built by bricks and mortar and they are also constituted by human understandings, power relations and discursive constructions.

Polarising concepts such as space/place (and their arrangement in gendered hierarchies) is problematic for a number of reasons. Firstly, the social processes that gender the

concepts become obscured as the alignments are naturalised. Women's place therefore *naturally* becomes the home: men are *naturally* suited to the public sphere and business. This conceptualisation delimits the sphere of activity for men and woman as these normative and naturalised constructions inscribe subjectivities and discipline behaviours. Secondly, understanding based on polarisations limits how we might conceive of the concepts themselves and the interrelationships between them. For example the mind/body binary underpinning Cartesian dualism means that it has been difficult to think about how the mind and body might work together; how the body and mind might be interrelated. Once established as binaries, it is more difficult still to problematise the very concepts themselves, to conceive that there might be no such thing as a discrete mind and a discrete body. A third issue is that these polarisations tend to fix definitions or homogenise the experiences that cohere around either end of the pole, as we shall see in the discussion that follows.

Home and Hospital

Literature exploring place of birth frequently presents the home and hospital as polarised concepts (Abel & Kearns, 1991; Lock & Gibb, 2003; Morison, Hauck, Percival & McMurray, 1998). The hospital is often described as the site of oppression for women in childbirth whilst conversely; the home is presented as the natural place of autonomy and control for the childbearing woman (Fannin, 2003). This may be true for many women but the polarisation of the concepts home and hospital with their attendant assumptions, denies the complexity and variety of women's experiences of birth in these places.

The natural childbirth discourse frequently constructs the home as the natural place of women's autonomy. The homebirth choice within feminist and natural childbirth discourse is constructed as an empowered choice by knowledgeable and assertive women who want to be in control of their childbearing experience (Abel & Kearns, 1991). In countries such as Australia and the UK, public hospital care is available and free to all women. While homebirth is theoretically available within the National Health Service in the UK, in many cases women must pay privately for continuity of care by a midwife. In Australia women choosing homebirth and continuity of care must also pay privately for this service. In these circumstances homebirth is often a choice of

educated, white, middle class women who can afford this option and who are cognisant of the political or feminist implications of their choice. In the USA where free public hospital care is not available to all women, homebirth may be imposed as a result of poverty. In New Zealand, where public hospital, homebirth and continuity of care by midwife are free to women, there is no financial impediment or inducement to choosing homebirth. The homebirth choice may easily be made by a variety of women for a variety of reasons. Among the many reasons women may choose to birth at home are religious beliefs, a desire to avoid the attention of state welfare agencies such as Child, Youth and Family and the need to avoid leaving other children in unsafe environments. Sadly, home is not always a place of empowerment or control for women; it may instead be a place of abuse, violence, exploitation and oppression.

Irigaray (1992, cited in Grosz, 1995) contends that men have created a world that seeks to erase women and to deny the central contribution that they make to this world, through the maternal body. All subjects and knowledges are made possible by the maternal body yet the cultural production of everything in our world, systematically and violently erases the feminine. Women are contained in men's physical space in the same way that they are imbricated within their constructed conceptual space (Grosz, 1995). The alignment of women with the body, domesticity and the home provides an example. The patriarchal processes that masculinise the mind and the public spheres have similarly feminised the body and the private domain. This naturalises the home as women's place as women are relegated to the role of guardian of interpersonal and private spaces. Within a patriarchal and phallocentric world women are denied the opportunity to utilise or define a space of their own.

> The containment of women within a dwelling that they did not build, nor was even built for them, can only amount to a homelessness within the very home itself; it becomes the space of duty, of endless and infinitely repeatable chores that have no social value or recognition, the space of the affirmation and replenishment of others at the expense and erasure of the self, the space of domestic violence and abuse, the space that harms as much as it isolates women. (Grosz, 1995, p. 122)

The home for Grosz is clearly not a place of freedom or empowerment for women.

The representation of home as the natural place of women's empowerment and the hospital as the natural place of their disempowerment obscures the reality of many women's experiences (Fannin, 2003). Women can certainly experience empowering and successful births in the hospital environment and experience disempowerment in the home. Polarising the concepts of home and hospital serves to fix the meaning of these places, homogenising the experiences of childbearing women and failing to take into account the way that the debate over place of birth itself constructs these places (Fannin, 2003). For example, debate centring on risk constructs the hospital as a safe birthing place whilst proponents of homebirth may emphasise emotional safety, and medical intervention in childbirth, constructing the hospital as an unsafe place for childbirth. The hospital (or home) is neither essentially safe nor unsafe, though it is constructed as such through discourse. The places in which women birth are constituted by more than bricks and mortar.

The obstetric hospital therefore, represents more than geometric space. It is more than a three-dimensional container, which houses the activities of those within. It is not the polar opposite of home but a place in which multiple social and spatial interrelations coexist; it is a place that invests and is invested with meaning. Power circulates among the occupants of this place and is exercised through the spatial and social interrelations taking place therein. The obstetric hospital therefore also represents a discursive space. It is in this place and within this discursive space that many case-loading midwives spend much of their time. It is a complex place in which the meaning of childbirth and the meaning of midwifery is frequently contested and negotiated. It is this complexity, as it plays out through the interrelations between place, space and bodies that the last chapters of this thesis is concerned.

The inside out: constructing gendered spaces

In this thesis the obstetric hospital is described as a place and a discursive space. It is further understood as a product of social (and embodied) activity and a *producer* of social (and embodied) activities. Following Grosz (1995) this section of the chapter focuses on the obstetric hospital as a product of social relations and corporeal functioning whilst the next section, "the outside in", focuses on the way the obstetric

hospital produces the social and corporeal.

In the paragraphs above, Grosz (1995) described how women are denied a place within patriarchal society. The public sphere is denied them as this is constructed as the realm of men and, like it or not, women are relegated to the domestic and private. Too often these private places too are places of oppression and exploitation for women. All these places are products of patriarchal discourse and therefore they are gendered places.

Grosz (1995) contends that women are contained within physical and conceptual spaces created by men. Nowhere is this more graphically illustrated than in the case of childbirth. The obstetric hospital is a product (and a technology) of the patriarchal, biomedical discourse of childbirth that predominates in contemporary New Zealand society. Women are confined within the physical space of the obstetric hospital during childbirth and they are also caught within the web of discourse that constructs childbirth as risky and their bodies as inadequate. Women are therefore contained by the physical and discursive spaces of men as Grosz contends, but as I will demonstrate in the next section, they are more than contained; they are inscribed and subjected.

(Re) placing childbirth: from home to hospital

State hospitals were first established in New Zealand during the second half of the 1800s. Some of these hospitals included maternity beds but most women at this time would have birthed at home or in small private maternity homes (Mein Smith, 1986). From the turn of the century however hospital birth increased rapidly and by 1920 up to 35% of births were occurring in hospitals (Mein Smith, 1986). While accurate figures are not available, in New Zealand today it is estimated that 94 - 97% of births occur within the hospital setting[22] (Ministry of Health, 2003; Pairman & Guilliland, 2003) making the hospital the predominant birth setting for the vast majority of New Zealand women.

Positioning the hospital as the most appropriate place for childbirth required that a particular construction of childbirth become dominant. This was achieved through

[22] This includes tertiary, secondary, primary and rural maternity facilities.

scientific and biomedical discourses which privileged the knowledge of the (male) medical profession, situating them in a place of authority over childbirth and other health care issues. The biomedical discourse constructs childbirth as risky, and, via this construction, justifies the prominent role of the medical profession and place of the hospital in childbirth.

At the turn of the 19th century the colonies of Australia and New Zealand were concerned with high rates of maternal and infant mortality and this is often cited as a major influencing factor in the move from home to hospital birth. In New Zealand the regulation of midwives and establishment of St Helens maternity hospitals were initiatives that aimed to address this issue. The Department of Health actively promoted hospital birth as a safer alternative despite the fact that deaths from puerperal sepsis failed to decline but in fact increased with hospital birth (Wood & Foureur, 2005). This is perhaps testament to the increasing authority of the biomedical discourse and political activity of the medical profession as they sought to establish the specialty of obstetrics and their place in childbirth (Mein Smith, 1986). Perinatal mortality rates were to decline some time later with the introduction of H. Mt. 20 regulations (Donley, 1998), antibiotics, and improved general health and living standards of women (Foureur & Hunter, 2005). In the minds of many a causal relationship between hospital birth and safety had been established. Tew's (1990) groundbreaking analysis of maternity care in the United Kingdom demonstrated the spuriousness of the medical profession's claim that birth in hospital or birth with a medical practitioner was safer and that this historical shift (from home to hospital and from midwife to medico) was responsible for declining perinatal mortality rates since the turn of the 19th century. Tew (1995) implicates the medical profession in the deliberate misinterpretation of data with the purpose of maligning home as a suitable place for childbirth and establishing hospital as the most appropriate and safest place of birth.

So, the hospital was established as the most appropriate place for childbirth without demonstrating that birth in hospital was an effective or safe intervention. The shift in place of childbirth from home to hospital was a result of patriarchal, scientific and biomedical discourses that privileged medical (masculine) rationality, constructed childbirth as risky, and women's bodies and knowledges as deficient. The organising structures of the modern hospital also reflect these patriarchal assumptions.

Studies of bureaucratic organisations have shown that women are both horizontally (different occupational groups) and vertically (lower status positions) segregated within organisations (Ramsay & Parker, 1992) and this is graphically illustrated by the organisation of health care where women commonly occupy the lower status and lower paid positions such as nursing and midwifery which are considered subordinate to medicine (historically the domain of men) (Davies, 1992). The hospital is embedded in the social and political context from which it arises and as such reflects (and re-produces) the masculinist and patriarchal assumptions that dominate in that society (Ferguson, 1984; Ramsay & Parker, 1992; Witz 1990; Witz & Savage, 1992).

Reflecting the bureaucratic concern for speed and efficiency and the technical needs of the medical profession the hospital is,

> ….a space born of modern health planning. The space of the hospital is an institutional space that represents the economies of the health service industry, transmits values about medicine, technology and industrial society. (Cartier, 2003, p. 2294)

Bureaucratic concerns for efficiency and the biomedical approach that draws on a mechanistic understanding of childbirth resulted in maternity hospitals that fragmented the childbirth experience. Through the 1900s to the present day maternity care is often provided in several separate and distinct areas of the hospital; the antenatal outpatients or clinic, the in-patient antenatal ward, the "delivery" areas, the nursery and the postnatal ward. Though not common today, historically, the "delivery" area was also divided into separate spaces; preparation areas where women spent the earlier phases of labour and where they were prepared for delivery (cleaned, shaved, administered enemas) and surgical theatres in which the "delivery" took place (Lepori, 1994). The biomedical discourse of childbirth converges with that of bureaucracy to give rise to a regimen of practices and routines that were enacted in functional (for health carers at least) spaces that reflected biomedical understandings of childbirth. Women commonly shared antenatal, postnatal and early labour rooms and bathrooms and the movement of family and friends within these spaces was strictly controlled. Delivery rooms resembled operating theatres. The rooms were dominated by a multi-functional bed that rearranged women into a variety of accessible positions including lithotomy, with the

pull of a lever. An overhead surgical light fixture illuminated the bed, the focal point of the room. Surfaces were easy to clean; linoleum on the floor and shining stainless steel trolleys laden with green wrapped surgical supplies. Medical equipment and supplies filled the cupboards, gas supply fixtures and alarm buttons dotted the walls. This place was the space of professionals. As Lepori (1994, p. 4) comments, "The organization of the entire setting is a function of the patterns of movement that occur during medical intervention…. [They] express a medicalized approach that requires from the woman a specific kind of behaviour". These are intimidating spaces; too clean, too technical, too specialised and too dangerous for those not educated in their use. This place clearly communicates childbirth as a medical/surgical event to be controlled by those appropriately qualified and knowledgeable. This is a place born of the biomedical childbirth discourse that subordinates women's needs to male medical knowledges and practices and constructs women as inefficient, insufficient and passive.

The modern obstetric hospital is not a place built for women. It is a place that reflects and services the rationalities of bureaucracy and medicine.

Hybrid birth spaces

The consumer and feminist movements of the 1960s and 1970s lobbied for a more humanising birth experience in which women's needs were accommodated and in which women could exercise greater personal agency. This movement has been largely unsuccessful in dislodging childbirth from the hospital setting (Murphy Lawless, 1998) but has resulted in the creation of a hybrid (obstetric-domestic) birth space (Fannin, 2003); the birthing room within the hospital setting.

In the United States of America where a robust private health sector exists, competition for maternity cases has driven the development of birthing rooms, birth centres, more aesthetically appealing delivery suites or service-orientated care packages (Fannin, 2003). While several privately owned birth centres exist in New Zealand and approximately 65 primary birth units (including small rural primary birthing facilities), over 80% of births occur within publicly funded secondary and tertiary hospitals (Ministry of Health, 2004). Many delivery wards in New Zealand have been

redecorated in line with creating a more homelike and welcoming environment for women and the name "birthing" suite or room has replaced "delivery" or 'labour" wards. The re-naming of these spaces suggests a transformation in maternity care philosophy from one medically dominated to one more natural birth-oriented. A "birthing" room is purported to be distinct from a "delivery" ward in that the care philosophy is usually influenced by the natural childbirth discourse which positions the woman in an active role; "one who births" rather than the passive "one who is delivered". Rather than reflecting a true shift in philosophy the new "homelike" birthing room may be no more than a chimera.

In a birthing room the domestic trappings of the family bedroom camouflage the surgical delivery room. Pastel patterned wallpaper lines the walls, the surgical beds are covered with printed, ruffled bedspreads, and lamps adorn nightstands that conceal sterile supplies or gas outlets. An armoire harbours a neonatal resuscitairre and prints depicting tranquil scenes decorate the walls. This space is a hybrid space, "…ambivalently situated as a site of domestic comfort and technological sophistication" (Fannin, 2003, p. 520). On one level this space proclaims childbirth as a natural, normal process appropriately situated in a domestic space but the domestic trimmings belie the more powerful message of the hospital setting and the concealed yet accessible emergency supplies; that birth is dangerous.

It is interesting that in relocating the domestic within the institutional, for childbirth the bedroom is assumed to be the appropriate replicable domestic space. In my experience of homebirth, women occupy various places within the home throughout labour. Their proximity to their support people and family members is also fluid. At times women share a common place with others and at other times they seek a more intimate or private place. In my experience the bedroom is rarely chosen as the place of birth and the bed more rarely still.

This is supported by Lepori (1994, p. 6) who states,

> studies with women who have given birth at home show that they seldom give birth in the bedroom, but more often in their sitting room where they select an empty and

protected area….Never exposing themselves at the centre of the scene as in a delivery bed…

Women frequently birth at home in living rooms and rather than take to bed following the birth, often establish themselves on the couch feeding their baby, socialising, and consuming refreshments. Women's use of space in homebirth suggests that a suite of rooms may be more appropriate to their needs than one birthing room. Lepori (1994) offers a one-room design that is constituted by several functional areas.

In a delivery or birthing room within the hospital setting the childbearing woman, her support people and caregivers are often enclosed in a single room, which means that the childbearing woman is under the constant scrutiny of others. Labour and birth is a spectacle in this setting and the centrality of the bed in both the delivery and birthing room provides a focal point that also positions the woman in a sick and passive role.

While feminist and childbirth activism has resulted in some changes to birth spaces within the obstetric hospital this influence has mostly been limited to superficial adornments to spaces that continue to function fundamentally and profoundly as technologies of the biomedical discourse of childbirth. While midwives participating in this study acknowledge the impact that this space has on both themselves and the childbearing woman, they also demonstrate the ways in which this space can be used and protected in the interests of the childbearing woman; in effect creating a place within a space. For the most part, the obstetric hospital presents a challenge to the midwives participating here, as it is a space that does not lend itself to their construction of childbirth as an active and dynamic event.

Midwives' use of birthing places

The obstetric hospital, for midwives participating in this study is not understood as the childbearing woman's place nor is it understood as the midwives' place. It belongs to an amorphous "other". As one midwife comments,

> There is the whole physical environment and also it's not actually our environment because it's the hospital's.
>
> (Interview 050603, text unit 740).

This is a place constructed *for* them in which many of them experience little functionality, ownership or control. Rural midwives in particular commented on how the obstetric hospital failed to meet their needs as midwives. After long hours spent with women in a rural primary maternity unit for example, and transfer to a secondary hospital, there was no place for midwives to rest before their long journey home. The design of the obstetric birthing space also offers midwives little respite from the intensity of being with women in labour. The single room of a hospital birthing room, and the separation of midwifery staff spaces (such as the tea room) leave the midwife with the option of being in the same room as the woman or being completely removed from her. In smaller maternity units or at home for example, midwives may spend time in a separate room to the labouring woman but their proximity means that they may remain accessible and attentive to the woman by listening to her. Some of the midwives participating in this study recognised that the midwives' continual presence altered the dynamics of the labouring woman, partner or support people in addition to being tiring for the midwife. This excerpt is from a section of interview in which the midwife is describing her rural primary birthing unit.

> So one of the things I thought was important was that the dynamics of the place allowed the midwives some privacy, we could actually go quietly in our room, sit and write notes, have a cup of coffee, keep out of the family's way. But they knew where we were. …
>
> (Interview 260503, text units 300-301)

Not surprisingly, homebirth midwives and those who also primarily access smaller primary birthing facilities are most vocal about the impact of the physical environment of the obstetric hospital on the dynamics of the birthing woman or the midwives' experience of this place. These homebirth midwives contrasted the comfort of home with that of the obstetric hospital.

Participant 1: Also like the surfaces in hospitals, no matter what kind, they are hard. The bed, the sink, the floors, walls. I even notice it … if I've transferred in with a woman, like when I go home my feet are sore, they are really aching… Everything is hard. The lights are harsh.

Participant 2: Nothing is ever quite warm enough too. Like trying to heat up a theatre for baby, like you can never get it warm enough and the towels are hard, it just says the individuality has gone.

(Interview 220501, text units 200-207)

These midwives describe the physical space of the birthing room as hard, cold and uncomfortable for the childbearing woman, her baby and the midwife.

Safe and risky places

Not all midwives feel uncomfortable in the obstetric hospital setting. Surtees (2003) for example found that some of the midwives participating in her study expressed a sense of safety in attending women in the obstetric hospital and profound discomfort with attending women outside this setting, such as in a primary birthing unit or home. This was found to a lesser degree in this study and may be a result of the particular population of midwives who participated. One midwife in this study did however express similar sentiments,

… I possibly feel safer in the hospital than I do at home just because my experience is more working in hospital than at home. That doesn't preclude me from doing homebirth, far from it, but I'm comfortable in a hospital situation because I'm used to it …

(Interview 010601, text units 1804-1808)

While the rhetoric of medicine certainly constructs the hospital as a safe birthing place midwives participating in Surtees' (2003) study and also those participating in this study, demonstrate the way that this safety is not absolute but partial and contingent. In Surtees (2003) study midwives acknowledge that the most up-to-date and accessible

obstetric assistance and technology did not prevent all babies from dying. Another midwife participating in my study describes the obstetric hospital as unsafe because the equipment that she would have had on hand at a homebirth is not accessible.

> Sometimes I feel safer at home actually. I mean I had an instance in room [number] … quite straightforward, efficient labour, baby that, I mean I'd just intermittently auscultated but sounded fine, quite a respectable second stage, and that baby came out flat as a pancake. And I did not have…. the oxygen and the suction sitting there blaring and I couldn't get the bloody stuff to reach me anyway. And by the time I got some help to get that baby disconnected and get it moved, I mean I would have had that, that baby ended up going up to the unit and I think that it would have been much safer at home where I have my stuff right there. So you know the safety of hospital birth?
>
> Interviewer: If you're not on the bed you're in trouble, if it's [the birth] in the bathroom or something, there's nothing there.
>
> Yeah if you end up having a baby, it's bloody nightmarish in there sometimes, it's actually not that safe.
>
> (Interview 010601, text units 624-639)

As an environment designed for obstetrically managed birth presuming a passive woman who births on the bed, the obstetric hospital environment was perceived as unsafe when used in ways for which it was not designed, that is with a mobile, active woman who may birth in places other than the bed. Midwives participating in this study also discussed the ways that childbearing women may perceive the birth environment. In one lively discussion two midwives debate women's perceptions of the obstetric hospital:

> Participant 1: …she's in there [the hospital], its an alien environment …
> Participant 2: It's not that alien an environment.
> Participant 1: It's not to you, it is to somebody having their first baby in there.
> Participant 2: This is New Zealand and this is a hospital in New Zealand and people here know what its like in hospital ...

