

**WOMEN'S EXPERIENCES OF PLANNING HOME BIRTHS
IN SCOTLAND**

BIRTHING AUTONOMY

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ABSTRACT

The general aim of this study was to provide an in-depth exploration of the experiences of a group of 30 women who planned home births. This was to expand on the small amount of qualitative research in the field and suggest avenues for further research.

With this general aim, I analysed the women's experiences in relation to the contexts in which they planned home births in order to provide a useful account for the women in the study, those who may plan home births in the future, as well as clinicians, managers and policy-makers involved in maternity services.

I considered some of the wider political, social and historical discourses, which underpin the present situation in Scotland regarding home births. While I acknowledged that these are unstable reference points, they were useful in gaining insights into the current situation. This was particularly the case when looking at home birth as part of a complex interplay between dominant and subordinate ideologies, which were partially played out through gender relations symbolised by the male doctor and the female midwife.

A postmodern reading of feminisms provided the conceptual tools to examine diverse belief systems around birth in relation to women's narratives. Suspending "truth" enabled diverse knowledges to become more visible. This validated women's experiential knowledge which could then be placed alongside other knowledge systems, and examined in terms of dominant and marginalised ideologies. The project became one of conflicts and silences, searching out and listening to, and making visible "other" voices. This raised issues of power, control, autonomy and resistance.

In most cases I interviewed each woman twice before her baby's birth and twice following the birth. Interviews were usually 1½ to 2 hours in length, taped and transcribed. A qualitative software program, NUD*IST was used to assist with analysis, but the conceptual framework for the analysis remained rooted in a postmodern feminist approach using a relational voice methodology.

The main findings were that National Health Service (NHS) community midwifery services were based on an attenuated technocratic model of birth. This imposed a philosophy and structure of care that prevented women and midwives from developing alternative ideologies based on their own knowledges. It prevented women and midwives from forming trusting, supportive relationships, which stand at the core of holistic philosophies of birth. Women and midwives were often obliged to draw on subversive techniques to use their knowledge and skills in order to make the best of a system which by definition could not be woman-centred or holistic.

The main conclusion was that birth requires to be socialised rather than medicalised, so that technology and medical practices can be developed and used to support women and babies, and midwifery practices when necessary, rather than birth being technocratised and social practices used to humanise an essentially inhumane system of care.

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PREFACE

he painted on the surface of the muddy brook itself
as the clouded waters ebbed and flowed and paid
their uncertain tributes to the river

a lady in timeless robes
riding a horse of many colours
passed by the edge of the brook
and asked him why he laboured so
and for so many years decorated a parchment
that edged it's way into the sea

he answered that her words changed meaning as she spoke
that his brush dies with each stroke
that the universe as it existed a moment ago
as she arrived on this shore
was no more

he told her that the only truth in her song -
was the music

Jacob Bush 1982

I attempted to keep the questions and challenges of postmodernism and feminisms to the fore in this thesis. The process of writing was a particular challenge because of the inevitability of fixing what is fluid: that which defies being captured in time and place¹. This is the weakness of the written word. Some fluidity remains between the lines, between text and reader (Rosenblatt 1978), and my hope is that this work will be an inspiration to the imagination for what could be in the future².

From a postmodernist perspective, Michel Foucault (1972) argues that writings are 'fictions' rather than truths and that time is neither linear nor follows any particular pattern or progression. It may therefore seem out of keeping with the spirit of this approach to have included any kind of historical analysis. The term "historical" contains a paradox when indicative of a unified whole, a direction, or a coherence. I acknowledged the instability of this concept and the specificity and disjointed nature of history. I therefore attempted to provide contexts for this study, by providing an exploration of some of the discourses³ and influences which have had a bearing on current debates about place of birth.

¹ In my attempt to 'melt' dominant language (Griffiths 1995: 162, see page 120), and to present a written report in keeping with academic standards and format, and maintain a degree of fluidity in the text, I have drawn on Mary Daly's (1979, 1986) use of language: sometimes running words together to highlight or maintain connections, using words experimentally or deliberately to fracture usual meanings, and using feminist rather than male-based language. I used footnotes extensively: partly to expand on theoretical debates and partly to illustrate the main text. But the relationship between the footnotes and the text also represents in written form, the multiple realities, fractures and contradictions exemplified by the thesis as a whole. Thus the footnotes are the material representation of the conceptual dialogues and becomingness I attempted to create.

² It was through the women's accounts, that I developed a greater understanding of the power of the imagination. As Catriona Mackenzie (2000) suggests, imagination is an important, but under-theorised aspect of liberatory thought, in feminist theory. She contends that 'this neglect is due to a tendency to think of critical reflection in overly rationalistic terms, at the expense of a recognition of the extent to which critical reflection can be prompted by the imagination and by emotion, desire, and bodily feelings (124).

³ I began by using the term discourse to introduce a distinction between so-called fact and the narrative constructions of postmodernism. It maintained the fluidity I sought, but at the same time lacked the clarity I subsequently found in Lorraine

Earlier radical ethnography (Clifford and Marcus 1986) contributed to raising research awareness about the existence of different knowledges. In the field of childbirth, the idea that different understandings of birth may be possible was largely suppressed. Anthropologist of midwifery, Brigitte Jordan (1993) raised this possibility in her explorations of birth in different cultures. This was developed by others (Davis Floyd 1992, Davis Floyd and Sargent 1997). That there can be opposing knowledges set in networks of power is at the heart of this work.

In postmodern/feminist fashion, Margrit Shildrick (1997) advocates the use of a 'bricoleur' (5) approach and Rosi Braidotti (1997) suggests a 'nomadic' one (60). These approaches do not confine themselves to one philosophy, discipline or standpoint, but draw on many, in order to deconstruct binaries and boundaries, and throw new light on old assumptions. I therefore moved between disciplines (midwifery, medicine, sociology, philosophy, anthropology, psychology and politics) and methodologies (postmodernisms, feminisms, ethnography, phenomenology) to stay with the concerns of the women in this study and the contexts in which these were shaped.

I rejected relativist arguments that postmodernism finally collapses into itself, falls back on modernist notions of truth and stability, and is essentially oppressive (see for example, Bell and Klein 1996, Doran 1989, Knorr-Cetina and Mulkay 1983). These are potential threats, but can also be interpreted as useful tensions, which reminded me to be vigilant and to acknowledge that this research was rooted in specific cultural definitions and assumptions (Nicholson 1999). Of course, some assumptions are so embedded as to be relatively ungraspable, but in uncovering some, I hoped others would surface, so that the process of making visible that which is less visible could continue.

It was unclear how feminism and postmodernism interact, so I drew on the work of those who had considered this, in the belief that a feminist reading of postmodernism is not only possible, but has the potential to bring fullness and clarity to the hitherto shadowy figures of women. It may ultimately refute rationalist binaries based on the positivity of male and negativity of female, and thereby create a place for women, that is neither negative nor 'other' to male (Braidotti 1997, Irigaray 1985). Home birth, as a particularly marginalised female activity provided a unique opportunity to explore the above notions.

I also acknowledged the limitations of this thesis. It necessarily confines itself to a predominantly white, western, industrialised country, where women have relatively more control over fertility than women elsewhere, and where overall affluence has improved general health and therefore birth outcomes⁴. There is evidence of a widening gap between rich and poor in Britain (Townsend and Whitehead 1992, see also Hogg 1999: 114), and it remains to be seen how this will affect birth and birth practices. The arrangements for birth here bear no resemblance to birth in most other parts of the world. The fact that place of birth is a choice (at least in theory) is highly contextualised.

Finally, in writing this thesis I attempted to follow in the footsteps of some of those who are actively working to create dialogues between sociology and midwifery. The dialogue between sociological theories and birth practices provides rich ground for examining the meeting places between theory and practice/experience. This dialogue forms a central concern within these pages.

Code's writing (1998). Her 'stories' provided me with a sharper understanding of the kind of narrative I referred to: coherent 'stories', which can simultaneously challenge normative epistemology, and their own coherency (208).

⁴ Inequalities (lack of appropriate health services and access to these; the dismantling of traditional birth practices; lack of sanitation, food, housing, education and employment) and resulting health problems continue to affect a large percentage of the world's women adversely. These are unlikely to be greatly improved by the introduction of inappropriate birth technologies and practices (Murphy-Lawless 1998b).

CHAPTER ONE - Introduction

Setting the scene

Chapter 1 briefly maps out the thesis and discusses the potential threat to home birth services. In Chapter 2, I explain the background to the study, what prompted it and what I hoped to achieve. While the original, tentative questions broaden out and the original ideas undergo a metamorphosis, the underlying puzzle about why home birth is problematic remains central to the thesis. I include a description of maternity services in Scotland: its localized similarities and differences formed part of the weave against which this study took place. I begin to unpick the rhetoric of sameness that hides a multitude of geographical and social difference, and the struggles on which taken-for-granted services are constituted.

My journey through feminisms and postmodernism gave me insights and understandings about my interviews that I could not have otherwise gained. I therefore devote time and space to explaining this journey in Chapters 3, 4 and 5. In discussing the possibilities of feminisms and postmodernism, I explain my move from phenomenology to feminisms, towards postmodernism in Chapter 3. Chapter 4 considers a number of interlinked discourses and debates around the changes in childbirth practices from being home-based and usually supported by midwives to being hospital-based, under the control of medical men. In conjunction with this, I trace how these debates were incorporated in policy and research, in Britain and abroad, where medical models of birth preside. Using insights about dominant and subordinated ideologies, I examine critiques of the medical model of birth and search out other ways of understanding birth. The issue of knowledge and what this means becomes central to this part of the project. I thus consider questions of epistemology in Chapter 5. Chapter 6 outlines the methods I used from first conceiving the study, to the writing up of the thesis. This includes the recruitment of women to the study, methods of interviewing, and analysis.

Chapters 7 to 10 provide a detailed analysis of the series of the 4 in depth interviews I carried out with each of the 30 women in the study⁵. In Chapter 7, I explore the context in which women made decisions to plan home births. In Chapter 8, I examine safety and risk and how women defined their priorities. For all the women in the study, the midwives provided both possibilities and limitations for actualizing their ideals. I thus explore these complex relationships in Chapter 9. In Chapter 10, I consider some of the implications of modernist medicine and ethics. In summary, the final chapter focuses on the key substantive themes to have arisen from the analysis.

However, I begin this thesis by raising the stark possibility that during the course of my study, home birth may have become less of an option than it was, due to a recent reinterpretation of the legal status of community services and whether or not these are optional (Rosser 1998).

Home birth under threat: Potential changes to the provision of home birth services

It seems relevant to begin the introduction by informing the reader of potential changes to one of the fundamental premises on which this study was based. The questioning of the mandatory provision of the home birth service has many potential implications. This home birth study was possible because of the existence of a community service to support it. Once located, the service enabled the women in this study to plan and book for home births. It was thanks to the midwives providing this service that women were able to join the study. Many of the conversations I had with these women were based on a shared assumption that home birth was protected in law through the provision of the community midwifery services.

⁵ 7 of the 30 women who planned home births gave birth in hospital. As these women experienced the comparison between community and hospital based services first hand, and their stories elucidated some of the fears and struggles of the other 23 women, I have woven these into the analysis.

When I embarked on this project, I held the unquestioned assumption that a woman's right to have a home birth and be provided with care during pregnancy, labour and postnatally by a qualified NHS midwife was enshrined in law throughout Great Britain. This assumption was held by all the women involved in the study, those providing maternity services, and those providing information for parents about maternity services. Books, booklets and leaflets written for parents often include information on what were believed to be women's rights and midwives' duties regarding home birth (Beech 1991: 43-45, Health Education Board for Scotland 1998: 48, Thomas 1998: 4-5, Wesson 1990: 52).

It was generally believed that it was the duty of the most senior midwife in any geographical area to make adequate provision for women planning and having home births, so that there would always be a midwife available to respond to calls from the community. If a midwife was called, whether or not the woman was officially booked for a home birth, it was her duty to attend the woman, whatever her circumstances or health status (Rosser 1998). Further, it was understood that the midwife would have support from both midwifery and medical services and that if she deemed it necessary, she could summon medical assistance. In practice, most midwives suggest that the woman transfer to hospital if medical help is needed.

These rights and duties were closely linked to the professionalisation of midwifery during the early part of the 20th century. In order to phase out the practice of unqualified women attending births in the community, it became illegal for anyone other than a qualified midwife⁶ or medical practitioner to attend births. While the woman herself cannot be prosecuted for failing to call a midwife, anyone attending her during birth without a midwife or doctor present could be fined £1000, as in the publicised case of Brian Radley (see for example Donnison 1988: 195-196, Robinson 1982)⁷. In effect, the replacing of an "informal" system of maternity care with a formal system was supported through professionalisation and legislation. While legislation outlawed the informal support for birth through 'handywomen' or 'bona fide' midwives, it made provision for all women to receive care at home from qualified midwives.

During the writing of this thesis developments in maternity services challenged the above assumptions about the woman's right to care at home during labour and birth. The notion that there may not be a "duty of care", or indeed any requirement to provide community services was raised in an editorial in a widely read British midwifery journal (Rosser 1998). This was taken up by the Midwifery Committee of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and legal opinions sought (UKCC 2000: 3). Apparently, since the 1977 NHS Act, when the term 'domiciliary' was omitted (Rosser 1998) there has been a mistaken assumption that women have the right to the services of a midwife during labour outwith the hospital setting. This was communicated to voluntary organisations at a meeting convened by the UKCC in December 1999. Meanwhile, some NHS Trusts began to withdraw their domiciliary service, and lay and midwifery organisations campaigned to clarify the issue in favour of home birth provision (see for example Beech 2001). Although the Department of Health stated that it expected women's requests for home births to be supported (Cooper 2000), it remained unclear how this could be enforced (subsequent correspondence to the Association for Improvements in the Maternity Services (AIMS) demonstrated that opinion at Government level is divided). There are anecdotal reports that women are being told that resources are not available for home births in some areas (Beech 2001, personal communication). Recently, a similar letter from Yvette Cooper, Department of Health, was sent to a

⁶I use "qualified" and "unqualified" here because these are the terms usually used, but add that they are socially constructed in relation to the professionalisation of midwifery, in line with the professionalisation of other areas of life.

⁷The Government (draft) Order (2001) for the establishment of the new Nursing and Midwifery Council includes Article 43(3) which proposes to increase this sum to £5000.

woman in England from the Department of Health, which reflected a theme running through this thesis, that although choices are said to be available, there are few mechanisms to support them.

At this point it is possible only to speculate about the impact of the above developments on women, midwives and the nature of maternity services to come. However, even in this study home birth was experienced by women as a marginalised activity with obstacles to its planning and achievement.

The fact that support for home birth was perceived as a right during this study and may be not be in the future will have ramifications. Although it became evident that many women regard rights with ambivalence⁸, the right to domiciliary midwifery provided a degree of external support and protection. In view of the importance women attributed to midwifery support (see Chapter 9), the removal of this service would remove a crucial layer of support.

The right to, and existence of a service was the critical factor in making home birth a reality. Indeed, on a number of occasions it was the midwives providing the service who facilitated home births by: including the option of home birth as one of a number of options for birth; openly offering the service; supporting women who had given up the idea, having been told it was not possible by their General Practitioner (GP); and supporting the growing confidence of women who initially booked for DOMINO births⁹. Support and encouragement from midwives was fundamental.

Profound changes in attitude have led to the reinterpretation of law in such a way that employers have gained in power and midwives have lost ground. This inevitably undermines the midwife's autonomy and the home birth service. The current move towards further entrapping the midwife between the authority of her employers on the one hand and medical authority on the other echoes with the historical discourses about the demise of both midwifery and home birth in relation to outside authorities (see page 51).

In terms of patriarchal dominance and short-term market economy, the attempts to redefine women's rights within existing legislation is perhaps not surprising. As employment and resource issues risk being prioritised over moral and ethical considerations, the voices of the women in this study seem all the more poignant and crucial.

The current situation leaves a curious anomaly. While a woman still has a right to have her baby at home, if she is refused the services of a midwife and gives birth helped by her partner and/or friend for example, a court case and fine could ensue. Moving through pregnancy and birth is a challenging journey for women; for those committed to home birth it could be all the more taxing, if the woman is forced to weigh up complex moral responsibilities and obligations in a society that is unsupportive of home birth and all too ready to blame women who challenge its norms.

However, some women will choose to have their babies at home despite the climate of opinion, and lack of legal or practical support. In Marie O'Connor's (1992) study, 1 in 9 women had their babies with the support of partners and/or friends, but without the help of a midwife or doctor in parts of Ireland where there was no provision for home birth. In North America, where midwives all but disappeared, a small percentage of women continue to be attended by lay/direct entry¹⁰ or "granny" midwives (Chester 1997, Gaskin 1990) and there is a small but growing number of women who

⁸ This was not unexpected, given a strand of feminist theory which suggests that women's moral decision-making processes tend to be based within relationship networks rather than rights (Gilligan 1985).

⁹ DOMINO (domiciliary in and out) meant that the woman would have received all her care from the same community midwives who provided the home birth service, but they would have attended her in hospital during labour and birth.

¹⁰ The term 'lay' is being replaced by the more appropriate term, 'direct entry' (Benoit, et al. 2001: 143).

choose to give birth with their partners or alone (Shanley 1994). This has occasionally happened in Britain (Sumpter 2001). Despite powerful attempts on the part of medicine in most Western countries, it has proved impossible to erase home birth altogether. And even where medicine is powerful, politicians are reticent about enforcing hospitalisation (Wagner 1994: 327).

Though some considered it, none of the 30 women I interviewed chose to give birth without calling a midwife. But the reasons they gave for considering this option pertained to avoiding the particular services on offer rather than rejecting support per se. Thus, this study was not only about the importance women placed on the availability of a home birth services, but also about how birth ideologies and place of birth interacted.

CHAPTER TWO - An overview

Introduction

A preliminary exploration of the research indicated that planning a home birth seemed a reasonable choice for women to make. Thus the question I brought to this thesis, about why home birth should provoke conflict seemed to be to do with matters other than research evidence¹. That it is an area of conflict was first brought to my attention in a very direct way when I attempted to gain support for planning my home births between 1976-80. I came to see this as an ethical, human rights issue and because I did not wish other women to be subjected to the difficulties I had experienced, I turned to campaigning for greater choice for women in maternity services, through a lay childbirth organisation, AIMS, having assumed that lack of choice was the problem. This campaigning often seemed frustrating and on the surface, at least, ineffective (Edwards 1996, 1996/7)².

Since then, because I have been a national point of contact for women considering or planning home births and have led antenatal and postnatal classes in Scotland since 1985, I have had the privilege of listening to the home birth stories of hundreds of women. These stories were frequently marked by conflict. Over many years I heard hurt, anger, desperation and confusion from these women, who felt committed to home births, but struggled with, in their eyes, lack of support, even hostility, with the ever-present threat of hospital transfer. I also heard the joy, power, and gratitude towards midwives when often, somehow all worked out at the end of the day.

I now understand the irony of hearing these muted voices 'from the margins' (Kirby and McKenna 1989) so clearly, while hearing the roaring mainstream voices working against them and the midwives they relied on, less clearly. Through the enlightening process of journeying through a thesis, listening to many voices along the way, I now have a clearer understanding about how individuals, or groups of people may create and draw on significantly different ideologies, depending on their locations and experiences, which may lead to different beliefs and actions. I also understand that these stories are set in networks of power and that powerful investments endeavour to keep some stories incessantly and overwhelmingly noisy, so that other stories cannot easily be heard, and that language itself is implicated in this process. I attempt to explain some of these stories about knowledges, power, conflict and silence in a way that gives voices to the muted stories of the women, while acknowledging that it is through my voice that the stories of the 30 women have become audible.

Why this particular study?

One of the main reasons for carrying out this research on birth from the woman's perspective was that despite birth affecting women more profoundly than other players, and despite the uneasy murmurings from women regarding the increasingly medicalised approach to birth (Department of Health 1993) their voices were and are least heard.

A number of studies have been carried out on place of birth. They initially focused on mortality rates of women and babies, but as maternal mortality rates declined, turned their attention to mortality and morbidity among babies, and morbidity in women. For the purposes of this introduction, suffice to say that as far as can be ascertained from the studies and reviews to date, home birth attended by skilled practitioners appears to be safe for healthy women and babies in

¹Paediatrician and former director of Women's and Children's Health in the World Health Organisation (WHO), Marsden Wagner remarked at the first International Home Birth Conference in October 1987, in London that debates about home births often generated 'more heat than light'.

²Over the course of this study I came to understand more fully that choice is constructed by and predicated onto powerful beliefs, thus, campaigning for choice without dismantling these beliefs is limited.

Britain (Campbell and Macfarlane 1994, Chamberlain et al 1997, Davies et al 1996, Ford 1991, Northern Regional Perinatal Mortality Survey Coordinating Group 1996, Shearer 1985, Tew 1985, 1998), and elsewhere (Ackermann-Liebrich et al 1996, Berghs and Spanjaard quoted in Eskes and van Alten 1994, Durand 1992, Howe 1988, Oleson 1997, Schlenzka 1999, Tyson 1991, Tew and Damstra-Wijmenga 1991, Treffers 1986, van Alten 1989, Wayne 1987, Wiegers et al 1996, Woodcock 1994). It may also have advantages to hospital birth, in terms of women retaining more control over the birth process, having fewer interventions and feeling more satisfied (Chamberlain 1997 et al). I discuss this in more detail on page 66. Problems have occurred when births at home are unplanned, and without skilled attendants (Burnett et al 1980, Haloob and Thein 1992, Murphy et al 1984).

There is relatively little qualitative research in the field, and much of this is retrospective and typically based on single interviews, or surveys (Alexander 1987, Bastian 1993, Bortin 1994 et al, Caplan and Madely 1985, Damstra-Wijmenga 1984, North West Surrey CHC 1992, Oswin 1993, O'Connor 1992, Ogden et al 1997a, Spurrett 1988, Viisainen 2000a). Research on women's experiences of home birth, and birth in general confirms that birth is a major life event, with lasting repercussions (Ogden et al 1997a, Ogden et al 1997c, Kitzinger 1992, Simkin 1991, 1992) and therefore worthy of further research. While this research has raised pertinent issues, it has limitations (Green and Coupland et al 1998: 9, Jacoby and Cartwright 1990): It has not provided us with a deeper understanding of the process, the wider issues involved, or why women may have difficulty in gaining support for home births (Ogden et al 1997b).

Given the strength of feeling among women, and our relatively limited understanding, it seemed important to explore some of the issues at stake; potential sources of conflict, and how women themselves experienced and made sense of this, through a prospective series of interviews. Before discussing this further, I provide descriptive details below about home birth in Scotland and about how community services work and fit into overall maternity services.

Numbers of home births and current provision of maternity services in Scotland

The population and annual number of births in Scotland have remained reasonably constant, but with a declining tendency since 1971 (Health Policy and Public Health Directorate 1993: 4). There are around 60,000 births each year in a population of around five million. The low planned home birth rate in Scotland of less than 1% has not changed significantly over the course of the study. This means that around 300 women have planned home births each year. The Scottish enquiry carried out in conjunction with the 1994 confidential enquiry into home births in England and Wales (Chamberlain et al 1997), showed that a further 300 women had 'unplanned' home births (Murphy-Black, 1995, personal communication)³.

Though the number of planned home births has not always been recorded, or has been included with unplanned home births and out of hospital births it appeared from the General Registrar Office Annual Reports from 1963 -1997, that there have been few home births in Scotland for many years. The decline was particularly sharp during the 1960s and 70s, dropping from nearly 22% in 1963, to just over 1% in 1973 and stabilizing at around 0.5% in 1980. Despite wide geographical differences in terms of urban, semi rural and isolated communities, wide regional variations in provisions for home birth and variations in the attitudes of professionals involved in maternity services towards home birth, the Reports show that the home birth rate was around 0.5% in all 15 Health Board Regions in the early 1990s. The only area that appeared to have a higher home birth rate was East

³The meaning of the words planned and unplanned in relation to home birth refers to whether or not the woman engaged with maternity services and whether or not the birth was planned to take place at home in conjunction with these services. The term unplanned also refers to births that occur at home, when the woman planned to give birth in hospital, but her baby arrived precipitously at home for example.

Lothian, in South East Scotland. A dedicated team of midwives provided a more accessible home birth and domino service and reported that 2.3% of the women in their catchment area had home births.

In England, while the home birth rate is low overall, at around 2% (Campbell and Macfarlane 1994) there are significant geographical variations. In 1998, 47% of services had home birth rates of over 2% (ENB 1999), and of these, there were rates of up to 23% (NCT 1999). This appeared to depend on midwives and doctors supporting the idea of healthy women having their babies at home. Where this was the case the numbers of women having home births increased (NCT 1999, Sandall and Davies et al 2001).