Participant 1: No, I remember the first time going into [hospital name] as a visitor to my sister and I thought it was the most horrific place…. "Who'd ever want to have their baby here"? It was very alien to me. I thought they were cubby-holes for rooms and it felt terrible.

Participant 2: I think for a lot of people it's a safe place.

(Interview 010601, text units 942-955)

Is the obstetric hospital an "alien" environment that raises the anxiety levels of the childbearing woman or is it one in which she finds comfort? Perhaps it is both. While the environment may be inhospitable to women, privileging bureaucratic functionality and the biomedical construction of childbirth with displays of frightening specialised medical equipment, it also communicates safety. It communicates risk and safety simultaneously; the expression of safety invokes the concept of risk. This was expressed in a discussion by a group of rural practicing midwives who wanted to remove the resuscitairre (a large, bulky apparatus for the resuscitation of newborns) from the birthing room in their rural cottage hospital.

… we wanted the resuscitairre out of the room because it was over in a corner and we couldn't get to it and so we as midwives took it out of the room and put it in here [a meeting room]. And by a week, [other] staff who we value because they are really important to how this place is run and organised, got upset about it.

… what they brought into the argument though which was quite interesting, was that out in the community women and couples saw that resuscitairre as the only valuable piece of equipment we had. [Laughter] And that gave them

confidence to actually birth here. I just find that so interesting.

(Interview 050603, text units 758 – 763)

Women who understand childbirth as a risky medical event may be willing to sublimate their desire for comfort or aesthetically pleasing surroundings for what is perceived as the more selfless pursuit of safety. As discussed in chapter 4.1 ("Body politics and the biomedical discourse of childbirth") the biomedical discourse of childbirth often

constructs noncompliant women (such as women choosing to birth at home) as selfishly pursuing their own trivial needs at the expense of the safety of their baby. This is a powerful disciplining technique. Certainly the medical model of childbirth has been criticised by feminist and childbirth activists for its privileging of physical safety over other conceptions of safety such as emotional, spiritual or psychological (see for example Oakley 1980, 1984a). The midwives' accounts of safety and the birth space demonstrate that like "risk", "safety" in relation to birth space is a fluid construction and that birth spaces may be at once safe and unsafe.

Public and private places within the obstetric hospital

Earlier in this chapter I described the way that women have been relegated by patriarchal discourses to private and domestic spaces. Public places and participation in public life has been constructed as more suitable to the rationality of the masculine mind. This remains a persuasive construction. Robyn Longhurst (1997) for example brings a geographical perspective to the study of the discursive construction of pregnant women. She found that a small group of pregnant women in one New Zealand city progressively withdrew from public places throughout their pregnancy. Longhurst suggests that the pregnant woman is discursively constructed as irrational and that this construction disqualifies them from participating in the public sphere.

Within the hospital setting there are also private and public places and access to these places differs for different groups. Professional staff generally have access to most areas such as patient rooms, bathrooms, corridors, storerooms, treatment rooms and staff rooms. Visitors are frequently seen in corridors and patient rooms. Sometimes they are accommodated in designated waiting areas but they may not trespass into other "private" areas such as staff rooms, treatment rooms or other patient rooms. Labouring women however are the most constrained as they are confined to the birthing room. This is often the only place that these women are invited to occupy.

Sometimes they can be seen furtively traversing a corridor in transit to a bathroom but they rarely linger there or use this space (for example by walking through contractions up and down the corridor). Waiting rooms, reception areas, and even corridors are

constructed as inappropriate places for the childbearing woman. Even her noises are not welcome there. Labour and birth are confined neatly within the birthing room in this setting. Visitors and support people may have greater access to the more public places such as corridors but when supporting a labouring and birthing woman, they too are confined to the birthing room.

In being confined to a room with birth partners, supporters and midwife the labouring woman has little opportunity to move around, to change position or scenery, to access fresh air or outdoors, or to experience privacy when she may require it. The bed dominates the often cramped room and the partner or support people the chair or couch if it is provided, leaving the labouring woman with no recourse but to occupy the bed. As one midwife comments on the birthing room within the obstetric hospital,

> … 99% of them would be on a bed, because the bed was the only thing in the room you could go on. So you couldn't kneel comfortably on the floor like you could over a couch or something, there were no rooms set up for normal birthing at [name of secondary hospital], family type rooms.
>
> (Interview 260503, text units 329-330)

The birthing area of the obstetric hospital was contrasted with that of the rural primary birthing unit,

> Participant 1: They [labouring women] were reasonably relaxed and also they were able to walk around. Their family would be playing cards up in the sitting room with the TV going and drinking cups of tea or whatever, they'd be walking around the building with their husbands and their friends rubbing their back, it was very, very relaxed environment.
>
> Participant 2: And the woman could go out and lean over the armchairs and walk around and have her family looking after her as well. It was totally up to her where she went and what she did. And I think the dynamics of a unit like that are really, really important if you want it to work well, the floor plan is very important.
>
> (Interview 260503, text units 257, 304-306)

In the rural primary birth setting as described by this midwife, women and their families and support people felt welcome to occupy and use a variety of places. This meant that women made use of a greater variety of places, (as they were not compelled to occupy a single room or bed) and also that they were able to access private or intimate places (away from family and support people) if they desired.

When discussing their practice midwives participating here, describe ways in which they use space to impact on the childbirth process. Midwives discuss how they sometimes encourage women to walk around or climb stairs as a tool to assist in the decent and optimal positioning of the fetal head and one midwife explains how she and another midwife encouraged a woman to "bunny hop" downstairs at a homebirth.

> I was involved with somebody and I was actually the backup midwife …we had an asynclitic, deflexed, posterior, good sized baby …, and we had this woman bunny hopping. She lived in a double story house and we had her bunny hopping down the stairs. … we had the freedom to get her out of the bath and get her to bunny hop down the stairs.
>
> ….
>
> This is like she was in second stage, trying to wiggle the head about. Finally, it did come out with a nicely moulded head. …I really do believe if she had had that baby in hospital she absolutely would have had probably at the least a ventous [extraction of the baby] …
>
> (Interview 010601, text units 1881-1904)

The midwives' discussion on their use of place and their contrasting stories of the way that women and midwives use space in obstetric hospitals and home or primary birthing units, illustrates the way that the birthing place of the obstetric hospital is not a functional place for women or midwives. The midwives' stories of birth construct it as an active and dynamic process that requires women to be active and mobile, taking up and using a variety of places. The obstetric hospital is a place constructed by men and befits a passive, controlled and confined labouring woman. As such, the geography of the obstetric hospital functions as a technology of the biomedical discourse of childbirth. It is a place that communicates the authority of medicine. In analysing the hospital thus, I do not mean to fix the obstetric hospital as an unchanging, bounded

patriarchal and biomedical construction. The hospital also represents a contested space in which women and midwives play an active part as they negotiate childbirth. This will become clearer in the pages to follow but for now I will begin by exploring the outside in; the way that spaces and places construct bodies.

The outside in: En(gendering) midwifery and maternal bodies

I have described the obstetric hospital as a product of masculinist assumptions; in particular it functions as a technology of the biomedical discourse. The relationship between bodies and space is a mutually constitutive one; the body is implicated in the making of space and so too is space implicated in the making of bodies. The involvement of space in the construction of the body may extend beyond the discursive construction of subjectivity, identity or the body without organs (BWO) (Deleuze & Guattari, 1984) of those who inhabit a particular space, to include a profound impact on the corporeal, organic body. Grosz (1995) for example, describes the way that one's environment can directly impact on the composition of the body. If one had to negotiate a mountainous or hilly environment daily this would result in the body developing certain muscularity. In the same way the environment of the birthing woman has been implicated in the chemical composition of the maternal body.

In a recent midwifery text, Foureur and Hunter (2006) draw attention to the work of researchers (such as Ginesi & Niescierowicz, 1998; Naaktgeboren, 1989; Newton, Foshee & Newton, 1966; Teixeira, Fisk & Glover, 1999) who explore the complexities of the body's chemical response to labour and birth. Drawing on this body of work they explain how the environment may trigger emotional responses such as fear and anxiety which in turn stimulate the neocortex to produce excessive amounts of the chemical transmitter catecholamine as part of the "fight or flight" response (Rowley, 1998 cited in Foureur & Hunter, 2005). Increased levels of catecholamine can reduce uterine contractility and blood flow resulting in uterine inertia and fetal distress (Foureur & Hunter, 2005). In the same way that a mountainous environment can shape the muscular construction of the body (Grosz, 1995), a space that engenders fear and anxiety can shape the chemical construction of the body and this may have profound implications for the labouring maternal body.

The midwives participating in this study recognise the hospital, as "not their place". The geography of the hospital is described as a dysfunctional place; one that cannot easily be used in a way that is congruent with their construction of women and childbirth. For these midwives there is a clear relationship between the birth environment and the birth process. They describe how women need to be able to mobilise and use their bodies actively to facilitate labour and also how they need control over their proximity to others during labour and birth. One participant comparing the obstetric hospital and primary birth setting states:

> So the ability to take up positions to potentiate their ability to have a baby is lessened [in the secondary hospital setting]…

She goes on to provide an example of a birth in a primary rural facility where a woman was able to use the setting to facilitate her birth.

> … this woman climbed her leg up the wall until she was almost doing the splits and then pushed out a ten pounder which I'm sure she would have ended up with ventous in [name of secondary hospital] because she wouldn't have had that ability to do that sort of thing.
>
> (Interview 260503, text unit 700)

As in the previous example of the woman who was encouraged to "bunny hop" down stairs, midwives associate the freedom to move the body in place and utilise various spaces, with the achievement of a natural birth. This construction of childbirth is constituted by the natural childbirth discourse, which constructs the maternal body as a capable and active body. Proponents of natural birth and homebirth such as Kitzinger (1979, 1991), Balaskas (1983), and more recently Banks (2000) in New Zealand have highlighted the importance of women being able to mobilise or adopt birth positions that facilitate the childbirth processes.

For these midwives, the consequence of women being constrained or confined may be obstetric intervention such as epidural pain relief, ventous delivery, forceps, induction of labour and caesarean section. The birth environment for these midwives has very real consequences for the bodies of women. Obstetric intervention potentially introduces

pharmaceutical chemicals into their bodies, breaches the integrity of the epidural or spinal space, and incises their tissues, permanently marking their bodies in a very physical and corporeal sense.

Childbirth activists and proponents of natural childbirth have long argued that the obstetric hospital and the dominance of the biomedical discourse in this setting profoundly impacts on the experience of childbearing women (Banks, 2000; Bortin, Alzugaray, Dowd & Kalman, 1994; Kitzinger, 1991; Walsh, 2000a). However, few have explored the way this space impacts on the midwife.

Space, place and midwifery practice

The obstetric hospital is one of the primary sites in which midwives encounter the practices and technologies which construct the biomedical discourse of childbirth. The obstetric hospital as a place is therefore highly significant. It is largely through this place that the biomedical discourse of childbirth operates. Midwives participating in this study recognise the significance of this place, describing the obstetric hospital as the seat of medical power, frequently conflating "the hospital" with "medical".

While two midwives participating in this study were initially ambivalent about the impact of setting on their practice "I just go in and I just do what I want within reason …" (Interview 071101, text unit 246) and "I feel just as comfortable in the hospital now as I do at homebirth" (Interview 01060, text unit 493) subsequent discussion revealed their relation to the physical or discursive space of the hospital and biomedicine to be more complex and problematic than first expressed. The obstetric hospital directly impacts on these midwives and their practice, something that has been alluded to in the midwifery literature (Katz Rothman, 1991; Kirkham, 2000) but rarely addressed explicitly. Midwives participating in this study feel watched in the obstetric hospital and this serves to discipline their practice in the same way that Bentham's panopticon disciplined its inmates. Obstetrics is therefore analysed here as a panopticon.

The obstetric panopticon

The panopticon was Bentham's design for a prison that enabled the monitoring of numerous inmates by relatively few guards. The architectural design situates inmates in multiple, individual cells surrounding a central tower or watch house in which a guard is located. Windows on each side of the prison cell allow the inmate to be clearly visible from the central tower. The architecture of the panopticon individualises the inmate, situating them within the (potentially) constant glare of a disciplining gaze. The design of the panopticon works to construct the subjectivity of the inmate as (under the scrutiny of surveillance) they discipline and normalise their own behaviour, becoming docile inmates. This demonstrates an effect of power that does not rely on violence or physical force; it is a "gentle master" yet ultimately, highly effective and efficient, working on the body from within. The panopticon for Foucault is an exemplar of the modern workings of power as individuals and populations are governed by a power brought to effect within the observed/observer relation (Fox, 1993).

Certainly for Foucault (1973; 1995) other institutions including the hospital, workhouse and school used the principles of the panopticon to discipline their populations. The design of the "Nightingale" ward is one example. Here a number of patient beds occupy a large open plan room. The nurse's station is positioned centrally so that the staff on duty can continually observe the patients (Fox, 1993). Patients are open and accessible to the gaze of health professionals in this setting. The critical eye of the observer, the behaviours and subjectivities required of the observed are positioned by discourse. Therefore, disciplining gazes such as those of medicine work not only to produce docility, but also to actively constitute their subject. The medical gaze constitutes the body of the observed, inscribing it with medical knowledges (1973). Katz Rothman (1989, p.178) acknowledging the politics of knowledge and practice comments, "I have come to see that it is not that birth is 'managed' the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed." This suggests that the body is not a natural body but a political one, able to be inscribed and constituted in a variety of ways by a variety of discourses.

The panopticon is a metaphor for a disciplining gaze. The medical gaze is a powerful technology as Foucault (1973, p. 39) comments; "A gaze that sees is a gaze that

dominates" and this is something in which midwives participating in this study and elsewhere (Crabtree, 2002; Hunter, 2000; Surtees, 2003) are only too aware. Their accounts of practice in the obstetric hospital setting in particular, are replete with descriptions of being watched; "Such a feeling of eyes…. People judging and watching" (Interview 010601, text unit 369). Once the biomedical gaze is cast on the childbearing woman her body and the experience of childbirth become a biomedical one. Biomedicine then determines the terms by which her progress, her behaviour and the practices of her midwife are judged. The bodies of childbearing women are accessed via midwives (and potentially disciplined by them) so midwifery practice becomes important to the circulation of the biomedical discourse of childbirth.

The hawk overhead

Midwives participating in this study describe the biomedical discourse of childbirth as infusing the social, juridical and legal systems providing the framework through which midwifery practice will be judged should it be brought into this arena.

In New Zealand anyone can lay a complaint against a registered health professional with the Health and Disability Commissioner (HDC) who will then investigate the complaint under the relevant legislation. The findings of the investigation are then forwarded on to the relevant regulatory body. For midwifery this was the Nursing Council of New Zealand up until September 2004. The regulatory body may then take disciplinary action against the practitioner if so required. The Accident and Compensation Corporation (ACC) operates New Zealand's Accident and Compensation scheme, which provides New Zealanders with personal injury insurance. New Zealanders do not have the ability to sue for personal damages other than to seek exemplary damages. ACC is a no-fault scheme so that fault does not have to be established for a claim to be successful. However, ACC does refer all findings in cases of medical misadventure to the Health and Disability Commissioner.

The threat of a formal inquiry, especially one by the Health and Disability Commissioner leaves many midwives feeling profoundly fearful.

> You worry about being hauled up, you have these nightmares of being hauled up in front of the court of law. Being struck off etc, etc.
>
> (Interview 010601, text units 756 – 758)

They are fearful of losing their livelihood and something they enjoy, of living under the burden of an inquiry that may span several years, and of the shame that the experience brings, especially if the media become involved as it had in one high-profile case which seemed to be burned into the minds of the midwives participating here. Midwives did not always distinguish between the formal complaints and disciplinary processes that could arise at the level of ACC, HDC and Nursing Council, and those more local confrontations that midwives may have had with the medical or hospital administrative staff.

> …like there is an eagle or hawk, circling overhead all the time just waiting for a wee slip or an error of judgement or something to go wrong and swoop, they're going to be right in there.
>
> Interviewer: And who is the hawk?
>
> Oh the medical, the medico-legal aspect of it. And the medical fraternity I think, like the legal aspect just backs them up.
>
> (Interview 061101, text units 115 - 118)

The term "medico-legal" is not an accidental pairing of words but for midwives refers to the ubiquity and power of the biomedical discourse as it intersects with legal processes to shape and discipline midwives and their practice.

Midwives consider that the standards against which their practice will be judged in any formal or informal inquiry (local hospital, media, Nursing Council or Health and Disability Commissioner for example) will be those derived from the biomedical childbirth discourse. Midwifery care within this framework for practice will be seen to be substandard or lacking and this presses some midwives into defensive practices. In this, intervention is key.

> It's kind of being seen to have done everything possible …, even if it doesn't change the outcome, but then it's like it absolves you from being the cause, doesn't it?
>
> (Interview 050603, text unit 429)

Similarly, participants in Surtees' (2003) research commented, "We don't get hammered for doing the most; we get hammered for doing the least" (p. 231) inspiring Surtees to theorise the midwifery strategy of "advance defence" (p. 237). In this the midwife instigates practices (such as monitoring of the woman and fetus and documentation of decisions made) thereby constructing an audit trail to act as "advance defence" for an imagined future.

> Birth cannot be 'normal' here unless proven otherwise; it is always lodged within a medico-legal framework whereby the midwife can be called to account in hindsight for her actions. In her advance defence of herself, she must imagine all that could possibly go wrong in the future, to avoid this risk to herself, regardless of risk to the woman, the midwife must leave a visible trace of all her actions (p. 238).

As a midwife participating in this study comments,

> And it is drummed in to us all the time, document, document, document. "If you don't do this, this will happen, if you don't do that then that will happen".
>
> (Interview 070801, text unit 370)

This trail of intervention and documentation, whilst not necessarily offering anything to the childbearing woman in terms of improved outcomes (it may in fact contribute to poorer outcomes) ameliorates the risk to the midwife.

As the dominant knowledge and practice model, obstetrics is constructed as safe whilst practices based on alternate knowledges are constructed as risky. While this study did not research the perceptions of core midwives or obstetricians, midwives participating here consider that their practice was perceived by these groups as inadequate or lacking in many circumstances. If midwives step outside of the obstetric expectations for practice their inadequacies are certainly brought to their attention, invoking criticism

and the potential for formal disciplinary action. These formal disciplinary processes can also occur at the level of the obstetric hospital.

There are a number of overt disciplinary or investigative processes that midwives can be involved in at the level of the obstetric hospital. These include forums such as "case reviews", "perinatal meetings" or investigations that could result in the revoking of access agreements, complaints to the Nursing Council or the Health and Disability Commissioner. Midwives sometimes recounted experiences of case reviews or perinatal meetings that served as effective education sessions where they could candidly discuss clinical cases and felt respected as health professionals. More often than not though, midwives see these types of forum as covert disciplining technologies as the following exchanges illustrate.

Participant 1	Um, having been drawn through the coals at [name of tertiary hospital] before.
Interviewer	What do you mean by that?
Participant 1	Committees.
Participant 2	Meetings.
Participant 1	Review committee.
Participant 2	What do they call that one? Oh that's the perinatal mortality meeting and then there's the one where you present in front of [name of maternity service leader] and obstetricians and paediatricians, where they query your practice.
Participant 1	Well it doesn't feel like they're querying your practice, it feels like they're telling you what's what.
Participant 2	Finger pointing.
Participant 1	It's like a court. Well it feels like it.
Participant 2	But the thing about it is, they don't own us but that's the thing, you feel like they do own you sort of eh.

(Interview 050603, text units 437 - 451)

Interviewer:	What could be the nature of the recriminations?
Participant 1:	The O and G [obstetrics and gynaecology] review, monthly review thing that they had.

Participant 2: The education meeting, the education meeting in the secondary care unit was really just a way of throwing midwifery care, it was a way of pushing the medical model of care basically.

Interviewer: Education in inverted commas.

Participant 2: Education for midwives on what the doctors expected and why you should do it this way.

(Interview 260503, text units 169 – 173)

When midwives "pushed the boundaries" of accepted obstetric practice they did so with confidence in the safety of the mother and baby but fearful of the recriminations that might follow.

> …and in the end when we were fully debriefed, the fear was … it was not about what was happening, we had no worry about the woman's well being, it was about getting into trouble. But after we'd gone for about three hours we figured that we were done for anyway so we still kept going and it [the placenta] came out absolutely in it's own time in a perfectly natural physiological way ….
>
> (Interview 29b0503, text units 152 - 153)

The midwives in the following discussion work in a rural maternity facility and frequently have to consider the issue of transfer to the obstetric hospital.

Participant 1: And I remember one woman, it took three hours …we knew that if we didn't get her up to the secondary care unit within a reasonable time we'd have absolute recriminations and they'd be calling us for everything. We weren't worried about the woman, we were worried about the reception we would get … if we left her any longer and then took her.

Interviewer: You were happy with the woman's condition.

Participant 1: We were comfortable with the woman but it was always that thought of "oh what are they going to say if we've had her in labour, in second stage for three hours and then we take her up and hasn't made progress".

Interviewer: Who is "they"?

Participant 1: "They" being the medical fraternity.

Participant 2: The O and G's [obstetricians and gynaecologists] and the medical review team.

(Interview 260503, text units 160 - 166)

Midwives require access agreements to provide care in maternity facilities and they also need to establish effective working relationships with their midwifery and medical colleagues. Fear of recriminations at professional and personal levels makes it difficult for midwives participating in this study to practise in a way that is not supported by the dominant obstetric model of practice. However, as the excerpts from the interviews above indicate, it does not stop midwives from practising outside of accepted obstetric norms. This was true for midwifery practice inside and outside of the obstetric hospital. Midwifery practice inside the obstetric hospital however brings its own challenges, as the next section of this chapter will explain.

The hound at the door

Midwives act as lead maternity carers to a variety of women, some of whom will require obstetric consultation at some point throughout the childbearing process. Many of the midwives interviewed in this study consider that the referral guidelines (Ministry of Health, 2002a) and individual maternity facility policies worked to sweep as many women as possible into the line of sight (and so bring under the control) of obstetrics. Once a consultation has taken place, many midwives experience a loss of control of the situation.

> My experience … is that if for any reason you become involved with the obstetric team in there, then you do lose autonomy to a degree because the decisions they make they expect you to adhere to …
>
> (Interview 010601, text units 964-966)

Once consultation occurs the woman then moves into the control of obstetrics where the biomedical discourse dominates, situating the obstetrician as the authority, marginalising the midwife's knowledge and skills, the woman's qualitative needs and

desires and sweeping the woman into a risk/intervention framework of practice. It is difficult then for the midwife to continue with the plan of care that the woman and midwife established together.

> …from the moment you consult, you find yourself begging because they fail to respect you as a professional, to have that input at an inter-collegial interface.
>
> (Interview 291101, text unit 399)

In the obstetric hospital it is not only those for whom the midwife consults that come under the gaze of obstetrics. The midwives participating in this study perceive that there is a desire to extend the obstetric gaze to all the women birthing therein. This desire stems from the privileging of obstetric knowledges and practices and the alignment of obstetrics with safety within the biomedical discourse of childbirth. There is concern then that case-loading midwives may not be working within an obstetric framework or obstetric guidelines for practice. The practice of case-loading midwives is therefore policed and this most often becomes evident to the case-loading midwife through the actions of the employed midwife staffing the area (known as a core midwife). Midwives in this study describe the ways in which they are frequently approached by core midwifery staff "wanting to know". One midwife describes this as the "hound at the door" (Interview 061101).

> Wanting to know what's going on and telling you what they think should be going on you know, "she's been fully [dilated] for a long time" or … "what's your woman doing?" … knocking at the door saying "haven't you had that baby yet" or "where's the placenta?"
>
> (Interview 061101, text units 210-214)

> They're waiting, they're waiting; "this woman's taking a long time, making a lot of noise, do you need an anaesthetist?"... "Are you all right in there?" "Hasn't that woman, isn't she pushing yet?" Or "she's been in labour a long time!"
>
> (Interview 220501, text units 180 – 185)

Core midwives have multiple roles within the obstetric hospital and birthing areas. They may provide labour and birth care to women in the absence of a lead maternity

carer, they have input into secondary or tertiary level care (for example they may assist during a caesarean section or manage the intravenous infusions and monitoring of a woman with hypertensive problems), they may give advice and support to case-loading midwives (experienced and less experienced), they may assist as a second midwife during normal birth or be called in to assist with sudden emergencies. Often midwife coordinators or charge midwives coordinate the maternity services in a particular ward area on a particular shift and this involves managing the availability of resources (for example room space). To function in this role core midwives need to be aware of what is occurring in any labouring room at any time and most midwives participating here acknowledge this:

> … those people are our workmates, and we use them … we press a buzzer three times and we expect them to come in and help us…. there's that trust that they'll come and help us and we play our part by telling them who's in there, what's, where we're at so that they know, …
>
> (Interview 01060, text units 1620-1626)

Core midwives can play a pivotal role in enabling the work of the case-loading midwife. The biomedical discourse can also function though them as they work to bring the practice of others into line with obstetric norms. Their "wanting to know" brings the childbearing woman and midwife into the line of sight of obstetrics and from there pressure may be applied to discipline the practice of the case-loading midwife.

As we shall see in the next chapter, midwives participating in this study often feel that they need to protect women from the incursion of obstetrics and obstetric intervention. It is interesting to note that midwives experience much greater potential for this in hospitals with obstetric training programmes. In hospitals that conduct obstetric training programmes there is a more constant obstetric presence in birthing areas, bringing with it the potential for these doctors to become involved with childbearing women. This may occur through direct consultation (their accessibility making this more likely) or indirectly. Midwives describe situations where these doctors sometimes overhear conversations between midwives or are present when midwives are informally discussing a clinical situation or seeking advice from a core midwife. In one case the midwife describes how a "charming chitchat" suddenly turned into a severe reprimand.

> It is interesting, you can have that charming chitchat and you're an equal as long as you don't actually do anything that they don't consider OK.
>
> (Interview 010601, text units 1323 - 1324)

Midwives also provided accounts of very supportive collegial relationships, though these were more likely to occur with consultant obstetricians, where these relationships had developed over time. When there is continuity of obstetric staff midwives are often able to develop trusting relationships where they find that they are respected professionally and their input is valued. One of the main complaints of these midwives is that they do not have the opportunity to develop relationships with obstetric registrars over time as they frequently rotate to other clinical settings or hospitals. This means that midwives have to establish relationships with new obstetric registrar staff members on a regular basis. They also complain that registrars, through their inexperience, are frequently more anxious, inpatient and interventionist than their consultant colleagues.

Midwifery practice is disciplined in the obstetric hospital by the actions of some obstetric and core midwifery staff and by fear of disciplinary action both formal and informal. Not only do the people in this place emphasise risk and incite fear but so does the design and equipment.

The biomedical discourse constructs women's bodies as flawed and childbirth as inherently dangerous. Mechanistic models underpin the obstetric understanding of the body and childbirth processes and with that, childbirth is expected to function like clockwork. Phases of labour and birth are delineated and time limits applied. Labour progress is monitored, measured and graphed and frequently managed so that it adheres to the timeframes and norms of obstetrics. This discursive construction of childbirth operates through place, as the architecture, design, equipment, staff and policies work to construct and reify childbirth as risk. For midwives participating in this study, the obstetric hospital communicates risk and engenders fear.

> The big resuscitation tray for the baby. It's all aimed at when things go wrong and even though you try … , it reinforces that things can go wrong, doesn't it. And it does for the woman, for her family and for me. … you're just are aware that, it sort

of, I don't know, it introduces fear in the midwife and the woman.

(Interview 260503, text units 251-253)

Birth is constructed as a dangerous event and this is highlighted in the environment of the obstetric hospital leading to a climate of fear that, to one midwife, seems as if it permeates the very building itself:

I think that there's more fear, it's sort of sucked into the walls or something.

(Interview 010601, text unit1859)

Fear is emplaced in the obstetric hospital. Childbirth as risk is constructed by the dominant biomedical discourse of childbirth and in the obstetric hospital the architecture, ward and room design, equipment, policies and actions of staff members work to reify this construction. The constant reminder of childbirth as risk and the authority of this construction serve to discipline the practice of midwives.

Bringing midwives into line

As the dominant discourse, the biomedical discourse of childbirth constructs the local practice context and the wider medico-legal context of midwifery. Midwives are reminded constantly of the expectations of obstetric practice and are fearful of recriminations at local and wider levels. Midwives can become fearful and careful practising in "advance defence" (Surtees, 2003) of an imagined disciplinary situation.

Those things impinge on you. I think no matter how experienced or confident you are … you certainly do find that it creates a bit of tension and you think "oh maybe I should be doing something" …

(Interview 220501, text units 184 – 185)

Midwives may be more likely to involve the obstetric team, more likely to monitor the woman with a CTG machine for instance, less likely to tolerate timeframes not supported by obstetrics (Saxell, 2000; Surtees, 2003; Symon, 2000). Midwives recognise that this over-careful and defensive practice serves in the long run, to

undermine midwifery. In the obstetric hospital in particular these midwives consider that some other midwives defer to obstetricians too readily.

> But I think if you're always working in that situation where you've always been deferring I think that does over time undermine how confident you are on making those decisions.
>
> (Interview 010601, text units 1677 - 1679)

> All of the experience we've had, where practice is stretched, and that's how we grow but if you're in a situation where you're always deferring you never get that stretch.
>
> (Interview 010601, text units 1695 -1697)

So while we celebrate midwifery autonomy we also need to acknowledge that the dominance of the biomedical discourse of childbirth and obstetric authority serve to constrain and shape midwifery practice. As chapter 4.3 ("Body politics and the neo-liberal discourse of childbirth") explains, while the rhetoric of informed choice constructs consumers as empowered individuals who are free to make choices in line with their own values, the context in which those choices are made serves to discipline their decision-making. Similarly, the dominance of the biomedical discourse of childbirth works to discipline midwifery practice.

This is not the expression of sovereign power but something more subtle, as the midwife in the following excerpt describes.

> So even though nobody is actually saying, "no you can't do that", you're just are aware that, it sort of, I don't know, it introduces fear in the midwife and the woman.
>
> (Interview 260503, text unit 353)

There is no sovereign master, dictating practice to midwives but the subtle working of a micro-politics of power that disciplines practice nonetheless.

Obstetrics functions for midwifery as a panopticon. Inmates in Bentham's prison are never sure if they are being watched. There is constant potential for surveillance and this works at the level of their mind and body, as they become their own monitors.

They are subjected by the constant potential of this gaze. In the same way midwives experience constant potential for surveillance by obstetrics. Whilst midwives provide care to childbearing women relatively independently of obstetrics for much of their clientele, they can never be sure which women will require obstetric input (or result in an inquiry) thus bringing their practice under the scrutinising gaze of obstetrics. There is constant potential for surveillance and just like Bentham's inmates, midwives monitor their own practice, judging it as it would be judged by obstetrics. This means that obstetricians do not have to be present, watching or involved to exert power over midwifery practice. This was demonstrated in the talk of rural and homebirth midwives who felt the power of obstetrics as keenly as those working within the walls of the obstetric hospital.

Conclusion

This chapter explored the biomedical discourse of childbirth, specifically as it operates through the place of the obstetric hospital. The obstetric hospital was described as a place that reflects patriarchal interests and assumptions. The obstetric hospital functions as a technology of the biomedical discourse reifying the construction of childbirth as risky and women as flawed and passive. This place is neither the childbearing woman's place nor the midwife's and does not necessarily serve either of their needs well.

Place and space can be considered a product of the social but it is also implicated in the creation of the social. Childbirth is constructed in a particular way by the design, architecture, policies, behaviours and equipment of the obstetric hospital. This has the potential to impact on the corporeal experience of childbirth. This construction as it is constituted by place also impacts on the practice of midwives.

While midwifery is celebrated as an autonomous profession it is never independent of obstetrics or biomedical constructions. Midwifery practice is disciplined by the biomedical discourse of childbirth as it constitutes obstetric norms to which midwives are expected to comply. Following Surtees (2003) I describe obstetrics as panopticon, as the threat of potential scrutiny by obstetrics causes midwives to monitor their own practice. Midwives are always aware of the obstetric expectations for practice and how their practice at any point in time might be perceived from this perspective. I do not

mean to suggest that these midwives are docile, thoroughly inscribed by the biomedical discourse of childbirth with no potential for resistance. Midwifery practice is complex as midwives traverse a variety of discursive frameworks and negotiate multiple and sometimes competing interests. They frequently do push the boundaries of accepted obstetric practice and draw on a variety of discursive resources for support. The next chapter of this thesis focuses on the politics of midwifery practice.

Landscapes of Practice

6.2. The politics of practice

Case-loading midwives traverse geographical and discursive spaces, negotiating multiple meanings of childbirth as they do so. This chapter explores midwifery practice and describes the way that midwives "make space" for childbirth.

Introduction

In their daily working lives case-loading midwives traverse place. They move from the place of the woman, her home, into other places such as that of obstetrics, the obstetric hospital. They also move through spaces, the discursive space of their own construction of childbirth, that of the childbearing woman's and that which dominates the maternity care context and obstetric hospital, biomedicine. Within this context (comprised of multiple and contested meanings) midwives must negotiate a plan of care with the woman. This is theorised here as "making space" for the childbearing woman. This space often (though not always) challenges obstetric meanings (of childbirth and woman), creating an opportunity for alternative constructions.

This chapter describes how some midwives work with the childbearing woman throughout the antenatal period, attempting to reconstruct (or reify) childbirth as a natural physiological process and the maternal body as a competent one. The childbearing woman is positioned as a consumer in neo-liberal discourse and midwives exploit the currency of this construction as they prepare women for the obstetric encounter. In the obstetric hospital, midwives work to restructure the birthing room and protect the birthing space that the childbearing woman and midwife have negotiated together. This space is always fragile and midwives must patrol the borders and work the margins to protect it.

Differently positioned midwives and women

It is difficult to talk of midwifery without alluding to a unified, stable and coherent sign

"midwife". In Chapter 5 "(Re)-Making midwifery and the professional midwifery discourse"), I presented midwifery as a construct; a product of a particular time in history and a particular discursive context. Within this context multiple discourses traverse the bodies of midwives (Surtees, 2003) constructing their subjectivities in ways that are multiple, fragmented and shifting. Midwives often position themselves and each other within the polarising concepts of the midwifery and medical models and in so doing, fail to acknowledge the instability of these constructions, the varying positions between them and the fluidity of subjectivity as it is discursively produced. Following Tully, Daellenbach, and Guilliland (1998), Surtees (2003) identifies (and indeed sought out) "differently positioned" midwives within her study, referring to the different ways that midwives understand and interpret the concept of partnership and the multiple ways in which midwifery subjectivities may be produced. In reference to midwives' positioning in relation to the use of epidural anaesthetic in an otherwise physiological labour, Surtees (2003, p. 193) goes on to describe "cyborg" and "goddess" midwives. The "cyborg" midwife supports women in their use of epidural anaesthesia, understanding empowerment as the transcendence of pain in childbirth, and "goddess" midwives are those who resist the use of epidural anaesthesia, constructing their role as one of guardians of normal childbirth. By this Surtees (2003) does not intend

> to create artificial divides or dualisms between those with different practice philosophies or between those with a commitment to primary care, and those with a focus on secondary care provision…. Nor do I intend to homogenise the groups of women with whom these midwives are in partnerships (p. 193-194).

Surtees disrupts the stability of these categories by suggesting a way forward for midwifery in which these metaphors can be strategically deployed in different ways; representing different beginning points for midwifery action.

The midwives interviewed for this study were not as diverse as those whom Surtees sought out. I focused on case-loading midwives and did not include those who worked as core midwives. Eight midwives participating in this study were employed whilst the majority was self-employed. In initially seeking to explore the effect of the obstetric hospital setting on the midwifery model of practice and framing my research agenda along those lines, I sought out or attracted midwives who identified with the midwifery

model of care. This resulted in what is arguably a less representative group of midwives than Surtees' (2003) research group, but has served to highlight the particular issues that arise for midwives who do position themselves more firmly within the midwifery model, or professional midwifery and natural childbirth contexts. Surtees (2003) may conceive of this group of midwives as more "goddess" than "cyborg" but I see their relation to biomedicine and biomedical technologies as highly fluid, largely directed by the childbearing woman who is positioned centrally by professional midwifery, natural childbirth and neo-liberal discursive constructions of maternity care.

The childbearing women with whom these midwives engage are similarly variously positioned. Midwives frequently engage with women who are positioned differently to themselves in terms of their constructions of childbirth, their expectations of the childbearing experience or maternity care. Midwives understand the relation between woman and midwife and the care practices involved as a negotiation. A woman's particular positioning is not always understood as stable and some midwives actively work to influence this, creating a discursive space that contests obstetric definitions and maternity care practices. While this disagreement between the positions of midwife and childbearing woman are rarely extreme, extreme circumstances certainly challenge midwives to more clearly articulate and act on the philosophical basis of their practice. This could occur, for example, when a childbearing woman was seeking a caesarean section for social or other non-clinical reasons. It could also occur if a woman was seeking a homebirth for a more complex clinical situation such as a breech presentation. The midwife is then pressed to make a choice; provide the woman's care although the practice may run counter to her own practice philosophy, or decline to provide her care though this decision may challenge the midwife's concern for "woman-centred care". Some choose the in-between path of providing care for the woman while using the antenatal period to attempt to change her mind. Whatever the midwife's response, it presses her to consider the philosophical basis of her practice and the various competing interests at play.

So while in the following discussion, I necessarily discuss "midwifery" and the "childbearing woman" it is acknowledged that these categories do not represent homogenous or even stable groups.

Traversing places and making spaces

In exploring midwifery practice with midwives I began to understand their work as the movement and negotiation between place and space, and the creation of a birthing space. In their daily work midwives traverse place and space; they move from home to hospital, from woman to maternity caregiver, from spaces constructed by biomedical and natural childbirth discourses, from private and public spaces (or these discourses traverse the bodies of the midwives, see Surtees 2003). They journey into the place and space of the childbearing woman attempting to understand their subjective experience and the way that this pregnancy and childbirth is situated within the landscape of their life world. They travel with this understanding as they negotiate other spaces; the biomedical space of the maternity context and obstetric hospital and the spaces of their own discursive constructions of childbirth.

Midwives work within a context that is dominated by the biomedical discourse of childbirth (this is particularly so in the obstetric hospital). As we shall see in the pages to follow, within this they attempt to create a physical and discursive space for birthing that is perhaps unique to every new birthing woman/midwife relationship. Multiple discursive frameworks construct our understanding of childbirth and these combine (compete or converge) in unique ways to constitute the subject. While there may be some common understanding, the meaning of childbirth may be different for different individuals (and may not remain constant). The midwife and childbearing woman therefore must negotiate multiple meanings of childbirth as they construct a plan of care. Midwives may be aiming to facilitate a natural birth for some women and one as free from pain as possible for others. They may be actively encouraging the involvement of family members such as partners or siblings or they may be facilitating childbirth as a very private event. Midwifery practice with each individual woman may vary and this individual negotiation is at the heart of the partnership model of midwifery practice (Guilliland & Pairman, 1995a). In a meta-synthesis of select qualitative studies Kennedy, Rousseau and Kane Low (2003, p. 209) describe the building of an alliance between the midwife and the childbearing woman as an important midwifery process.

> The alliance was dynamic and changing, based on social, emotional or physical

needs, it was influenced by the uniqueness of the individuals involved, and the environment in which the care or practice occurs.