In Scotland, a policy review of maternity services (Health Policy and Public Health Directorate 1993) devoted little attention to home birth. It stated that there was little demand and anticipated a small rise to 1% in the foreseeable future. The main discussion focused on DOMINO births as the best option for healthy women and babies and resources. The intention of the review group appeared to be to enable Health Boards in Scotland to make their own service provisions. In order to gain more of an overview of general attitudes and policies on home birth in Scotland, I carried out a postal survey in 1994 requesting information about any documentation regarding the provisions of home birth (Edwards 1994a). 14 of the 15 Health Boards responded, and sent existing guidelines, but commented that their guidelines were being revised. Less than half the responses were reasonably positive, others were non-committal and some were overtly negative. Guidelines ranged from a 'commitment to ensuring women have a choice of where and in what manner they deliver their babies', and in some areas, midwives were expected to receive requests for home births in a 'professional and sympathetic manner'. Only one region had a more comprehensive package, which included a leaflet for women. In addition, it was stipulated that 'Each Community Midwife [...] must take responsibility for maintaining and developing her skills for home deliveries' - though the only provision made for maintaining or increasing skills appeared to be to spend a period of time (usually a week or two) on a labour ward in the maternity unit. A number of guidelines included the need to provide women with information about place of birth. However, at the opposite end of the spectrum, one Health Board claimed that home birth was considered to be 'foolhardy by medical and nursing (sic) staff' and another suggested that a woman may have to defend herself in court, if a child was injured during a home birth.

Organisation of NHS hospital and community-based maternity services in Scotland

As the concepts of postmodernism enlightened my data, it permeated through the rest of my thesis. I saw how the rhetoric of standardisation based on equity and evidence-based practice muted the everyday practices of individual practitioners in different places and spaces. This became evident in the women's narratives, particularly around issues such as continuity of care and what this meant.

The organisation of maternity services varies throughout Scotland, perhaps more so than in England, because of the geographical and demographic variations. In 1992 there were 24 obstetric units in Scotland. Most of these formed part of larger district or regional general hospitals, but some remained free standing. One or two had 'normal delivery units' or 'midwifery led units' attached, which could be used by 'low risk' women providing that they met the criteria for the unit throughout pregnancy, labour and birth. There were in addition 25 GP or community units with similar criteria for use (Health Policy and Public Health Directorate 1993).

Over the course of the study, services have been further centralised and some of the smaller obstetric units catering for 2000 births or less per annum, have been closed. Many of these planned closures met with fierce opposition (see for example McLaren 1990) and occasionally campaigns to keep small units open have been successful (Jones 1991, Teijlingen 1994). At the same time, a small

number of new community units have been opened in rural areas of Scotland to provide a limited service for women who would otherwise have to travel distances of up to 100 miles to have their babies in large obstetric units. These are usually in areas where midwives and sometimes GPs are particularly committed to providing a service, or where there was a history of a small unit and a strong enough community voice to argue for resources to retain it. Different notions of risk featured prominently, in the two distinct voices: those in authority and those dissenting. The women's narratives demonstrated how these voices fragmented across ideologies to form many different voices.

A few of the Scottish islands have small GP units with one or two maternity beds, but few women give birth there. The rhetoric of risk creating a cycle of fewer births, lack of skills and confidence means that women on the islands and in some areas of the highlands usually fly to the nearest obstetric unit at 38 weeks of their pregnancies to await their labours. The effects of a medical definition of safety and risk is perhaps more immediately visible in these rural areas, where women have been persuaded to leave their homes and families to have their babies. But its influence permeates all women's experience of birth (Murphy-Lawless 1998a). It was the pivotal axis around which this thesis developed.

While services vary, the first point of contact for maternity services in Scotland, was and still is almost universally, the woman's GP. A woman can book directly with a midwife, who can provide all her maternity care, as long as the woman's pregnancy remains "normal" as defined by the midwives rules of practice (UKCC 1998) and the medical policies in her area. Some women planning home births contacted their community midwives, but were often asked to see their GPs first 'out of courtesy', and to request a referral back to them. I discuss the issue of demarcation between professions, and the hierarchy in which this exists on page 53.

Each of the 15 Health Board regions in Scotland had its own arrangements for providing a home birth service and as already noted, its own guidelines and attitudes towards these. This perhaps masked that regions were divided into much smaller areas, each with its own interpretations of these guidelines. This could depend on local resources, the views of senior midwives and obstetricians, and the beliefs, skills and commitment of individual practitioners providing the service. The individual contacts between women and practitioners were instrumental in shaping women's experiences of planning home births. It was in the context of these contacts that different birth ideologies and knowledges surfaced and were explored or suppressed; encouraged or discouraged; voiced or silenced (see Chapters 7 and 8), and that medicalised practices were materially carried out on women's bodies, as I describe in Chapter 9.

While many parts of Scotland had some sort of team arrangement for providing community services, these teams could vary from 2 or 3 community midwives to over 30. To my knowledge, case load midwifery and one-to-one schemes that run elsewhere (McCourt and Page 1997, Sandall and Davies et al 2001) were not available in Scotland through the NHS services. Although this is changing, in rural areas midwifery services were not always available and a midwife was often employed on a double or triple duty basis, (which meant that she was the area nurse and/or health visitor and that her workload was taken up with nursing duties).

In the areas included in my study, most women booked with teams of 6-8 NHS community midwives, and a few women had small teams of up to 3 midwives. (These teams are now larger, with up to 20 midwives per team) Although the stated policy was for women to see a different team midwife at each antenatal appointment, so that she could meet each of the 6-8 midwives, on at least one occasion before giving birth, most women found that this was variable in practice, and that patterns of care were unique. For example, one woman saw the same midwife for her first 5 antenatal appointments and had not met at least 2 of her team midwives in very late pregnancy.

Independent midwifery services

The term independent midwife usually applies to the few midwives in Britain who are self-employed and offer themselves for service to individual women. Their training, rules, code of conduct, supervision and disciplinary body is the same as that of any other midwife in Great Britain. The main differences are that they are less bound by the policies and practices of individual NHS Trusts or hospitals and are therefore more able to rely on their own clinical judgement; they usually offer a home birth service; and usually practice single-handedly or in small groups of 2 or 3. Some have contracts with their local hospitals and offer a DOMINO service, some have been unable to secure contracts, so that if a woman booked with them requires medical services, the independent midwife can only accompany her to hospital as a friend⁴.

There have been few independent midwives in Scotland over the last decades. One midwife practised independently from 1960-1999 in northern Scotland and one or two practised in the areas of my study prior to it commencing⁵. Both ceased independent practice when insurance problems arose. However, during the third year of the study, they commenced practice again, without insurance, and provided a limited service which 2 of the women in my study made use of. Since then a small number of midwives have continued to practise independently in parts of southern and central Scotland. These midwives provide a one-to-one service.

The one-to-one approach, embedded in holistic midwifery philosophies, is one of the hallmarks of independent midwifery practice. The experiences of the 2 women in the study of their independent midwives' ideologies and practices brought the issue of different ideologies and related issues such as continuity, control, support and trust into sharper relief. It brought into clearer focus, not only the oppression and silencing of pregnant and birthing women, but the oppression and silencing of midwives: the constraints under which they practice and the ways in which they attempt to subvert these in order to support women. However, keeping the notions of postmodernism to the fore brought out similarities as well as differences between NHS community and independent midwifery, which enabled me to see the blurring of boundaries as well as the distinctions.

To summarise, there are many different approaches to providing maternity services, but the political/medical climate is leaning more towards standardisation of services throughout Scotland. Despite a rhetoric of choice and an apparent acceptance of community-based care, centralisation, and thus medicalisation continues largely unabated. The women in this study provide a profoundly thought-provoking challenge to this trend.

⁴ NHS midwives do occasionally practice independently in addition to their NHS work and in these circumstances usually make individual arrangements with women and their local supervisor of midwives. In some countries midwives combine independent work with part-time hospital work for financial reasons. This is the case for nearly all the home birth midwives from the south of Norway, I met in Oslo in 2000 and some German midwives (Sandall and Bourgeault et al 2001: 127).

⁵ The Scottish Independent Midwives (SIMS) group was formed in 1994 and has continued to meet and campaign for better midwifery services and for small autonomous groups of midwives to provide services within the NHS.

CHAPTER THREE - Beginning the journey

Introduction

At this juncture it seems important to chart something of the journey I made before reaching the end of this thesis, as the starting point bore little resemblance to the final analysis. Like many of the women in my study, I had assumed that the conflict evoked by home birth centred on the issue of safety and risk. Like them, I therefore set out in search of information about the research findings on safety, and any other research I could find. I hoped to furnish myself with some of the facts and figures that I thought would shed light on why home birth had become such a marginalised activity and why it appeared to evoke such strong feeling both in those providing maternity services and in the wider community.

To this end, I carried out a literature search based on medical and midwifery notions of systematic reviews (Chalmers and Haynes 1994, Clarke and Stewart 1994, Dickersin et al 1994, 1994, Knipschild 1994, Murphy-Black 1994a, 1994b) using both electronic databases such as Medline, BIDS and local library systems, and searches such as Index Medicus and MIDIRS. I then followed up references from the material I had gathered. I concluded that other issues must be at stake, as I was unable to find good research that suggested that home birth with skilled attendants was unsafe¹.

I then carried out a broader search, amassing anything and everything to do with home birth; past and present, here and elsewhere. I studied Parliamentary and Health Department documents for England and Wales, and Scotland from 1904-1994, which had anything to say about place of birth, to see if these could shed light on the issues at stake (CRAG/SCOTMEG 1993, 1994a, 1994b 1994c, 1994d, Department of Health 1993, House of Commons 1980, 1992, Maternity Service Advisory Committee 1982, 1984, 1985, Ministry of Health 1930, 1932, 1954, 1956, 1959, 1961, 1970, 1979, SHHD 1965, 1973a, 1973b, 1988, 1993). While these gave some clues about the state agenda in childbirth, I found a rather linear debate progressively supporting medicalisation, hospitalisation and finally centralisation of birth and progressively phasing out domiciliary care. That is, until the apparent sea change in the Winterton Report (House of Commons 1992), which focused on demedicalisation, decentralisation, midwives providing care for healthy women and babies and support for women's choices, including that of home birth (see page 42).

The anomalous (Treffers and Eskes 1990) situation in the Netherlands drew my attention. The home birth rate there has been consistently higher than in other westernised country. It has remained between 25-30% during the early 1990s (Eskes and van Alten 1994), and midwives are apparently the main brokers in maternity services. I therefore studied the research and attempted to gain an understanding about the history of birth and midwifery there (Declercq et al 2001, Eskes and van Alten 1994, Lieburg and Marland 1989, Smulders and Limburg 1988, Kloosterman 1984, van Teijlingen 1992, van Teijlingen and Hulst 1995). I concluded that although birth is perceived as normal, and that midwifery is indeed a strong profession (Declercq et al 2001, Eskes and van Alten 1994, Treffers et al 1990, van Teijlingen 1992), home birth has been retained largely through structural differences encoded in legislation, due to State support (Torres and Reich 1989, van Teijlingen 1990, 1992, 1995) as much as any significant conceptual differences in ideology. Cost is increasingly a key consideration (van Teijlingen 1995). Strict medical risk criteria and identifying abnormality appeared to be the mainstay of the Dutch maternity services (Declercq 2001). Debates about the medicalisation of birth are increasingly similar to those here, technological interventions are increasing (Pasveer and Akrick 2001, Rothman 2001) and differences around pain perception

¹I was less aware then of the positivistic framework in which this research was located and therefore less aware of its limitations and omissions. The omissions I noticed in my review of the research findings (see page 67 for example) became the basis for a more consistent discourse of muting and silence. While safety and risk continued to be central issues, these turned out to be more complex than I initially anticipated.

which have contributed to home birth remaining an option (Oakley and Houd 1990, Rothman 1993, van Teijlingen 1994) are slowly changing, as a Dutch newspaper article, entitled 'Pain or Prick', shown to me, demonstrated. This view was further confirmed by the talks and seminars given by Dutch midwives in the Netherlands at the 4th International Home Birth Conference in Amsterdam, in March 2000. In contrast, I acquainted myself with some of the literature from North America (Rooks 1997), where midwives and births at home have all but disappeared. While I acknowledge that direct comparisons cannot easily be made, contrasting definitions of birth broadened my understanding of some of the issues involved, including the impact of different ideologies on birth practices and place of birth.

It became clearer to me that the change in place of birth was inextricably linked to the change in attendants at birth, and I searched the literature for historical accounts and commentaries about the rise of the male midwife, the development of obstetrics, and the simultaneous suppression of the midwife and midwifery practice. I considered not only home/midwife birth and hospital/medical birth, but the possibilities of homelike births in hospital (Macvicar et al 1993) and hospital-like births at home (Hall 1999). I examined literature about the few freestanding Birth Centres in England (Saunders et al 2000) and about freestanding Birth Centres in North America (Chester 1997, Rooks 1997 which challenged sharp distinctions between home and hospital birth. Considering some of the theoretical debates about this issue (Annandale and Clark 1996, 1997, Campbell and Porter 1997) opened up the possibility of moving beyond the stylised natural/technological dichotomy.

While many of the accounts I read provided limited understanding about the changes in childbirth practices and the move away from home birth towards hospital birth, the references to feminism and hints of postmodernism contained within some of these seemed worthy of further exploration. I was aware of criticisms of the hospitalisation and medicalisation of birth. I was after all one of the critics. I knew that the development of maternity services was less based on women's needs than on other agendas. But this was primarily based on experiential knowledge, and a general understanding that patriarchy in one form or another was implicated in the development of obstetrics and the subsequent changes in childbirth practices - particularly clear in Jean Donnison's (1988) meticulous documentation of historical events. I was however, less aware of feminist contentions that ideological, structural and material arrangements are consistently and thoroughly saturated by patriarchy in its many different guises (see Chapters 4 and 5). In the light of the dazzling insights of feminism and postmodernism, the somewhat flat surface of my literature review took on the shape of a restless quantum sea - a myriad of shifting connections and disconnections, illuminating the puzzling conflict about home birth which initially inspired the thesis.

The ongoing dialogue between feminisms and postmodernism provided the conceptual lens through which I finally viewed the literature I explored. This dialogue became part of the construction of the thesis and transformed the review from a commentary on a series of historical events locked in time and place, to a series of transient discourses set within networks of shifting power and knowledges. Any flat historical account of events now seemed wholly inadequate. As my thinking was transformed, the thesis became as much a continuation of the dialogue between feminisms and postmodernism as about home birth. I therefore map out my journey from phenomenology to the debates between feminism and postmodernism, over the next 3 chapters as an integral part of the review².

² The challenges of postmodernism had a layering effect on what could no longer be assumed and I was aware that voice itself is a contested term (along with every other term). While I set out the review as a series of discourses, I realised that discourses themselves are a collection of voices and that issues of epistemology, identity and agency are implicated. I explore these debates in Chapter 5. With some reservations, this moved me towards a more fully-fledged feminist reading of postmodernism. I was thus able to consider: the move from birth at home to birth in hospital in terms of the material manifestation of competing and coinciding historical, cultural, social and political discourses; how these were captured in

Conceptual framework

From the outset, my priority was to develop a framework and methodology that would enable women to recount their experiences in their own words (in so far as words are our own) and enable me to hear and understand their meanings more fully. As I developed the conceptual framework, my second priority became to provide theoretical concepts in which to compare and contrast these women's experiences. In other words, I wanted a framework that could focus on both the collectivity and diversity of women's experiences.

The first stage of my journey from phenomenology to feminisms with a hesitant foray into postmodernism provided me with more critical feminist senses and enough postmodern uncertainty to reconstruct the original literature review into a series of themes. The second stage of my journey into the debates between feminisms and postmodernism provided me with a concept of a feminist reading of postmodernism and deconstruction. I gained a more complex, situated understanding of knowledge, without losing the political project central to feminism.

These journeys lie at the heart of this thesis. They simultaneously reached back into the original literature review to produce a reconstructed version and reached forward into the interviews and analysis to construct and reconstruct these. They became a bridge from the place I started off to the places I eventually reached.

My journey became a similar rite of passage to those experienced by the women in my study as they constructed their stories through pregnancy, birth and beyond. Our marginalisations were mirrored as they planned home births and I planned a feminist research project. Our needs coincided around finding our voices, complementing our existing knowledges and finding support and affirmation to realise our ideals. These parallel but different journeys further sensitised me to their experiences.

I hope that in summarising the paths I took and those I omitted, the reader will be more able to understand my story and be in a better position to dialogue with the conclusions I reached.

From phenomenology to feminisms

I designed the study to be a prospective one, following 30 women through their pregnancies until 6 to 8 months after birth (see Chapter 6). I saw this as an opportunity to explore the unique lived experiences of each woman and was initially drawn to phenomenological approaches to lived experience. The deeply embedded ethical intent to respect and interact with those involved in the research process appeared to fully support a woman-centred project (Anderson 1991, Bergum 1989, van Manen 1988, Edie 1962). In addition, given the experiential nature of birth and the controversy surrounding home birth, I was impressed by both the commitment to experience and the potentially emancipatory developments in phenomenology. I was particularly impressed by the depth of understanding, sensitivity and respect shown to women and their experiences of birth and motherhood by Vangie Bergum (1989), in her critical study on the transformation from woman to mother and by Juliana van Olphen Fehr (1999), in her phenomenological study of the caring relationship between women and midwives.

Phenomenology appeared to have its roots in both an exploratory and discovery orientation designed to uncover meaning in, and an understanding of the life-world, in a very human(e) way. I approved of its attempts to do this from the actor's point of view, in the belief that people are

Government policy and embedded in the research agenda; the less visible sites of resistance; and finally how different understandings of birth initially exposed in anthropological findings (Jordan 1993) coexist in a powerful, hierarchical framework of dominant ideologies.

'skilled actors' acting intentionally from conscious feelings, ideas and impulses (Anderson 1991: 30). This appeared to sit well with my intention to bring the women's voices to the fore.

My experience of activism had provided me with enough scepticism to be reassured by phenomenology's commitment to go 'beyond the taken-for-granted' (Bergum 1989: 9) while at the same time remaining grounded in the life-world; describing the 'lived experience of people [...] in such a way that it is true to the lives of the people described (Anderson 1991: 35); carrying on the reflexivity into the text; and considering the relationship between words and their meanings (Field 1994, Bergum 1989, van Manen 1988)³.

More interesting still was that one of the central tenets attributed to existential phenomenology was of 'locating consciousness and subjectivity in the body itself' (Young 1990a: 161). This seemed even more promising given the embodied nature of pregnancy and birth. The phenomenological concepts of defining lived experience in terms of corporeality, temporality, spatiality and relationality (van Manen 1988) already resonated with some of the issues contained in the lived experience of being pregnant and giving birth: the nature of lived time, the environment, the experience of self and other, and the more fluid boundaries between self and other. Phenomenologist, Max van Manen (1988) even related one aspect of spatiality to the meaning of the "home" (102). Again, I was unaware of just how contested subjectivity could be, but the concerns of phenomenology and its inclusion of the body as a site for consideration became pathways into many fruitful areas about women's experiences and oppressions. Without Iris Marion Young's (1990a, 1990b) phenomenological writings on the body, I may not have been so alerted to the disappearance of, and ambivalence about the body in feminist and postmodernist writings.

In summary, the qualities and concerns described in phenomenological theory and those evident in its application appeared to offer an approach to research that was respected, searching, and open to creative woman-centred interpretations. Thus I originally planned to adopt a hermeneutic phenomenological approach.

However, as I continued to explore the tenets of phenomenology and other research methods more critically, and at the same time considered the patriarchal issues involved in the hospitalisation and medicalisation of birth highlighted by some of the historical accounts (Donnison 1988), it became more apparent that while I may want to draw on methods as diverse as phenomenology, critical ethnography and grounded theory (Denzin and Lincoln 1994), these on their own may prove inadequate. The beginnings of a 'bricoleur' approach referred to in the Preface and advocated by feminist, Margrit Shildrick (1997: 5) took hold. I concluded that I needed a more robustly critical framework that would not only illuminate women's experiences, but would also locate them in the largely invisible, complex matrix of social relations. This matrix seemed to systematically privilege men rather than women and define women and their bodies in certain stereotypical ways. In the realm of childbirth, this resulted in obstetrics acquiring childbirth for its own domain and functioning as an agent of social control - where those controlled were largely women (Roberts 1981: 19). Put simply, feminism suggests that women as a group are oppressed in a variety of ways and that feminism has an overtly political, transformatory dimension.

'the overt goal of feminist research is to make visible women's experiences and, by so doing, reveal and correct the distortions which have maintained women's unequal social position' (Fleming 1994: 64)

³ I had no formalized conception of the deeply problematic notion of uncovering meaning or appealing to subjectivity and hence identity. Little did I know then, just how central to my work the contested notion of truth was to become and how far I would move from my own assumptions largely shaped by modernity.

As I began to consider feminist theories, it became clearer to me, that the term “humanistic” used to describe phenomenological and ethnographic approaches amongst others were somewhat problematic, because the “human” referred to was male and thus excluded any meaningful sense of women. By this stage it seemed that humanistic approaches on their own were not only inadequate, but incapable of addressing women’s experiences, lived or otherwise, in the way that I had intended (Martin 1990, Soper 1990, Stacy 1991).

On the basis of the above, it became clear that I needed a more critical way of looking at the patriarchal discourses in which women’s childbearing experiences are based; one that could acknowledge difference, and enable less audible discourses to surface. In the next section I focus on the developments within feminisms.

What feminist research can tell us

I became convinced of the need for a feminist approach as I read feminist research findings. These appeared to offer different interpretations of women’s lives. They were sensitive to the context in which women often struggle and could tell us about the diversity of women. Given the often negative, stereotypical images of women in general, and those of women planning home births in particular, the fact that feminist research challenged stereotypes and provided insights about women’s experiences which were both supportive of and plausible to them seemed crucial.

For example feminist research with young black women and pregnancy challenged the oppressive white view of black women as licentious (Kelly in Cornell 1995: 98). Research on women’s views of pregnancy, birth and related technology showed that women’s apparent desires for more rather than less technology represented a complex desire for more control rather than for technology itself. (Evans 1985). By being sensitive to the material reality of women’s lives, research on so-called “non-compliance” following prescribed treatment by a doctor showed that this was to do with the constraints on women’s lifestyles rather than assumed failings on their parts (Hunt et al 1989). An ethnographic study of women during labour and birth and the midwives attending them in hospital showed that the apparent passivity of the women and the over-controlling behavior of the midwives was an almost inevitable by product of the medically-dominated hospital structure (Hunt and Symonds 1995).

Other research not directly related to childbirth, but powerful in its findings, involved women suffering from chest pains. A feminist interpretation provided a very different possible explanation to the previously-held assumptions that these women either had heart problems, or psychological problems. Chest pains in some women were shown to be associated with anxiety following experience of rape and other forms of sexual abuse (Burt and Code 1995: 32).

Feminist theories

Feminisms: Getting closer

In order to determine more fully just how a feminist approach could increase my sensitivity and improve my theoretical stance and methods, it seemed crucial to explore the debates currently engaged in by feminist theorists and practitioners, to identify some of its possibilities and limitations.

Feminism is far from a single entity. Its original project of increasing women’s visibility has generated a host of other related concerns and questions. There are many different definitions of feminism and approaches to feminist research, many of which hold currency today. There are in addition many others engaged in research who would not call themselves feminists but who

nonetheless have drawn on feminist insights or work in woman-centred ways. It is difficult to say where it began, and indeed, feminist Shulamit Reinharz (1992) urges us not to define its historical roots too specifically lest we eclipse women's past lives and writings (12). It is also evident that while feminism has developed in more systematic ways more recently, there have been many women throughout history who saw and understood some of the consequences of patriarchal structures on their sex and who attempted to voice these insights (O'Neill 1998)⁴.

Undoing silences: Bringing women back from the margins

Feminisms have evolved in response to, and from the realisation that 'to a stunning extent, the interests of one half of the human race have not been thought about through history' (Minnich in Reinharz 1992: 11). More recent commentators have suggested that feminism only concerns itself with silence: 'vigilance for traces of the untold story is central to many feminist research and activist methods' (Burt and Code 1995: 32). To use Luce Irigaray's term, it has developed from enforced silences to provide a proactive 'noisy resistance'. One of the initial intentions of feminists was to address the omission of women more systematically and in the 1960s a feminist approach usually meant research on women, by women, for women (Stacey 1991: 111). The aim was to include women in humanist discourses as equals. It was assumed by some, that women had been omitted almost as an oversight. The 'add women and stir' (Oleson 1994: 159) view was commonly held and it was often assumed that adding women into existing structures would remedy the situation. It is only more recently that some feminists have questioned 'the maleness of the subject place to which these earlier feminists were staking their claim' (Soper 1990: 11). Or considered that the "oversight" might be based on the 'structured necessity of a system that can only represent "otherness" as negativity' (Braidotti 1997: 64).

Looking at the past as a series of discourses rather than events made the missing discourses all the more visible. Amidst the cacophony of competing and complementary voices about birth and how it should be defined and managed, silence reigned. Nowhere in the official discourses did there appear to be any reference to women's discourses; how they defined birth: or what their priorities and needs might be. Of course this silence is relative, and part of my work has been to seek out alternative voices. It was to add to these voices that I carried out the interviews in the first place.