For some midwife/woman pairings the space that the midwife creates is one dominated by the natural childbirth discourse but even when the birthing space and birth event is thoroughly infused by obstetrics and obstetric practices, midwives draw on the technologies of "woman-centred care" and "informed choice and consent" (engendered by the professional midwifery and neo-liberal discourses) in an attempt to create a space that will maintain the woman as the focus of care. Hence midwives do not just traverse space, leaving the landscape untouched, but actively work to create space. We cannot assume however, as some of the studies into midwifery practice (Kennedy, Rousseau & Kane Low, 2003) and much of the "midwifery model" rhetoric does, that the midwife and childbearing woman are un-problematically united in a common goal, as this is not always the case.

We also cannot assume that midwives or women can create a place or a space for birthing that is free from biomedical constructs. As previous chapters describe, the dominant discourse of biomedicine is always already present even in those spaces from which midwives and/or women may seek to exclude it. Midwives and the childbearing woman must engage with biomedicine. Even as they embrace natural childbirth or homebirth they invoke the antagonist, biomedicine.

The work of creating space begins in the antenatal period as midwives attempt to counter the hegemonic influence of biomedicine and create a space that will allow for alternate constructions of childbirth such as natural childbirth. This work carries through to the postnatal period, intensifying during labour and birth particularly if this is occurring in the obstetric hospital. Here midwives employ a range of techniques to construct the physical and discursive birthing space. In all settings, but particularly the obstetric hospital, midwives patrol the borders of this space to protect the environment of the birthing woman, prevent unwanted intrusions and maintain the woman as the central focus of the experience.

Making space

In beginning the maternity care relationship many of the midwives participating in this study seek to establish the childbearing woman's expectations and understanding of childbirth, contextualising this within the landscape of their lives. "Woman-centred care" is a concept that is central to the professional midwifery discourse and predominant in the talk of midwives in this study. In an Australian study Brodie (1996) found that the introduction of a continuity of carer model of maternity care resulted in the shifting of midwives' loyalty away from their employer or profession toward their clients. Midwives participating here are mostly self-employed though, regardless of employment status, they centre the woman's needs as the focus of care. When I asked midwives about their aims for midwifery care they mostly stated that they strive to assist women to achieve the sort of birth experience they want.

Participant 1: It's a bit like supporting them to achieve what they want to, you know.
Participant 2: Absolutely, yeah.
Participant 1: That's right, finding out what they want and I think that is the thing in the beginning isn't it.

(Interview 220501, text units 16-17)

…what you want to achieve is empowering women to make decisions and give birth the way they want to and helping women achieve that and if that is an epidural or whatever then that's OK …

(Interview 071101, text unit 605)

At times, however this support for "woman centred care" and meeting the needs or desires of women brings midwives into conflict with other professional or personal values or imperatives such as those deriving from natural childbirth or professional midwifery discourses.

And that's quite hard sometimes 'cause sometimes they'll make choices that I don't think are good choices, they might want to have an elective epidural, or go for an elective section or they want to bottle-feed.

(Interview 061101, text unit 135)

In this situation some midwives use the antenatal period to attempt to influence women toward a more natural childbirth orientation, for example. In this process midwives might supply or direct women to select literature or evidence, explore in some depth the basis of their fears or expectations and generally work to bolster the woman's confidence in her abilities to grow, birth and parent her baby. This is particularly important for rural midwives whose income or the viability of their rural maternity units is dependent on women having the confidence to birth in an area or facility that is geographically distant from the obstetric hospital. The practice of rural and homebirth midwives in this study is constituted by the natural childbirth discourse to a greater extent than many of their urban or obstetric hospital counterparts.

> So the whole antenatal visit is focussed on building confidence and their trust in us, to birth here and not have to think about going to [name of city]. And that often works, you get people who come in quite adamant that, through past experiences, or friends experiences, they would like to birth in a central unit and through the antenatal period you can see that desire and fear wilting away and finally they just want to stay here.
>
> (Interview 050603, text units 102-103)

In building the woman's confidence in her ability to birth naturally, the midwife's work runs counter to the prevailing biomedical discourse that persistently constructs the woman's body as failing. The following excerpt describes the gentle way that this midwife works with a woman in her care, over time to influence her toward breastfeeding her baby.

> …And I guess that I do often revisit decisions, like I had a woman recently who was absolutely adamant that she was going to bottle-feed and I said, "yep, that's fine. What I'd like to do is run past you the advantages and disadvantages over the next few months" and then I wrote down in her notes, "going to bottle feed" so I felt that I was listening to what she was saying and I would go with that however, and the however is mine, like I want her to breast feed. So revisiting it [the decision to bottle feed] and starting to explore why she doesn't want to breastfeed and what does she know about it, what is her experience of it? Her experience is her sister in law, who I also happened to look after, who had terrible nipples and we had the

> lactation consultant involved for about 3 or 4 weeks and reduced supply because she couldn't tolerate baby suckling, all those hassles. Often I'll say "even the colostrum is brilliant, if you feel you could let the baby have that" and as she took little steps of "maybe, maybe, maybe" and just got a bit further and a bit further on and like six weeks postpartum she was still breast feeding beautifully, you know. And then I look back and I think, and she says she's really pleased that she's doing it but whose need have I actually been meeting? My need or have I been meeting her needs and sometimes I think, well, there's quite a fine line. So while I wasn't directive with that I was certainly engineering for that to happen.
>
> (Interview 061101, text units 139-146)

This is like the "protective steering" that Levy (1999) describes in her grounded theory study of midwives and informed choice in the UK. In Levy's study the categories orienting, raising awareness and protective gate keeping constituted protective steering. Midwives first oriented themselves to the childbearing woman's situation and needs, raised awareness of the available choices and provided information, though this was done in such a way as to guide the woman's decision making.

> Midwives often held strong views on what was safe or potentially dangerous or undesirable, and these views affected the direction in which midwives steered women when helping them make informed choices. (Levy, 1999, p. 110)

In New Zealand the maternity care structure allows for continuity of carer and this certainly provides midwives with an opportunity to develop a relationship with the childbearing woman that may allow her to influence her decision-making in ways that do not necessarily represent an oppressive model of care, though there are tones of paternalism in this approach. This midwife demonstrates that this can be done in a way that is gentle and respectful; acknowledging and respecting the woman's needs and desires and ultimate right to make her own decisions.

> My need is for that woman to have as few interventions and interruptions in that process [and] that I believe women can do well. So my need is to work in my role as a midwife to enable her to achieve that, now if she doesn't want to achieve it, the

epidural goes in on request.

(Interview 270503, text units 237-238)

This is a different positioning to that of midwives who construct their role as "neutral conduit" of information within the neo-liberal discursive maternity care context that was described in chapter 4.3 ("Body politics and the neo-liberal discourse of childbirth"). In this, midwives see it as inappropriate to attempt to influence women's decision making on a variety of choices, claiming that to do so diminishes the level of responsibility that the childbearing woman and/or her partner must bear for the decisions they make. In Levy's (1999) study however even those midwives claiming neutrality were noted to be steering women in their choices. For these midwives the childbearing woman is constructed as an empowered consumer within the rationalities of the neo-liberal discursive frame. The midwife above has no such qualms, articulating her positioning within the natural childbirth discourse and her strategy of attempting to influence women's choices during the antenatal period.

And with the, I mean if you asked me which of those was my leading light, I guess that I'd certainly be toeing for the normal and the natural, using informed choice but with a pretty coercive sort of choice really. So, while I'm not directive, I'm still manipulative.

(Interview 061101, text units 162-163)

Preparing an alternate space for childbirth (one that resists aspects of the dominant biomedical discourse of childbirth) in the antenatal period however is problematic. The biomedical discourse is always already present, constructing much of midwifery practice. The midwifery work of asserting the naturalness of childbirth and building the woman's confidence in her ability to grow and birth her baby is continually eroded by antenatal obstetric monitoring and screening practices that have become the norm for maternity care. These include ultrasound scanning, testing for diabetes, swabbing for Group B streptococcus to name a few. These practices have become expectations for care by obstetric colleagues and for many childbearing women, though their efficacy as screening tools remains largely contested. Whether or not midwives recommend or support these tests, their need to engage in the informed choice process with women means that they are continually highlighting the risks and dangers of pregnancy.

> Because I think that if you are going to tell women everything, that if you are going to be put in that position you have to tell every woman, every thing that may go wrong and all the tests that are available. I just don't agree with it because you actually add to their anxiety state.
>
> (Interview 050603, text units 134-135)

This practice contradicts their attempts to construct a competent maternal body and build women's confidence in growing and birthing their babies. In this situation midwives must balance the imperatives engendered by a variety of competing discourses such as risk management within the dominant obstetric discourse, informed choice and consent within the professional midwifery and neo-liberal discourses and pregnancy as a state of health within professional midwifery and natural childbirth discourses. There is no easy answer for midwives as they traverse these very different discursive spaces attempting to prepare a birthing space for the woman that is physically and emotionally safe, meets her needs and expectations and is also safe for the midwife.

The obstetric consultation presents a challenge to midwives in their preparation of a birthing space for women. Whether this space is one that aims for natural birth or a woman-centred experience in which women's needs and experiences are central, the obstetric consultation always threatens to disrupt this preparation. As described in chapter 4.1 ("Body politics and the biomedical discourse of childbirth"), the biomedical discourse constructs women's bodies as failing and childbirth as fraught with risk. Risk management within obstetrics involves the exertion of obstetric control and the sublimation of what is constructed as irrelevant or less important qualitative aspects of the subjective maternal experience. The obstetric encounter disrupts the midwifery work that has sought to assert the importance of the woman's experience and choices or her plans for a particular type of birth. Midwives engage in a variety of strategies in this situation, including using the system and grooming the woman.

Using the system

In some situations midwives are able to ensure that the childbearing woman accesses a particular obstetrician for consultation, one that they know will be more amenable to the woman's wishes or at least maintain the woman as the central focus of the experience. If the woman has private health insurance or can afford to pay for private obstetric care, this can easily be arranged. If however, the woman is using the public health system the midwife can attempt to direct the clinic appointment so that it occurs on a day that a certain obstetrician is covering the clinic. There is no guarantee, however, that the public hospital obstetrician consulted antenatally will be the same consultant seen in future appointments or during labour and birth. The lack of continuity provided by obstetric care results in frequent changes to the care plans of women requiring obstetric input, something that is a source of frustration for midwives participating here. For one homebirth midwife and a group of rural midwives, their strategies include using the employed midwifery staff of the obstetric hospital to advocate for the woman and negotiate care.

> Participant 1: It's quite interesting because I have just twice now used a core midwife for women that need to negotiate at length with the obstetric team and she has done a really good job. And I have used her because she knows the system, and she has done a really good job for both these women. She can negotiate with the paeds [paediatricians] for the woman, she will negotiate with the obstetrician, haematology. And both women have felt really good about that. It's because she knows all that inside out ….
>
> Participant 2: [She's] familiar with those hospital systems.
>
> (Interview 050603, text units 714 - 717)

These core midwives know the hospital system and have perhaps, developed relationships with the other health professionals involved. Kirkham and others (Anderson, 2004; Kirkham, 1999; Kirkham & Stapleton, 2004; Stapleton, Kirkham, Thomas, & Curtis, 2002) have undertaken extensive research in the United Kingdom exploring the issues that midwives face in attempting to meet the requirements of the

Changing Childbirth policy (Department of Health, 1993) that aims for a woman-centred maternity service (Kirkham, 1999). These authors have produced a body of work that describes the way that structural, social and cultural factors profoundly constrain the midwife's ability to refocus maternity care with the woman as central, or offer her informed choice in any meaningful way. Midwives in the UK are largely employed by the National Health Service (Kirkham, 1999). Kirkham describes the NHS as a patriarchal organisation in which midwives are relatively powerless. In this environment midwives are "caught in the crossfire" (Stapleton, Kirkham, Thomas & Curtis, 2002, p. 607) as they attempt to balance a variety of competing interests that include those of the childbearing woman, their profession, other health professionals, and their managers.

In this study (Stapleton, Kirkham, Thomas & Curtis, 2002, p. 607) the dominant interest influencing midwifery practice is that of obstetrics, and midwives found it easier to "go with the [obstetric] flow" than place themselves in the vulnerable position of contesting or resisting this influence. This means that, rather than acting as an effective advocate for the woman, these midwives tend to steer women toward choices that are sanctioned by obstetrics. Midwives' relationships with medical colleagues, managers and their professional organisations are more important than those with childbearing women. All midwives undoubtedly balance a variety of competing interests in their daily work but as Brodie (1996) has shown in her study of the introduction of continuity of midwifery care in Australia, this model of care can transfer midwifery allegiance to the childbearing woman. The structure of maternity services in New Zealand which supports continuity of carer and the self-employed status of many New Zealand midwives contributes to the central place that "woman-centred care" holds amongst all the midwives interviewed for this study. Kirkham (1999) and Stapleton, Kirkham, Thomas & Curtis's (2002) work in the UK (whilst pertinent to all midwives in New Zealand) is particularly pertinent to those midwives employed by obstetric hospitals in which patriarchal, biomedical and managerialist discourses predominate. While these employed midwives "know the system" and in that, may be well positioned to advocate for women requiring obstetric input, there is room for further research in New Zealand to assist in understanding the complexity of this role and whether the same factors impact on these midwives to the same degree that they do in the studies by Kirkham and others in the UK.

Constructing neo-liberal subjects

Midwives described to me the way that they prepare women for the obstetric encounter, frequently providing them with strategies and skills for maintaining control over the situation. There is generally more scope for this strategy in antenatal consultation where decisions are often less urgent but it is also used for obstetric consultations that occur during labour.

> I don't mind giving them some ideas; we might role-play all those sorts of things if we know something's coming up.
>
> ….
>
> Trying to put it in a nice way [suggesting the woman could ask] "well if I don't have an induction what do you think will happen?" And "why can't we go another day another week another whatever?" Just role-playing that at home and then her being able to use that strategy. And I think that to me, that's more empowering than me going along and saying, "She doesn't want to be induced".
>
> (Interview 061101, text units 283 – 286)

> … [I]f you do need some sort of medical input that's another difficulty like you've got to try and act as a bit of a buffer … and give the woman some strategies. …[A] common one I'll talk about is, "even if the doctor says you should have this or you should have that, if you're not 100% happy with it just say that you'd like to talk about it with your husband first before you make a decision". So that they've got some sort of retort that just gives them a breathing space so that they can actually be involved in the decision and say "well yes, we do want to do what he says or no, we don't want to do what he says" and a lot of the obstetricians find that quite hard but I think that's quite a good tool.
>
> (Interview 061101, text units 265 – 266)

The midwife as a buffer is an important concept that will be returned to in the pages to follow. Midwives also attempt to create space for decision-making in labour by suggesting that women and their supporters or partners take time to consider the advice of the obstetrician or by offering to arrange for a second opinion. This reframes the obstetric input as advice or opinion rather than as a fait accompli. These strategies are

situated within a neo-liberal discursive context that positions the woman as the key decision-maker in her maternity care. They also work to constitute an active and involved woman in ways that counter the prevailing construction of a passive woman within the biomedical discourse of childbirth.

These strategies may also disrupt the obstetrician-midwife relationship if its success is based on the expectation that the midwife will comply with obstetric instructions or collude with the obstetrician in convincing the woman of a certain course of action, which it frequently is, according to midwives participating here.

> It's like this woman that's had two previous [caesarean] sections and she [obstetrician] thinks she should have another section. I sort of said, "well I'm happy to support her [pregnant woman] with her choice but I'm also happy to reiterate what your concerns are or what you've said if that would be helpful" cause she said "I don't think she heard what I said". Well the woman heard very clearly what she said in fact …. But [with] some of the others [obstetricians] its really hard and I just keep coming back saying "well if the woman knows the advantages or disadvantages … or whatever, then I'm happy to support her with that". And the odd one will say, "oh you'll be up before nursing council within ra ra ra. You're being negligent". But mostly they're a bit too scared to say anything, I've had one or two give me an earful.
>
> Interviewer: What do they think your role should be in that situation?
>
> Oh I guess to do as I'm told which means doing what they think is right.
>
> (Interview 061101, text units 290 –296)

As obstetrics gained control over childbirth historically, the role of the midwife became one of handmaiden to the obstetrician (DeVries & Barroso, 1997). Midwives carried out the orders of the obstetrician and frequently managed the interface between childbearing woman and obstetrician. She became a "physician extender" (DeVries & Barroso, 1997) who collected and relayed clinical information from the woman to the obstetrician and in turn, relayed and carried out the orders of the obstetrician to the childbearing woman. The midwife and the childbearing woman were expected to

comply with obstetric orders. The accounts of the midwives participating here suggest that some obstetricians may continue to have these sorts of expectations.

> … it is the expectation that the midwife will support, get the women to understand
>
> why the doctor wants this to happen.
>
> (Interview 27b0503, text unit146)

If the childbearing woman does not acquiesce to obstetric recommendations it is assumed that either she does not understand the information given by the obstetrician or that the midwife has not properly fulfilled her role in gaining the woman's compliance. So, while the concepts of "informed choice" and "woman-centred care" occupy a predominant place in the rhetoric of maternity care policy in New Zealand, their implementation at the level of practice remains problematic, as Kirkham (1999) and Stapleton, Kirkham, Thomas and Curtis (2002) have found in the UK. In challenging the power of obstetrics however the neo-liberal discourse, which constructs the "consumer" as an informed decision-maker, does provide midwives with a valuable discursive resource. The concept of "informed choice" has currency in the obstetric arena and midwives participating here frequently use it as a strategic tool to challenge obstetric authority, thereby making space for the woman to participate in decision-making regarding her care.

Midwives must negotiate multiple discursive contexts in creating space for the childbearing woman. Many midwives in this study attempt to create a space that builds women's confidence in growing and birthing their babies and at least allow for the possibility of natural childbirth, though this work was continually challenged by the predominant biomedical childbirth discourse. They also work to create a space for the childbearing woman in which she can exert her needs by providing the woman with strategies for the obstetric consultation and by using their knowledge of or contacts within the maternity system. These strategies begin in the antenatal period and are aimed at creating a space for birthing that includes a central role for the childbearing woman and perhaps the potential for natural childbirth. The specific birthing space created by midwives is unique to each birthing woman.

The normalising gaze

Chapter 3.1 ("A feminist, poststructural approach to research") explored Foucault's thesis on the disciplinary effects of the panopticon. The observation of individuals in institutions (such as schools, prisons, hospitals, work houses) has also enabled the development of a body of knowledge that has been categorised and organised (for example, medical knowledge) (Foucault, 1973). Observation or the 'gaze' is therefore a technology of power as it makes the object knowable. This is the productive effect of power as it produces a subject that is constituted by knowledge. In childbirth, obstetric knowledge constitutes the maternal body in a certain way and this knowledge provides the basis for obstetric domination (Murphy, Lawless, 1998). The hospital has played an important role in creating this knowledge, as bringing women to the hospital for childbirth allows for repeated and continual examination, documentation and observation of childbirth.

Foucault describes how the disciplinary and productive effects of the gaze are dependent on two other factors: a system of hierarchical supervision and examination. The ability to relay information effectively became increasingly important in the 18th to 19th centuries with the increasing size of production and complexity of organisations. This was achieved through the use of uninterrupted supervision in the form of a hierarchical network. In the workhouse, for example, each individual within the network is continuously observable by a supervisor of increasing seniority. This is true also for the hospital setting where a hierarchical structure is clearly evident. In midwifery prior to 1990, childbearing women were observed by midwives, who were observed by more senior charge midwives, who were answerable to medical staff that were supervised by more senior medical staff and so on through the ranks.

Power within this system of hierarchical surveillance is not something possessed or owned by those at the top of the hierarchy but it is the apparatus as a whole that produces the effects of power. This makes this power both discreet, in that it functions silently, yet indiscreet, because it is constantly at work throughout the entirety of the network (Foucault, 1995). What is so important about these techniques of power is, as Foucault (1995, p. 173) asserts, "They secreted a machinery of control that functioned

like a microscope of conduct". Within the network of hierarchical surveillance each individual is not only visible but also knowable. As the object of disciplinary power is to train, individuals must be measured and compared in order to assess the success of training; judgements have to be made and Foucault (1995) refers to these as normalising judgements.