The main conclusion I drew from my first understandings of silence was that it is as constructed as any other discourse and that the work of feminists evoked these silences: 'A crucial first step in developing an adequately feminist methodology is learning to see what is not there and hear what is not being said' Burt and Code 1995: 23). Michelle Fine and Susan Merle Gordon suggest that women hold secrets, which maintain silence: 'Feminist research must get behind "evidence" that suggests all is well' (1992: 23). Mary Maynard and June Purvis (1994) suggest one way of going beyond experience 'is to use our theoretical knowledge to address some of the silences in our empirical work' (24) - I would add, *and vice versa*. As my knowledge increased, I came to see silence in terms of muting and erasures. Silence seemed in the end, too absolute a term for what I heard in the literature and the interviews. It precluded the experiences of resistance, co-option and manipulation of oppressed voices. But for the present I return to some of the different strands of feminist theory.

Feminist empiricism

Feminist empiricists approached the task of breaking silences and bringing women back into focus by attempting to improve research and eliminate sexism through rigorous attention to objectivity.

⁴ As already mentioned, however, talking about history became more problematic when I took on board the questions of postmodernism, as I explain on page 36).

They asserted that sexism in one form or other entered into the research process. The resulting “bad science” or “bad sociology” was attributed to individual researchers rather than any underlying epistemological problems (Harding 1987: 183). Thus feminist empiricism was criticised for predicating women onto ‘malestream’ research while failing to acknowledge or address inequality and androcentricity (Eichler 1988) or the researcher behind the research (Harding 1987: 183). Ironically, the criticism that feminist empiricism failed to recognise or challenge dominant frameworks of oppression was the very reason for its relative success. It was less threatening and more transferable to mainstream research (Harding 1993: 53)⁵.

In fact, Sandra Harding (1987) has suggested that although feminist empiricism appeared to leave normative scientific values unruffled, it could not help but raise issues about the anonymity of the researcher, how research is constructed and whether or not traditional empiricism can indeed move beyond the world of men (184). In doing this, it unwittingly laid the groundwork for the complex questions in recent feminist debates.

Standpoint theories

A rather different response to raising the profile of women and their worlds was the feminist use of standpoint theories. These were not originally feminist innovations (Bar On 1993: 83), but arose as a way of identifying and exploring the struggles of subordinated groups against dominant ones. In modernist fashion, this is usually attributed to a single source: Hegel’s realisation that master and slave must have different perspectives on the world and that this could be attributed to their different places within it. This notion was further developed by philosophers, and is particularly attributed to Karl Marx, Frederick Engels and Georg Lukacs, and their examinations about the differing perspectives of workers and owners against a framework of production and materialism (Harding 1993: 53). These approaches showed more sensitivity to collective differences and the existence of unequal power relations between groups of people. They acknowledged that for subordinated groups ‘any explanation would have to encompass their experience, which can only be understood in the context of social relations constituting their marginality or oppression’ (Charles and Freeland 1996: 27).

Standpoint theories rest on the belief that subordinated groups are epistemically privileged in at least two ways. Oppressed groups ‘are likely to have insights denied to dominant groups about their own experience’ (Charles and Freeland 1996: 27) and, ‘social subordination generates specific critical insights into the dominant mind-sets’ (McLennan 1995: 396). In other words, ‘one’s social situation enables and sets limits on what one can know’ (Harding 1993: 54-55) and in societies stratified by gender, race and class for example, dominant groups have limited understandings about the world, while subordinate groups have insights that can potentially render the world more visible⁶. These theories gain currency from the insights of oppressed groups of people. The embedded assumption that oppressed peoples can somehow stand outside their experiences and see “reality” is problematic. In answer, sociologist, John Holmwood (1995), suggested that ‘an adequate social science must combine an emphasis upon the ‘internal’ subjective meanings of actors with an ‘external’ appreciation of the operation of large-scale social processes in terms other than the actors’ meanings’ (420). Apart from thorny issues of identity and whose judgement counts, this relies on the existence of some kind of metaphoric inside/outside barriers between dominant and subordinated groups and within individuals themselves. In the light of the debates throughout this thesis about the internalisation of dominant views and the demonstrated existence of horizontal

⁵ In appealing to objectivity, feminist empiricism is clearly located in modernist (patriarchal) thought, privileging reason and liberal views of equality. It still holds currency today and is the methodology most associated with liberal feminists.

⁶ With the hindsight of feminist/postmodernist debates it is possible to see that the tenets of modernism contained within standpoint theories present problems as well as possibilities.

violence within oppressed groups (Freire 1972, Hadikin and O'Driscoll 2000, Leap 1997, Stapleton et al 1998), this now seemed untenable.

A similarly problematic debate arose about the political nature of standpoint theories. Empiricists accused standpoint theorists of being deliberately political rather than striving for neutrality, and asserted that 'sociology relies on a claim to intellectual authority' (Hammersley 1994: 298). The notion of 'intellectual authority' is of course controversial, but standpoint theorists answered that social situatedness is 'a systematically available resource' (Harding 1993: 58) and that knowledge production is de facto political but that traditional empiricism lacks the ability to identify its own political nature. In fact, by examining both the knower and the known, standpoint theory is more objective than empiricism (Harding 1993: 70).

Despite criticisms, standpoint has continued to be appropriated and developed by feminists. It has been seen as a way of not only grounding research in women's everyday experiences, but as a useful vehicle for legitimising these experiences and ultimately giving voice to women. While standpoint theories appeared to address the criticisms of feminist empiricism by recognising structural sexism and androcentrism in the production of research they were accused of being insensitive to difference. The category "woman" was seen by some feminists as conservative and oppressive, because of its tendency to homogenise women. Just as the 'view from nowhere' was exposed to be the view of the western, white, educated, and usually well off males (Code 1993: 21), women of colour, non heterosexual women and women in less prosperous circumstances accused standpoint theories of attributing the term 'woman' only to western, white, heterosexual, academic women (hooks 1990, Oleson 1994).

Whatever one concludes about the potentials and limits of feminist empiricism and standpoint theories, it is clear that the main concern is unquestionably women, and the framework transformatory, whether overtly or covertly political. Women and transformation remain the cornerstones of feminist research. More complex notions of what feminisms are and do have since been developed. Rosi Braidotti (1997) describes the essence of feminist theory as 'a two-layered project involving the critique of existing definitions, representations as well as the elaboration of alternative theories about women' (61). As I observed on page 24, feminist research is about making visible women's experiences in order to transform the constructs of inequality. This was the "stuff" of feminist research in which I wanted to be involved.

However in raising the possibility of situatedness, specificity and difference, the door to postmodernism could no longer remain shut. I saw the glimmerings of a literature review, which could examine the rise of male midwives and obstetrics and the demise of the female midwife and midwifery through different belief systems and knowledges. I began to see the possibilities of reconstructing the story of obstetrics (often told as one of unmitigated success); and the story of midwifery (often told as one of unmitigated failure), to point out the messiness of these stories, the partiality of these discourses and to question the very notion of success and failure on which these assertions are made.

Michele Barrett (1992) made the (appealing) comment that 'feminism straddles the modernist and postmodernist divide, refusing to abandon values on which the modernist project of liberation is founded but also recognising the validity of different women's experiences and the different ways of knowing and being that these encompass' (216). It was appealing because it creates spaces for women and other oppressed groups without challenging the basis on which these oppressed groups exist. But this compromise seemed both too easy and uneasy to warrant immediate acceptance.

On the edges of postmodernism

Opening spaces/meeting challenges through the debates between feminisms and postmodernism

Having left all but the essential ethos of phenomenology behind, along with other humanistic methodologies, and found a safe haven in feminisms, I ventured onto the edges of postmodernism. Commentator on postmodern architecture and art, Charles Jencks had this to say about postmodernism and its origins

'Sir, - The first use of the term "postmodernism" is before 1926, and extends to the 1870s, when it was used by the British artist John Watkins Chapman, and 1917 when used by Rudolph Pannwitz. "Post-Impressionism" (1880s) and "post-industrial" (1914-22) were the beginning of the "posties", which flowered intermittently in the early 1960s in literature, social thought, economics and even religion ("Post-Christianity"). "Posterity", the negative feeling of coming after a creative age or, conversely the positive feeling of transcending a negative ideology, really develops in the 1970s, in architecture and literature, two centres of the post-modern debate (hyphenated half the time to indicate autonomy and a positive, constructive movement). "Deconstructive postmodernism" comes to the fore after the French post-structuralists (Lyotard, Derrida, Baudrillard) became accepted in the United States in the late 1970s, and now half the academic world believes postmodernism is confined to negative dialectics and deconstruction. But in the 1980s a series of new, creative movements occurred, variously called "constructive", "ecological", "grounded", and "restructive" post-modernism.

It is clear that two basic movements exist, as well as the "postmodern condition", "reactionary post-modernism" and "consumer postmodernism"; for example, the information age, the Pope, and Madonna. If one wants an impartial scholarly guide to all this, Margaret Rose's *The Post-Modern and the Post-Industrial: A critical analysis*, 1991, serves well.

I should add that one of the great strengths of the word, and the concept, and why it will be around for another hundred years, is that it is carefully suggestive about our having gone beyond the world view of modernism - which is clearly inadequate - without specifying where we are going. That is why most people will spontaneously use it, as if for the first time. But since "Modernism" was coined apparently in the Third century, perhaps its first use was then'

(Jencks in Appignanesi and Garratt 1995: 3)

This suggested a wide scope of influence; defiance of being attached to any historical moment, political stance, or direction; and a commitment to disrupt. Alison Assiter (1996) provides another brief but useful overview in an introduction to her persuasive arguments to locate feminism in modernism rather than postmodernism, because of its perceived instability and apolitical (and therefore oppressive) stance.

Why did I not abandon postmodernism immediately? The issues of knowledge and power, central to postmodernism, struck a cord. I saw within the deconstructive processes, particularly those developed by Michel Foucault (1980), the potential to examine more extensively, the knowledge bases and power structures on which childbirth practices are based. Their deconstruction of rationality, objectivity and truth seemed to undermine the foundations of reason (and thus of so-called scientific knowledge) on which liberal humanism is built, and on which patriarchy sustains itself. Rene Descarte's statement, 'I think therefore I am', closed the gap between identity and reason. In destabilising reason it seemed that feminists could trace the steps that locked oppositional terms into a series of hierarchical dichotomies based on the super dichotomy "male" and "female". Not only could the marginalised (female) oppositional terms be brought into 'noisy' opposition, but the 'very structuration of the binary model' could be displaced (Shildrick 1997: 111). This presented the possibility of moving away from rigid thought patterns based on modernist dichotomies to more fluid, co-existing ironies. It was by creating this sort of space that I was able to hear the women in my study construct meanings of childbirth which were profoundly different to the narrow, medical definitions provided for them. It also opened the door to reconstructed identities based on emotion, corporeality and other senses besides reason, which I address in Chapter 5. Oppressive grand narratives from which the medical model of childbirth arose could be exposed as a belief system among others. In short, truth, knowledge, and the human subject became destabilised (Shildrick 1997: 5-6) so that the world looked less like a map to be discovered and more like transient maps under construction and reconstruction. The gaps and spaces opened up seemed dizzyingly inviting.

Postmodernism seemed to entertain the notion of individualism and difference to the extent that questioning the stereotyping of women, especially those planning home births could become a more legitimate part of the project. By exploring the gap between stereotypical "woman" or the 'fantasy' of woman, and the complexities of actual women, more inclusive ways of researching women's experiences could be developed (Cornell 1995)

It thus appeared to support rather than undermine the feminist project and I gained confidence from observing that committed feminist theorists (see for example Benhabib et al 1995, Nicholson 1990, Nicholson 1999, Shildrick 1997) were dialoguing with postmodernism and attempting to integrate it with feminism. But it seemed that many other feminists had and still have a troubled relationship with postmodernism and that there was and is a reluctance in various quarters to abandon the final remnants of modernism (Assiter 1996, Bell and Klein 1996, Brodribb 1992). Most appeared to stop short of a thorough investigation of the possibilities of postmodernism and whether there could be a feminist reading of it. Some suggest that in fact feminisms and postmodernism have existed in parallel but 'have kept an uneasy distance from one another (Fraser and Nicholson 1990: 19). The difficulties centred on a number of issues: the apparent disintegration of any notion of meaningful historical analysis; the disintegration of any commonalities and thus the means to identify woman or oppression as meaningful categories; the disintegration of feminism and critical voices; the subsequent lack of political direction; and finally the complete disintegration of absolutely everything into text and chaos. These are serious charges.

The death of history?

Postmodernism has indeed posed serious questions about the value and authenticity of historical analysis. In particular, it has challenged the notion that the past can be viewed as a linear progression (Foucault 1982) or accurately filtered through the eyes of the present. There are arguments to suggest that history is disjointed and that interventions can have random, unplanned, even unwanted consequences. For example, while cultural changes impacted on birth practices, the introduction of the NHS in 1948 had unpredicted and unexpected influences on maternity services

and midwifery⁷. Postmodernism has, however encouraged acceptance of multiplicity and the notion that different or opposing influences and events could occur concurrently; and may be interconnected through networks of power. Thus, while it would have seemed negligent to ignore history, a series of concurrent discourses, rather than a chronological series of events, was more in keeping with postmodernism. None of this seemed out of keeping with feminist projects.

However radical feminist historian, Joan Hoff (1996) argues persuasively that the logical conclusion of poststructuralist theory is the annihilation of history, and along with it women's history: a history that feminists have painstakingly resurfaced in order to produce examples of herstory. She sums up the situation in North America thus:

'The potentially paralyzing consequences of this theory upon the writing of women's history in the United States arose innocuously enough in the mid-1980s as many scholars in women's history sought to find concepts in French postmodernist theory that would enhance the emphasis already being placed on gender. Unfortunately, most began with Michel Foucault who in his work on sexuality talked extensively about gender, but largely neglected to focus on women. Moving on to the other male post-structuralists whose theories were equally insensitive or hostile to half the human population, a male-defined definition of gender that erased women as a category of analysis emerged as a major component of American post-structuralism' (393).

She continues that postmodernism denies history any reality and that all that exists is the moment, 'therefore historical agency - real people having an impact on real events - is both impossible and irrelevant' (395). Research becomes powerless to reveal anything of substance from the chaos or non existence of history (396).

It is thus incumbent on feminist postmodernists to harness history as a tool for liberation. And as Starhawk suggests, any liberation story must look both backwards and forwards (1987: 26), without privileging Western history as the only story of culture (33). The potential death of history necessarily relates to the next charge.

The death of woman and political analysis?

In terms of the second challenge, the work of feminists has raised the issue of women as an identifiable, subordinated group. This thesis rests on the belief that the category "woman" can remain intact. As mentioned above, the influences of postmodernism and feminisms have encouraged us to abandon stereotypes and focus on individual women; examine detail; and understand that networks of power and control can be experienced both collectively and individually (Meyers 2000) and may not be consistent. So for example, while there was a move from midwife attended births at home, to doctor attended births in hospital in most of Western Europe and North America over the 19th and 20th centuries, resulting in almost 100% hospital

⁷ The 1936 Act and the NHS Act of 1946, which came into force in 1948 provided women with medical and midwifery services for birth, free of charge at home or in hospital. In the context of a developing discourse about risk and safety, greater acceptance of hospital as a legitimate place of birth, and the opportunity for women to escape, briefly from the grind of domesticity, it is perhaps not surprising that a move which extended choice, in fact encouraged the shift from home to hospital and eventually served to reduce the choice of home birth and phase out independent midwives. Importantly, the GP became the first point of contact for maternity services - a gatekeeping role, which has increasingly impacted on home birth because many GPs today, (as confirmed by my study) are opposed to home births. It is impossible to know how many women consider a home birth but are directed towards hospital birth at an early stage - but in surveys that have been carried out, there appears to be a significant gap between numbers of home births and the numbers of women who would like the option to be available (Department of Health 1993, Scottish Health Feedback 1993). And as I mentioned on page 20, in areas where home birth is supported by midwives and GPs, the numbers of home births have tended to rise to between 10-23%.

births, there were exceptions, dissenting voices and places of resistance (DeVries 2001, Donnison 1988, Marland 1993a, Peretz 1990, Robinson 1990) (see page 51).

However some feminists have suggested that postmodern feminism is a contradiction in terms, politically and materially (for example, Benhabib 1995). Others have cautiously debated the costs and benefits of accepting postmodernism. The potential fragmenting of the term “women” would not only curtail feminism’s critical ability, but indeed its very *raison d’être* (Butler 1995, Fraser 1995, Holmwood 1995, McLennan 1995, Nash 1994, Phillips 1992, Hartsock 1990). If, ‘to undertake feminist research is to place as central to the inquiry the social construction of gender’ (Fleming 1994: 64) and the suggestion is that gender can no longer identify itself, feminists (and I include myself) have a problem. It is for these sorts of reasons that postmodernism has been described as both ‘promising and dangerous’ (Nash 1990: 65), and why Lorraine Code’s (1993) ‘mitigated relativism’ (41) was deemed by some feminists to be more acceptable because of its capacity to examine rather than disappear gender constructions and relations.

Kate Soper (1990) poses the pertinent question about whether the apparent dissolution of feminism and its political critique complete a circle, leaving women once again, silenced and vulnerable (13). This is echoed by radical feminists (Hoff 1996, Mikhailovich 1996, Thompson 1996, Waters 1996). Hoff quotes Sandroff, asserting that postmodernism is oppressive because of its ‘powerful tendency [...] to drift inexorably to the male point of view’ (406). Somer Brodribb (1992) succinctly paraphrases postmodernism as ‘the cultural capital of late patriarchy’ (21). In other words, does postmodernism, like modernity, mask its political nature? Katja Mikhailovich (1996) asks us if we can afford ‘the erasure of words like oppression, exploitation and domination’ (343). And in replacing reality by texts, French feminist Christine Delphy (1996) asks if textual analysis can relate to the materiality of women’s lives. Finally Hoff (1996) suggests that politics is replaced by linguistics (408). It is along these lines that standpoint theorist Dorothy Smith deplores the rejection of materialist reality and acceptance of idealism and relativism leading to ‘a pluralism of more or less equal views’ (Rosenau 1992: 22):

‘Judgemental (or epistemological) relativism is anathema to any scientific project and feminist ones are no exception. It is not as equally true as its denial that women’s uteruses wander around in their bodies when they take maths courses, that only Man the Hunter made important contributions to human history [...] that sexual molestation and other physical abuses children report are only their fantasies - as various sexist and androcentric scientific theories have claimed’ (Smith in Mann and Kelley 1997: 404).

Another proponent of standpoint approaches, George McLennan argued that ‘without some degree of epistemic grounding, without some coherent notion of the knowing, acting subject, distinctive political projects and articulations of *any kind* cannot be sustained (MacLennan 1995: 393). The charges become ever more serious.

The death of everything, especially knowledge and truth: or if not, why not?

In a searching article about feminism and postmodernism, Katja Mikhailovich asks ‘whether deconstruction inevitably leads to relativism or nihilism (basically the end point of which is, nothing exists, nothing really matters, and anything goes), and if not, then when, and where do we stop deconstructing?’ (1996: 342). This appears to be the position of sceptical postmodernists who ‘reject any bases for adjudicating knowledge claims’ (Mann and Kelly 1997: 401) but less so for affirmative postmodernists who lean towards ‘intersubjective consensus’ (Mann and Kelly 1997: 403) - something similar to Richard Rorty’s ‘conversations’ (1991) criticised by feminists as being naive, lacking attention to power differentials and dangerously open to dominant ideologies and groups enforcing their ‘conversations’ (Code 1993). On the other hand, in asserting that there are no

truths, postmodernism is claiming a single truth, or, 'as Kate Soper has argued [...] postmodernists implicitly appeal to the very values they are rejecting in claiming their position to be preferable to the one they are criticizing' (Assiter 1996: 5).

Perhaps at the end of the day, Diane Bell and Renate Klein were right in asserting that 'in fact, feminism has already traversed much of the terrain currently claimed as newly articulated by the postmodernists. "So, genealogically," Kristin Waters writes, "feminist theory in the US largely precedes and informs post-modernism, not the reverse." It is feminist theory which, from the beginning has provided self-conscious critiques of modern theories from the Enlightenment to the present. Post-modernism, on the other hand, with its move to "destabilize the subject," is a reiteration of the modern argument against abstract ideas.' (Bell and Klein 1996: xxvii).

The questions remained. Were the above criticisms necessarily implicated in postmodernism and could it be read in any other ways? The points at issue seemed to be whether or not feminisms could make their mark on postmodernism and whether or not postmodernism could be infused with a feminist morality and materiality. If these cannot be satisfactorily addressed, it seems that indeed, as Alison Assiter argues 'enlightened women' should look to modernism despite feminism and postmodernism appearing on the surface to be 'natural allies' (Assiter 1996: 4).

Answering the charges, uncertainly

I had initially seen few problems and several advantages to: positioning myself somewhere between standpoint theories and postmodernism; grounding my framework largely in standpoint debates while making selective forays into postmodernism; asserting the standpoint position that knowledge is possible and based on experience (but not necessarily experience alone) rather than calling into postmodern question the very notion of knowledge (Charles and Freeland 1996); using standpoint theory to locate women's experiences of planning home births in a political/emancipatory struggle (Harding 1994) based on the solidarity and strength of groups of women who had united in a network of resistance against medicalised birth; and using postmodernism to refrain from stereotyping these women. This now seemed less tenable. Could it be a careless use of postmodernism which would result in faulty methodology? Should I exercise more caution? Or could postmodernism be seen as a collection of disparate deconstructive discourses which on their own are incomplete and posit a collection of theoretical tools? Could they be infused with values that are either oppressive or liberatory and could the work of feminists be to produce a reading of postmodernism based on individual women's morality and materiality, as I suggested above?

I remained convinced of the potential of postmodernist discourses and unconvinced that 'it is a capitulation in the face of our problems, rather than any solution to them' (Holmwood 1995: 415). The unease engendered by the uncertainty of postmodernism seemed to be partially located in modernity's need for certainty and in terms of birth, the need for certainty within the medical discourse on childbirth. In fact some of the criticisms levelled at postmodernism could be construed as a modernist criticism unable to step outside itself and thus construing postmodernism in judgemental, dualistic, modernist concepts and language. I appealed to Margrit Shildrick's feminist reading of postmodernism and her view that deconstruction is not synonymous with destruction, and that openness need 'not be interpreted as weakness, nor as indecision, but rather as the courage to refuse the comforting refuge of broad categories and unidirectional vision' (1997: 3) Indeed, as Jane Flax suggested, 'if we do our work well, reality will appear even more unstable, complex and disorderly than it does now' (Flax 1990: 57). Margrit Shildrick's rejection of dichotomous thinking is particularly important, if a feminist reading of postmodernism is to be entertained. It allows for the co-existence of differences and similarities, discontinuities and continuities. In short, I rejected the relativist, nihilist cycle, and thus the death of history, women, politics and knowledge.

My stance is clearly political in that it attempts to be 'with women. Hence, I have answered my own question and take the view that postmodernism is a tool which can be put to different political purposes. In my attempt to balance postmodernism with a feminist, political stance, I do not allow it to be a free floating entity, but attempt to harness it judiciously, ethically and in keeping with feminist principles as suggested by Margrit Shildrick (1997). Allowing postmodernism to dictate to us mirrors the problems identified within positivism/modernism; perpetuates the modernism/postmodernism dichotomy; and does little to address the issue of researcher responsibility. As previously stated, postmodernism need not indicate a "free for all" (Shildrick 1997). It is my hope that this approach may contribute to a basis for future work, that could extend further the boundaries of postmodernism and its possibilities for feminist research.

In summary, whether or not my thesis had been primarily located in modernity, and appeals made to objectivity, truth, reality, or any other so-called legitimising authority, the effects of postmodernity have destabilised the foundations of modernity enough to posit the notion that we are at a point of no return and that modernity has already been transformed. This study can only be my interpretation of the narratives I collected, from the literature and the interviews. I attempt not to relinquish responsibility, and strive not to misrepresent those I listened to. It is my hope that the end result will be acceptable and coherent to the women involved.

At this point I leave the dialogues between feminism and postmodernism, to return to the literature I reviewed. My understanding of the debates thus far provided me with what I considered to be a reasonable basis for a literature review focusing on the demise of independent midwifery and the development of obstetric ideology and practice in the context of changing political and social influences.

CHAPTER FOUR - Continuing the journey: From fact to discourse

Introduction

Staying with the debates in the previous Chapter, I consider the context in which obstetrics replaced midwifery as the authoritative ideology on childbirth in Britain; and how that authoritative knowledge developed and expressed itself through practice. I attempt to locate and expose the layers of discourse in which this was possible, even desirable. In doing this, I strive to honour my earlier assertion that silence is as constructed as any other discourse (Clair 1997, Morgan and Coombes 2001), by searching out some of the less told stories. Of course, postmodernism challenges the notion of tying historical accounts to a chronological series of dates, and questions the significance of isolated historical events. Despite doubts about the material credibility of these, in the interests of clarity and readability I compromise by providing accepted dates, in order to give some kind of time frame to this review.

In essence, I try to understand why it is, that from as far back as we can reach until recent times, in most communities, women's (and sometimes men's) socially, experientially based knowledges and skills prevailed in matters of birth and health (Donnison 1988)¹. And why a rapid move from hospital to home birth resulted in the move from 1% of women giving birth in institutions at the beginning of the 20th century, to around 1% of women giving birth at home by the 1980s in Britain (Campbell and Macfarlane 1994). I draw on feminist critiques of patriarchy, and postmodernist influences to show how patriarchy is embedded in a series of changing discourses, which were implicated in the development of a medical model of childbirth, but attempt to avoid attributing all women's ills to patriarchy in a simple cause and effect framework.

I do not provide a comprehensive review of the history of midwifery and obstetrics, as this has been well documented elsewhere (Arney 1982, Donnison 1988, Murphy-Lawless 1998a, Towler and Bramall 1986), but focus on the discourses running through it. In staying close to feminism and postmodernism, this is not a definitive historical account at all. It is rather an attempt to make visible and critically reflect on the many story lines that preceded the current stories of birth².

The discourse of patriarchy

Carol Pateman (1989) suggests that patriarchy underlies oppressive discourses and despite feminist doubts about whether or not it is still a meaningful category, she argues for its retention in order to make women's oppression more visible (55). She and other feminists traced the discourses of patriarchy through creation myths (Pateman 1989: 38, Rabuzzi 1994, Starhawk 1990). These powerfully demonstrate some of the mechanisms for the subordination of women. Pateman asserts that patriarchy mutated from a paternal to a fraternal form during the social contract theories of the 17th and 18th centuries which formed part of the basis for civil society, but is still a major determinant. Pateman's (1989) contention that society is so thoroughly patriarchal that it 'lies outside the reach of most theorists' (34) provided a basis for suggesting that the patriarchal discourse forms the weft against which other discourses are woven³. In creating a modern

¹Changing patterns of birth care reflected broader changing patterns of health care: the move from healing to medicine, which I discuss briefly on page 39). These changes represented an overall move into modernist views of science, knowledge and expertism which I discuss below.

²Inevitably, at this earlier stage of my thinking, much of this review resembles an assembled patchwork of pockets of knowledge, rather than the more comprehensive integration of theory contained in my analysis.

³This is not to say that it has passed unnoticed. Even by the end of the 17th century, 'Mary Astell was asking: If all Men are born Free, how is it that all Women are born Slaves' (Pateman 1989: 40) and that while contract theorists were unable to provide an answer, 'three centuries of feminist criticism was suppressed and ignored' (40).

patriarchal order based on fraternal social contract, a distinction between public and private was established, strengthening dichotomous, hierarchical definitions. This laid the basis for the distinction between men's reason and women's bodies and the development of male-based professions and structures such as medicine (Pateman 1989: 45 Witz 1992), thus laying the foundations for modernity to flourish in men's favour.

.... includes power and violence

Bringing the concepts of power and knowledge bound in patriarchal discourses to bear on midwifery shows a story line of control that necessarily includes power and violence (Murphy-Lawless 1998a). Patriarchy manifested itself in materially different ways. The modern, medical model of childbirth has only relatively recently taken control of midwives in westernised countries (and increasingly other countries) and attempted to appropriate or erase their knowledge claims, but in so doing, it takes over from other parties structured around patriarchy such as the Church and subsequently the State.

There appears to be a long history of control, from at least the 12th century, if not earlier when Christianity in the form of the Church interested itself in midwifery, in order to exert control over women's sexuality and reproduction. The religious/patriarchal focus on midwives was largely structured through morality: having appropriate religious beliefs, and being of the appropriate age and circumstances to uphold the dominant beliefs about morality (Donnison 1988: 14, Marland 1993). While ritualistic practices surrounded birth and death, women's bodies were not the direct subject of these rituals in the way they are within a medicalised model of birth. Without the means to intervene in birth, how it was enacted remained in the hands of women and its outcome was apparently in the hands of God: designated fate. The health of the woman and skill of the midwife have remained largely unacknowledged discourses.

The means of control necessarily include violence (Foucault 1980). This was initially more visible as punishments were inscribed forcefully on individual bodies. The witch hunts were a particularly shocking enactment of violence against women and often involved healers and midwives from the 14th to the 17th centuries. Though the extent cannot be known, Barbara Ehrenreich and Deirdre English suggest that it could have involved millions of women (1973: 24). As control was more consistently exerted over women, midwives and birth, the violence enacted became institutionalised and thus less visible. The patriarchal discourse of power and violence was implicated in the development of invasive technological intervention in childbirth and the coercive setting in which these have been imposed on women (Murphy-Lawless 1998a).

A number of studies have attempted to show how power is exerted over women, despite their initial thoughts and feelings and despite efforts by them to retain autonomy and exert agency. According to Steven Lukes' (1974) three-dimensional theory of power, this can be by overt or covert coercion, or manipulation. A number of researchers have found that women are apparently manipulated to accommodate medical views and practices (Lane 1995, Levy 1998, Machin and Scammel 1997, Shapiro et al 1983)⁴.

The discourse of violence against women through obstetrics is perhaps one of the most hidden discourses of all and has been reconstructed and legitimised in such a way as to render it less visible

⁴ A more complex feminist analysis, suggests that: 'There are three different but interrelated levels at which socialization can impede autonomy: first, at the level of processes of formation of our beliefs, desires, patterns of emotional interaction, and self-conception; second, at the level of the development of skills and abilities that constitute what Diana Meyers calls autonomy competence; third, by frustrating a person's ability or freedom to act upon or realize her autonomous desires or an autonomously conceived life plan' (Mackenzie 2000: 144). The significance of these debates is more apparent in Chapter 9 where I discuss autonomy in more detail.

than ever. Few researchers have focused on this issue, though where this has been the subject of research, women describe experiences not unlike those described by women who have been sexually abused (Kitzinger 1992). As Jo Murphy-Lawless (1998a) observes, the 'deep violence to us carefully handled as science [...] is a violence about which we have all too rarely been able to speak.' (103). 'The problem with the actual violence entailed in operative midwifery is the way it was redeployed within the area of 'representational' violence. When the two become intertwined, the latter is used to legitimate the former and even encourages actual violence, becoming ever more tangled on the issue of female vulnerability and the need to rescue women from their own bodies' (96).

.... and then modernity

The above discourses became very much more complex in the context of modernity from around the 17th century. The continuing control over midwives became set within a power struggle between the established Church and the challenges of the developing modern State. The patriarchal paternal and fraternal power struggle moved the power base from the traditional order of kings, to a new order of liberalism, capitalism and the modern family. (Pateman 1989: 36). In relation to childbirth, modernity provided the underlying belief system that nature could be improved upon and provided a scientific/technological framework through which childbearing and its management could be redefined (Murphy-Lawless 1998a).

.... and materialism

Sociologist Anne Witz (1992) suggests that in addition to patriarchal gender relations, the transition from what she calls pre-modern, to modern practices of medicine, in which midwives and medical men were engaged took place in a 'structural matrix of patriarchal capitalism' (66). Among other influences, the restructuring of medical markets was instrumental in promoting medical men and demoting women healers. In premodern times, women practised healing in domestic and community settings and medical knowledge, like women's knowledge was informal, experiential, and distributed orally. Literacy was rare and few published sources existed (77-78). At the end of the 18th century, an expanding middle class with disposable income made the expansion of medical services into the public sphere possible. As Witz argues, the control of this public sphere, the control over medical practice and the exclusion of women from occupational specialisation, institutionalised patriarchal power over medicine (and subsequently childbirth, as it was co-opted into medicine). In terms of patriarchal materialism, the control of market economy was necessary to control the generation of and access to wealth in general - and male midwifery was initially seen as a way into the more lucrative practice of general medicine (Donnison 1988)

.... rationalism, science and technology and the binaries

Broadly speaking, the construction of (male) reason underpinned the development of modernity. Its assumption that a rational scientific approach would provide a more accurate understanding of reality and thus provide the means to manipulate and control it more effectively (Oakley 2000), promulgated a set of beliefs that made the suppression of midwifery more probable and the rise of medicine more possible. The construction of reason through the (violent) severance of emotion formed the basis of dichotomous thinking, which spawned a host of other binaries: culture/nature, mind/body for example. These were attributed to the fundamental patriarchal dichotomy; male/female. Feminist anthropologists have argued that in all cultures women are subjugated by a nature/culture dichotomy, where they symbolise nature (Ortner and Whitehead 1981). Postmodernism might suggest that this is rather a grand claim, but the point I make is that dichotomies based on male/female were not unknown. The issue at stake here is that modernity's reason embedded these dichotomies in a hierarchy that systematically defined and disadvantaged

women. This was crucial in providing the basis for 'upstreaming' male medicine, 'downstreaming' female practices and providing the direction that medicine could take. Reason's rationalism provided the conceptual milieu in which science evolved as its methodology, and technology its main tool for acquiring and legitimating knowledge.

The conceptual violence perpetrated by excluding women from reason in a belief system that privileged reason over emotion not only excluded them from the public sphere, as I explained above. They were excluded from all modernist projects and from the possibility of acting as full moral agents, leaving (medical) men free to follow their "rational" pursuits at women's expense. This rationalism and the modern mind's faith in science (Devries 1989) laid the foundations for the development of alternative (obstetric) birth practices based on the belief that nature could be improved upon. As Arney commented, 'rationalism freed birth from the constraints of nature and opened it to improvement' (1982: 25).

Technology has often been seen as central to the development of the medical profession, and the invention of the forceps is often cited as a turning point in the ascendancy of medical men over female midwives (Devries 1989). However, as Arney (1982) points out, while technological developments may have hastened the medicalisation of childbirth, it is the belief system underlying its development that shapes the tools and how they are used, giving them currency and status⁵. Without the belief that the scientific underpinnings of modern medicine were accurate and desirable, the actual violence perpetrated by forceps for example, could not so easily have been construed as teething problems in need of refinement (Murphy-Lawless 1998a: 151).

.... mind/body dichotomy

In the context of patriarchal discourses it seems that, control of the body and its representation of uncertainty has been one of modernity's main projects. 'Throughout history women's bodies have been treated as especially threatening to the moral and social stability of society' and attention on the womb in particular has taken place all over the world from earliest times (Turner 1987). 'The idea that the body is the central metaphor of political and social order is ... a very general theme in sociology and history' (Featherstone et al 1991). The imposition of social order through control of the body and bodily functions frequently arises. Anthropologist, Mary Douglas' (1966) work on ritual, 'purity and danger' suggested that the body is the principle medium for the creation of order through classification. General control of the body was replaced by the notion that individual minds could control their attached bodies. Foucault suggested that the modern state depends on internalisation of self-restraint through 'disciplined' bodies. Dichotomous thinking cemented a mind/body split that left the body as brute mass, and paved the way for the mechanistic construction of the body, central to the medical model of childbirth. The body provided the material site on which to improve nature through science and technology, where control is the mediating factor. Women's particularly unruly bodies have been a focus for this (Braidotti, 1997, Douglas, 1966, Featherstone et al 1991, Martin 1989, 1990, Shildrick 1997, Turner 1987).

Thus bodies are reconstructed through the beliefs of the day. Max Weber suggested that capitalism produces heartless, soulless bodies, and others suggest that bodies and culture produce each other (see Featherstone et al 1991: 13-15). Jo Murphy-Lawless (1998a) suggests that the woman's body is reconstructed 'within the hospital setting with its tremendous range of technical possibilities.' (44). The resulting normalised body is then thought to represent the "natural" or "biological" body. Childbirth practices are played out directly on women's bodies and I consider the question of

⁵Similar theses are provided by Ann Oakley who suggested that a body of knowledge, as well as technology is essential for professional development (1984) and by Raymond Devries, who observed that knowledge is demonstrated through both discourse and technological tools (1989).

embodiment, and how bodies are constructed biologically, socially or otherwise in the section on obstetric discourses on page 57, the Risk section on page 61 and the section on bodies on page 90. The extension of dichotomous thinking in obstetrics led to the maternal/fetal separation, which both created and set the scene for further monitoring technology and surveillance of another 'patient', the fetus (Arney 1982, Duden 1993). Jo Murphy-Lawless (1998a) puts this pairing as central to the existence of obstetrics, in which it claims to be 'in the best position to preserve and protect the interests of both' (58). Ironically, obstetrics has focused more and more exclusively on the fetus. For example, an obstetrician asserted that 'the important thing is to define who is at risk. The problem of maternal mortality has been largely overcome - pregnancy and labour are no longer a risk to the mother. It is the problem of the fetus that concerns us at the moment, because the quality of the fetus is our investment for the future in the family and for the country'. (Beard in Oakley 1984). Woman is transformed from 'a complete physical and emotional being, part of a wider social circle' to an 'active uterus' (Kennedy 1998: 10), all but disappearing her and her relationship to her unborn child (Duden 1993). The relative silence of being in relation to rather than separate from reverberated in my interviews, and forms the basis of my discussions in Chapters 8, 9 and 10.

... all played out through the State agenda and normative policies....

As the Church's control decreased and the State's increased, the discourses of patriarchy influenced birth in different ways through the State. The detail of how midwives were increasingly controlled through local and subsequently broader legislation is well documented by Jean Donnison (1988). Initially, midwifery was regulated in much the same way as other trades through training, certification and remuneration (Donnison 1988, Marland 1993b Witz 1992). As science and technology gained currency, and reconstructed the birthing body, men were able to involve themselves in childbirth more systematically. They had done so on an ad hoc basis during the 17th century, if not before, but it was only in the context of other possibilities for managing birth that this occurred systematically.

Meanwhile, until the Inter-Departmental Committee (1904) considered infant mortality, the State took a rather *laissez faire* attitude towards childbirth and midwives. The passing of a Midwives Act took from 1890 until 1902 in England and Wales and 1915 in Scotland (Donnison 1988)⁶. A series of demographic changes following the Industrial Revolution formed the backdrop to the change of State heart. Large numbers of people were left clustered together in abject poverty and squalid housing conditions. Statistics collected since 1838 showed that despite a decrease in overall death rates and a drop in birth rates, infant mortality showed no improvements between 1838 and 1900 (Oakley 1984). But the issue of health was finally catapulted onto the state agenda when it was alarmed into thinking that the British race was in a state of deterioration following the humiliating defeats of the Boer Wars in 1899-1902 and reports that significant numbers of young men were ineligible for recruitment into the army because of poor physical health. This was later refuted, but concerns persisted (Interdepartmental Committee 1904). At this juncture, a number of agendas coincided. The Government became interested in infant mortality arising from concern about the availability of fit young men to sustain British interests abroad and provide labour for industry at home. Medical men wanted to expand their jurisdiction over childbirth and large numbers of women were living with the harsh realities of bearing children in inadequate homes and suffering from the long-term effects of childbirth related ill-health. Inevitably, in a patriarchal State, men in Government, and medical men arise from the same mould (Wagner 1994). Their agendas were thus more likely to coincide, as they did on maternity issues throughout most of the 20th century⁷.

⁶ By this time medical men were well established and ensured that while the Act ostensibly provided a mechanism for public protection against unqualified practitioners, midwives, lost control over their profession (Donnison 1988, Robinson 1990: 65).

⁷ This was the case until the early 1990s, when a conservative government sought to reduce the power of medicine through

Though it was evident from the health reports produced in the first 2 or 3 decades by Dr Janet Campbell and the Ministry of Health (Ministry of Health 1930, 1932, see also Lewis 1990, Tew 1998) that incorporating medical solutions was not immediate⁸, as medicine became the established authority on health, its solutions were increasingly incorporated. As resources became a growing issue on the State agenda, it was seen as cheaper to promote medicine and medical solutions to health than to address poverty and other causes of ill health. Hospitalisation and then centralisation fulfilled two coinciding needs to rationalise health and resources. Just as 'dealing with the social conditions which might contribute to maternal ill-health was never going to be the bailiwick of obstetrics' (Murphy-Lawless 1998a: 76) it was not going to be that of the State's either.

Despite the lack of evidence on which to base the belief that hospitalisation and medicalisation increased the safety of birth, this was increasingly incorporated into policy-making: home birth and small birth units were phased out⁹. The dis-association of the social experience (and its reduction to emotionalism) from the physical outcome of birth, and the attributing of risk to the former and safety to the latter, provided the mechanism for incorporating medical ideology into maternity care policies. On this view, as Celine Lemay (1997) commented in her critical analysis of obstetric risk, 'les besoin emotifs ne present pas tres lourds face aux risques' (88), (emotional needs carry little weight in the face of risks) or in the words of a North American doctor, talking about birth centres, 'we don't believe in taking an added risk in order to satisfy an emotional need' (Payer in Lemay 1997: 88). Severing the physical outcome of birth from its qualitative impact on the lives of women and families further entrenched mechanistic views of the body that separated the body from feeling. I discuss this in Chapters 8 and 10.

... but includes fractures

The House of Commons Health Committee Report (1992) and the Report of the Department of Health Expert Maternity Group (1993) (usually known as the Winterton and Cumberlege Reports), provided an interesting fracture from previous reports. They demonstrate how alternative ideologies interact with mainstream dialogue and display a complex interaction between the resistance and acceptance of dominant ideology. This partially reflected growing concerns about the power of the medical profession, and a politics of individual choice; though the more philosophical Winterton Report recognised poverty as a major cause of ill-health and inequity during childbearing, as well as the existence of alternative ideologies¹⁰. The final Cumberlege Report, while more radical than its

a number of measures, including linking it more directly into the market economy and focusing on a rhetoric of choice. Rhetorically, at least, there was a move away from medicalisation and hospitalisation, and the centralisation of services was debated more critically (Department of Health 1993).

⁸ For example, it did not escape the attention of Janet Campbell, Senior Medical Officer of the newly formed Ministry of Health set up in 1919 with a separate department for maternal and child health, that women who had any intervention during labour, were more likely to develop puerperal fever (Campbell in Tew 1998: 196-7). And even in 1930, the home was seen as a safe place for birth in normal circumstances (Ministry of Health 1930: 38). Despite the nutrition debates and campaigns of the 1930s (Lewis 1990: 24) the Government, increasingly looked to medical rather than social solutions, reluctant to 'uncover a mass of sickness and impairment attributable to childbirth, which would create a demand for organized treatment by the state' (Lewis 1993: 23-24). The link between poverty and health is unwelcome by Governments, as can be seen by the suppression of the Black Report (Hogg 1999: 114). In line with the medical discourse, improved training for attendants was recommended, and there was a growing abnormality discourse (Ministry of Health 1954: 124), and it was recommended that 'obstetric beds should be available for all women who need or will accept institutional confinement' (Ministry of Health 1956: 212). This trend continued in England and Wales, and Scotland (House of Commons 1980, Maternity Services Advisory Committee 1982, 1984, 1985, Ministry of Health 1959, 1980 SHHD 1965, 1988).

⁹ In order to consolidate their project, medical men required sufficient bodies in convenient places. This was made possible by the Local Government Act of 1929, in which hundreds of poor-law hospitals came under their, and the municipalities' control (Robinson 1991: 70, Donnison 1988).

¹⁰ The debilitating effects of ongoing poverty cannot be overstressed. Poverty forms one of the main risks to women during childbirth. Researchers and commentators on health and childbirth (for example, Black 1980, Oakley 1992) suggest

predecessors did not engage with some of the more challenging aspects of the Winterton Report. As I commented above, poverty was never going to be the prime mover in policy-making and the construction of risk through poverty was omitted¹¹. It did however provide some support for innovative midwifery practices incorporating less medicalised approaches to birth, and a more flexible approach to place of birth.

As Starhawk (1990) described in her analysis of the pre-Christian move from female-centred ideologies to male-dominated societies, examples of ideological shifts can be located within texts particularly clearly over the time of greatest change. Through examining the policies on maternity services over the twentieth century, I was able to trace the reconceptualising of childbirth from a normal part of women's lives, to a medical event requiring medical supervision. The focus of this change centred on the concepts of medical risk and safety and their gradual prioritisation over other social concerns. Taking an increasingly postmodern approach identified not only normative, oppressive patterns in policy-making, but also highlighted some of the fractured, muted discourses that were gradually excluded.

For example, the medical/midwifery dichotomy remained controversial in Government policy during the 20th century over the role of doctors and midwives. While in one report (Ministry of Health 1959) the role and status of the midwife was supported, it also recommended that both doctors and midwives should be present at antenatal examinations and births and that doctors should be in overall charge. And while risk was increasingly part of the discourse of birth, it was suggested that maternity homes should be located near women's homes, and 'small enough for them to feel that they were getting individual attention and consideration' (Cumberlege 1948: 77). In another example (Ministry of Health 1970), women's concerns were acknowledged on the one hand, but ignored on the other, as the hierarchical claims of medicalisation separated out and prioritised the physical safety of the baby and deprioritised the social meaning of birth in women's lives.

So while fractures existed, the overall influence of dichotomous thinking increased medicalisation and mechanisation of birth. The obstetric response to women's concerns was to humanise its approach (Ministry of Health 1970) by "educating" women and "refining" obstetrics. Both attempted to package the medical model of birth to render it more acceptable, muting women's concerns and its own internal inconsistencies. Many of the current debates and changes continue to attempt to humanise obstetric practice rather than question its hegemonic ideology¹².

that risk may lie outside the knowledge and expertise of modern medicine and that health may be improved by addressing poverty and social exclusion, rather than focusing on sophisticated medical and technological solutions and/or impossible expectations of self-care (see footnote 40 on page 155, and footnote 99 on page 193)).

¹¹ Financial implications of policy are high on the political agenda and in terms of maternity services, it is frequently assumed that medicalisation and technocratisation is more cost-effective than a social approach. Research suggests that low-tech midwifery services have better outcomes and are at least as cost-effective as obstetric services (Jewell et al 1992, McCourt and Page 1997, Sandall and Davies et al 2001, Schlenzka 1999, Saunders et al 2000). Dutch research (Butter and Lapré 1986) suggests that cost and ideology are intimately connected and that changing ideology may change cost. To my knowledge, more complex research into the broader and more long-term costs of maternity services has not been carried out. For example, during the course of my work with AIMS, I, and other colleagues have witnessed negative experiences of childbirth having long-term health effects on women and children. These have sometimes necessitated repeated visits to GPs/hospitals and/or psychiatric or counselling services over many years. In 1996, a panel on cost effectiveness in health and medicine set up by the US Public Health Service recommended that cost-effectiveness analysis 'needs to take a more comprehensive view by framing the analysis from a social perspective, assessing effectiveness and costs to society at large, and highlighting all the impacts of an intervention and not just those which pertain to a narrow perspective' (Schlenzka 1999: 58).

¹²It becomes clearer in Chapter 9, that many of the attempts to provide continuity of care and carer through team midwifery for example fall into this category. While relationships remain unimportant in medical ideology, attempts to define and provide continuity often reflect a lack of understanding about how relationships matter. What is provided often reflects a rhetorical understanding, not matched in practice, and based on the more mechanistic approaches of modern medicine. As Helen Stapleton (2000, personal communication) pointed out to me, midwifery has been largely deflected from creating change and has instead been absorbed into the humanising project of obstetrics.

But considering broader cultural fractures, there are alternative frameworks and discourses in which women and midwives feature as actors rather than recipients of dominant ideology. As a prelude to my discussion about the discourses of women and midwives, I now summarise some of the main points of the previous chapter about knowledge and discourse, and what this means in terms of birth.

Looking from different standpoints

Standpoint theories and postmodernist concepts of knowledge move beyond “truth” to suggest that different belief systems have degrees of status in the knowledge stakes (Jordan 1997). Knowledge is relatively undetermined by facts, but is socially constructed to reflect core, cultural beliefs and values (Davis-Floyd 1992). However as Fleck argues, in scientific systems, knowledge ‘appears to be systematic, proven applicable and evaluated to the knower because it has been generated within the framework’. Other knowledges appear ‘unproven, inapplicable, contradictory, even fanciful’ (Fleck in Murphy-Lawless 1998a: 256).

The medical model is a relatively closed system which, by definition cannot easily appeal to knowledge outside itself¹³, unless a paradigm shift occurs (Kuhn 1970). It develops its knowledge base, according to its own assumptions and develops a ritualistic series of practices to reflect these (Davis Floyd 1992, Murphy-Lawless 1998a)¹⁴. While acknowledging that belief systems are not necessarily fixed, discrete entities (Davis-Floyd and Dumit 1997, Davis-Floyd and St John 1998), Davis Floyd (1992) makes a useful distinction between ‘technocratic’ and ‘holistic’ belief systems of childbearing. In the British context these are often referred to as the medical model, as opposed to midwifery, social or woman-centred approaches to birth¹⁵. Of course these distinctions themselves are fractured¹⁶.

¹³A related view suggests a “chameleon” analogy, where dominant ideologies such as medicine display appropriation and closure. It swallows other systems, adapts and incorporates them as its own, and creates a pot of knowledge from which to draw in any eventuality (Saks 1992: 198).