Foucault (1995) describes how those within the workshop, school or army were subject to a range of punishments for anything that was not seen to measure up to a certain standard, "the whole indefinite domain of the non-conforming is punishable" (Foucault, 1995, p. 179). This normalising judgement also serves to measure gaps (from normal) and situate individuals according to rank or grade, and according to an established level or norm. In the hospital setting for example the patient is compared and ranked according to standards of normal health and normal behaviour.

The examination is another important element that brings into play both hierarchical observation and normalising judgement. Foucault (1995, p. 185) refers to the examination as an "innovation of the classical age" as it became an exercise of power. Through examination, the collection of documentation about an individual creates a 'case'; it creates a wealth of information about a person making them highly visible and, through this intensive "individualisation", they can more easily be differentiated and judged. Foucault (1995) credits the examination and the development of the hospital as an "examining apparatus" (p. 195) with the epistemological "thaw" of medicine at the end of the eighteenth century. The examination acts as a technology of the sciences such as medicine; one that implements power relations that make it possible to constitute knowledge of the field.

Foucault (1995) describes how from the seventeenth to the eighteenth centuries, the function of the physician in relation to hospitals changed significantly. Where they had once been external to the hospital, visiting sporadically and briefly, over this period of time they became a much more integrated part of the hospital. Physicians became employed by the hospitals, and routines of examination were established, with the consequence of making the patient therein almost in a constant state of examination. The employment of the physician within the hospital structure also had two other important consequences. The physician was insinuated within the hospital hierarchy in

positions senior to the religious and administrative staff and the category of nurse appeared (Foucault, 1995). The nurse was able to extend the normalising gaze of the physician, monitoring the patient, collecting and extensively documenting information on each patient.

In traditional forms of discipline such as the spectacle of public torture, those masses of people deterred by the spectacle are relatively invisible. It was the sovereign and the power of the sovereign that was visible. The examination on the other hand makes the subject highly visible, it inverses the relations of visibility evident in traditional forms of discipline because its disciplinary power is invisible. As Foucault (1995, p. 187) states,

> In discipline, it is the subjects who have to be seen. Their visibility assures the hold of the power that is exercised over them. It is the fact of being constantly seen, of being able always to be seen. That maintains the disciplined individual in his subjection.

Not only are individuals placed within a field of observation but along with the examination comes an accumulation of documentation with the effect of both "capturing" and "fixing" the individual concerned in a network of writing (Foucault, 1995, p. 189).

As the next paragraphs will illustrate, in the area of maternity the clinical gaze of obstetrics fixes the childbearing woman within the discursive field of biomedicine and this intersects with a masculinist gaze that constitutes appropriate feminine behaviour for the childbearing woman and midwife.

Gendered midwifery subjectivities

The normalising gaze of obstetrics determines "appropriate" behaviour for the childbearing woman and midwife. Chapter 3.1 ("A feminist, poststructural approach to research) explores the ontological positioning of women within a masculinist context, in particular their alignment with the body in opposition to the mind. Chapter 4.1 ("Body politics and the biomedical discourse of childbirth") also described the

legitimacy of obstetric knowledge and the authority of obstetrics vis-à-vis other practices such as midwifery. Masculinist constructions and biomedicine converge powerfully to marginalise the knowledges of women and to deny women an authoritative, knowledgeable, speaking position. These gendered assumptions construct roles and relationships within organisations (Davies, 1992; Davies, 1996; Ferguson, 1984; Pringle, 1992, 1993, 2001; Ramsay & Parker, 1992) including the maternity system and the obstetric hospital. Within this discursive context a good midwife or woman (the norm) is one who complies with obstetric directives.

In New Zealand, even though the concepts of woman-centred care and midwifery autonomy predominate in the natural childbirth and professional midwifery discourse, commitment to woman-centred care and the enactment of autonomous midwifery decisions in the obstetric hospital setting can marginalise midwives. Compliance and passivity are normalised through the technologies of gendered power relations in this setting. Midwives in Sharpe's (1997) Canadian study felt that their practice was scrutinised and judged within the obstetric hospital and that there was an expectation that they would comply with hospital policies and rules. To maintain credibility and hospital privileges they were expected to "behave like good girls" (p. 222).

These normalising technologies push "deviants" to the fringes and, from the fringes the subject position of "normal midwife (good girl)" (in this context) is not available to them. In constructing a midwifery identity these midwives invariably take up alternative subject positions, commonly 'the mad midwife' and 'the battle-axe'. Mad midwives and battle-axes describe more confrontational or assertive approaches to protecting the birthing space and advocating for the women in their care. These midwives are frequently "non-compliant" in that they do not necessarily adhere to hospital policies, clinical guidelines or obstetric recommendations. Their focus and loyalty is to the childbearing woman in their care rather than obstetrics or the institution of the hospital.

The "battle-axe" is highly experienced and somewhat battle-worn, she is not afraid of confrontation, pays little heed to hospital clinical policies or guidelines and assertively advocates for the women in her care.

> And I think as I'm considered a bit of a battle-axe,... they're just not too game to take me on.
>
> (Interview 061101, text unit 200)

Similarly the mad midwife (usually a homebirth midwife) is vehemently committed to the birthing woman and her needs and often has her own way of doing things that may be seen as unconventional within the obstetric hospital.

> One of the students …had been working in labour ward and she said that she'd been sitting in the office … and said they [ward staff] were talking about "You know what the homebirth midwives do?" And she was expecting something like, like dancing naked at the full moon and it was just something like "they get the woman just to pee straight on the stick and not in a pot". [laughter]... And she was just completely stunned and it was like, well if they can't think of anything else to talk about well it's getting pretty desperate really.
>
> (Interview 220501, text units 442-444)

As non-compliant midwives, these women are in a vulnerable place. Their work in advocating for the women in their care and protecting her birthing space often brings them into conflict with obstetrics. These conflicts always have the potential to progress to formal complaints, which can threaten midwives' access agreements with the hospital or their registration as a midwife and can also result in what the midwives describe as punitive action against the women in their care. As one midwife describes,

> Well the midwives who don't do as they're told, who don't follow the line are actually targeted with complaints. Not only Nursing Council complaints but with incident reports and just the paediatrician comes and speaks to the parents and all the nasty stuff that goes on underneath.
>
> (Interview 27b0503, text units 186-187)

While these midwives do see themselves as vulnerable and marginalised within the obstetric setting, this marginalisation can also create some liberating effects. These midwives develop a reputation for non-compliance, assertiveness and sometimes confrontation, and with this comes certain freedoms. As the midwife claims above,

"they're not too game to take me on". They may be left to work more autonomously without the same level of surveillance that may be imposed on their case-loading midwifery colleagues and obstetricians may also become accustomed to and accepting (or respecting) of their practices. These are also experienced midwives who felt that they had earned some respect from their midwifery and medical colleagues. They proclaim their autonomy and speak with authority and confidence, albeit from the margins.

Midwives participating in this study are generally more experienced midwives so I can only speculate that this same authority may not be claimed from the margins for less experience midwives. Surtees (2003) included a number of new graduate and core midwives in her study, describing the way that midwifery practices in the obstetric hospital are governed by a shifting balance of external surveillance and internal self-monitoring. Some core midwives "silently watch" the practice of new graduates, which she suggests can support the learning of the new graduate and act as a form of governance. New graduate midwives in Surtees' (2003) study felt that core midwifery staff scrutinised their practice and that it was perhaps spoken about in tearooms and corridors. The lack of direct communication, the omnipresence of the potential for surveillance and the uncertainty regarding exactly who may be watching or talking when, constituted the obstetric hospital as a panopticon. These practices normalise the behaviour of those caught within and I suggest that this impacts as much on the experienced case-loading midwife as it does on the new graduate midwife.

The midwife who fails to normalise her behaviour however, may be constructed as mad or as a battle-axe. This depiction of midwives is not particularly flattering and serves to demean those who do not conform to the gendered role norms of passivity and subservience. The technologies of power that construct a "normal" midwife or a "good" midwife with these gendered role expectations press "other" midwives to the margins where they represent deviance.

As this thesis demonstrates, midwives are not thoroughly constructed by the normalising masculine gaze and often do act in ways that resist or counter the expectations arising from this dominant discursive field. The work of McNay (2004) is useful here. Chapter 3.1 described the concept of "situated intersubjectivity" developed by McNay (drawing on Habermas and Bourdieu), in which identity and behaviour are

understood as developing out of a complex interplay between "habitus" and "the field". Material conditions and relations of power (including those positioned through discourse) constitute "the field" while "habitus' is understood as the physical and psychological disposition of an individual. Subjects such as midwives, maintain agency within this account, as it is not only the field but also their disposition that shapes their identity and behaviour. I described in chapter 3.1 how subjects move between fields and how they might be positioned differently in these different fields. This movement gives rise to "…contradictory and dissonant power relations" (McNay 2004, p. 182). While a thoroughgoing analysis based on McNay's (2004) concept of situated intersubjectivity is beyond the scope of this thesis, this line of inquiry will be useful for further studies examining midwifery practice particularly as it is impacted by place.

While the masculinist and biomedical gaze constitutes appropriate midwifery behaviour and presses those who are non-compliant to the margins, the obstetric gaze also fixes the childbearing woman within a biomedical framework. Within this she is examined, documented and her progress graphed and measured. Normalising judgements constitute her as normal or abnormal. In acknowledging this, disrupting the obstetric gaze becomes an important midwifery strategy for resisting obstetric control of childbirth. If the childbearing woman cannot be seen, she cannot be fixed and judged according to obstetric categories and standards. This process begins with the gaze and this is something the midwives participating in this study are profoundly aware of.

Disrupting the obstetric gaze

One of the most powerful techniques for obstructing the obstetric gaze on women planning to birth in the obstetric hospital is to delay the woman's admission to hospital. This was a strategy that was also used by midwives participating in the New Zealand study by Crabtree (2002). Many midwives support women at home by spending time with them at home if this is necessary.

> So I encourage women to stay home as long as they're comfortable and I say, "I can always come out and see you, see what's happening and talk about what is going to be our plan. Review it if we need to, stay with you if it looks like things are getting strong". Or if it's still early days I just ask, "what are you going to be doing today,

have you got some bills to pay, have you got your children organised …" Just so they're doing normal things around the home for as long as they're comfortable.

(Interview 281101, text units 332-335)

Participants explain that this is a useful strategy both to keep the childbearing woman preoccupied (and so not focussed on labour progress and time) and also to avoid obstetric intervention. Premature admission to labour ward has long been understood by midwives as a factor that may contribute to increasing rates of obstetric intervention (Anderson, 2000; Warwick, 2001). Once a childbearing woman is admitted to the obstetric hospital there is greater potential for them to come to the attention of obstetricians as the midwife describes in the following excerpt.

My personal strategy when I was an independent midwife was to keep them at home as long as possible, even if they didn't intend to birth at home. That was the key thing, keeping them at home as long as possible.

Interviewer: Why was that?

Because [there were] like, time limits once they reached hospital. People were watching them and their name was on the board, and an obstetrician was aware of their presence and wanted to know how they were doing and you felt kind of pressured to give them a run-down on what was happening even though it wasn't a formal sort of thing.

(Interview 290503, text units 108-111)

Within the obstetric hospital, midwives attempt to create a physical place for the birthing woman that facilitates the childbirth process (as they understand it). Midwives often manipulate the birthing room to facilitate childbirth. They told me how they frequently move the bed from the centre of the room and push it to one wall, sometimes removing the mattress and placing it on the floor with pillows and beanbags. This aims to discourage the childbearing woman from occupying the bed and thereby encouraging a more physically active labour. Women are also encouraged to bring personal belongings into the birthing room of the obstetric hospital (such as photographs or pillows etc), to play their own music and sometimes to bring their own scents (such as electric scented oil burners). These are attempts to domesticate or personalise this place

and delineate it from the more public obstetric place within which it is located. In doing this work, midwives are creating and claiming this physical place for women. The creation of this place communicates to the woman, her supporters and, importantly, to other health professionals, that this is the woman's place over which she has some ownership and in which she has sense of autonomy. Asserting ownership of this place and delineating it from the rest of the obstetric hospital is important and this is achieved often by simply closing the door.

When I asked midwives about their practice within the obstetric hospital, in particular their strategies for achieving what they want to achieve with/for the woman in their care in this setting, their first response, almost without exception, was that they close the door.

> Keep the door closed! (Interview 24080, text units 388 – 389)

> Doors, shut the doors! (Interview 240801, text unit 605 – 609)

> Close the door and don't tell them what's going on behind it. (Interview 270503, text units 276 – 276)

Some followed this comment with a laugh as if it was something trivial or ridiculous. For some midwives this strategy is simply aimed at providing the woman with a private birthing space ("I'm not a closed-door person that nobody knows what's going on" 29b/1101, text unit 185) but for many others it is more strategic and concerned with protecting the woman from the unwanted intrusion of obstetric involvement or practices. This was also a strategy highlighted by participants in Crabtree's (2002) study. When I asked the midwife below about her relationship with a particular obstetric hospital she replied,

> Yeah, it's very intrusive. I feel that I've almost got to not quite lock the door but almost. Build a boundary between the woman I'm caring for and them. And it's that protective thing, to protect the woman from them and their influence.
>
> Interviewer: Who's "them"?

> Well it's mostly the core midwives and in particular some of the charge midwives and I think the charge midwives play quite a crucial role really. I mean there's two or three of them there that just think they have to be responsible for everything. And they're not quite game just to walk into the room where I'm working but they certainly do for some of my colleagues.
>
> (Interview 061101, text units 194-199)

Observation is a powerful technology of biomedicine. Drawing on Foucault (1973), Braidotti (1994) explores the workings of biopower through/on women and in particular the maternal body, through reproductive technologies. In a reversal of Delueze's "bodies without organs", Braidotti conceives of "organs without bodies" referring to the way that biomedical technologies have denaturalised the body, isolating organs from their whole-body context.

> Of great significance for feminism is the way in which the new reproductive technologies, by officializing the instrumental denaturalization of the body, also institutionalise dismemberment as the modern condition, thus transforming the body into a factory of detachable pieces. (Braidotti, 1994, p. 61)

The development of technologies that enable the visualisation of organs or fetus (such as ultrasound, endoscopes) are motivated by a scopic drive which in psychoanalytic terms, is related to a desire for knowledge in order to dominate. Within this light the desire to see engendered by biomedical discourse, enacts violence on women's bodies (Braidotti, 1994). Certainly reproductive technologies such as ultrasound and cardiotocographic monitoring focus on the fetus, isolating it from the maternal body and in so doing constructing a new "patient"; the fetus as subject. This is a point I have explored in chapter 4.3 ("Body politics and the neo-liberal discourse of childbirth"). I am suggesting here that obstetric hospital birth, which delivers women into the obstetric gaze, is a result of this scopic drive and so functions as a powerful technology of biomedicine. This thesis has described the multiple ways that childbearing women are brought into the line of sight of obstetrics. During childbirth in the obstetric hospital there is often intense pressure from doctors and some midwives to gain access to the birthing room; to see and to know what is occurring within. Midwives participating here recognise this as a strategy of control. Obstetrics needs to "see" the childbearing woman, without this there is no control. Hence, the simple midwifery strategies of

keeping women at home or of closing the door can be seen as significant transgressive acts that work to disrupt the obstetric gaze.

Midwives interviewed for this study also engage in strategies that are aimed at obscuring the obstetric gaze. Whist delaying hospital admission and closing the doors to the birthing room obstructs the obstetric gaze the strategies presented here disrupted this gaze in a slightly different way.

Chapter 4.1 ("Body politics and the biomedical discourse of childbirth") describes the way that the biomedical discourse of childbirth inscribed the maternal body and the process of childbirth with time constraints. In constructing the maternal body as faulty and creating an adversarial relationship between mother and baby, time spent in utero for the fetus constitutes risk. Length of pregnancy and the various stages of labour are therefore tightly controlled within the biomedical discourse of childbirth (Simonds, 2002). Obstetric intervention is frequently introduced because the maternal body has not functioned in accordance with obstetric definitions of normality. Pregnancies extending beyond 40 weeks duration are induced, labours extending beyond certain time limits are augmented, babies not born after a certain time from full dilation of the cervix are "assisted" (ventous, forceps) and intervention follows a third stage that is not completed within two hours. Time is all-important and midwives participating here are well aware of the "ticking of the [obstetric] clock" and the milestones that start the "countdown" for the labouring woman. The "ticking of the clock" starts for the childbearing women once they are seen by obstetrics and once they are accurately situated within a continuum of progress (an actual or virtual partogram) constituted by finite time constraints. Midwifery strategies are concerned then not only with obstructing this gaze (as the preceding section described) but also in preventing the childbearing woman from being accurately situated within this continuum. In this they are working to obscure the obstetric gaze and, as they frequently describe, they are "buying time".

The commencement of labour, rupture of membranes and the moment of full dilation of the cervix are significant milestones within the biomedical discourse of childbirth. These serve to firmly locate the woman within this obstetric continuum and clearly delineate a future time in which labour and birth must be concluded according to obstetric norms. Midwifery strategies for resisting this endeavour include the provision

of imprecise or vague information or avoiding practices (such as vaginal examination to establish full dilation of the cervix) so that the occurrence of these events cannot be established with certainty.

In the obstetric hospital midwives acknowledge their obligation to their core midwifery and medical colleagues to be informed (and so prepared should they be needed to assist in a birthing room) but balance this with the pressure that often follows once a woman's location is clearly established within obstetric timeframes. Midwives negotiate this balance by providing core midwifery or medical staff with what they consider adequate information, but information that was sometimes vague or inexact.

> Like I mean, I sort of would probably keep them a bit informed. [It] depend[s] who's on, how much I'll say and I'll usually underestimate what's happening. Like, I might think she's been fully [dilated], getting pretty pushy for the last half hour or an hour but I'm not going to tell them until she is really actively pushing and maybe got a peep [of the babies head showing]. Cause they're going to be setting their watches and I don't want them knocking at the door saying "haven't you had that baby yet" or "where's the placenta" or whatever else.
>
> (Interview 061101, text units 213 – 213)

> Participant 1: I'd use another strategy, it's stretching the truth somewhat.
>
> Participant 2: Yes, yes, yes
>
> Participant 1: When they say "how long has she been fully dilated", [I'd say] "well she's not quite fully dilated, she's got a bit of an anterior lip" you know, but you'd been pushing for half an hour. But that is a strategy I use to try and cope with things in hospital and hiding in the room. Going in the room, shutting the door and not coming out because if I don't come out nobody can ask me, they can't see me, and they can't ask me…
>
> (Interview 010601, text units 1464 – 1471)

> Yeah, like filtering the information, I think might be a good way of putting it….
>
> Interviewer: So it's more within the realms of their framework?

Yeah, 'keep them happy' sort of information.

(Interview 061101, text units 234 - 236)

In this, midwives are attempting to prevent the normalising judgment of obstetrics from fixing the childbearing woman in a certain obstetric category or within an obstetric temporal framework. They are drawing on an alternate construction of birth (constituted by alternate measures of safety and progress) and creating space for the childbearing woman to birth without intervention by "buying time" or pushing out the time limits imposed by obstetric norms. These strategies do not confront or challenge obstetric norms head on, and can in fact work to reinforce these norms as midwives conspire to construct (for core midwifery and obstetric staff) a labour and birth time line that does in fact align with obstetric norms. It could be argued that these strategies are gendered in that they involve subversive acts of resistance rather than direct confrontation. Midwifery and nursing have a long history of playing this sort of "doctor-nurse game" (Stein, 1967; Stein, Watts, & Howell, 1990; Sweet & Norman, 1995). When doctors managed childbirth, midwives were well known for dropping the episiotomy scissors at the opportune moment, hiding the obstetric gumboots or calling the doctor for a birth too late.

As this study has shown midwives do continue to use these subversive acts of resistance. In the UK Pollard (2003, p. 119) describes the practice of "autonomy by stealth" (somewhat a contradiction in terms) as midwives quietly and "craftily" practice in a way that does not comply with obstetric policies. Kirkham and Stapleton (2004) too found that many midwives who were not compliant with the spoken or unspoken rules of obstetrics, preferred to keep a low profile rather than engage in direct confrontation and face the consequences of reprisal. Midwives do sometimes engage in direct confrontation though arguing from a position of marginality is extremely difficult. Midwives are fearful of the informal and formal disciplinary (or punitive) actions that might follow confrontation. They are also concerned with how confrontation might impact on the creation of an environment that is conducive to a positive childbearing experience for the women in their care.