¹⁴ In looking at the role of ritual within belief systems, Davis-Floyd (1992) suggests that a closed system usually intensifies its rituals in response to perceived failures. Murphy-Lawless (1998a) gives an example of this from Irish obstetric literature, in which the death of a woman following the use of forceps, reinforced the obstetrician’s belief in forceps as beneficial for women (151).

¹⁵ It may be of limited value to define some of the features of these distinctions because they are symbolic rather than universal and continuously open to re-interpretation. Nevertheless, they provided a useful starting point to explore how the technocratic or medical model has absorbed the body as machine metaphor (Martin 1990, 1989) and how they have privileged professional knowledge and muted that of the patient. The professional is the moral agent empowered with authority for decision-making and action and the patient’s role is one of passive acceptance (Shildrick 1997, Jordan 1997, Davis-Floyd 1992, see Chapter 10). On the whole, the more modernist/technocratic/medicalised the model, the more norms and assumptions are defined and encoded within the model and the more prescriptive and enforced its regime.

¹⁶ Kathryn Allen Rabuzzi (1994) has categorised and described some of the different approaches to birth in North America, which highlight some of the background influences, traditions and counter-cultural movements from which different meanings of birth and birth practices have developed. Social movement theory provides a conceptual framework for this way of thinking (Daviss 1999, 2001). These approaches are based on the concept of connection rather than separation, incorporating some kind of union between body, mind and spirit, woman and baby, woman and midwife: focusing on the rhythms and processes of birth in the context of women’s lives and relationships: and implicitly trusting in women’s knowledges and abilities to carry, birth and nurture their babies. Given their marginalised location, these approaches have perforce been more reflexive (Murphy-Lawless 1998a: 256), but have tended to emphasise the naturalness of birth. While technical assistance is not shunned, it is usually considered to be undesirable and harmful unless needed. More recently, feminist sociologists (Murphy-Lawless 1998a, Annandale and Clark 1999, Cosslett 1994), have challenged any sort of strong demarcation between ‘natural’ and ‘medical’ discourses as being in themselves, dichotomous, oppressive and often not rooted in women’s material experiences or expressed needs. Additionally, the postmodernist recognition of networks of power undermines any simplistic notion of equality and mutuality between women and midwives. Midwife researchers (Fleming 1995, Smythe 1998) in New Zealand, where a partnership approach

The most significant difference between the two broad approaches is the medical model's definition of, and focus on risk. Obstetrics attempts to control and manage uncertainty by structuring time and interventions in relation to one another, in ways that pay little attention to the individual woman and baby. Alternative philosophies focus on normality and attempt to develop skills to work with uncertainty, where the time/intervention pairing is replaced by an alertness to the individual woman and baby's actual condition.

In the next section, I continue to focus on fractures. Medical men appeared to have been successful in; seizing 'childbirth and stake[ing] it out as the exclusive domain of a new profession' (Arney 1982: 3); becoming the authoritative knowledge on childbirth; developing a viable and recognisable alternative to the practice of midwifery; negotiating the ideological demarcation between normal and abnormal birth (Oakley 1984); reconceptualising and controlling birth through the appropriation of abnormal and then normal birth (Oakley 1984); imposing the demarcation of different spheres of practice over which they retained overall control (Witz 1992); legitimising demarcation through legislation (Donnison 1988); developing a professionalisation strategy (Arney 1982); creating a base from which to practice and gain access to pregnant and birthing women; gaining support from the wider community¹⁷ (Arney 1982); ignoring or repelling critics (Arney 1982); and moulding the desires of their clients (Devries 1989, Shapiro 1983).

However, attendance of women during birth in their own homes by female midwives was part of the ongoing social fabric of society (Towler and Bramall 1986). As Arney (1982) suggests, making a significant cultural change is never straightforward. As I continue to explore the fractures involved in the move from midwifery to medicalisation, I include the more muted discourses of women and midwives: the series of changing discourses through which childbirth was given meaning as it moved from being constructed through social relationships to being constructed through patriarchal rights and choices. Thus the following looks at how patriarchal discourses interacted with women's experiences, and their subsequent acceptance and dissent, collusions and rejections.

Focusing on women

Finding voices

Modernist values, concerns about the nation's health, even philanthropic concerns contributed to changes in childbearing practices, but the voices of childbearing women are almost inaudible. Jane Lewis (1990) suggested that 'professionals and policy-makers have always tended to abstract childbirth from the fabric of women's lives' (15). Those that struggled through featured pragmatism based on their needs and those of their families. They showed women to be resourceful within the constraints they faced. Above all they demonstrated that women's concerns and measure of success

to birth has been developed, point out that partnership is difficult to achieve in practice. And yet, ascribing agency to women and midwives and their knowledges is a feature of holistic birth philosophies. For example, drawing on Susan Weed's work, midwife, Maggie Banks (2000) suggests that while different traditions draw on different modalities, the home birth or wise woman midwife will 'always start with the least interventionist step that is appropriate for effective resolution of the problem' (141).

¹⁷A powerful mechanism for change is to create demarcations between old and new. The community had to be convinced that a midwifery, or social model of birth belonged to the old order of things, and was thus inferior to the new order of the medical model. In Jo Murphy-Lawless' (1998a) words, for 'newly organising groups [this] has entailed the work of defining, organising and publicising their claims to expertise and authority, often by contrast with historical examples' (52). A striking example of this old/new dichotomy is quoted by Jane Lewis; 'one consultant congratulated the 1926 conference of the National Association for Maternal and Child Welfare on having 'travelled today very far from the old view that a confinement is an interesting domestic occurrence which should be celebrated in the family like Christmas or a birthday party' (1990: 22).

in childbirth do not necessarily coincide with those of obstetrics (Graham and Oakley 1991). For women, they include personal values as well as physical outcomes (Lewis 1990: 15). In the words of Jo Murphy-Lawless (1998a), our criteria for success are to do with the 'ongoing experience of being a mother to a child', but 'obstetrics remains in a position to practise an immortality strategy quite separate to the needs and desires of pregnant women' (47-48).

In terms of place of birth, the shaping of women's voices arose from the material circumstances of their lives as well as the inevitable internalisation of their culture. This gave rise to the simplistic notion that the move from home birth with midwives, to hospital births supervised by doctors, was led by women themselves. The University College Hospital Magazine of 1930 included a quotation from the Professor there, who 'claimed that this demand [for hospital births] was so great that if the hospital did not expand its obstetric unit, women would seek attention in the poor-law infirmary rather than give birth at home' (Lewis 1990: 22).

Indeed, the 'revolutionary' and 'accommodative' strategies, which Anne Witz (1992) used to describe midwives' struggle for existence was equally evident in the women's narratives in my study. The co-existing desire to retain power and control, and the irresistible pull towards negotiation and compromise to avoid alienating others, causing disruption or attracting hostility, is a feature of women's discourse.

Women's organisations: Focusing on maternity through poverty

The 160 letters from working women about their experiences of maternity, collected by Margaret Llewelyn Davies (1978), general secretary of the Women's Co-operative Guild (WCG) and published in 1915 provided insights into the concerns of married women on low incomes. These and the campaigns of women's groups such as the WCG showed how women's discourses were culturally defined through their material circumstances¹⁸. How, where and with whom women gave birth was part of a wider concept of maternity, motherhood and women's health (Llewelyn Davies 1978) in the context of grinding poverty. The focus of many of the early campaigns by women's organisations such as the WCG, the Women's Labour League and the Fabian Women's Group was the pressing need to relieve it (Lewis 1990: 24)¹⁹. Hospitalisation was one response to women's enforced struggle with poverty and its consequences. It could at least provide some respite from their lives and families.

To some extent, the campaigns for improving women's health around childbearing in the first third of the 20th century were predicated on to State concerns with increasing the population and maintaining its health to keep the wheels of the Industrial Revolution turning and defend its national interests. At the same time, they increasingly reflected medical discourses of medicalisation and hospitalisation. Luke's (1974) three dimensional analysis of power, has been used in other writings about birth (Levy 1998, McAdam-O'Connell 1998: 26) and can be seen in Lewis' (1990) account of the WCG campaigns:

¹⁸ Often commentators (Dallas 1978, Lewis 1990) have not fully addressed the imbalances of power or how women's views were shaped by ideology; the interests of medical men; the medicalisation of birth; the discourses of modernity; the poor circumstances in which they lived; their lack of knowledge about their bodies and childbearing; and the unresponsiveness of policy-makers to relieve their circumstances - reminiscent of Carol Pateman's (1989) claim above, that these lie beyond the visibility of most theorists. For example, Jane Lewis' final conclusion that 'early twentieth-century women's groups were content to exchange their power to determine the meaning of childbirth as a domestic event in return for increased safety and pain-relief' (Lewis 1990: 26) constructed the struggles to define the meaning of birth, to a neutral trading of conveniences. This neutralizing of power through the rhetoric of choice became increasingly evident to me and the women in my study as they struggled to make choices - even those supposedly open to them (see page 272).

¹⁹Maternity benefits and family allowance came into existence through these campaigns.

‘each successive proposal paid more attention to the need to provide poor women with the best skilled medical assistance available. In 1914 the demand was for trained midwives; in 1917, for a trained midwife and easy access to a doctor, with specialist care and hospital accommodation where necessary; and by 1918, for a doctor to supervise every case and enough hospital beds to accommodate those in poor home conditions’ (19)

Thus most of their demands had to be made in the knowledge and context of the rhetoric of the day and from the possible rather than the potential²⁰. The manifestation of this is socially and historically specific but the notion cuts through time and space. I therefore continue to focus on continuities and discontinuities; the balance between pragmatism and idealism; and the external and internal constraints experienced.

Women’s organisations: birth, consumerism and feminism

New organisations and shifting discourses during the 1940s and 50s continued campaigns to address poverty and increase hospital beds. In addition the emergence of pharmaceutical pain relief initially led to calls for adequate pain relief for women during labour²¹ (Kitzinger 1990). The National Childbirth Trust (NCT), (formerly the Natural Childbirth Association set up in 1956) and AIMS (formerly the Society for the Prevention of Cruelty to Pregnant Women set up in 1960) formed the two main, lay, national childbirth groups. There are many other diverse, national, regional and local lay groups often based on single issues such as stillbirth and neonatal death, miscarriage, home birth, caesarean support, waterbirth etc, each group with its own ethos, beliefs and interpretations of birth. Some have close affiliations with the medical profession, others are more closely aligned to feminism and critical of the medicalisation of birth (Durward and Evans 1990).

While views of individual members varied and continue to do so, the stance of AIMS and the NCT on place of birth reflected the complex responses women had (and continue to have) towards birth, its social meaning in the context of women’s everyday lives, and its location in dominant and subordinate ideologies. The developments of the two organisations are well documented elsewhere (Beech 1990, Kitzinger 1990, Durward and Evans 1990). In response to increasing medicalisation, the NCT campaigned for a woman’s right to give birth without pain relief, and to remain in control²². This control was located in the context of compliance, where the woman remained in

²⁰Women did not however simply reflect dominant ideologies. The need for home helps for example has been consistently identified in fragmented societies beset by poverty. Indeed it seems clear that in the Netherlands, the statutory provision of home helps after birth has been a contributing factor in the continuation of a higher level of home births than elsewhere in Europe (1990).

²¹ This discourse grew in strength and over the course of the 20th century, middle and upper class women campaigned for the right to effective pain relief in childbirth for all women, reflecting a negative view of pain rather than pain as a feedback system (see Leap 1996, Mander 1998). This was linked to the discourse of progress, and “new scientific” approaches, and because pain relief was available only in hospital, promoted hospitalisation (Lewis 1990). Pain and its relief came to symbolise complex debates in my interviews, as some women identified the provision of pain relief as an arbitrary and unnecessary demarcation between the care provided at home and that provided in hospital. However while many of the women in the initial interviews stated that they wanted pethidine available at home, most held different perspectives on pain at the end of their pregnancies. They discussed the difference between the pain of normal labour and the pain of interventions, and felt more confident that they would be able to cope with the pain of normal labour. While pain relief is a management issue in medical birth discourse, pain for women was about coping with birth by avoiding interventions. Jo Murphy-Lawless (1998a) locates the emphasis on pain relief as oppressive, confirming the belief in the frailty or weakness of women, their subsequent inability to give birth, and the need for rescuing technologies. It is this (male) reading of the body, which is crucial for the development of invasive techniques and technologies. The muted discourse of birth in terms of power, sexuality and spirituality are clear in my analysis in Chapter 10.

²² This was in the context of hospital birth. Any view on home birth remained outside the Trust’s remit until it became more acceptable to support it in the context of “choice” debates, and the organization became more overtly political (Durward & Evans 1990).

control of herself. The deferential notion that 'doctor knows best' located control in both patriarchal and strategic discourses²³. As noted by sociologist, Jenny Kitzinger (1990), NCT antenatal teachers attempted to align themselves with doctors, truth and science, distance themselves from 'old wives' tales' and unorthodoxy, and portray themselves as just 'mothers' (101-105): 'the NCT's campaign for the more humane treatment of women drew on and reinforced mainstream values of male chivalry, doctors' paternalism and female weakness' (105). The notion of female weakness underpins the suppression of women, the power of birth and the female body (Murphy-Lawless 1998a).

AIMS' first campaigns focused on hospital beds and pain relief during labour. In taking on board the material reality of women's lives and some aspects of feminist ideology in relation to women's access to medical treatment, AIMS initially failed to see what Jo Murphy-Lawless (1998a) described as the 'representational violence' reinforcing 'actual violence' against women during interventionist birth (96). This is a consistent theme within feminist discourses of birth, as feminists have remained ambivalent about the issues embedded in industrialised childbirth.

While the NCT took a more muted stance against the rise of interventions during the 1970s (Kitzinger 1990: 111), AIMS became overtly critical of interventions such as induction and began its ongoing campaign to maintain the woman's right to have a home birth, along with the Society to Support Home Confinements set up in the 1970s. But given the need to campaign against oppressive birth practices, the lack of feminist constructions of birth, and the perceived need to be pragmatic, like others, it has often felt obliged to challenge the medicalisation of birth, rather than set up its own agenda. The difficulty of setting up alternative agendas can be compounded, because, like some of the nationalist movements (Davies 1996), childbirth organisations often share tensions between traditionalism and feminism (Daviss 1999)²⁴.

However, these organisations laid the political groundwork for public debates, which could incorporate different concepts and meanings of birth. In addition, a growing affiliation to feminism among women and midwives has begun to address the divisiveness of medicalising birth. The New Zealand experience provides an example of the sort of positive change that can happen when women and midwives unite on a woman/midwife-centred definition of birth (Guilliland and Pairman 1995).

As I noted earlier, there is a tendency to dichotomise medical and holistic birth ideologies. Jo Murphy-Lawless (1998a) identified a problematic tendency for feminists to embrace either the 'naturalist thesis' ascribed to obstetrician Grantley Dick Read or attempt to abandon female reproduction altogether through the use of technology, as suggested by Shulamith Firestone (38)²⁵. The challenge is to: engage with women and ideology in ways that accept diversity; avoid silencing women's experiences; avoid replacing medical interpretations of childbearing with other oppressive interpretations; and legitimate the passing on of woman-to-women knowledge which has been delegitimised as 'old wives tales' (Cosslett 1994, Dalmiya and Alcoff 1993). Yet, while

²³ The strategic aspect of the campaign is highlighted by Kitzinger: 'looking through the papers in the NCT archives, it is fascinating to see the way in which the same information would be drafted and redrafted as committee members debated which refinement would be most acceptable to health professionals, or at least would incite the least antagonism' (1990: 101).

²⁴ In an interview, feminist obstetrician, Wendy Savage, stated that: 'it seems to me that the woman's movement in this country has not managed to set up a network of women who are able to achieve change in these entrenched systems [...] Women who are getting anywhere in the system are frequently reluctant to commit themselves to the feminist movement ... So we have not got a strong women's movement. Also, what women's movement we do have has not been particularly interested in birth' (Savage 1990: 340). Betty-Anne Daviss (1999, 2001) however, suggests that in North America, traditionalists, feminists and others formed a coalition to operationalise home birth.

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supportive, and non-interventionist care from a known midwife, the benefits of a gentle birth for the new baby, the largely negative context in which home birth is chosen, the different meanings of safety and risk held by women, the importance of supportive organisations and written material, and the concept of health being within the woman's domain. There were no perinatal deaths and a low rate of interventions and morbidity in both women and babies. Finally O'Connor was able to separate women into those who had 'traditional' views about birth, which reduced its significance and those who held 'modern' views, which invested it with different meanings (144). I found more complex, less definable views on this, which were often predicated onto a basic need for control. I discuss control below on page 75.

Community midwife Jane Oswin's (1993) retrospective questionnaire study of 24 women who had home births, while less comprehensive, identified the same sorts of themes. Women chose home births because they felt 'relaxed and safe' at home (6), had had previous negative hospital experiences, wanted to maintain family togetherness around the time of birth, wanted to avoid intervention, wanted to be in familiar surroundings, wanted to have personalised care from a known midwife, and wanted to maintain privacy. In talking about the benefits of home birth most women reported feeling more relaxed and in control (10). 'Feeling relaxed' is a theme that echoed throughout my interviews: a theme I follow up in my analysis as its meanings unfolded. As in my study, all the women involved said that they would plan a future home birth. Other studies show varying, but higher rates of preference for home birth in women who have experienced one (Alment 1967, Campbell and Macfarlane 1994, O'Brien 1978, Wright 1992)

Qualitative, retrospective research by Jane Ogden, Adrienne Shaw and Luke Zander (1997a, 1997b, 1997c) was carried out to explore the notion that the experience of home birth has long-term consequences. The researchers interviewed 25 women (contacted through GPs and word of mouth), about their experiences of having a home birth 3-5 years previously. This research identified: an emphasis on the normality of birth; the importance of the home environment in increasing this sense of normality; a feeling of being in control and able to cope with pain; a sense of ownership over the birth; a feeling of continuity and integration within the family unit and surroundings after birth; a generally positive feeling about home birth; a belief in the safety of home birth and disadvantage of hospital birth in normal circumstances; the complex context in which decisions to have home births take place; the need for support for planning a home birth from the woman's own social networks and the professionals she meets; women's confidence in themselves as mothers; women's confidence in their ability to give birth; and the possibility of healing negative, past experiences. Again, all these themes arise in my analysis.

A dissertation by French Canadian midwife, Celine Lemay (1997) focused on the meaning of safety and risk for a group of women planning home births and the midwives attending them. She provided a critical analysis of obstetric risk and safety, which I discuss in the section on risk on page 61. Like the above studies, her retrospective qualitative study, found that women's meanings of birth were broader than those defined by obstetrics, and that they were keen to avoid hospital unless a complication developed (91-92). Like me, she found that relationships between women and their midwives were crucial to the women (see Chapter 9). The different structuring of the services in this Canadian study encouraged women to see their midwives' power and knowledge as supportive, validating and complementary to their own. The relationships were therefore fundamental in contributing to the feeling of confidence and security within the woman herself (98-99).

Kirsi Viisainen's study in Finland (2000a, 2000b, forthcoming) reflects similar themes to those in the above studies and the women's quotations were often strikingly similar to those of the women in this study (see pages 323 and 338). Her main focus on how women engaged with obstetric definitions of risk contributed to my discussion about acceptance of and resistance to dominant ideology.

From her long-standing experience as a community, and independent midwife, Mary Cronk (2000) suggests that decision-making about birth is located in experiences and narratives from early childhood to adulthood. Women's own narratives suggest that planning a home birth may be rooted in specific circumstances (Robinson 1998). My research suggested that women approached planning home births from multi-faceted positions located in life style and beliefs, and/or had arisen from specific events, experiences or relationships (Edwards 1996). I now consider the discourses in midwifery, as they engaged in similar struggles to those of women giving birth.

Focusing on midwives

Unpicking seams: Moving between resistance and compliance

Patriarchal discourses both generate and are generated by beliefs that predisposed moves towards the development of the medicalisation of birth and the discontinuation of the social or midwifery ideology of birth, and its partial appropriation into medical ideology. Drawing on feminisms and postmodernism, I attempted to search out the muted discourses of midwives and women, and locate midwives in a power struggle of competing knowledges. This demonstrated that despite the institutionalised deskilling and undermining of midwives at different historical junctures, midwives have not been completely silenced or deskilled, nor have they been entirely acquiescent. I thus examine both oppression and resistance in the material contexts of their lives and those of childbearing women. I again acknowledge the limits of historical accounts, but my aim is not to provide definitive descriptions (a futile exercise in the light of subjective realities), but to uncover networks of power and resistance and trace the interconnecting threads, which portray women in less oppressive ways.

It has typically been assumed that midwives were vulnerable, easy prey because they had no recognised body of knowledge, were often illiterate, and formed a collection of individuals rather than an organised group (Dalmiya and Alcoff 1993). They were supposedly unaware of the developing medical model, and in the words of Turner, 'were particularly unsuccessful in achieving a professional structure [...] and closing their ranks to competition' (Turner 1987). Even more recently midwives have been criticised for failing to be political animals, with little attention to the hostile environment in which they practise (Declercq 1994).

In terms of organisation, political action, and midwifery readings of birth, feminist historians and sociologists, tell a rather different, messier story. Like women, midwives provided what resistance they could within a thoroughly patriarchal society, stratified by gender and class (Heagarty 1997, Marland 1993b, Witz 1992). While there were outspoken and visionary individual midwives and groups of midwives, the constraints they faced often appeared to lead to pragmatic compromises, echoing with a survey showing women's expectations to be lower than their ideals (Green and Coupland et al 1998: 64). As I discuss in my analysis, a realistic appraisal of the possible, often muted the desirable.

In the struggle for authoritative knowledge, medicine often depicted the midwife as an ignorant, dirty, dangerous, poverty stricken, old woman, (personified in Dicken's (1844/1998) character, *Sairey Gamp*) or an irresponsible 'hippy' (Daviss 2001), despite evidence to the contrary (Evenden 1993). In a collection of historical works on midwives in Europe during the 17th and 18th centuries, David Harley (1993) suggests that this view 'has been abandoned [...] because it owes more to medical disdain than historical accuracy (31). What emerges is a story of multiplicity, diversity, and characterful women. Drawing on archival material, historians suggest that while midwives came from different walks of life (Ortiz 1993), many were in fact literate and from the 'solid' middle classes (Evenden 1993, Harley 1993, Hess 1993). There is also evidence that in some localities,

midwives were well trained through apprenticeship schemes, and were well established, respected members of sophisticated social networks of women (Evenden 1993, Hess 1993, Lindemann 1993). Midwives' wide sphere of practice included not only attending births, but sexual morality; menstrual irregularities; breastfeeding; sterility; stillbirth, prematurity, alleged infanticide and abortion; emergency baptisms; and rape (Harley 1993, Hess, 1993, Filippini 1993, Marland 1993, Weisner 1993)

In terms of a political discourse, we know that midwives in Britain, as early as 1616 and 1635 organised themselves and campaigned, unsuccessfully for charters to enhance their skills and form a society (Donnison 1988, Witz 1992). Though midwives were successful in gaining state legislation in other parts of Europe (Donnison 1988), this has not significantly altered the course of midwifery (except perhaps in the Netherlands), or prevented a medical model of birth being widely practiced in the West. The point is rather to demonstrate that the portrayal of midwives as ignorant, naive and apolitical is not only simplistic, but oppressive.

There may have been many strong, visionary midwives, and we know something of at least a number of these women. Elizabeth Cellier's (King 1993) colourful life in London in the later part of the 17th century, provides an example of how midwives attempted to create their own agenda by: attempting to formalise midwifery training through colleges; arguing for the continuation of female midwifery and a rejection of male midwifery; and arguing against knowledge gained only from books rather than experience. Historian Nina Gelbart (1993) singles out Mme Angelique Marguerite Le Bousier du Coudray 'as unique, for she was a political midwife, a public figure.' (131), travelling throughout France over three decades to teach midwifery. Their stories are set in a shifting ideological and political milieu, in which midwives were coerced into patriarchal patterns of thought and action based around organisation, professionalisation, legitimation, and legalisation, not unlike today.

Elizabeth Peretz (1990) and Sarah Robinson describe other discontinuities (1990). Peretz asserts that several models for maternity services coexisted in the 1930s only one of which was based on the hospital, consultant-led model we have today (30). She suggests that in the 1920s and 1930s the state, medical men, midwives and voluntary organisations were in agreement that the ideal service 'should be based on midwife deliveries at home, backed up where necessary by general practitioners or, in exceptional circumstances by consultant obstetricians' (32). Any difference in views lay in where the division should be drawn between home and hospital births. Both Peretz and Robinson describe what appeared to be the revival, even 'heyday' of the domiciliary midwife following the 1936 Midwives' Act (Robinson 1990: 71). Services based on this model seemed to be operating throughout Britain until at least 1948 and apparently deemed appropriate - though the subtext of steadily increasing numbers of hospital births from 15% in 1927 to 54% in 1946 belies a more complex situation. Wide geographical differences in service provision, costs of services to women, and numbers of home and hospital births highlight diversity and warn against drawing any general conclusions.

Robinson (1990) describes other recognisable sites of resistance and acceptance, preceding the introduction of the National Health Services Act in 1948. Following a Government white paper in 1944, both the College of Midwives (previously the Midwives Institute) and the Central Midwives' Board expressed concerns that obstetric discourse was proving to be so influential, that the midwife's role was being eroded to that of 'hand maiden', and the normality of birth and the midwife's ability to provide a service for women was being lost sight of (73). But, a textbook for midwives, asserted that independent midwives had been 'superseded [...] It would now be considered a retrograde step for a midwife to take sole charge of an expectant mother, thereby depriving her of the scientific expert care only the obstetric team can provide.' (Myles in Schwarz 1990: 58). Discouraged from using her own knowledge or expertise, the midwife could become the

intermediary between obstetrics and women: the go between (Schwarz 1990: 58), or 'piggy-in-the-middle' (Murphy Lawless 1991). Running through all the above discourses are those of resistance, success, failure, and persecution, grounded in and shaped by patriarchal concerns and structures.

This is clear in Witz's (1992) historical analysis of the struggle for power between midwives and medical men and Brooke Heagarty's (1997) analysis of events surrounding the Midwives' Act of 1902. Witz demonstrates first of all that the patriarchal project of medical professionalisation was successful in shifting medical services from the domestic to the market arena, establishing medical men as holders of authoritative knowledge and establishing a structural link between their occupation and education, within the public arena from which women were excluded. This effectively 'sealed the historic construction of the modern medical profession as an exclusively male sphere of occupational specialism' (82).

Her 'concepts of demarcationary and dual closure' (108) provide a detailed sociological account of gendered professional projects. Suffice here to say, that this was embedded in a number of patriarchal discourses, such as the uniting of physicians, surgeons and apothecaries into a powerful medical profession through the Medical Registration Act of 1858; a gendered discourse on appropriate division of work leaving caring aspects to women and the use of surgical instruments to men; the dependence of women on 'proxy male power' to defend their interests; a 'stratified market in midwifery services' to provide cheap midwives for the poor and more expensive doctors for the rich; 'as well as patriarchal structures in which male power was institutionalised within the spheres of civil society and the state [which] facilitated the gendered demarcationary strategies of medical men and constrained the female professional projects of midwives.' (125-127). The de-skilling of midwives strategy was won by medical men and legitimated in the Midwives' Act of 1902, which gave midwives limited autonomy within a medical framework (Donnison 1988).

While discourses of class and power are often applied to midwifery in relation to medicine, Heagarty (1997) examined the intermidwifery impact of these during the early 20th century in relation to a complex network of feminist, modernist and medical discourses in which midwives attempted to assert some autonomy. Core societal values of upper and middle class morality stratified midwifery and cut across the feminist principles on which solidarity was based. The desire to raise the status of midwifery through the Midwives' Act was often on the back of eradicating working class midwives, accepting subservience, promoting "science", and removing 'ignorance and dirt'²⁹ (74). A dangerous morality/humility pairing became the banner for the new style professional midwives (79). Resistance was persecuted in an effort to ensure allegiance to the Midwives' Act, its officials, and professionalisation, rather than to childbearing women. Echoes with the present sound loud and clear. As I discuss in Chapter 9, breaking the allegiance between midwives and women breaks the weave of relationship on which the strength of women and midwives depends. In practice, it often creates an irresolvable oscillation of allegiance between external authorities and women (Clarke 1995)³⁰.

²⁹ The materiality of modernity's discourses through rationalisation, orderliness and cleanliness appeals to mechanisation and influenced the structuring of society through a series of factory like institutions.

³⁰ The more recent development of evidence-based policies and protocols, ostensibly to protect women and babies, seems to have furthered this division. In addition the midwife's working conditions are now such that her allegiance to employers is becoming embedded in employment legislation, severing the final vestiges of relationship between midwives and women. Clinical judgement and responding to women's needs could become a secondary concern for midwives employed by the NHS. The suppression of bonds between birthing women and midwives through oppressive mediating forces; midwifery ambivalence about aligning itself with the power of medical knowledge (the powers that be) or aligning itself with women (Kirkham 1996); and the suppression of other forms of knowledges are central to this study.

The continuation of this discourse of separation of women and midwives was described by historian Susan Pitt (1996) when she explored the meaning of a seemingly innocuous change in terminology from midwives being 'on the district', to being 'in the community' in the years between 1948 and 1970. She suggested that this indicated a profound change in the status of the midwife and birthing woman. 'On the district', the midwife was more autonomous, and geographically and socially part of a community of birthing women and their extended families. 'In the community', she became a community outreach worker of a hospital service; part of a complex system of surveillance, which placed the hospital at the centre of a new network, isolating the birthing woman, and medicalising a normal community event.

The pressure on beds and rising birth rates within the more "streamlined", factory services of the 1960s and 1970s further fragmented relationships, as midwives increasingly worked in specialised areas (Robinson 1990: 76-77). Furthermore, the introduction of 'active management of labour' (O'Driscoll and Meagher 1986) and the ensuing sharp rise in the use of interventions in the 1960s and 1970s saw obstetricians supervising all births. In response to midwives' concerns, a survey carried out showed, 'that although midwives were responsible for much of the care provided for childbearing women, many were not able to exercise their clinical judgement in decision-making about the management of that care' (Robinson 1990: 79). The mechanised style of active management of birth seemed to have collapsed any sense of meaningful relationship between the woman and her midwife; one in which they could relate to one another autonomously, with the midwife supporting the woman through the process of birth. A more stylised relationship between women and midwives mediated by medical men and their practices and policies seemed to focus on processing woman rather than on the process of birth; in which each had her role and responsibilities within a medical hierarchy: the midwife to carry out the doctors orders and the woman to acquiesce - not unlike the relationships described by midwife researcher, Sheila Hunt in her ethnographic study of the labour ward in Britain (Hunt and Symonds 1995)³¹.

Midwives' research: Resistance to medical ideology

In recent decades, wide fractures have been created by midwifery research. For example, some of the first, formal midwifery research on routine procedures such as episiotomy showed these to have detrimental rather than the assumed beneficial effects (Sleep et al 1984). More recently, research on continuity of midwifery care showed this to be beneficial (Flint and Poulengeris 1987, McCourt and Page 1997, Perkins and Unell 1997). While midwifery knowledge attempts to shape itself on its own terms rather than through the networks of patriarchal power in which it is largely captured, the current concept of research lies in the discourse of reason, science and medicine, rather than other forms of midwifery knowledge (see Chapter 8). Midwifery research had a similarly radicalising but limited influence to that of the voluntary sector on the statutory services (Durward and Evans 1990). For example, it has not questioned the fact that almost all birth research takes place in a hospital setting, which may impact on its outcomes³². In the main, it thus provides limited resistance to the medicalisation of birth, paralleling feminist empiricism's attempt to influence mainstream research, by providing "better" research.

³¹ Thus current midwifery locates itself in the space between medicalisation and women. In Margrit Shildrick's (1997) terms, midwifery could be seen as a mitigated version of 'pathologising individuals and positioning them as objects of the medical gaze' (76). It forms a complex, hybrid model, balancing women's needs within an oppressive framework.

³² For example, more recently, qualitative research has focused on the woman/midwife relationship in the home setting and highlighted features of this relationship that remained muted in official continuity discourses (Kirkham 2000). My findings show that women re-interpreted safety and risk, relationships, and the ethics of medicalisation in ways that they could not easily have done in a hospital setting. A quantitative midwifery study (Pritchard et al 1995) on the third stage of labour in the home setting showed different results to those of other research projects carried out in hospital (Prendiville et al 1999).

Midwives' knowledge base: skills

Within some of the literature I discussed above, a more hidden discourse attempted to be heard: that of midwives' own knowledges and skills. From the few historical accounts and commentaries (Marland 1993, Murphy-Lawless 1998, Schrader 1987, Wilson 1995), it seems that midwives had an understanding about birth and their potential to reduce mortality and morbidity. These discourses focus on the safety embedded in midwives hands, and the dangers of relying on invasive tools such as forceps (Murphy-Lawless 1998a: 97)³³. The discourse of midwives' skills raised in the literature, provided a potential route to begin to examine their subordinated knowledges and how definitions of women, women's bodies and birth differ within different knowledges. Their knowledges and skills have often been further muted through the medical risk discourses.

The opposition of midwifery skills and obstetrics tools symbolised competing ideologies in which women's bodies and the birth process were redefined (Murphy-Lawless 1998a). As I noted earlier changing ideologies are exemplified in texts over the period of greatest change (Starhawk 1990). Earlier readings of the body can be seen in the writings of both medical men and midwives, such as Henrik van Deventer, Sarah Stone, Elizabeth Nihill (see Murphy-Lawless 1998a) and Catharina Schrader (1987) and contrast with readings indicative of competing definitions of the body in which forceps, for example became a possibility and a reality (Murphy-Lawless 1998a). Historian Adrian Wilson (1995) identified three main discourses for managing obstructed births during the 18th century. These demonstrated the changing construction of the woman's body. The obstetric forceps used by male practitioners largely ignored the woman's body except as an obstacle and applied traction to the baby's head. A set of manual manoeuvres developed by Deventer involved physiologically enlarging the woman's pelvis by taking into account her posture and the position of her baby³⁴. This fell somewhat between gender distinctions and was incorporated to some extent in the midwifery approach discussed by Sarah Stone, author of *A Complete Practice of Midwifery* published in 1737. The midwifery approach developed by Elizabeth Nihell, author of *A Treatise on the Art of Midwifery* published in 1760 involved the midwife working with the woman and using her hands to manipulate soft body tissues to assist birth. As exclusionary tactics suppressed debate about manual midwifery skills, and the labouring body was reconstructed through modernist discourses, 'the skills to support a woman's body in labour, especially with the hands', was replaced by a 'reliance on instruments as the sole method of supporting the birth process' (Murphy-Lawless 1998a: 81)³⁵.

Historian Nadia Maria Filippini (1993), writing about Italian midwives during the 18th century describes two 'instruments' used by midwives. 'One was the birthing chair, the other her own hands.' (155). The main way of working was however through touch; massage and pressure; providing adequate nourishment if labour was long, or the woman's contractions stopped; and bleeding, which was a common practice based on particular views of the body at that time. However, in the event of a difficult birth, Filippina suggests that 'above all, the midwife intervened with a variety of manual operations, dilating the cervix and turning the fetus inside the uterus. Such

³³This has been influenced by the discourse of cleanliness, and the growing ambivalence about touch and contact with bodily fluids. The fear of HIV and AIDS has further reduced the opportunities for manual skills to be a focus in midwifery.

³⁴ The knowledge and articulation of supportive and manual midwifery skills remains in the minds and hands of relatively few experienced midwives today. New Zealand midwife Jean Sutton's work could be seen as a revival and progression of Deventer's manoeuvres (Sutton 2001). Articles about midwifery skills in relation to breech birth (The Practising Midwife 2000) and twin birth (Cronk 1992) for example also contribute to the re-awakening of midwifery's potential.

³⁵ Modernist beliefs about the body, recast the pelvis and surrounding soft tissue as rigid rather than fluid; unyielding rather than flexible.

practices were widely known and used by midwives, long before obstetricians formally codified them and claimed them as belonging to their own sphere of practice' (156). I would suggest however that these 'manual operations' used within a midwifery framework described by Filippini may have looked similar to those used in obstetrics, but were conceptually different. And that it was the midwifery concept of working with the woman in the (fluid) body, rather than on the (fixed) detached body that could provide a catalyst for conceptually different forms of practice today.

The perceptions of the body as fragmented and mechanical, or flexible and feeling have led to different birth practices, located in technology and tools, or midwives' hands and women's bodies. For example, the use of episiotomy or perineal massage to help the woman birth her baby, the use of active or physiological third stage management, the use of syntocinon or movement to stimulate the woman's uterus to contract during labour:

'The irresistible conclusion is that the body works differently according to the ideological frame of reference within which it is thought to be captured and that the problem is one of cognition, which is itself bound up both with the way the production of knowledge is an exercise in power and with the way autonomy and agency are established' (Murphy-Lawless 1998a: 258)

In other words, the patriarchal definitions contained within Cartesian hierarchies construct the female body as a defective machine not to be trusted (Turner 1991, 1987), weak or frail, in need of help (Murphy-Lawless 1998a), transferring power to the male body both physically and metaphorically.

In privileging technological solutions over the non-technological assistance, midwives' skills became less definable, muted and finally all but lost by reductionist medical ideology. They have been reduced to limited emotional support for normal birth and detection of abnormality through surveillance. Apparently the midwife can practice on the body to detect abnormality but has few bodily practices to effect normality. There is a (false) sense that the midwife has no impact on how the birth process unfolds (Shallow 2000, personal communication). By contrast, it is the concept of working with women rather than on them, and the belief that midwives influence birth that provide the framework for the interpretations of the women's accounts of safety in Chapter 8, the importance of relationship in Chapter 9, and their accounts of their bodies and birth practices in Chapter 10.

Midwives' skilled support

While the midwife is said to provide "support" often referred to as emotional support (Robinson 1990), the nature of that support is unclear (Green and Coupland et al 1998). The loss of visibility of support through skill has become an increasingly hidden component of midwifery care/skill. Not surprisingly, while there were examples of it in practice, and although this was exactly what the women in my study desired from their midwives, it remained muted. The crucial connections in midwifery between relationship, support, skills and safety have been replaced by the disconnected risk discourse in obstetrics³⁶. This is not to say that all midwifery care was/is good and all obstetric

³⁶ This became particularly clear to me following a formative experience, in which I was privileged to support my sister during her pregnancy and the birth of her twins. During the birth I observed the physical, emotional and spiritual skills of the two independent midwives who attended her. I was able to witness and understand at first hand, the potential of midwifery skills and their ability to maintain both the safety and the integrity of woman and baby, while effecting least physical and emotional harm. What makes birth safe took on a different meaning, depending less on the apparently dichotomous approaches embedded in holistic or technocratic philosophies of birth and more to do with the different knowledges and skills, which have been arbitrarily segregated. The midwifery knowledges and skills, which still survive have been largely excluded from birth discourses, existing as anecdotes. But what I witnessed led me to believe that these "anecdotes" carry within them an understanding of the social meaning of birth and how midwifery skills work with the

care, poor, but to observe that midwives' sophisticated skills based on knowledge of birth and manual manoeuvres were upstreamed while those of medical men based on instrumental techniques were downstreamed. As the women in my study observed again and again, the potential of midwifery is under-developed. While midwifery skill became a muted discourse, it did/does not cease to exist³⁷. In the next section, I examine some of the current discourses within obstetrics and maternity care, to illuminate some of the issues above.

Obstetric discourses

Imposing its own meaning

I have not provided a full critique of the medical model of birth. This has been more than adequately covered by commentators such as Jo Murphy-Lawless (1998a) and Marsden Wagner (1994). I have instead looked at some of the discourses arising from it, which have most influenced beliefs about birth and practices today; the definitions of normality and abnormality, the construction of risk, the imposition of clock time on birth, and the research agenda.

Redefining normality and abnormality

'birth being treated as normal depends on who has the power to define normality' (Murphy-Lawless 1998a: 255)

To establish itself as the main authority on childbirth, medicine separated abnormal birth from normal birth in such a way as to give it jurisdiction over the latter³⁸ (Arney 1982, Oakley 1984, Witz 1992). Arney located this in the arrival of the French rational/scientific school of thought to Britain which 'undermined the symbolic basis of the traditional midwife's practice by blurring the demarcation between "normal" and "abnormal" births and then removing the control over decision-making of this distinction from midwives' (1982: 25). This took place in two stages through birth's 'incorporation into medical discourse in the 17th and 18th centuries as a "natural" state and the redefining of it as pathological' (Oakley 1984)³⁹. But if, as Wagner suggested, this rests on an internal contradiction and indeterminacy, none of its conclusions can be trusted.

Medicine then re-integrated abnormality as a 'gradation' from normality (Schwarz 1990) giving it sole claim to authoritative knowledge over all births. In tracing changing discourses in British obstetric textbooks from 1960-1980, Eckart Schwarz identified how terminology and emphasis

woman and her bodily processes, which avoid inflicting the muted violence which women in my study identified (see also Katz Rothman 2001, van der Hulst and van Teijlingen 2001). It was obstetrics' move from the 18th and early 19th century discourses of working with women and the birth process, to intervening, by cutting across the birth process (Murphy-Lawless 1998a: 171-173) that roots the medical and midwifery approaches in different traditions (McAdam-O'Connell 1998: 25).

³⁷There are interesting echoes with feminist theory here. Mary Poovey (1988), for example discusses the claims that most feminists appeal to women existing outside the 'dominant representational system': Luce Irigaray's 'other'. There are complex debates about whether or not "outside" and "otherness" can exist, or represent what is there but shadowy. I discuss this in the next chapter, in relation to identity, and come back to this in the Introduction to Chapter 10.

³⁸'Normality' as we know it apparently came into use in the 1820s. (Murphy-Lawless 1998a: 167). And yet, while obstetrics depends on distinctions between normality and abnormality, Marsden Wagner suggested that this is beyond the scope of obstetrics and thus the premise on which it is based is illogical:

'Logically, the abnormal cannot be identified without a clear scientific definition of the variations of normal. Obstetrics lacks this because the risk concept implies that all pregnancy and birth is risky and therefore no pregnancy or birth can be considered normal until it is over. In other words one cannot claim both the ability to separate normal and abnormal during pregnancy and the inability to determine normality until after birth. The wide variation which occurs in the healthy experience of childbirth is too large for a single, uniform definition of 'normality, which can be used to define 'abnormality' (1994).

³⁹She identifies the distinction between normal and abnormal birth as the distinction on which the demarcation projects between doctors and midwives rested.

moved from a relatively narrow definition of abnormality, (usually based on ‘mechanical failures’ during birth and dealt with through operative and surgical techniques), to an expanding definition of abnormality which incorporated a discourse of prevention, where abnormality was defined ‘as a gradational deviation from the physiological norm’ (52). In other words this resulted in the collapsing of normal/ abnormal boundaries, ‘where the traditional dichotomy of normal childbirth versus childbirth with distinct abnormalities was absorbed into the new concept of abnormality as representing a dynamic departure from normal physiological functioning’ (54-55). Obstetrics moved from providing crisis intervention (last minute rescues) to being in charge of the smooth running of ‘all systems’ (55). The collapsing of the normality/abnormality distinction resulted in the notion that labour is only normal in retrospect and that all women and births should therefore be under the control and Foucauldian ‘gaze’ of obstetricians. In other words, if normality is part of a normality-pathology continuum, it is unstable and contains within it the constant potential for abnormality and can thus only be claimed ‘after a last possibility for a pathological symptom has been eliminated.’ (Murphy-Lawless 1998a: 168), despite the fact that the ‘majority of infant deaths occur outside the grasp of obstetrical knowledge’ (233). In this view, normality all but disappears and can only be identified in retrospect.

Normality itself became heavily constructed on a discourse of science and maths, and aspects of labour that could be seen and measured (I discuss this in relation to time and risk below). Cervical dilation along with fetal descent was recorded and plotted against a timeframe for large numbers of women in order to extrapolate a “norm”, known as Friedman’s curve, still used to assess the progress of women’s labours today. If labour “deviates” too far from this timeframe (the stereotypical ‘textbook’ birth), oxytocin is used to speed it up (Schwarz 1990: 54). The management of birth through time and technologies to maintain progress (Active Management) remains largely unevaluated or discredited when used routinely (Schwarz 1990: 56-57, Thornton 1994).

Normality and time intersect on the measuring, quantifying and plotting of individual women’s bodies and labours to construct a theoretical norm, based on an assumption of averages; how things should be or usually are. Individual women and their unique patterns of labour and birth disappear (Murphy-Lawless 1998a: 162-171). Although women are not necessarily aware of the poor foundations on which obstetric practices are based, it is clear from the small amount of research that has been done that those women who resist a medical reading of birth feel that their bodies, their labours, and themselves as active agents are constrained by norms that ignore their individual bodily rhythms. Many of the women’s stories in this study were about letting birth take its own time rather than hospital time. In other words while a discourse of sameness runs through medicalised birth, a discourse of difference is often appealed to by women.

Time

Sociological perspectives on the meaning and role of time, time and bodies, and distinctions between different timeframes operating in medical and other settings (Adam 1992, 2000, Armstrong 1987, Frankenberg 1992, Murphy-Lawless 2000, Pizzini 1992, Thomas 1992) suggest that time itself could be deconstructed through networks of power and that conflicting meanings may coexist. Indeed, the control of labouring women’s bodies through time is part of a wider discourse of power and control over bodies which produced what French philosopher Michel Foucault termed ‘docile’ bodies. Feminist ‘Sandra Bartky points out that in the disciplinary regimes of modern society, ‘the body’s time [...] is as rigidly controlled as its space’’ (see Murphy-Lawless 1998a: 208-209). Ronald Frankenberg (1992) suggests that the allocation and control of time is not only bound up with the professional project to reinforce the different statuses attributed to professionals and patients, but is central to the ‘pathway from the person to the patient’ (17). This results in practitioners systematically retaining power and patients systematically having less autonomy (25). Furthermore, it is material bodies that enter hospitals, and those bodies that are subject to socialising

and normalising procedures based on the control and ordering of time. Thus time in medical frameworks is not only a sociological phenomenon, but an integral force in defining attitudes (24), relationships and bodily processes (Pizzini 1992)⁴⁰.

As normality became conflated with averages (Murphy-Lawless 1998a), (the so-called 'text book' labour), the length of labour became consequential. The argument made in the 19th century was 'that the absolute length of labour beyond which it becomes dangerous, can be determined by a set rule and that it is in the power of the practitioner to judge how to achieve delivery to meet that set rule' (88). Other aspects of the birth process become insignificant. As Franca Pizzini pointed out, interventions may be carried out 'where the only pathology is that the duration of the process is considered to be excessive (Pizzini 1992: 72). Ronald Frankenberg (1992) observed that 'time is the most important basis of medical power and control' and that the maintenance of this control and imposed conformity is the ongoing control of patient's time (13). A stark example of this can be seen in the following quotation: 'a formal decision was taken on 1st January 1972 to restrict the duration of labour to 12 hours. After this date, no provision was made on the official record for labour to last a longer time' (O'Driscoll in Kennedy 1998). Patricia Kennedy (1998) suggests that it is no coincidence that O'Driscoll and his colleagues had already identified the labour ward as a 'bottleneck' (13) which suggests that time had become embroiled in a more complex discourse which links clinical decisions and resource issues through power networks. In other words, time delineates normality, abnormality and pathology (Thomas 1992: 56) in relation to control, clinical decisions, and the availability of time and resources in a busy institution: clinical decisions and resources are as value-laden as any other term.

Although not usually explicit, the imposed timeframe in hospital regimes was visible to women in my study. One of the reasons women give for planning home births is to avoid being captured by a timeframe that their bodies may not conform to and which they could see no reason to conform to. Enabling their bodies to take their own time to: go into labour; labour and birth their baby; birth the placenta; and meet their new baby was a primary concern to these women.

The notion of institutional time and women's time has been explored by Hilary Thomas (1992) in her research on time and the role of the cervix and by Franca Pizzini (1992) in her research in Italian labour wards. Time is transformed into a series of averages, measurements, sizes and weights, in order to impose orderliness and control over women's 'disorderly' bodies and bodily processes. Using Mary Douglas' metaphor of matter out of place, Thomas suggests that it can also be out of time (1992: 64). In this sense, managing time manages uncertainty (the spectre of modernity and its experts) and inherent anxiety. As a resident in training commented in Diane Scully's study, 'If I section her, I don't have to worry about it' (1994: 193)⁴¹.

The mechanistic principle of modernity contributed to the notion of speed and efficiency. Sheila Hunt observed an emphasis on moving women from the pre-labour to postnatal wards (Hunt and Symonds 1995). In her observations of residents in training, Diane Scully noticed that the single foremost skill required was speed⁴² (1994: 162), and student midwives are currently assessed on their ability to perform tasks quickly. As understaffing in maternity hospitals becomes chronic, in a curious twist of values, it seems speed takes precedence over quality of care. Quality assessment becomes a misnomer for measuring efficiency.

⁴⁰ Advice on feeding and caring for babies earlier last century provides an example of how this infiltrated the lifeworld, and continues to this day.

⁴¹This may be compounded by a further time framework in relation to training needs, where students are obliged to perform a minimum number of procedures in pre-arranged blocks of time in order to move through their training successfully.

⁴²This is not just a feature of hospitals. The linear nature of clock time infuses life with the constant sense of time 'running on and out' (Adams 1992: 161).