Midwives are attempting to create a space around the birthing woman that is facilitative of birthing. In this study this means creating a safe, relaxed and convivial environment where the childbearing woman feels she has some control. Midwives in Powell

Kennedy's (2002) USA study were concerned to create a similar sort of environment. Midwives do confront obstetrics head-on at times but they also have to balance this against the maintenance of this birth environment and their collegial relationships. Midwives participating here describe how head-on confrontations were not always the most effective way of assisting the childbearing woman to have the sort of experience she hoped for. A direct confrontation often resulted in disaffected obstetric colleagues which made them less amenable to the childbearing woman or midwife's suggestions or, worse still, could result in what the midwives perceived as punitive action against the childbearing woman. Midwives therefore engaged in complex negotiations in the obstetric hospital setting. The relations between obstetricians and midwives are gendered as midwives assume responsibility for the "soft" outcomes of relationships and qualitative aspects of the childbirth experience. From the perspective of the midwives participating in this study, maintenance of the inter-professional relationship and a qualitatively positive birthing environment often require compliance rather that assertiveness.

As we shall see in the pages to follow, the work of creating and maintaining a facilitative birthing space, responding to the environment of the obstetric hospital, and the constant potential for unwanted obstetric attention requires additional work that is not required of midwives when they support women birthing in other environments (such as home or primary birthing units). This is the work that I understand as "border patrol".

Border patrol

The previous paragraphs described the way that midwives in this study attempt to create a physical and discursive space for the childbearing woman; one that is conducive to birthing and holds the woman at the centre of the experience. Midwives begin preparing this space in the antenatal period, with an important element being the midwives contextualised understanding of the woman and her individual needs and desires. Other authors have described this midwifery work as advocacy (Powell Kennedy, Shannon, Chualhorm & Kravetz, 2004; Walsh, 1999), describing the way that midwives negotiate with other health professionals to help women obtain the sort of

birth experience they desire, especially in the face of obstetric intervention. One participant in a study by Walsh (1999) described her midwives as "buffers". "[They] acted as a buffer between what the hospital wanted and what I wanted" ('Rita' cited in Walsh 1999, p. 170). Crabtree (2002) also describes the midwifery actions of closing the door and delaying admission to the birthing unit as strategies that protect women from medicalisation. Midwives in her study were creating a "buffer" between the childbearing woman and obstetric intervention. Midwives in this study also used the word "buffer" to describe their work in the obstetric setting. While this work certainly entails some advocacy and may in fact safeguard the childbearing woman from obstetric intervention, the concepts of advocacy and buffer do not adequately describe the active role that midwives play in creating and protecting a particular birthing space or orchestrating a particular maternity care environment (Powell Kennedy, Shannon, Chualhorm & Kravetz, 2004) for the childbearing woman.

Feminist, professional midwifery, natural childbirth and neo-liberal discourses provide discursive resources for midwives in this work. They invariably highlight the importance of woman-centred care and the role of the childbearing woman in making choices in relation to her care. In the obstetric hospital (the discursive space of biomedicine) the vulnerability of this space becomes clear. The integrity of this space is threatened on many fronts and midwives must continually work to protect this space and patrol its (admittedly fluid and permeable) borders. Midwives participating here used the word "protect" when they described their work in the obstetric hospital.

> Yeah, it's very intrusive, like for me I feel that I've almost got to not quite lock the door but almost. Build a boundary between the woman I'm caring for and them. And it's that protective thing, to protect the woman from them and their influence.
>
> (Interview 061101, text units 194 – 196)

> So I suppose I protect the woman from the [name of hospital] staff which seems bizarre doesn't it?
>
> (Interview 071101, text unit 334)

Midwives participating in this study use a variety of strategies in the obstetric hospital to protect this birthing space. Within the prevailing discursive context that positions the childbearing woman as an empowered decision maker, the childbearing woman is key,

and ultimately controls this alternate discursive space (though she frequently loses control of the space once it becomes an obstetric space). Thus the importance of the "preparation work" in which midwives engage in the antenatal period. Midwives demonstrated a profound understanding of the way that the birthing space can be altered by the introduction of certain obstetric practices or personnel. These practices or people can communicate values or philosophies that run counter to those the midwife has been trying to establish within the birthing space, or drastically alter the course of events. For example if a midwife seeks obstetric advice for a woman whose labour is progressing slowly she knows that pharmacological augmentation of labour is a likely outcome and the midwife often understands this as the beginning of a cascade of intervention. The message that is communicated to the childbearing woman is that her body is deficient and this often results in a loss of confidence in her body and her ability to birth her baby unaided by obstetric intervention. Another midwife described how the introduction of obstetric personnel could alter the atmosphere of the birthing space with the private and relaxed birthing environment becoming a "three ringed circus" (interview 28b0503, text unit 368). So it wasn't always the interventions that midwives objected to (acknowledging that some women will require obstetric intervention), but the way in which it was conducted.

More experienced midwives in particular describe how they will direct their core midwifery colleagues should they be needed in the birthing room, so as to maintain the integrity of the atmosphere of the birthing space.

> But nonetheless I feel that I'm still having to put that protection up and it's the intrusion and the taking over. Like if I ring for assistance, I know I need to be very directive and very clear about what I want done or they will take over, very inappropriately and like this real panic mode and "ohh!!"
>
> (Interview 061101, text units 203-204)

What these case-loading midwives want from their colleagues is for them to respect the decisions made by the midwife and childbearing woman and for their presence in the birthing room not to disrupt the atmosphere that the midwife has worked hard to create. These midwives explain that they appreciate the knowledge and skills of their core

midwifery and medical colleagues, but do not want this support to come at the expense of the carefully created birthing space.

> Some of them [core midwives] are really good and they'll come if you want assistance, they'll just come quietly into the room and say, "what do you want me to do?" And I'll say, “just sit” and “I'm just a bit concerned cause I've got this and I just might need a hand at delivery". And they are great, they will just do as you say and instead of waiting for a third stage and sitting there, fidgeting cause it’s an hour or whatever they'll say, "shall I come back if you need me?" [I’ll say],"that's just fine". So they are prepared to just slot in with the way that they know some of us work and I guess if you could see that more often, a willingness to slip into the framework of what's there. …. [T]hat they respect what has been sorted out between the woman and the midwife.
>
> (Interview 061101, text units 422-425)

These more experienced midwives describe themselves as “battle-axes”. Their experience and maturity constitutes a subject position that allows them to assert their expectations with confidence. Previous confrontations (especially with core midwifery colleagues) had made their expectations clear to others and they consider that, as a result of these confrontations and their experience, core midwives are less inclined to intrude into their practice. It must be acknowledged that core midwives do have an important role in working with and supporting midwives with a range of experience levels and, while this study did not include core midwives, they too will have a perspective on this issue that has not been presented here.

The midwifery work of creating a birthing space and protecting this space is work that midwives may undertake in all birth settings. The obstetric hospital, however, presents a particular challenge to midwives, as many factors in this setting threaten to disrupt this space. The creation, maintenance and protection of this space is demanding work for midwives. Several midwives interviewed consider that their energies are often required with the childbearing woman inside the birthing room rather than outside it and so recruit others from their practice to do the work of “border control”. In the homebirth situation there is funding available to pay for the services of a second midwife but this is not the case for obstetric hospital births, as the facility is obliged to

provide this midwifery support.

> Participant 1: [W]hat we do now to help us with that process is that we … bring a second midwife into the hospital environment much earlier than we would at home. …
>
> Participant 2: Just let them know what is going on.
>
> Participant 1: Yeah it is but it's a buffer, it's exactly what it is. So that we can actually maintain our little bubble there, without them having to intrude.
>
> (Interview 220501, text units 191 – 194)

These midwives are also selective in whom they choose to discuss clinical situations. They may use a midwife from their own practice, select core midwives or sometimes even other midwives known to them who happen to be in the birthing unit at the time. These midwives are interested in discussing clinical situations or gaining opinions from experienced midwives who shared a similar philosophy or practice style and, at this time, this is not commonly found in the core midwifery staff. Occasionally core midwives are seen to share similar practice philosophies and values and actively supported and advocated for case-loading midwives and their clients, something that made a significant positive difference to the case-loading midwife.

While the New Zealand College of Midwives' professionalising strategy of the early 1990s alienated the core midwife, considerable effort has been made in the years since to address the divide between core and case-loading midwife and to develop the core midwifery role (Campbell, 2000). Kirkham (2004) and others work (such as; Kirkham, Stapleton, Thomas, & Curtis 2002; Stapleton & Kirkham, 2004) has highlighted the complexity and challenges of the employed midwife's role in the obstetric hospital setting in the UK, demonstrating that despite a national maternity policy that emphasises the importance of woman centred care, the interests of obstetrics continue to dominate. This is an under-researched area in New Zealand and a study exploring the discursive construction, roles, experiences and practices of the core midwife would be fruitful at this time.

Working the margins

Core midwifery and obstetric staff play a pivotal role in shaping the experience of the childbearing woman in the obstetric hospital setting. Case-loading midwives participating in this study understand the importance of these roles and work at establishing relationships that will assist them in providing woman-centred care.

Midwives explained how they had established trusting and mutually respectful relationships with some obstetric colleagues and how this enables them to advocate more effectively for the childbearing woman and negotiate a plan of care that is acceptable to her.

> That's one of the advantages too, of working with somebody you know because you sort of get a bit of professional respect I guess and sometimes I'll say [to the obstetrician] as we're walking down to the room "now you're not allowed to offer an epidural, she's very clear, antenatally, she doesn't want it".
>
> (Interview 061101, text unit 512)

DeVries and Barroso (1997) reporting on the maternity system in the Netherlands, identify the ability of midwives to refer to their choice of obstetrician as an important strategy for achieving a woman-focused maternity system. Here, midwives work as gatekeepers to the obstetrician and in a competitive environment this means that many obstetricians actively court the patronage of midwives. Midwives in New Zealand are able to consult with public or private obstetricians, though private obstetricians are able to charge the client a fee for this service, making the service inaccessible to many women. In accessing their choice of obstetrician midwives are able to recommend an obstetrician whose approach or recommendations would be appropriate to a particular woman, ensure continuity of obstetric care and perhaps a more cohesive team approach to care, as the midwife and obstetrician have been able to develop a trusting and respectful working relationship.

The ability to develop these relationships however is hindered by the provision of public maternity care because it most often provides fragmented obstetric care and encourages first-line consultation with junior obstetric staff in obstetric teaching hospitals. In hospitals with obstetric teaching programmes a variety of junior medical

staff work shifts to provide ward cover. These house surgeons and registrars also rotate to other ward or maternity placements after a certain period of time, making it difficult for midwives to establish relationships with them.

> I think the other difficult thing is, that it depends who is registrar or consultant at the time how the place feels. It changes on a regular basis with the change of consultants and registrars. So you're swimming along nicely feeling like you've got things sorted and then there's a change in something and you have to explain yourself all over again.
>
> (Interview 010601, text units 416-420)

These midwives also comment that the lack of experience in junior obstetric staff makes them more fearful and therefore more likely to want to be directly involved in some women's childbearing experiences.

> I think it would be fair to say that as a general rule that the people who harass you the most are new registrars who are scared rigid that they've made a wrong decision. So they want to be in there making sure that it's all OK and if you are aware of that then you've got a whole different basis for communication.
>
> (Interview 010601, text units 1042-1046)

In the public maternity system midwives are able to consult directly with the consultant obstetrician on call and many midwives did eschew the services of house surgeons or junior registrars, choosing instead to go directly to the consultant when obstetric advice or consultation was required.

In the obstetric hospital some case-loading midwives make a concerted effort to establish a convivial environment outside of the birthing room.

> I think it is about communication. I do go in there and I do sort of chitter-chatter away. I make a point if I've got the time, … [to] pop out and sort of have a bit of small talk with the staff. I suppose it's about maintaining relationships with your midwifery colleagues and the doctors I suppose. I do, do a bit of work there.
>
> (Interview 010601, text units 1287 – 1293)

This is an important element of their work in patrolling the borders of the childbearing woman's birthing space. These midwives perceive that it helps to position them favourably from the perspective of their colleagues and perhaps provide them with greater leverage should they be required to advocate or negotiate a plan of care with others for the childbearing woman.

If consultation is required some midwives explained how they might also spend time with the doctor first, beginning the work of advocacy by attempting to highlight the individual situation of the childbearing woman and thereby situating her at the centre of the experience.

> You can prime them up, I try and prime them up to be honest. …before they get anywhere near the woman I like to have a chat with the obstetrician or whoever it is .., probably the registrars in there.
>
> Interviewer: What do you say?
>
> I give them a bit of an outline. I give them a bit of an outline as to what's going on ...but I also give them a bit of an outline of the woman. So I try and really give them an idea of, like make that woman a person to them, not just another, you know. And give them an idea about where they've come from and what they're really hoping to achieve.
>
> (Interview 010601, text units 900-910)

Whilst the midwife closes the door to the birthing room in the obstetric hospital, attempting to create an oasis of calm, privacy and "woman-centredness" within, the space outside of this room is awhirl with activity and power relations that have the potential to breach or threaten the integrity of this space. The space of the obstetric ward is therefore a liminal space; it is the threshold of the birthing room and, in the obstetric hospital setting, midwives must work at making this space one that is advantageous to them and the childbearing women in their care. Much of this work is concerned with relationship building.

Conclusion

Midwives and childbearing women do not represent homogenous groups and neither do they necessarily share common goals. Yet in childbirth they must work together to negotiate a plan of care. Midwives may not always agree with the goals of the childbearing woman and they sometimes use the antenatal period to challenge biomedical constructions, attempting to re-construct childbirth as a natural process. Midwives utilise the currency of neo-liberal discourse to position the woman as consumer and thus active in decision-making. As Kirkham (2004) found in the UK, while the rhetoric of the maternity care system supports the concept of informed choice and woman-centred care, this is not always borne out in practice. Roles and relationships within the obstetric hospital are highly gendered and disciplining technologies press women (as midwives and childbearing women) towards compliance.

The birthing space that midwives create with the childbearing woman may be unique to each midwife and woman pairing. Whatever the birthing experience, midwives attempt to create an atmosphere of safety and calm, focusing the woman at the centre of care. Midwives recognise the importance of the obstetric gaze in obstetric control of childbirth and they actively work to obstruct or disrupt this gaze. The space that midwives create with the childbearing woman is always fragile, particularly in the obstetric hospital, and midwives must patrol the borders and work the liminal spaces of the margins to protect it.

The next and final chapter of this thesis discusses some of the major issues arising from this thesis, turning attention to the implications for the future of midwifery.

Chapter 7: With an eye on the horizon

Nomadic midwives? Where to from here?

This concluding chapter focuses on some of the questions that arise from this thesis as I look to the future of midwifery.

Introduction

When I began this study I felt confident in my understanding of midwifery. Midwifery for me was naturally concerned with feminism and natural childbirth, the polar opposite of obstetrics. The midwifery model of childbirth was good and represented everything the medical model was not. Home was polarised against the hospital, which represented the place not only of the childbearing woman's oppression but also the midwife's.

I am not so confident any more. Things are much more complex than I at first appreciated. This thesis represents the problematising and deconstruction of the concepts and practices that I thought I understood, and that midwifery holds dear; woman, the body, midwifery model, normal birth, woman-centred care to name a few. Whilst I understood patriarchy as oppressing, I never appreciated the way that patriarchal and masculinist assumptions shape the very framework through which we think and communicate, thus profoundly influencing every aspect of human endeavour. This impacts on all of our theorising, all of our actions and even the way that we can imagine our future.

Any research endeavour, but particularly a feminist one inevitably concerns itself with the future. Researchers must consider the value of their project for the future of their discipline. If feminist research is concerned with advancing the conditions of women, how does this thesis contribute? If poststructuralist theories problematise the notion of grand narratives and the promises of liberation and empowerment, what can a project based on these theories offer the future? What I wanted to offer midwifery was simple solutions. I wanted to offer a clear understanding that the midwifery model of care delivered normal birth and satisfied mothers. I wanted to demonstrate that childbirth at

home or in other primary sites would free midwives and women from the oppressive power of obstetrics. I understand now that there are no simple solutions.

Those western nations struggling for a more autonomous midwifery profession often assume that this will bring reductions in obstetric intervention and empowerment to childbearing women. In New Zealand a more autonomous midwifery was made possible by the Amendment to the Nurses Act 1977 and the majority of women now have a midwife as their lead maternity carer (Ministry of Health, 2004). Yet most women also continue to birth in obstetric hospitals and there has not been a reduction in obstetric intervention rates (Ministry of Health, 2004). This was the central issue that inspired my interest in case-loading midwifery practice within the obstetric hospital setting. Midwifery and obstetrics ascribe different meanings to childbirth and the maternal body. A crisis is precipitated when the competing interests of midwifery and obstetrics are forced to occupy the same space, the obstetric hospital.

This thesis describes several major discourses that are implicated in the discursive construction of case-loading midwifery in New Zealand. The construction of midwifery is explored in the sections "Exploring the Terrain" and also in "A place to stand. Remaking midwifery in New Zealand". In chapter 6.1 "The politics of place", I focus on the obstetric hospital and describe it as a product and technology of the biomedical discourse of childbirth. Chapter 6.2 "The politics of practice" focuses on the midwifery response to this place. Here I describe how midwives make space for childbirth and how in the obstetric hospital, they need to protect this space by patrolling the borders of the birthing room and working the margins and liminal spaces outside of this room.

What of the future of midwifery? How does this exploration help us to understand the ways that midwifery might proceed? In this concluding chapter I do not offer simple solutions but focus on some of the questions that arise from this thesis as I look to the future of midwifery. Throughout this discussion I also note the limitations of this study and suggest fruitful lines of inquiry for future research.

Em(Placed) birth

Natural childbirth, neo-liberal and professional midwifery discourses provide midwives with resources that assist them to subvert biomedical regimes of truth, thereby creating space for alternate constructions of midwife, woman and childbirth. As this study demonstrates, obstetrics acts as a panopticon, disciplining both the childbearing woman and the midwife. As the case of rural midwives demonstrates, geographical distance does not prevent the disciplining effects from extending to these distant places. Birthing within the obstetric hospital however, brings particular challenges (see also Hunter, 2000; Sharpe, 1997) as the space that the midwife has created for the birthing woman is frequently threatened by the normalising practices of obstetrics. The space that the midwife creates is often an exceedingly fragile space, one that the midwife must continually work at protecting. This environment makes additional work for the midwife and is not one in which alternative constructions of childbirth can easily flourish. To assist midwives in their work of making space for birthing and to support midwives in challenging obstetric constructions of childbirth it is imperative that we acknowledge the importance of birthing places.

This thesis describes the influence of place on the childbearing woman and midwife. Midwives describe the obstetric hospital as a place that does not facilitate childbirth, as they understand it. Childbearing women are denied the ability to move around in the obstetric hospital and in the birthing bed, which dominates obstetric birthing places, they become the focus of scrutiny. We are beginning to see design literature (Loperi, 1994) that focuses on the interrelations between the childbearing woman and place in childbirth. Loperi for example has designed birthing rooms within the obstetric hospital that facilitate mobility and offer women support in a variety of active positions within the one room. This is important for midwifery, as this study has shown that midwifery is concerned with the utilisation of space to assist women in childbirth.

Midwives spend concentrated periods of time with women in labour and have developed a body of knowledge relating to their use of space. Obstetric hospital birthing spaces are designed to meet the needs of the caregiver or institution and reify the biomedical construction of childbirth. While further research in this area is needed, birthing spaces need to be considered in terms of the type of subjectivities and behaviours they engender and the type of understandings (of childbirth, for example)

they communicate. Redesigning birth spaces will mean more than cosmetic change and more than the creation of a domestic bedroom façade. It will mean addressing the very way that childbirth and the maternal body are thought about. In the obstetric hospital, this is a real challenge.