Not surprisingly, the time agendas of control, managing uncertainty, increasing speed and efficiency, and training needs merge as birth becomes imminent. Both Hunt (1995) and Pizzini (1992) commented on the speeding up or intensity of action at the time of birth, described as a 'speeding up of gesture and movement, an increase in the number of staff present and a kind of frenzy of activity (Pizzini 1992: 73), poignantly described below:

'As soon as I started pushing, there was hysteria in the room, everyone was frantic and screaming at me to PUSH! I thought to myself, 'Something must be wrong! They've seen lots of births - they wouldn't be acting this way if everything was okay.' When my baby was coming out, someone asked, 'Do you want to touch him? I said 'No' because I thought he was dead. I assumed he was dying or dead for them to be in such a panic about my pushing faster. When he was born and put on my belly, I was afraid to look, or to touch [But the baby was healthy.]' (England and Horowitz 1998: 138)

Barbara Adam (1992) suggested that even when time is theorised, it remains elusive because of a lack of distinction between clock time and nature's rhythms and their fusion in westernised, clock-based cultures, where time is understood through clock time alone. Her analysis on clock time, health and illness has a bearing on childbirth⁴³. In the same way that Jo Murphy-Lawless (1998a) deconstructed statistics to demonstrate the abstract nature of these, Adam deconstructed time, to demonstrate how clock time is an equally abstracted, constructed artifact, at variance with the rhythmic, cyclical time of bodies and nature. She suggests that imposing clock time on body rhythms can increase stress and result in ill-health (157) and that ruptures to their continuity can fragment and affect mental health (159)⁴⁴.

When institutional time takes precedence over women's time, knowledge about women and birth is produced by professionals and machines. Women's knowledge is irrelevant - even confusing. Interventions become inevitable in order to maintain conformity: physiological, psychological and social diversities are erased. Women may feel unable to reject this powerful interpretation of birth, 'but at the same time may also recognize the violence being done and the doubtful utility of its application to each single case' (Pizzini 1992: 70), as I discuss in Chapter 10.

These debates integrate a number of disparate strands - all of which point to the potential disadvantages of intervening with the finely tuned bodily processes of birth, which are attuned to other bodily rhythms and the environment. In Adam's words, 'our multiple body rhythms are not only orchestrated into a coherent whole, but are also synchronized with the rhythms of the environment (1992: 156). Nature's rhythms leave space and time while clock time locks us into a worldview based on urgency, time-management, deadlines and ultimately fear (161-162). One of the ways in which birth could move closer to some women's articulation about time is for: 'Temporal time, the symbol of life, [...] to be allowed to take a position of high visibility' (163). Constructed time provides a tool for managing uncertainty (risk), central to modern obstetrics and it is this that I turn to next.

⁴³ Pizzini (1992) also suggests that distinctions between physiological, psychological and social time would be useful and asks if there should be further distinctions which include pregnancy and childbirth time based on an interior time related to the body (68).

⁴⁴ In terms of place of birth, Pizzini's (1992) research showed birth to be perceived as a rupture and suggests that this could be because birth is, a priori, a traumatic experience, or because of the move from home to hospital, which involves the transition from body time, to social time. Hospital birth involves not only a temporal rupture, but a spatial rupture. She suggests that when birth took place in the woman's home, with known attendants, this rupture may have been 'less violent' (69). The coupling of time and place (territory) was apparent in my interviews. I discuss this in Chapter 10

Risk

The medical construction of risk

Risk discourses appeal to the unpredictability/uncertainty of birth and the claim that obstetrics alone can predict and reduce it in the context of surveillance, medicalisation and hospitalisation:

‘the outcome of every first labour is rather uncertain since there is no reliable method of knowing beforehand which will be easy and which will be difficult, although it is now possible to give statistical probabilities in groups of cases with certain characteristics’ (Baird in Schwarz 1990: 51).

Peeling back layers of discourse, exposing modernity’s preoccupation with numbers, measurement and regularity, Jo Murphy-Lawless (1998a) provides an account of science and obstetrics which shows how both are socially constructed systems in a complex power/knowledge dyad from the moment of observation to the theorised concept, law or premise. She thus deconstructed the statistics and probabilities on which risk management is based, with precision and clarity (1998: 158-162). Suffice to repeat here that the:

‘search to defeat death with obstetric techniques, aided by a pre-set bundle of risks, has become the equivalent of the philosopher’s stone for obstetrics, to the extent that the whole of the current system of childbirth management is determined by this frame of reference’ (174).

It provides what Celine Lemay (1997) describes as ‘l’ideologie securitaire’, in which hospital medicine, normative practices, and technology form the links of the safety chain (83-84). In focusing on the risk of death, the obstetric discourse has developed a hierarchy of risk, emphasising physical safety and de-emphasising emotional safety of any sort (Lane 1995) - so that the word “risk” applies only in relation to physical risks (As I noted on page 42, emotional needs carry little weight).

And yet other risks of hospitalisation and centralisation find themselves barred from the risk agenda (Murphy-Lawless 1998a: 243): the risk of infection (Which Way to Health 1990), the risks of interventions (Downe et al 2001, Wagner 1994) and subsequent morbidity, the risks of the woman giving birth on her way to hospital⁴⁵.

Home birth as a particular site of risk

Most westernised obstetricians argue that all women should give birth in obstetric units. Despite the fact that the value of risk scoring has been challenged (Strong 2000), the division of pregnant women into low or high risk categories forms the basis for deciding which women should be particularly discouraged from having their babies at home, and which women can be “allowed” to have their babies at home. Those examining risk from a global perspective suggest that not only is risk scoring unpredictable of events, but that the normalising concept of risk is insensitive to demographic, social and cultural circumstances of individual women (Maine 1991, Murphy-Lawless 1998a, 1998b, Wagner 1994)

⁴⁵ In the 1990s, when a midwife, ambulance driver and baby were killed, during a journey to transport a labouring woman from a Scottish island with a small hospital in which the woman wanted to give birth, to a large obstetric unit, the incident was seen as a tragedy. But there was little comment about the morality of an obstetric regime which contributed to these events. Had her baby died in the small maternity unit, she and anyone supporting her would have been blamed.

They suggest that focusing on appropriate skills would unhitch “risk” from place of birth debates and would move the focus to individual women’s social circumstances, so that low interventionist birth technologies could be further developed to assist with birth before moving to higher level technological solutions. The idea would be to bring together the previously natural/technical dichotomy into a more continuous concept based on skill and support rather than risk. But risk assessment and management are pursued with greater and greater tenacity by obstetrics:

‘According to Carter, the authority of risk assessors lies in their power to make the distinction between safety and danger - this separation constitutes a boundary which defines a space in which the dangers are more controllable. Finnish obstetricians and policy-makers clearly had drawn the safety boundary line between home and hospital. In hospital the medically acknowledged uncertainties and risks of childbirth are under the control of the professionals. Parents who give birth at home deliberately cross this socially and culturally constructed boundary. In the medical discourse they are defined as a ‘risk group’ because of their non-compliant behavior. The language referring to home birth as risky can be seen as a social coercion technique to keep everyone in compliance with the system’ (Viisainen 1998: 810)

Risk and morality are deeply intertwined on issues of birth (and beyond).

Risk/morality: ‘Handing over [the] pregnant body to the authority of the hospital’

Diana Scully (1994) provided insights into how not only the beliefs and values of a society are played out and inscribed on pregnant and birthing women’s bodies through the practices of the day, but that society’s morality is both reflected and reinforced through childbearing and gynaecological practices. These are inextricably tied into gender relationships and the “proper” role of women. The morality inscribed on women through current practices is one of selflessness and subordination.

The notion of risk at birth has been so powerfully infused with a sense of obstetric morality, that any woman who considers defining her own meaning of birth is obliged to examine her own motives, morality and responsibility in a framework which tells her that she is selfish, immoral and irresponsible (Lemay 1997, O’Connor 1992, 1998, Viisainen 2000a, 2000b, forthcoming). One of the contexts in which debates about where and how to have a baby, and who should attend, is the unspoken contract that if women comply with obstetric regimes, risks are minimised. If they reject this, they put themselves and their babies at risk, and if death or damage occurs, they are to blame. Morality can only be observed in hospital; thus, in a powerfully oppressive inversion of morality over death, if death or damage occur there, it is morally tolerable from an obstetric perspective, as the system of care is not usually seen to be responsible. But when death or damage occurs at home, the woman and/or the midwife are seen to be responsible through their risk-taking behavior (Bourgeault et al 2001: 54, Wagner 1995). Jo Green, Vanessa Coupland and colleagues (1998) point out that there is another curious inversion of morality/responsibility around birth: women who hand over responsibility to professionals are attributed the higher moral ground, despite the fact that this could be construed as irresponsible (24).

This sense of morality had a deeply coercive influence over women in my study and how far they felt they could maintain their own meanings of birth. It raised questions about how women’s decision-making processes reflected or suppressed this sense of morality and responsibility, which enabled me to hear the potential gap between feeling and acting. It raised the issue of subjectivity addressed in Chapter 10, which challenged the patriarchal definition of the autonomous, rational subject, steeped in clear cut rights and morality (Belenky et al 1986, Gilligan 1985). It raised questions about what autonomy means in a coercive setting. Reflecting the above, Jo Murphy Lawless (1998a) points out that, ‘for women the reality of acting responsibly, most especially

around reproduction, is far messier, a context in which our decision-making is utterly social and relational' (253)⁴⁶.

The obstetrics/morality/death linkage makes it difficult for death to be discussed openly (Murphy-Lawless 1998a: 240-241), but as women are well aware, death at birth is a reality (see Chapter 8). The question is whether there are other ways of negotiating risk that could usefully deconstruct the hospital-obstetrics-safety and home-midwifery-danger dichotomy.

We are thus left with a number of conflated and under-developed notions - that of what risk means, how place of birth and risk are related, whether place of birth is the main influencing factor or not, how risk reflects dominant ideology, and how that ideology frames our under-developed interpretations of the above.

But the currency and tenacity of the risk/morality discourse, that risk is manageable as long as women accept the obstetric meanings of birth is almost impossible to prize apart (Lane 1995). It produces a debilitating, coercive fear around birth, greater than the 'peurs normales' (normal fears) discussed by women in Lemay's (1997) study. Elizabeth Smythe (1998) points out that it is in fact 'in the professionals interests to create a moderate fear of birth, in order to provoke the woman into handing over her pregnant body to the authority of the hospital' (58). Obstetrics remains silent about the morality of this coercion that affects women's confidence, trust and decision making (which I discuss in Chapters 8, 9 and 10). The obstetric risk discourse is rooted in and collides with other health risk discourses, creating tensions between medicalisation and expertism and the emphasis on individuality and personal responsibility. It is to these that I turn next.

Communities 'at risk'

Sarah Nettleton (1997) observed that, an 'analysis of medical journals in Britain, the USA and Scandinavia found that the increase in the use of the term 'risk' has reached 'epidemic' proportions' (215). From a wider sociological perspective risk is linked into powerful state agendas for managing changing populations and resources. Medical sociology, the new public health discourses, and sociological commentators on risk provide examples of how discourses are interconnected but contain fissures and fractures (Cartwright and Thomas 2001).

Obstetrics is currently negotiating community care discourses, gaining acceptance through public health policies, which incorporate individualism and the need to protect scarce resources. The tension between these policies and medical ideology has resulted in the importation of

⁴⁶ For example, the women in Robbie Davis Floyd (1992) and Emily Martin's (1989) studies, apparently rejected medical ideology, but Kirsi Viisainen (forthcoming) suggests that in her study women adopted a 'pragmatic' approach: 'the important aspect was not to give birth completely outside of the system but to use the system for their own purposes, including medical risk assessment.' (2000a: 81). Women's apparent adherence to medical ideology may speak of coerciveness and a lack of strong alternative discourses, but an awareness of diversity and that home birth can 'fit' with diverse ideologies and lifestyles is crucial if we are to dismantle oppressive home/natural and hospital/technological polarities in the light of women's accounts. Women in my study positioned themselves on a spectrum of ideologies, but none of them demonstrated the level of coexistent ideologies, as that of one of the women in Viisainen's study, who apparently wanted to trust herself and replicate the hospital in her home:

'Jaana was not seeking support in alternative natural birth ideologies for her home birth plan. She used biomedical knowledge to support her view that birth can safely be conducted at home when risks have been excluded by prenatal care. For this purpose, she and her husband had searched medical databases to find research on home births. To secure her own low-risk status she had extra examinations done during pregnancy. She organised her home birth to represent conditions in the hospital as far as she could. She felt it was important to have all the instruments neatly in order on a tray and draw up a partogram according to regulations. Yet, she felt the most important thing was that she knew herself what she was up to. She needed to trust her own ability to give birth' (Viisainen forthcoming)

medical/institutional values and practices into the community through increasing rather than decreasing the emphasis on risk. Self-management and self-care practices are constructed through which individuals monitor themselves (Murphy-Lawless 1998a, Peterson 1997) and obstetric practices and technologies are increasingly transferred into the community, extending the institutional 'umbilical cord' (Davis Floyd 1992) through ultrasonography and telemonitoring. This is carried out in the community but interpreted in hospital⁴⁷. Foucault's 'gaze' provides the mechanism through which this process is internalised, extended and monitored⁴⁸. Paradoxically, but not surprisingly, medical ideology attempts to control decisions about, and create boundaries around what can and cannot be "managed" in the community. Thus risk is focused on birth and only antenatal and postnatal care can be supervised in the community⁴⁹.

Competing discourses of risk

In broader discourses about risk, technology itself has been identified as a substantial risk. In the sociology of scientific knowledge for example, Dorothy Nelkin (1982) among others suggests that it was the scientists of technology who first raised questions about its safety. Similarly, sociologists, Ulrich Beck (1992) and Anthony Giddens (1991) focus risk back on professions and their technologies⁵⁰. In discussions about 'risk society', they assert that technology presents one of the greatest risks to humanity. Giddens's arguments focus on how to stop the technological 'juggernaut' causing mass destruction.

In the west, as resources seem finite and the population grows older, there is a perceived need for an able-bodied population: the young to work and the old to take care of themselves and others. Alan Peterson (1997) suggests that the broad scope of the new public health agenda has collapsed the boundary between healthy and unhealthy (in much the same way that obstetrics collapsed the boundary between normal and abnormal), 'since everything potentially is a source of 'risk' and everyone can be seen to be at risk' (195). The resulting 'multi-levelled and multi organisational network of surveillance and regulatory practices' (197) embedded in modernist ideologies, parallel on a wider scale, processes in obstetrics. Relying as they do on ever more complicated, statistical calculations of risk, they are increasingly less comprehensible to the lay person.

Feminists such as Jennifer Harding (1997) and Alexandra Howson (1995) point to Hormone Replacement Therapy (HRT) and Cervical Screening, as sites where large categories of women's bodies are continually at risk and in need of surveillance and treatment. The linking of risk to morality is as clear here as in obstetrics: submit to surveillance to remain healthy. Harding suggests that in the case of HRT, the women's health movement has failed to move the debate beyond risk and individual responsibility, focusing instead on healthy behavior, and falling into the same

⁴⁷ Like obstetrics, the construction of community care provides another example of the circular nature of beliefs, research and the development of the practical means and tools to reinforce these.

⁴⁸ There is a paradox in reducing physical distance but increasing that between individuals and decision-making structures through the development of community care within a less accessible medical ideology/profession. This has parallels in the increasingly automated telephone and computer services, where access is from home, but controlled by faceless others. In critic Ivan Illich's (1975) terms, solutions that distance us, or provide limited accessibility disempower us and are unlikely to feel safe or 'convivial'.

⁴⁹ The separation of antenatal and postnatal care from birth is reflected in much of the research on continuity (see page 70).

⁵⁰ Beck singles out medicine as a field, which has remained relatively free of both internal and external criticism. Medical professionals have largely convinced the public that it is 'conceptually uninformed' and lacking in knowledge (Lane 1995: 54). Both Giddens and Beck have been criticised for their modernist view of the autonomous, disembodied and fixed subject and their lack of attention to the circulation of power. While they attribute agency to individuals unproblematically, medical sociology attributes power and domination to medical ideology and practitioners. Neither discourse provides a more nuanced understanding of the relational aspects of ideologies and individuals, or the coexistent resistance and complicity, or domination of the (unstable) subject (Lupton 1997: 103, Peterson 1997: 203). In other words, the macro-micro power interface between institution and individual requires further examination.

exclusionary, medical rhetoric as medicine itself (Harding 1997: 141-144). Again, risk is posited as an unproblematic category, 'represented as a self-evident danger to be avoided' (137) and statistics and cost-benefit calculations unproblematically applied across populations of difference (137).

The pregnant body in particular is constructed through risk. New antenatal screening technologies provide each woman with a risk factor, but the risks of its own regulatory regimes are rarely scrutinised. Some researchers have followed up radical philosopher, Ivan Illich's (1976) claims that iatrogenic risks of technology and pharmacology outweigh its benefits in some cases. For example, Murray Enkin and colleagues (1989) warn that 'the introduction of risk scoring into clinical practice carries the dangers of replacing a potential risk of adverse outcome with the certain risk of dubious treatments and interventions (30). Indeed, the cornerstone of risk management, antenatal care, has been cited as a possible location of risk, because of its stress inducing potential (Teixeira 1999, see also Strong 2000)

Peterson (1997) observes that while risk narratives circulate, there is no agreement 'about what constitutes a risk, levels of risk, how to respond and so on' (201). Particularly ignored in obstetric discourse is where risk originates, its 'general and systemic nature (Lane 1995:66) and its prime location in poverty, as I noted in footnote 10 on page 42.

Risk/control

Wherever risk is located: in global or local environmental issues; technological developments; bodies; medicalisation; or elsewhere, similar to obstetric risk, a number of commentators suggest that its main function and outcome is restraint and compliance. As medical ideology infiltrates more and more of the lifeworld, it forms a powerful control mechanism through which risk is identified and managed: 'People are constantly urged to conduct their everyday lives in order to avoid potential disease or early death', putting us all 'under the medical regime (de Swaan quoted in Lupton 1997: 101). Frank Furedi (1997) for example challenges the concept of risk and locates it as a response to a particular moment in political history, which is pitting risk against potential, leading to an oppressive curtailment in human potential. In other words, we are attempting to reduce risk by deliberately minimising our activities and those of others. A good citizen thus becomes a passive citizen who abides by accepted norms and avoids what normalising culture defines as risks.⁵¹ (See also Douglas 1992).

The emphasis of these risk discourses is on self-management and control of a body that remains fixed and stable. Thus 'experts' seem less obviously directive of people's lives, relying instead on the individuals to manage themselves appropriately according to dominant ideology (Peterson 1997: 203). In Foucault's terms, disciplinary power circulates, replacing sovereign power and creating self-regulating subjects, through the internalised gaze of the state.

While the risk discourse of modernist ideology promotes security and certainty, the tensions between knowledges and 'experts', and the social construction of risk makes for instability and uncertainty. Risks not only change over time (Peterson 1997: 202, Smythe 1998: 39), but, as we see from the birth debates, what constitutes a risk in one ideology, provides safety in another. Very little research has focused on women's perception of risk or safety during childbearing, though I found that women were well aware of obstetric uncertainty (see page 139). I come back to the recent study

⁵¹Furedi's arguments are based in oppressive patriarchal discourses which suggest that violence towards women, children and minority groups is being exaggerated. Nonetheless, his risk/potential analysis echoes with other views about positive aspects of risk referred to by Lemay (1997) and Murphy-Lawless (1998a). Both suggest that in other situations, taking risks is part of an entrepreneurial spirit, valued in a materialistic culture and seen as part of the heroic tradition in sports for example. The powerful experience of birth is excluded from these (male) discourses and defined through medicalisation or romanticism (Lemay 1997: 90), which disappear or weaken women.

by Viisainen on how women planning home births located and responded to risk, that I quoted in the footnote on page 63. Although she stated that women located themselves in medical ideology, she concluded that they interpreted the medical risk discourse through their own experience and intuitive knowledge:

‘they challenged authoritative knowledge by assessing for themselves what was valid and important in medical risk discourse. They chose to use the medical practice to the extent they felt necessary to ensure the medical safety of their plans, counter arguing against the pervasive risk discourse either with the ambivalence of its own knowledge base, or by trusting their intuition’ (Viisainen 2000: 812)

Apparently medical risk discourse remained the ideology through which parents developed their own meanings of birth. And yet, ‘the women’s trust in their own bodies’ ability to give birth [having] for them the status of authoritative knowledge’ (Viisainen 2000: 812), suggests an undercurrent of a different discourse of birth and safety, based on women’s experiential and embodied knowledge.

In relation to dominant ideology, Viisainen identified three potential loci: medical, iatrogenic and moral risks, which the parents in her study negotiated (Viisainen 2000a: 74). The research and commentaries on place of birth that I examine next cover these different aspects.

Risk as a motivating factor: The research agenda and debates on place of birth

Safety and risk has been subsumed into a discourse of risk, where risk is narrowly defined in terms of life or death and where all births are seen to be at high risk or low risk. It is this discourse of risk, embedded in a modernist/scientific framework, which has constructed much of the research agenda and debates on place of birth.

Trust in science and medicine and distrust in nature and women’s bodies ensured that the assumption about the greater safety of hospital birth became embedded in the fabric of society. This was reinforced by the assumption of a causal link between the decrease in perinatal mortality rates and the increase in births taking place in hospital. This formed the basis for further assumptions that well-equipped large obstetric units were better than smaller hospitals and general practitioner units. When research challenged this (Campbell and Macfarlane 1990, Tew 1985), obstetricians continued to argue that hospitals were the safest place of birth and ‘that safety was paramount, if not the only criterion on which the argument should be based’ (Campbell and Macfarlane 1990: 222). Rona Campbell and Alison Macfarlane suggested that the debate became polarised around the home/hospital divide, based on the different paradigms of birth as normal, or hazardous and unpredictable (223).

A trawl through the research on place of birth revealed a growing body of quantitative, retrospective, observational research based on physical outcomes carried out in the late 1970s to the 1990s. This challenged the belief that birth in hospital is always safer, but stayed within the broader assumptions of risk, science and medicine (for example, Burnett et al 1980, Campbell et al 1984, Damstra-Wijmenga 1984, Ford et al 1991, Haloob and Thier 1992, Howe 1988, Murphy et al 1984, Shearer 1985, Tyson 1991, Wayne et al 1987, Woodcock et al 1994). In keeping with the medical health model described above, (that client views and experiences are largely irrelevant), with few exceptions (Bastian 1993, Caplan and Madeley 1988, Chamberlain et al 1997, Damstra-Wijmenga 1984), the research excluded women’s views and experiences. Staying within the limited confines of the risk and statistical outcomes, commentaries focused on the problems of methodology - definitions of: mortality; preventable mortality; risk; and how to incorporate planned and actual place of birth when this differed. Studies ranged in numbers from 57 unplanned home births (Habob

and Thier 1992) to 8856 home births (Campbell et al 1984)⁵², with or without matched or unmatched cohorts, and including or excluding women classified as high or low risk, (where these classifications varied).

Standard statistical adjustments for selection biases have been questioned because they must be identified in the first place (Macfarlane 1986). Researchers have argued the case for and against defining home and hospital births by initial booking or actual place of birth, on the grounds that other unexplored mediating factors may come into play, such as: the different styles of antenatal care by place of booking; the different environments of home and hospital (Macfarlane 1986); the motivation of the women themselves; the quality of links between community and hospital services and time taken to transfer from home to hospital (Ford et al 1991, Iliffe 1987); and the type, attitude, skill and support of attendants (Bastian 1993, Bortin 1994, Cronk 1992, Floyd 1992, Iliffe 1987, Muller-Markfort 1994, Pearse 1987, Reid 1993, Wayne et al 1987, Winter and Davies 1992, Young 1993, Zander 1981). In addition, cross-cultural studies have their own inherent problems. Even in apparently similar populations, definitions and registration processes for perinatal deaths, and cultural attitudes to home birth may vary (Treffers et al 1990).

Ensuing debate focused on the impossibility of carrying out what was considered to be the only definitive method for ascertaining the medically defined question of safety, the randomised controlled trial (RCT), because of the low numbers of women planning home birth. Using accepted statistical norms and definitions of risk (which I address in the next section), it has been estimated that even if a RCT included 700,000 women at low risk of complications, only moderately reliable conclusions about perinatal mortality rates could be expected (Ford et al 1991). A RCT would in any case not be able to provide the sort of sensitive data about an individual woman, her pregnancy and birth, and the complex events surrounding her own mortality or that of her baby (Maine 1991, Murphy-Lawless 1998a, 1998b, Wagner 1994).

Rona Campbell and Alison Macfarlane (1990) suggest that the debate is likely to remain unresolved because it reflects a 'profound 'clash of values' between the main protagonists' (232) and is still largely conducted through the limited medium of medical safety (233). The support for home birth has largely been defined through rights and informed choice based on the conclusion that home birth is safe as far as we can establish this, but with some awareness of ethical issues (Zander 1981) and the powerful, underlying discourses within which choice is limited (Campbell et al 1991, Flint 1989, Kargar 1993, Mason 1992, Muller-Markfort 1994, Young 1993). The values of obstetric ideology have not only limited the research agenda, but have limited interpretations of the research which has been carried out.