As this study and the work by Annandale (1988) demonstrate, removing birth from the place of the obstetric hospital does not remove the influence of obstetrics and the biomedical discourse of childbirth on the practices of midwives and childbearing women. Women are disciplined in their behaviour and choices by the biomedical discourse as they construct themselves as responsible consumers and worthy mothers. Midwives similarly must demonstrate that they are responsible and creditable midwives in a context that is predominated by biomedical discourse and obstetric norms of practice. The pervasiveness and the dominance of the biomedical discourse means that it co-produces midwifery and midwives wherever they practice. In the obstetric hospital, though, midwives are constantly made aware of childbirth as risk and this makes it more difficult for them to assert alternative constructions. So, while places other than the obstetric hospital do not eliminate the influence of obstetrics on midwifery, they can provide midwives with a place that is more amenable to facilitating active childbirth and a discursive space that allows for alternative constructions of childbirth.

It is not surprising that many midwives prefer to assist childbearing women in their own home (see also Sharpe, 1997). A number of studies have identified that the place of the home provides the childbearing woman with a greater sense of control and autonomy compared with the hospital setting (Abel & Kearns, 1991; Lock & Gibb, 2003; Morison, Hauck, Percival & McMurray, 1998). The design of the home allows women to choose from a variety of rooms in which to labour and birth. They can choose to be in the company of their supporters or seek the privacy of more intimate spaces (such as the bedroom or bathroom). Homebirth proponents construct childbirth as a domestic event situated within the continuum of family life, and one in which the childbearing woman may have a greater sense of control (Able & Kearns, 1991). Though it must be acknowledged that this is not the case for all women.

The power relations constituting different places also work to construct and shape the practice of midwives, as this study and the work of Hunter (2000), Lock (1999), Lock

& Gibb (2003) and Surtees (2003) have shown. Lock and Gibb (2003, p. 134) comment,

> While analysis unveils the power place exerts in directly shaping the experience of these mothers as their expression of comfort, self agency and security show, place also indirectly influences mothers through its strength to directly shape the behaviours of midwives.

Some midwives participating in this study describe how they are better able to facilitate the process of childbirth in the home setting and midwives in Sharpe's (1997) study described it as "...the crucial site where the essence of midwifery care could most be preserved" (p. 206). This is not a universal finding as some midwives in this study and Surtees (2003) did not feel comfortable supporting women to birth at home. In New Zealand the maternity system supports homebirth as an option for childbearing women. Midwives are funded to provide care to childbearing women wherever they birth, with additional funding provided for homebirth to pay for supplies and the attendance of a second midwife (Ministry of Health, 2002a). Midwives are enabled to have all the necessary equipment (oxygen tanks for example) and supplies (including pharmaceuticals such as Syntocinon) and in my local area the Central Sterilising Department of the hospital contracts external work and sterilises the instruments and supplies of midwives. Linen contractors also supply "linen packs" for homebirth, which consists of towels, sheets, flannels and waterproof sheets. For a small fee a linen pack can be hired and, once used, the linen is returned to the linen contractor to be laundered. These may seem like small or trivial details but they are important in that they support midwives and women to more easily make the homebirth choice. These factors also legitimise the homebirth option and this is important in creating an alternative discursive space for birth. These factors alone however (as the New Zealand experience illustrates) have not been effective in attracting the majority of women to birth at home, suggesting that we need to explore the effectiveness of other birthing spaces.

Birth centres and other primary birthing facilities (such as rural maternity units) have also been demonstrated to provide safe (Rosenblatt, Reinken, Shoemack, 1985) and satisfying (Ministry of Health, 2002b) childbirth experiences for women (see Campbell

& McFarlane, 1994; Foureur & Hunter, 2005; Kirkham, 2003; Walsh, 2000b; Walsh, El-Nemer & Downe, 2005 for discussions and précis on the evidence relating to place of birth). Birth centres and primary birthing units provide an environment in which midwives feel more able to practice the "art" of midwifery. For example Hunter's (2000) research explored the experiences of independent midwives providing intrapartum care in small maternity units and large obstetric hospitals in New Zealand. The midwives in her study described practice in smaller maternity units as "real midwifery" as they were able to practice more autonomously, free from some of the constraints that the larger obstetric hospital imposes (Hunter, 2003 p. 241). A midwife in Sharpe's study (1997) comments, with time spent in the obstetric hospital "you feel yourself being sucked back into the medical model" (p. 224). Spaces outside the obstetric hospital can facilitate midwifery practice based on alternative constructions of childbirth. The accounts of midwives participating in this study illustrate some of the ways in which midwifery work is interrupted and unsettled in the obstetric hospital setting. This birthing place does not lend itself to alternative constructions of childbirth and, while midwives frequently modify the birthing room, their options here are very limited. Midwives describe how they engage in a variety of practices to create and protect the birthing space in this setting, demonstrating the ongoing fragility of alternative birthing spaces in the obstetric hospital and the additional work that the midwife must take on, within this setting.

While support for birthing spaces outside of the obstetric hospital (home, birth centres and other primary or rural maternity units) will not offer a panacea for the medicalisation of childbirth or free the childbearing woman or midwife from the imperative to engage with obstetric norms and definitions, they may provide midwives and childbearing women with the space to more easily engage in practices that challenge biomedical constructions of childbirth. These settings may facilitate the creation of alternative discursive birthing spaces.

Midwives making space

Historically, midwives in New Zealand and other western nations provided care in medically dominated settings within fragmented service models. Since 1990 midwives in New Zealand have had to learn how to provide continuity. Midwifery-led care and

the way that this has evolved since that time reflects New Zealand's social, political and historical context. Few western countries employ continuity midwifery care as the dominant model within the maternity service, therefore the process of care provided by midwives (particularly within this model of service) is not well understood (Kennedy, Rousseau & Kane Low, 2003).

A beginning point in this research was to understand how case-loading midwives construct midwifery in New Zealand. Feminist, midwifery and childbirth activists constituted midwifery in opposition to interventionist and medically dominated childbirth. The professional midwifery discourse in New Zealand is therefore dominated by liberal feminist, neo-liberal and natural childbirth constructions though the biomedical discourse of childbirth predominates in the wider context. Midwives today provide lead maternity care to the majority of childbearing women in New Zealand and not all of these women share the interests of feminists or natural childbirth advocates. Within the wider social context dominated by biomedicine, childbearing women and midwives are disciplined by the construction of childbirth as risk and the emerging concern for the fetus as citizen. The neo-liberal consumer who is empowered by the ability to make "free" choices is more mirage than reality, as their choices are in fact heavily circumscribed by societal and obstetric norms.

In this study midwives position themselves in two main ways in regards to choice in childbirth. They either position themselves as neutral conduits for information, providing the childbearing woman with what they perceive as unbiased information on which to base their choices, or they openly acknowledge that they attempt to influence the choices women make. In this study, perhaps due to the type of midwife participating, this was toward a more natural childbirth orientation. Midwives describe how they work with the childbearing woman throughout the antenatal period attempting to reconstruct childbirth for her as a natural, active process and her body as a competent, able body that is well equipped for childbirth and parenting. Midwives may not be successful in reconstructing childbirth as natural for many women but they do frequently centre her as the key decision-maker whatever she chooses or whatever eventuates for her. The construct of the neo-liberal consumer is prominent in government and professional midwifery discourse and this provides midwives with an important resource to support them in asserting the primacy of woman-centred care, no

matter what childbirth experience eventuates for the childbearing woman.

I have described this process as 'making space'. Midwives work with the childbearing woman to create a discursive space for childbirth that may be unique to each midwife and childbearing woman pairing and will often challenge the norms and assumptions of biomedicine. Midwives also recognise the importance of the environment of childbirth and in this study they attempt to create a place that is private and calm and in which the childbearing woman feels a sense of control and autonomy. In a metasynthesis of qualitative studies conducted by the authors in the USA, Kennedy, Rousseau and Kane Low (2003) describe a similar midwifery process. Midwives in these studies approached childbirth as a normal process and partnered with the childbearing woman, to negotiate an individualised plan of care. The midwife and childbearing woman formed an alliance that was dynamic and changing, allowing either the childbearing woman or midwife to take control as the circumstances dictated. The environment of care was important in these studies and this was described as creating an atmosphere of care, respect, and concern for normal birth.

Studies examining midwifery practice, whether from the perspective of midwives, childbearing women or both, tend to construct unproblematic (natural) childbearing woman and midwifery relationships, highlighting common goals and productive alliances (Davis, 1995; Kennedy, Rousseau and Kane Low, 2003; Pairman, 1998). This speaks to the political and strategic intent of some midwifery research and perhaps the shared philosophy of some midwives and childbearing women (for example homebirth). This natural midwife and woman alliance tends to essentialise and homogenise those represented by the categories midwife and woman, and obfuscate what can be competing interests between and within these groups. While this study problematises these relations to a degree, in the final analysis I have united midwife and woman in a common (though negotiated and individualised) goal. There would also be much to gain from exploring the more problematic relations or disruptions that are not represented in the rhetoric of partnership and accord.

The space created for birth by the midwife and childbearing woman is described in this thesis as one that often challenges obstetric norms and biomedical constructions of woman and childbirth. In the obstetric hospital midwives are expected to comply with obstetric norms, and these are asserted by hospital clinical guidelines, obstetric and core

midwifery staff. Case-loading midwives are required not only to be attentive to the childbearing woman but also to manage the margins of the birthing space as they deal with normalising judgements and coercion from core or obstetric staff. Some midwives in this study brought a second midwife from their own practice to the obstetric hospital to manage these margins, thus freeing them to concentrate on the childbearing woman. The core midwife in particular has a vital role to play in creating space for the case-loading midwife to carry out her work. Several midwives in this study acknowledge the valuable role of the core midwife and some are using their knowledge of the hospital system to advocate for women requiring specialist input. The importance of the core midwifery role has also been acknowledged by NZCOM who is focusing attention on how to revalue this role in New Zealand's maternity care context (Campbell, 2000)). As Kirkham and Stapleton's (2004) work has shown, the situation of the employed midwife is a complex one as their loyalties may be divided between the childbearing woman, employer, obstetrician and their profession. They are pressed to comply with obstetric and institutional norms (as case-loading midwives are) and these do not always support woman-centred care or the right of women to make informed decisions. This study did not include core midwifery or other perspectives (such as midwifery managers or obstetricians) and so presents a fairly one-sided exploration of the issues in this regard. While it is important to understand these issues as case-loading midwives see them, there is certainly room for future research work, which includes multiple perspectives on practice within the obstetric hospital or within multi-disciplinary teams.

This study conceptualises case-loading midwifery practice as making space for childbirth. This space is an individually negotiated space and so this conceptualisation reflects the liberal feminist concerns that construct the professional midwifery discourse in New Zealand. In this, the childbearing woman is constructed as an informed consumer, empowered through her ability to make choices in childbirth (Bogdan-Lovis, 1996). As Bogdan-Lovis states, this liberal feminist approach has largely failed to emancipate women from medicalised childbirth practices or biomedical constructions of childbirth. While midwives work with individual women attempting to bring about change within existing structures, primary and rural maternity facilities continue to close (Pairman & Guilliland, 2003), concentrating care within large obstetrically-dominated hospitals, obstetric intervention rates continue to rise (Ministry of Health, 2004) and poverty impacts disproportionately on Maori and Pacific Island peoples

(Ministry of Health, 2006). It is also important therefore that midwifery look beyond the individual midwife and woman relationship in making change. What other (micro and macro) factors make space for women to birth in ways that positively impact on their health and wellbeing? What other factors support midwives in creating alternate childbirth spaces with women? These may be productive directions for future research.

It may also prove more useful to think about midwifery in more fluid and dynamic terms rather than as locked rigidly in oppositional definitions or politics.

Nomadic midwives blurring boundaries

The previous chapter describes the ways that midwives traverse place in their daily work. Midwives work at establishing relationships with women and the intimate nature of their work means that they transgress the usual boundaries of the personal and private. Their knowledge of the childbearing woman and her unique needs are brought to bear in negotiating a plan of care that balances a variety of competing interests. Midwives often spend their working days visiting a variety of women at home and may also spend some time in clinics or the obstetric hospital, caring for women during antenatal, postnatal or labour and birth phases of childbearing. These are very different geographical places constituted by differing power relations.

In their work midwives also traverse a variety of discursive spaces. The biomedical discourse of childbirth continues to predominate, considered by midwives to set the benchmark for "acceptable" practice. This discourse constructs childbirth as a risky event and presses midwives and the childbearing woman toward practices of risk management including screening, monitoring and the imposition of obstetric time constraints. The natural childbirth discourse challenges biomedical constructions, reconstructing the maternal body as a knowledgeable, able body and childbirth as an individually unique, holistic and empowering experience for the childbearing woman. The neo-liberal discourse constitutes the maternity consumer who is empowered through the process of informed choice and consent. Within this construction some midwives distance their own values and beliefs, functioning as conduits for information so that the childbearing woman can become appropriately informed. Aspects of all these discourses infuse the professional midwifery discourse. The childbearing woman

is constructed as a feminist, neo-liberal consumer and the focus of maternity care. Within this discourse the midwife is at once a champion of natural birth and women-centred care and also a health professional who is able to participate knowledgeably in medical and scientific arenas. Parker and Gibbs (1998) describe this midwife as hybrid; one that mediates between the "communities of everyday life …. and the community of Western medical practices" (p. 151).

In describing the major discourses constructing case-loading midwifery in New Zealand as I have done here, I do not intend to imply that these discourses represent discrete or internally coherent categories. The context of childbirth and midwifery practice is constituted by a matrix in which a variety of discourses intersect, constructing childbirth and midwifery (and childbearing women and midwives) in a myriad of different ways in different contexts. Discourses are positioned by power and are socially, politically and historically derived. Childbearing women and midwives are active in this process; conspiring, subverting, colluding, resisting, and transgressing discursive constructions and boundaries. Our subjectivities (as midwives and women) are multiple, fragmented and contingent[23].

Braidotti (1994) suggests that her figuration of the nomad might offer feminist politics and practice a valuable direction for the future. Braidotti's nomad is fluid and mobile, she resists essential and fixed subjectivities and refuses to settle "into socially coded modes of thought and behaviour" (p. 5). This nomad moves across established categories "blurring the boundaries without burning bridges" (p. 4) making strategic and situated connections. The nomad embraces difference in and between women, acknowledging that identities are multiple, fluid and transitory. Reminiscent of Spivak's (1984-85) strategic essentialism, the nomad may create temporary, strategic identities and connections.

> Being nomad, living in transition, does not mean that one cannot or is unwilling to create those necessarily stable and reassuring bases for identity that allow one to function in a community. Rather nomadic consciousness consists in not taking any kind of identity as permanent. The nomad is only passing through; s/he makes those

[23] It must be acknowledged also that the subjectivities of obstetricians and other medical practitioners are similarly multiple and fluid. The subjectivities of these groups are not explore here however, as they have not been the focus of this study.

> necessarily situated connections that can help her/him to survive but s/he never takes on fully the limits on one national, fixed identity. (Braidotti 1994, p. 33)

A unitary identity or foundation is not required for political agency as the nomad's political effectiveness is situated in her/his transitory nature. This means that the nomad is dynamic and changing and can therefore respond to changing circumstances and contexts.

Case-loading midwifery can be seen in terms of such a figuration. These nomadic midwives travel from public to private places, through, in and around a variety of discursive spaces blurring definitions and the boundaries of what is normal/abnormal, private/public, natural/technological and medical/midwifery. These midwives create temporary, transitory spaces and places within other, more permanently established, spaces. Each of these temporary spaces may be unique to that midwife/childbearing woman pairing. This midwife opens up spaces for women where there was no space, allowing for alternative forms of subjectivity and agency to be engendered. Their strategic connection is the childbearing woman. Parker and Gibbs (1998) suggest that the midwife in post-modernity must construct "productive hybrids of practice" (p. 151) in which they must at once accommodate the hegemonic truths of western medicine but also critique their legitimacy, thereby making room for the valuing of different cultures and notions of truth, beauty and virtue. For them, the midwife is a broker.

> Brokering between medical science and alternative ways of doing that are grounded in different cultures or different or emerging notions of truth, virtue and beauty. This brokering needs to be done in ways that are sensitive to the values, belief and tastes of culturally diverse peoples and those wishing for alternatives (p. 152).

In working the borders between the truths of the biomedical discourse of childbirth and marginalised knowledges, midwives are creating unique and alternative spaces for birthing.

DeVries and Barroso (1997) explore the ways that midwives have recreated themselves in changing health care contexts. Historically the rise of medicine and the speciality of obstetrics meant that many midwives had to recreate themselves as obstetric

handmaidens. The feminist and holistic health movements provided a context for another midwifery creation, the natural childbirth midwife. DeVries and Barroso (1997) refer to this midwife as "low-tech, high touch" (p. 253) and draw attention to the irony of the situation, as the same construction that weakened the midwifery profession (as society was embracing science and technology) now provided it with a niche in the maternity market. The continued medicalisation of childbirth and seemingly inexorable march of science has marginalised these natural childbirth midwives and within contemporary, western maternity systems they seem somewhat of an anachronism. This has pressed some midwives to embrace the "high tech" of obstetrics (Hartley, 1997) and, as DeVries and Barroso (1997) and midwives in Sharpe's (1997) study caution, this is a strategy that may result in the decline of midwifery as its construction becomes indistinguishable from that of medicine. For Flanagan, writing in 1993 on nurse midwifery in the Unites States of America, the differing constructions of midwifery (as midwives align with opposing poles; high tech /low tech birth or obstetric hospital/ home or birth centre birth) results in confusion regarding the role and identity of midwives, undermining their professionalising project. Internationally this presents a conundrum for midwifery. How to balance the need to distinguish midwifery as a profession with a unique product distinct from that offered by others, with the need to remain relevant in a changing health care context?

Surtees (2003) following Braidotti (1994, 1997) and Stabile (1997), approaches this question by problematising the binary structure on which it is based. She suggests that we need to move beyond the binaries of nature/technology, normal/abnormal to explore the interconnections. In exploring these interconnections Surtees (2003) plays with the metaphors goddess, cyborg (Haraway, 1990), nomad (Braidotti, 1994) and hybrid suggesting that the figuration of a "monstrous sisterhood" (Lykke, 1996) might provide the most fruitful way of envisaging a midwifery future. The "monstrous sisterhood" explores the differences (monstrous) and similarities (sisterhood) in and between interconnecting constructions such as the "cyborgoddess" (Surtees, 2003). Relating this to midwifery Surtees (2003) describes the way that technologies may be used in facilitating a natural birth (providing the example of the administration of intravenous fluids to an exhausted woman) or the way that the use of technologies (for example epidural anaesthesia) may be naturalised by midwives.

> These are some of the situations in which I imagine midwives drawing from the cyborg or the goddess metaphors, from within fractured and multiple selves in highly mobile, contingent and strategic ways, and that the multiplicity and difference, rather than the either/or, is what makes the "monstrous sisterhood". (Surtees, 2003, p. 315)

The professionalising project of midwifery in New Zealand cohered strategically around pivotal constructs such as normal birth, continuity, woman-centred care and partnership. My reading of the political rhetoric (for example the New Zealand College of Midwives Journal and Parliamentary Hansard) suggests that the alignment of midwifery with normal birth (midwives as specialists in or guardians of normal birth) was an important rhetorical tool in the struggle for and eventual achievement of midwifery autonomy. The midwifery rhetoric of the same time emphasised continuity of care, identifying this as the point of distinction between midwifery and other maternity health carers. The midwifery that has evolved for case-loading midwives since this time as evidenced by the talk of midwives participating in this study, is one in which the concept of woman-centred care is pivotal. Midwives in this study did not often explicitly refer to the partnership model of practice per se (Guilliland & Pairman, 1995a), though concepts within the partnership model (such as woman-centred care) were prominent in their constructions of midwifery.

In constructing midwifery as "with women" New Zealand midwifery is able to address aspects of DeVries and Barroso's (1997) problematic. They can be curiously hybrid, with one foot in the natural childbirth camp and the other in the biomedical. The critical factor that directs the negotiation between these often competing discursive frameworks is the childbearing woman herself who is positioned centrally by natural childbirth, neo-liberal and professional midwifery discourses. The value attributed to woman centred and continuity of care allows the midwife to remain active as an autonomous professional in whatever childbirth experience eventuates for the woman. The professional midwifery discourse provides midwives with a resource that promotes fluidity by facilitating their movement in and between discursive constructions of childbirth rather than remaining encamped in one.

In New Zealand this "with woman" approach has been incorporated into the structure of

the New Zealand College of Midwives as non-midwives are invited to become members and are included in the executive committee. David (2000) questions the membership of non-midwives in midwifery's professional body in Australia, suggesting that the push for such an inclusive membership comes from a desire to enhance midwifery's professionalising project. On this basis non-midwife involvement represents tokenism at best and exploitation at the worst. She also raises the question of how this representation should be established, asking who should be included. "Which women, representing which interests" (David, 2000, p. 105)? In New Zealand childbirth and feminist activists (both midwives and non-midwives) united with a common interest in challenging obstetric control over childbirth. My sense today is that those included in the college membership and political activity continue to be largely be driven by feminist and natural childbirth concerns. However, we cannot assume that the interests of midwives and childbearing women are always mutual. Judy Strid (2000) a childbirth activist involved in the campaign for midwifery autonomy challenged midwives at the national NZCOM conference in Hamilton (2000) over the increasing rates of obstetric intervention in childbirth. Clearly midwifery has not delivered the maternity care that she (and many others) had hoped for (indeed fought for). While I don't support David's (2000) position (on non-midwife membership to professional colleges) I do consider that if this "with woman" approach at the macro level is to represent more than tokenism then midwifery certainly needs to respond to the concerns raised by members such as Strid. We also need to seek some strategic connections with non-midwives representing a broader set of interests. David (2000, p. 105) suggests that midwives could form "shifting and opportunistic alliances with specific groups that have common agendas" for specific purposes. This might be a useful strategy to develop midwifery services in a way that responds to a broader set of women's interests.

While the imperative to create or maintain a distinctive product within the neo-liberal health care context is an important issue for the future of midwifery as an autonomous profession, it is not the only important issue with which we must grapple. The health and wellbeing of childbearing women should be of prime concern and this means that midwifery must be concerned with providing women with safe and satisfying childbirth experiences. Uncritically aligning with either end of the nature/technology spectrum is problematic. Many women are choosing (or are pressed to "choose" as subjects of

governmentality) technological intervention in childbirth and, if women-centred care in this situation means passively following women into whatever "high tech" birth experience they choose, then midwives may be colluding in practices that we know can bring harm to women. As Davis-Floyd comments,

> It's very cool to analyze the human-machine symbiosis of a woman hooked up to the EFM [electronic fetal monitoring] as cyborgian; it's very uncool to know that the price she may pay for being that kind of cyborg is an unnecessary caesarean. (cited in Davis-Floyd & Dumit, 1998, p. 274)

What is more, we collude in the patriarchal project of biomedicine, which erases the woman (as the fetus or specific internal organs become the focus of care) (Braidotti, 1994), inscribes the maternal body as deficient or as a site of risk and relegates the category of woman to the realms of the irrational and unknowing. In this, we leave unchallenged the biomedical regimes of truth; we fail to open spaces in which other forms of subjectivity and agency may be engendered.

If on the other hand, we valorise natural childbirth on the basis of it being an expression of a woman's essential nature or its empowering potential then we collude in re-inscribing women with the patriarchal constructions of woman that feminism has struggled to overcome. We also condemn women who cannot or do not "achieve" natural birth to failure, constituting them as incomplete or insufficient women. We do know that in most situations childbirth without obstetric intervention is the safest form of childbirth (Leap, 1996) and that childbirth experiences in which the childbearing woman is well supported and feels in control are the most satisfying (Enkin et al., 2000; Oakley, 1992). On the basis of this we can use our knowledge and experience to assist women to have the safest and most satisfying childbirth experience possible and, as the midwives interviewed for this study demonstrated, this work may involve the active creation of alternative birthing spaces; both physical and discursive.

Where to from here?

I am suggesting that midwives maintain a primary and strategic hold on the construction of midwifery as "with women". This construction problematises the

normal/abnormal, low technology/high technology binaries and provides midwives with the opportunity to move fluidly through a variety of maternity contexts and settings. I am also suggesting that we do not abandon our connection with natural childbirth because this can provide a discursive resource that supports childbearing women and midwives to challenge, transgress and subvert the dominant discursive construction of childbirth and create alternative birthing spaces. Within this, however, midwifery must continually interrogate its own place in maternity care and the discursive constructions, fabrications and strategic alliances in which it participates. There is nothing essentially good, empowering or feminist about midwifery.

As Annandale (1988) found in her study, the reality and complexity of the health care context means that midwives tend to "standardize" childbirth and practice in ways that sometimes contradict the childbearing woman's wishes, the midwives' construction of childbirth as instinctive and their philosophy of providing woman-centred care. In fact from a postmodern perspective, there is nothing essentially midwifery about midwifery and for Braidotti (1994) it is this lack of unified identity and permanence that holds the key to an effective feminist politics. A more fluid midwifery can change and adapt to changing social contexts. Midwifery is constructed by the play of discourse and the circulation of power and is always situated, temporary and transient. Midwifery as "with women" and as "guardians of normal birth" should be recognised as perhaps transient constructions, representing strategic alliances that provide midwives with discursive resources for challenging dominant biomedical constructions of childbirth at a time when obstetric intervention (and the attendant adverse effects on the bodies of women) continues to rise.

This study demonstrates the ubiquity of the biomedical discourse of childbirth, highlighting that there is no place that this discourse does not already inhabit/construct. Therefore, the strategy of re-locating childbirth or midwifery practice to places such as home or the birth centre will not offer a panacea for medicalised childbirth. However, this study also demonstrates the limitations of the obstetric hospital in terms of providing women with an adequate place in which to labour and birth or an opportunity to develop or maintain alternate constructions of childbirth. In this place, the childbearing woman and midwife are constantly reminded of the dangers of childbirth and the inadequacy of the female body. Childbearing women are pressed to occupy the bed and labour and birth becomes a spectacle as midwife and supporters and have little

choice but to centre their attention on the focal point of the birthing room; the bed. In the obstetric hospital, midwives must work continually to re-construct and protect the space of the birthing room; additional work that is not always required to the same extent in other birthing places. Midwives in this study describe childbirth as an expression of wellness, requiring an active labouring woman and within this understanding, places other than the obstetric hospital (such as home and birthing units), while not offering a panacea for medicalised childbirth practices or expectations, will provide a more functional place for birthing.

Reform in maternity services in New Zealand has centred on primary maternity care and the provision of one-to-one, continuity of care from a lead maternity carer. Certainly this represents significant qualitative gains for childbearing women in New Zealand. The provision of public maternity obstetric care however frequently remains fragmented. Women who require ongoing public obstetric care will usually see a variety of consultants or registrars, all of who may develop varying management plans. Furthermore, in hospitals with obstetric training schemes this training is insinuated into the care of childbearing women. The maternity service in these places is usually structured in such as way as to make registrars rather than consultant obstetricians, the most accessible (and implicitly expected) first point of contact for midwives. Also, the distinction between registrar and consultant is not always clear to the users of the service.

Midwives in this study highlight the difficulties that arise from the involvement of inexperienced registrars and fragmentation of obstetric care for the women in their care. These midwives also describe their dissatisfaction with the transient nature of their relationships with registrars suggesting that more effective working relationships can be developed over time. This research alludes to the importance of social capital, particularly in interdisciplinary teams, making this issue an important one for future research on maternity services in New Zealand.

The focus on maternity care at the micro level of the one-to-one relationship (a liberal and liberal feminist inspired strategy) has largely failed to change the face of the widespread medicalisation of childbirth (Bogdan-Lovis, 1996). In maintaining a strategic hold on the concept of "midwife as guardian of normal childbirth", midwifery

must concern itself also with the macro level of maternity care and health structures. While continuity of midwifery care and the lead maternity carer concept promote maternity as an important primary health intervention, the continued concentration of childbirth in obstetric hospitals seems to run counter to this primary health care approach. Therefore rural and primary birthing units and the option of homebirth need not only to be protected but also actively promoted. As this study illustrates however, the interface between primary maternity and obstetric care will continue to be challenging. As mentioned in the paragraphs above, it cannot be presumed that re-placing childbirth (from obstetric to primary settings) will remove the effects of the biomedical discourse of childbirth.

Conclusion

An analysis that problematises the constructs constituting midwifery and the binary thinking that underpins my understanding of midwifery and my imagined midwifery future, brings both hope and despair. Acknowledging that there is no place to escape the effects of the biomedical discourse of childbirth, that it inscribes my subjectivity as woman and midwife and inhabits all the places of midwifery and childbirth, brings despair. Conceptualising midwifery as a construct and problematising the notion of essences and natural alliances while challenging brings an understanding that there is potential for change. There is hope in imagining a versatile and more fluid midwifery and in acknowledging that a constructed midwifery means the potential for a changing, dynamic and tenacious midwifery.

Appendices

Appendix A. Participant consent form

Centre for Family Health and Midwifery
PO Box 123
Broadway NSW 2007
Australia

Tel. +61 2 9514 2977
Fax +61 2 9514 1678

University of Technology, Sydney

CONSENT FORM -

I _____ agree to participate in the research project "Independent Midwifery Practice in New Zealand" being conducted by Deborah Davis as part of her Ph.D. with the University of Technology, Sydney. Deborah works for the School of Midwifery at Otago Polytechnic and can be contacted at Otago Polytechnic, Private Bag 1910, Dunedin. Ph: (03) 479 6151.

I understand that the purpose of this study is gain an understanding of the factors that constrain or enable midwives to work within a midwifery model of care, particularly the influence of the hospital setting.

I understand that my participation in this research will involve being interviewed by the researcher, and will take approximately one to two hours. These interviews will be audio-tape recorded and later transcribed by either a professional transcriber or Deborah. I will be able to stop recording the tape at any time through the interview and will also have the opportunity to review the transcript and delete any of my own comments if I wish.

I am aware that I can contact Deborah Davis (contact details above), her supervisor Professor Lesley Barclay or Dr. Alison Stewart in Dunedin, if I have any concerns about the research. Their contact details are as follows:

Lesley Barclay
Centre for Family, Health and Midwifery
UTS, P.O. Box 123, Broadway NSW 2007
Phone: 9514 2977 Fax: 61 2 9514 1678
Email: Lesley.Barclay@uts.edu.au

Alison Stewart
School of Nursing, Otago Polytechnic
Private Bag 1910,Dunedin
Phone: (03) 479 6135 Fax: (03) 474 1957
Email: ALISONS@tekotago.ac.nz

I also understand that I am free to withdraw my participation from this research project at any time I wish and without giving a reason.

I agree that Deborah Davis has answered all my questions fully and clearly. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ___/___/___
Signed by

_____ ___/___/___
Witnessed by

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer, Ms Susanna Davis (phone Australia: 0061 2 - 9514 1279 or email: susanna.davis@uts.edu.au). Alternately you may contact Alison Stewart, School of Nursing, Otago Polytechnic Private Bag 1910,Dunedin Phone: (03) 479 6135. Email: ALISONS@tekotago.ac.nz . Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Office The Terraces, No 11 Broadway, City campus, Sydney NSW Australia

Appendix B. Ethical approval from the University of Technology, Sydney.

PO Box 123
Broadway NSW 2007
Australia

Tel. +61 2 9514 2000
Fax +61 2 9514 1551

UTS

University of Technology, Sydney

21 December, 2000

Professor Lesley Barclay
Faculty of Nursing, Midwifery and Health
CITY CAMPUS

Dear Lesley

UTS HREC 00/82 - BARCLAY, Professor Lesley, WALKER, Dr Kim (for DAVIS, Ms Deborah) – "Independent midwifery practice in New Zealand"

The Committee considered the above application at its meeting of 15 December 2000 and approved it, subject to evidence of ethics approval from Otago Polytechnic when obtained.

Your approval number is UTS HREC 00/82A.

The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. The attached report form must be completed at least annually, and at the end of the project (if it takes more than a year), or in the event of any changes to the research as referred to above, in which case the Research Ethics Officer should be contacted beforehand.

I also refer you to the AVCC guidelines relating to the storage of data. The University requires that, wherever possible, original research data be stored in the academic unit in which they were generated. Should you submit any manuscript for publication, you will need to complete the attached *Statement of Authorship, Location of Data, Conflict of Interest* form, which should be retained in the School, Faculty or Centre, in a place determined by the Dean or Director.

Yours sincerely,

Production Note:

Signature removed prior to publication.

Professor Ashley Craig
Chair
UTS Human Research Ethics Committee

Appendix C. Ethical approval from Otago Polytechnic Ethics Committee

OTAGO POLYTECHNIC
DUNEDIN NEW ZEALAND
A *VERY* SMART CAREER MOVE

LINDA WILSON
CHAIR, ETHICS COMMITTEE
Forth Street, Private Bag 1910,
Dunedin, New Zealand
Telephone +64 3 479 6177
Homepage http://www.tekotago.ac.nz

30 March 2001

Deborah Davis
Faculty of Health & Community
Otago Polytechnic
Private Bag 1910
DUNEDIN

Dear Deborah

Research Proposal No. 190
The Politics of practice: Towards an understanding of Independent Midwifery Practise in the secondary hospital setting

Thank you for your resubmitted application dated 5 February 2001 regarding the above proposal.

Thank you for detailing the probable publication outputs as requested from the R & D meeting on 10 November 2000.

Ethics approval is now given for you to proceed with your research.

Yours sincerely

Production Note:
Signature removed prior to publication.

I
Chair, Ethics Committee

c:\windows\temp\deborah davis.doc

Appendix D. Ethical approval for amended recruitment strategy

27 August 2001

Professor Lesley Barclay
Faculty of Nursing, Midwifery and Health
The Terraces
BROADWAY CAMPUS

Dear Lesley

UTS HREC 00/82 - BARCLAY, Professor Lesley, WALKER, Dr Kim (for DAVIS, Ms Deborah) "Independent midwifery practice in New Zealand"

The UTS Human Research Ethics Committee considered your request for an amendment to the above application at its meeting of 14 August 2001. The Committee approved your request to amend the above research by altering the method of recruitment by contacting individuals over the telephone to invite participation, and then following up the initial contact with the written material already approved by the Committee.

If you wish to make any further changes to your research, please contact the Research Ethics Officer, Ms Susanna Davis, immediately.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

Production Note: Signature removed prior to publication.

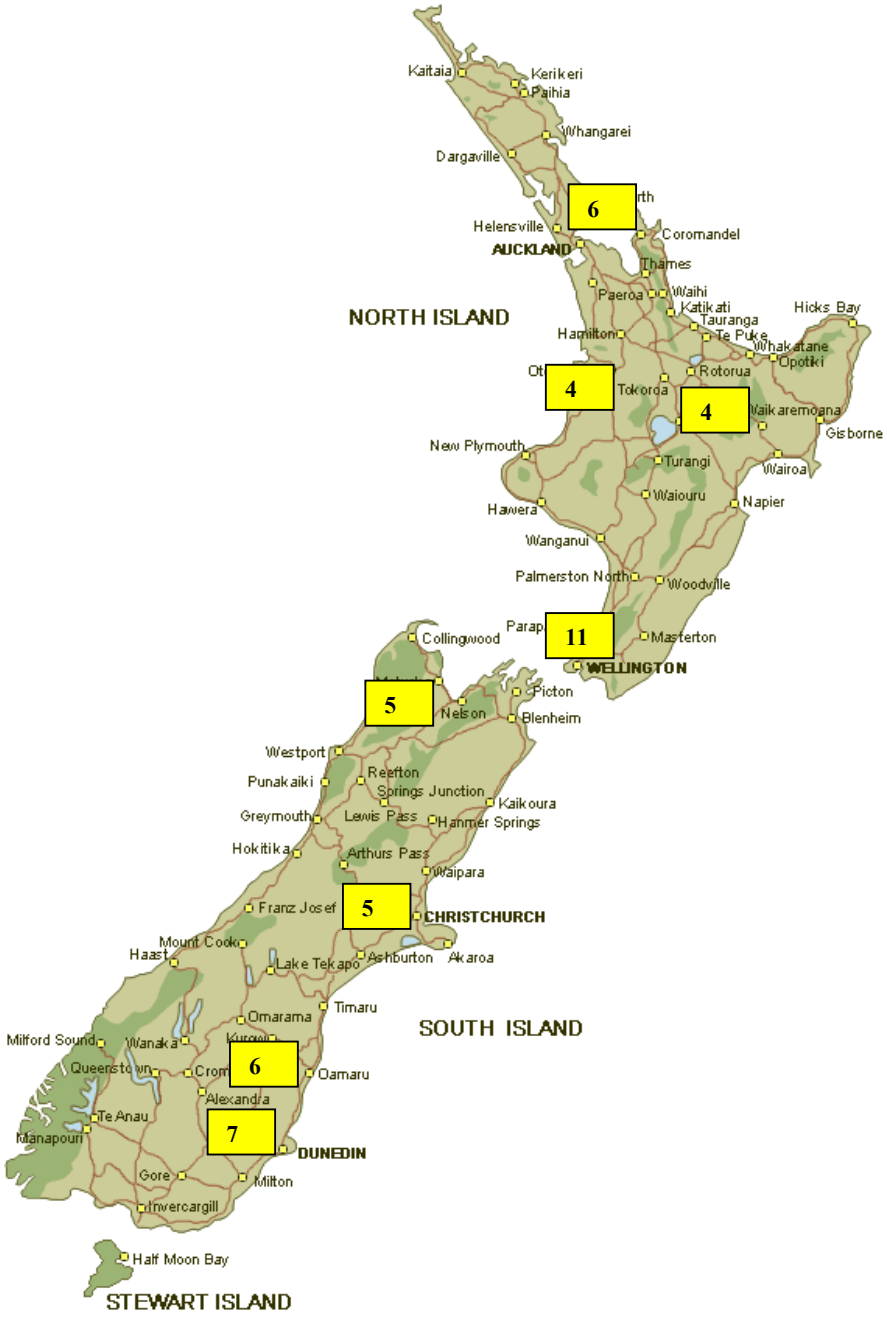
Professor Ashley Craig
Chair
UTS Human Research Ethics Committee

++

Susanna Davis
Research Ethics Officer
University of Technology, Sydney

Ph: 61 2 9514 1279 Fax: 61 2 9514 1244

Appendix E. Geographical Spread of Participants



Appendix F. Schedule of interviews

Date	Participant no.'s	Participant Type	Birth settings
22/5/01	3 (Group practice)	Case-loading, self employed	Home only
1/6/01	6 (Focus group)	Case-loading, self employed,	Mix of home and secondary hospital
7/8/01	1	Case loading, employed	Secondary hospital
24/08/01	5 (Group practice)	Case-loading, self employed	Home and Secondary hospital
6/11/01	1	Case-loading, self employed	Home, primary and secondary hospitals
7/11/01	1	Case-loading, self employed	Home, primary and secondary hospitals
28/11/01	1	Case-loading, self employed	Home, primary and secondary hospitals
29/11/01a	3 (Group practice)	Case-loading, self employed	Home, primary and secondary hospitals
29/11/01b	1	Case-loading, self employed	Home, primary and secondary hospitals
30/11/01	1	Case-loading, employed	Primary facility
26/5/03	2	Recently retired from practice. Case-loading, self employed	Primary, rural facility
27/5/03a	9 (Group practice)	Self employed, case-loading	Home, primary and secondary hospitals
27/5/03b	1	Case-loading, self employed	Home only
28/5/03a	1	Case-loading, self employed	Primary facility
28/5/03b	1	Case-loading, self employed	Home, primary and secondary hospitals
28/5/03c	1	Case-loading, employed	Secondary hospital
29/5/03a	1	Midwifery manager, previous case-loading, self employed, homebirth	Secondary hospital
29/5/03b	1	Case-loading, self employed	Home, primary and secondary hospitals
29/5/03c	1	Case-loading, self employed	Home, primary and secondary hospitals
29/5/03d	1	Case-loading, self employed	Home, primary and secondary hospitals
5/6/03	6 (Group practice)	Case-loading, employed	Primary, rural facility

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