Meanings of outcome

The focus on maternal and perinatal mortality rates de-emphasises other important debates. The continued assumption within obstetrics, that hospital birth is safer than home birth creates the climate in which research is both carried out and reported. The meaning of "outcome" has assumed a particular definition, whereby, medical concerns (babies' lives) are privileged, and women and babies' health and well-being is de-emphasised. Many of the home birth studies I have referred to showed advantages for women and babies who had home births attended by midwives, but most were used to support the argument that there are no grounds to claim that home birth is unsafe. For example, research by physician, Mark Durrand (1994) comparing home births attended by lay midwives in Tennessee in North America with standard obstetric care in the same area, concluded that there were no grounds to believe that the care provided by lay midwives is substandard to

⁵²The necessity to separate planned and unplanned home births because of the apparently very different outcomes was addressed in England and Wales (Murphy et al 1984) but less so in Scotland (Murphy-Black 1993) until recently (Murphy-Black forthcoming).

obstetric care. However the comparison showed that women cared for by lay midwives had significantly reduced levels of interventions and morbidity, even though some of the women included were considered to be women at risk of complications. Research including similar groups of women, shows that those who had their babies at home had fewer interventions (Chamberlain et al 1997, Mehl 1976). Research that takes women's views into account shows greater levels of control, satisfaction and choice (see for example Chamberlain et al 1997), but Patricia Kennedy and Jo Murphy-Lawless (1998) suggest that in the wider arena of women's health, 'the goal of women-centred health care has been defeated because of a tendency within medicine to trivialise and psychologise women's own accounts and analyses of what their needs are' (8). In other words, their experiences did not count and were rarely reported. In noticing this suppressive regime in the research agenda, I was able to hear that a number of women in my study felt muted or silenced by their positive experiences of home birth and felt that these could only be recounted occasionally, cautiously, or through a currency of "luck" rather than by an acknowledgement of the advantages of home birth and their own agency (see page 179).

In a similar vein, the conclusion often reached by researchers, commentators, activists and others is that home birth is relatively safe for women at low risk, or healthy women with normal pregnancies. Marjorie Tew's (1998) conclusion that home birth is safer for most women and babies is shied away from. The attempts to prevent her completing and publishing her work (Tew 1995: 31) suggested that it moved too far away from the indeterminacy of research findings and threatened dominant ideology too strongly. Yet her findings are supported by a large scale retrospective study in California (Schlenzka 1999), where a change in the recording of birth data made it possible to study the outcomes of births at home and in midwife run birth centres and those in obstetric units⁵³. The extensive review of the literature concluded that midwives' perinatal outcomes are consistently as good as those of obstetricians and that women having midwife care have fewer interventions, even though midwives are trained and practice within a hospitalised/medicalised culture (26). The study itself confirmed that there were slightly better outcomes when natural birth approaches were used, at all levels of risk and the researcher suggested that:

'We need to keep in mind that the natural approach, while operating today in the United States under suboptimal conditions, still is able to produce these results. We would expect the natural approach, when being part of a shared maternity care system and supported by society's beliefs to produce even better results' (174)

Moving from risk to safety

Safety, like risk has been narrowly and negatively defined through medical ideology, as a series of monitoring procedures during pregnancy and hospitalisation and medicalisation. The acceptance of the social construction of obstetric risk in the context of beliefs about birth, cultural norms and fears, a litigious/materialistic society, and its deconstruction provided a rhetorical space in which women could consider focusing on safety/confidence rather than risk/fear.

As Marie O'Connor (1992) and Kirsi Viisainen (2000b) found, where obstetrics is practiced, the powerful ideology of risk forces all women to view birth through the medical lens, whatever they eventually decide (see also Murphy-Lawless 1998a: 229). Most women considering home births negotiate this risk discourse before being able to consider the potential of birth⁵⁴. Yet, as a midwife

⁵³ Place of birth was used as a proxy for a midwifery or a medical approach to birth in this study, and natural birth was synonymous with midwife attended birth.

⁵⁴I often see women in their first pregnancies gradually question obstetric ideology. The move to a social model is often too big an ideological step to take during the limited time of pregnancy. These women sometimes plan home births during subsequent pregnancies.

in Lemay's (1997) study commented, 'le calcul c'est une façon de voir les choses il y en a d'autres' (95) (statistics is one way of seeing things ... there are others).

In trying to understand concepts of safety and risk, and how these are viewed by different players, midwife Lemay, identified two conflicting ideologies, one of which suggests that 'la maison n'est pas un lieu sécuritaire pour un accouchement' (the home is not a safe place for birth) and the other that 'l'accouchement à la maison est un choix sécuritaire pour des femmes' (home birth is a safety choice for women) (Lemay 1997: 81). Kirsi Viisainen (2000a) suggested that in medical ideology risk resides in the pregnant and birthing body; but in alternative ideologies, it resides in medical ideology: 'According to the medical model, physicians seek to control the inherently risky pregnant body, while according to alternative models women seek to control the risks they are subjected to in the hospital environment (51). The risks are not so much to do with biomedical risks, but the risks imposed by institutionalised birth (Lemay 1997: 92): the risk of losing control; inhibiting factors such as strangers, bright lights, noise, lack of privacy which may prevent the woman from giving birth; and the increased risk of interventions.

These different constructions of risk and safety take into account the psychological, emotional and spiritual well-being of the woman, her baby and her family. Using Robbie Davis Floyd's (1992) above distinction between technocratic and holistic approaches to birth, one of the core differences between the two belief systems is that the technocratic or medical model conceptualises birth through risk. Its practices and policies arise from constructed assumptions, which define safety through the carrying out of a series of tasks. More holistic philosophies use normality as their main indicative tool. The meaning of normality is not defined in absolute terms, but is closely aligned to the individual mother/baby unit. General policies and practices become less relevant and there is more scope for individualised care and creative solutions drawing on other forms of knowledge, such as 'tricks of the trade' (the North American publication, 'Midwifery Today' exemplifies this approach) and intuition (Davis-Floyd and Davis 1997, Roncalli 1997). Thus safety in medical ideology is an apparently stable, bounded commodity, which is defined through minimising and managing risk according to questionable rules of obstetric ideology. Safety from the women's perspective appears to be more procedural and circumstantial, created through the complex intersections of the multiple contributions to well-being.

Of course, as Elizabeth Smythe (1998) points out, "being safe" does not guarantee safe outcomes' (249) anymore than obstetric regimes guarantee safe outcomes (Murphy-Lawless 1998a, 1998b) - but the nature of, and ambivalence about those outcomes could be usefully examined. An example of a mother whose baby died after being kept alive some weeks in hospital raises the issue of whether or not death is always the worst possible outcome (Murphy-Lawless 1998b: 226). I return to this issue in the analysis of my interviews, where some of the women in my study suggested that while the death of a baby at birth is devastating, they purposefully avoided the medicalisation of death at birth by planning home births (see page 174).

Creating safety rather than managing risk

In tracing safety through its historical, political and professional career, Smythe (1998) suggests that safety has been as constructed as its dichotomous partner, risk - and removed just as effectively from the hands of women (38). In a partial deconstruction of safety⁵⁵ she suggests that safety is an unstable process, rather than a quantifiable entity, open to influence and located between the knowledges of practitioners and women and the trusting, enabling relationship between them (121). As in other work (Lane 1993, 1995, Lemay 1997), safety is defined in the broader sense of well-

⁵⁵I say partial, because she provides a deep understanding about the meanings of being safe, but less of the power/knowledge context in which she deconstructs it. And in the final analysis, she stops short of deconstructing the belief that the preservation of life takes precedence over all else.

being and the distinction between being safe and feeling safe is blurred (Lemay 1997, Smythe 1998: 20-21). It draws on evidence-based care, while simultaneously acknowledging this as a form of knowledge among others; experiential, embodied, intuitive for example. It is vigilant, anticipatory, and engages with individual woman through relationship (Smythe 1998: 145-151). In contrast to the obstetric risk discourse, it acknowledges the dangers of commission as well as those of omission.

'Being safe is a paradox between doing and not doing, and knowing which to do when'
(40)

Locating safety in relationships

Research and commentaries based on holistic, social approaches to birth suggest that the potential for the development of safety centres on relationships, subjectivity and multiplicity, rather than objectivity, technical expertise and normative values. While relationships have been ignored in mechanistic approaches, feminist research suggests that relationship is central to ways of learning and caring (Belenky et al 1986, Gilligan 1985, Ruddick 1989). Almost in answer to Jo Murphy-Lawless' (1998a) query about the risks of ignoring women's knowledge, Celine Lemay (1997) observed that medical knowledge and power invalidates women, but that the women in her study saw their midwives' knowledge and power as supporting, validating and complementary to the extent that they developed a joint knowledge, power and confidence (98). The relationship between them was fundamental to women feeling confident and secure (99)⁵⁶.

Relationships matter wherever women give birth (Berg 1996, Fleming 1995, 1998, Halldorsdottir and Karlsdottir 1996, Kirkham 2000, Pairman 2000, Smythe 1998, van Olphen Fehr 1999). However, that the development of relationship, trust and confidence might be implicated in safety is not a concept that can easily surface in a medical model of birth. Where the body is defined as essentially mechanistic rather than a complex dialogue between body, mind, and spirit, "mechanics" are arranged through hierarchies, shifts and training needs (Scully 1994). Technical competence becomes the main definition of a good practitioner. In other words, safety based on mutual trust cannot feature, if "relationship" is mediated by obstetric policies, which have nothing to do with individual women or midwives (Smythe 1998). Of course, the facelessness is tempered by the influence of midwifery and individual midwives' attention to qualitative aspects of the experience of childbearing - but this remains an uneasy, if not confusing compromise.

And those who have researched women/midwife partnership models in relation to power (Fleming 1994, 1998, Guilliland and Pairman 1995, Smythe 1998) reflect Smythe's finding that the 'practitioner woman relationship is very open to the tentative hopes of the women being over-ridden by the practitioner' (174) and where women and midwives are unable to get to know each other, women can feel at risk (Edwards 2000a, 2000b). It is this aspect of "knowing" that I examine next.

Continuity

As I suggested elsewhere (Edwards 1998), research, reviews and commentaries show that there is no agreement on: what constitutes continuity; whether this means continuity of care and/or continuity of carer; women's needs for continuity; or what the advantages and disadvantages might be (Fleissig and Kroll 1997, Flint 1991, Green and Curtis et al 1998, Lee 1997, McCourt 1998, McCourt and Page 1997, Murphy-Black 1993, Page 1992, Perkins and Unell 1997, Price and Williams 1998, Sandall 1995). Because of the apparently contradictory findings, the need for continuity has been seen as equivocal. Survey research, which does not understand dominant

⁵⁶There was both accordance and dissonance among the women in my study. Exploring where the similarities and differences lay, in Chapter 9, gave a much clearer picture of what it was about the relationship between women and midwives that could promote or detract from feeling confident and secure.

assumptions about relationships cannot adequately answer these questions or make visible the qualitative issues embedded in the term continuity. Nor can research based in a medical model of care show the benefits of something that is peripheral to its priorities. In this sort of research continuity is often separated from and compared to other isolated qualities such as information, control etc (Hundley 2000) with apparently no recognition of the relationship between these components⁵⁷. A reluctance to provide continuity may also shape the lens through which it is viewed and lead to a focus on antenatal and postnatal care. However, the in-depth studies that have evaluated women's (and midwives) experiences of continuity have shown both quantitative and qualitative benefits (Flint 1991, McCourt and Page 1997, Sandall and Davies et al 2001, van Olphen Fehr 1999). I was therefore interested in the views and experiences of the women in this study about continuity in relationships and struck by their strength of feeling about it (see Chapter 9).

Caring as a legitimate or illegitimate pursuit? Or a necessity?

In Julianna van Olphen Fehr's (1999) discussion on caring relationships, and in the extensive review and theory development on caring carried out by Sigridur Halldorsdottir (1996), it was evident that while there were different meanings and roles located within caring, relationship was at the very heart of this. In addition, while some of the qualities attributed to caring encounters were located in the individual carer, some such as trust, respect, and seeing the whole person could only easily develop within the context of a relationship (van Olphen Fehr 1999, 138-9). Running throughout Halldorsdottir's work is the strong connection between caring and empowerment, and uncaring and disempowerment. Connection and trust seem to form the essence of these encounters based on reciprocity, mutuality, personal disclosure and the removing of anonymity and stereotyping (34).

A crucial, if overlooked factor, to emerge from their work on women's experiences with midwives was the way these relationships could permeate other aspects of the childbearing experience such as safety: 'Collaboration and planning for their births with their midwives seemed to be a cornerstone of the overall experience and created rapport and trust that women needed to feel the safety to experience childbirth in their own unique way' (van Olphen Fehr 1999: 106). The summaries of the narratives of the women in van Olphen Fehr's study were strikingly similar to the narratives of the small number of women in my study who were attended by known and trusted midwives. She describes the woman/midwife relationship journey in terms of the Heideggerian concept of "leaping in" and "leaping ahead". The midwife "leaps in" to protect the women in her vulnerability and "leaps ahead" returning to watchful waiting in the background while the woman is empowered (135). She beautifully describes the continuum of the relationship, forming from the weaving together of these caring "leaping in" and "ahead" encounters during pregnancy in which the woman and midwife get to know and trust each other. This lays the groundwork for them to move knowingly, trustingly and intuitively through labour and birth. (136). Her work exemplifies the intimate fusing of safety and relationship, not dissimilar to that defined in Elizabeth Smythe's study (1998). Both describe meanings of safety, which are far removed from a medicalised view of safety. Both link many of the currently compartmentalised components of woman-centred care, through relationship. Both suggest that a safe environment meant that the midwife understood the beliefs and attitudes of the woman and could in addition, relate to them: 'The creation of safety therefore began at the moment the caring relationship commenced, through a sharing of knowing, collaboration and imparting of information (van Olphen Fehr 1999: 134). The midwife becomes a

⁵⁷For example, in one view feeling in control depends on being in a relationship with a midwife, but if control and continuity are separated and compared women may prioritise control, and continuity is assumed to be less of a priority. If fragmented care is the norm, it may be difficult to imagine derivable benefits of continuity, especially given the tendency to assume that 'what is must be best' (Porter and MacIntyre 1984). There may be other overriding issues that the woman has to contend with, such as poverty. In addition, if the woman experiences professionals as judgmental or controlling, continuity could be seen as threatening.

(professional) friend (Pairman 2000) so to speak, supporting women to give birth in the way they believed to be right for them and their babies.⁵⁸

In the next section, I consider how relationship relates to the discourse of professionalism, currently so central to midwifery. Smythe (1998) claimed that 'detachment and indifference', have become all but synonymous with professionalism, particularly in terms of providing continuity of care rather than carer (268).

Professionalisation

In its struggles for survival, I have already described how midwifery incorporated male values and beliefs, as it was obliged to engage with medical men on their terms. In the same way that women planning home births have often had to focus on the struggle to secure this, rather than on their needs, midwifery has had to focus on a struggle for survival rather than on its own needs and those of the women it serves. This has compromised their self-expression, identities and autonomies. Thus, in an effort to secure a power base, professionalism in midwifery is based less on its own values, and more on the values of obstetrics.

Professionalisations developed both from, and in tandem with the patriarchal discourses I examined above. Rationality in the form of science was expressly intended to replace other forms of knowledge (Oakley 2000). Professionalisation was the medium through which this occurred. As I mentioned above, patriarchal capitalism simultaneously carved up the public/private domain in favour of male professions, limiting the possibilities for how midwifery could develop its own agenda (Witz 1992). Its transformation through the campaigns for, and introduction of the 1902 Midwives Act (Heagarty 1997), moved it towards claiming professionalisation. While this professionalisation, or semi professionalisation (van Teijlingen and Hulst 1995) arose in part from a struggle for survival, it was defined through modernity's construction of "scientific" knowledge, incorporating many of the beliefs and values of medicine. It has aspired to a male professional persona and aligned itself more closely with dominant ideologies, knowledges and powers. Thus the scene was set for the disengagement from the women it purported to serve (Heagarty 1997, Kirkham 1996, Pitt 1999). The process of medicalisation and institutionalisation fosters allegiances between groups of professionals rather than between midwives and women (see page 53).

Ruth Wilkins (2000) suggests that the current conceptualisation of professionalism manifests ways of knowing and practicing that are based on dualistic patterns of thinking that make it 'conceptually blind' (29) to relationships. It exists to assert its own authoritative knowledge, which denies other ways of knowing: in her words, '[p]rofessional practice is the application of professional knowledge in an object-orientated relationship of domination and control, whether of a body, a mind or a situation' (30). This necessarily excludes relationships based on mutuality and subjectivity (partnership). Thus, as Wilkins suggests, clinical assessment, monitoring and giving of advice take precedence over caring (34). The professional 'biographies' (histories, experiences and experiential knowledge) described by Carolyn Weiner and colleagues (1997), which professionals necessarily embody are at odds with the concept of professional knowledge. By denying other epistemological spaces, professionalism cannot comprehend midwives' or childbearing women's knowledges. Despite the many examples of women and midwives' knowledges outside scientific evidence, it is often packaged into the supposedly mysterious and untrustworthy anathema to science – intuition. Located as it is in dualistic thinking, it is difficult to envisage how current concepts of professionalisation could move towards the kind of partnership described by Sally Pairman (2000) without rethinking the values on which it is based. This would mean collapsing some of the binary

⁵⁸Women who have experienced this kind of support often become more politicised and understanding of the importance of holistic midwifery care. They have often supported those apparently dissident midwives who supported them, as campaigns in Britain, North America and Ireland attest to, demonstrating the mutuality of caring.

distinctions, which underpin it: public/private, science/experience, rational/emotional, care/competency, being/doing, to mention but a few.

Professionalisation in midwifery is essentially about maintaining standards set by medical ideology from which it has developed, and staying within the boundaries of the knowledge sanctioned by that ideology. It cannot provide the medium in which women and midwives could expand their joint knowledges about childbearing, and reconstruct their own subjectivities.

Important work on engagement and caring in midwifery and nursing (Halldorsdottir 1996, Halldorsdottir and Karlsdottir 1996, van Olphen Fehr 1999) runs counter to professionalisation, objectivity and detachment⁵⁹, and as feminists have pointed out, dualistic thinking has resulted in us having:

‘learned a great deal about the development of autonomy and independence, abstract critical thought and the unfolding of a morality of rights and justice in both men and women. We have learned less about the development of interdependency, intimacy, nurturance and contextual thought’ (Belenky et al 1986: 6-7)

Relationships have been largely replaced by professionalism for midwives and choice and control (rights) for women, as if midwives are interchangeable. It is this issue that I turn to next.

Disappearing relationships through ... choice ...

Choice is located within the ‘power/knowledge system of obstetrics’ (Murphy-Lawless 1998a: 231). As sociologists, midwives and others have pointed out, women make choices that are already limited by intersections of ideology, resources, class, race and other factors, to a predetermined, medically-oriented menu, over which they have little control to define or change (Browner and Press 1997, Cartwright and Thomas 2001, Kitzinger 1990, Lazarus 1997, Mander 1994, 1997, Mason 1998, Wagner 1994). Not only are choices limited by obstetric regimes, but also, making choices about these is largely meaningless when women are likely to have little understanding about or control over the value systems on which these are based⁶⁰. They are denied knowledge about technological and pharmacological interventions, which Bridget McAdam-O’Connell (1998) suggested is ‘in the realm of professional or specialist knowledge’, leaving them ill-informed or mis-informed (22). In other words the knowledge/information on which choice is based is embedded in medical ideology and therefore tends to reinforce that ideology⁶¹. Even where there is a commitment to information and choice, Elizabeth Smythe (1998) found that women might be encouraged to make their own decisions until there was a decision to be reached about which the midwife felt strongly (173). The medical definition of safety means that while minor choices exist, conceptual choices cannot. As Shelly Romalis (1985) pointed out:

⁵⁹This recalled to mind a particularly stark example which left a woman feeling rejected and puzzled. She had found it difficult to engage midwives in positive discussions about birth, but at an antenatal visit noticed that her midwife was pregnant. When she attempted to engage her in conversation about their shared experience of being pregnant, she was rebuked and told that the midwife was there to discuss the women’s pregnancy only (Edwards and Sullivan 1994 unpublished interview).

⁶⁰So the assumption by liberal feminists that increasing choice is good for women and enhances their perception of control, conflates choice and control. Radical and socialist feminists see choice for what it is: ‘a social construction that makes people feel free even in the context of oppression and supports the status quo: capitalism and patriarchy’ (see Gregg 1995: 27).

⁶¹Bernike Pasveer and Madeleine Akrich (2001) suggest that choices are inscribed in the body: ‘Bodies are trained, or educated, and during that process they become “loaded” with experiences and competencies that match the trajectories designed for them (232)

'The "final say" clause in the doctor-patient contract is negotiated relatively early in the pregnancy relationship. "You can have your baby any way you like as long as you understand that I must step in when the safety of you and the baby is involved' (190)

As cross-cultural analyses demonstrate particularly clearly (Davis-Floyd and Sargent 1997, DeVries et al 2001), choices are constructed in line with what others want and expect women to choose based on networks of power, knowledge, and resources. For example, in some cultures home birth is an almost impossible "choice", whereas in others it is almost impossible to "choose" anything else. There are striking variations even within Britain that I referred to on page 20, depending on how available an option it is seen to be and how far it is supported by midwives and other practitioners. Women apparently make different choices in different areas or hospitals serving similar populations (Green and Coupland et al 1998) and David Machin and Mandy Scammell (1997) demonstrated the irresistibility of the medical model in hospital during labour. Sheila Romalis' (1985) research in Canada confirms that choice is constructed by medicalisation and the influence of practitioners and that 'when the doctor is reluctant, drags his feet, or does not heartily encourage innovative practices, most patients will hesitate to take the initiative' (194)⁶².

When different ideologies exist, 'there is no necessary relationship between choice and control' (Green and Coupland et al 1998: 19). Choice, information and control are mediated by relationships. Relationships cannot be disappeared through choice. And even when women are well informed and know their rights, most women will not make "choices" that antagonise their carers (see page 249 for example). As Elizabeth Smythe (1998) confirmed:

'no choice is a free choice when others have feelings, beliefs and values about the choice that is made. The choice becomes much more than 'will I do this or that'. It is about 'will doing this bring other consequences with it, will it harm a relationship, will it offend, will it create barriers to on-going help?' (232).

This is a very different reading to that of medical choice where rationality and equality exist unproblematically and uniformly, and power differentials remain unacknowledged within the narrow boundaries of the medical encounter (Shildrick 1997: 84).

The rhetoric of choice is also deeply embedded in far more limiting modernist discourses. Deconstructing hierarchical, dichotomous pairings, Margrit Shildrick (1997) demonstrated how women are excluded from "reason", occupying instead, its inferior partner "emotion" and are thus excluded from modernity's moral agency. Choice does not require moral agency and thus excludes moral decision-making. Choice does not provide an adequate forum for women to make responsible, moral decisions, and yet no other forum exists⁶³. I return to these theoretical issues in Chapter 5 and again in Chapter 10 in the light of the women's accounts.

⁶²There are a variety of investments in steering or manipulating women towards certain choices and various means to accomplish this (Levy 1999, Lukes 1974). Regarding place of birth this can be seen in past medical literature, where it was suggested that women should be dissuaded from planning home births, and only if they are insistent should the practitioner finally agree to her plans (Day 1993). Another view suggests that hospitals and birth centres should be made attractive enough to appeal to women and thus circumvent the home birth issue altogether (BMJ Correspondence 1981). Seldom mentioned are the possible effects of attempting to remove a choice that some women feel strongly about (Zander 1981).

⁶³Shildrick's (1997) reading of ethics and medicine enabled me to look at health care and the bodies within it in different ways and clarified why professionals and women might see birth and their responsibilities differently. It highlights how the medical model is shaped by culture, power and politics, as I discuss in Chapter 10.

... and communication ...

The communication discourse has entered the field of childbirth, as it has in other areas of medicine and elsewhere. It is portrayed as a neutral bridge between information and choice. The location of communication in networks of power remains unacknowledged, to the extent that it is often assumed that differences in opinion between professionals and women are due to lack of understanding on the part of the woman (Kitzinger 1990: 109) which can be resolved by better communication. The resulting control and manipulation remains hidden. For example, Roseline Barbour (1990), suggests that some men attempted to act as advocates for their partners, 'one expectant father told me: 'We've come to see the consultant about Helen being induced and, frankly, it'll be over my dead body.' Both this man and another attending for the same reason later revealed that the inductions were to take place as the doctor had satisfied them with the medical explanation he had provided.' (203).

... using birth plans ...

The birth plan is part of the communication/choice package. It was initially developed by the Association of Radical Midwives in response to women's unsatisfactory experiences of birth, where lack of continuity meant that women were unable to discuss their views with professionals beforehand. The attempt to regain some control reflected some midwives' concerns about medicalisation and women's desires to have normal births, as well as the need for some authoritative mechanism for communication outwith relationships. However, while the birth plan was initially in the hands of women in the form of a 'letter to the midwives', most hospitals responded by producing their own limited birth plans, once again regaining control over choice. There were indications in the research literature, that the birth plan has been appropriated by medical ideology as another mechanism for aligning women's choices with localised practices and policies, and that those women who hold the strongest views and attempt to assert these are least likely to be supported in their plans (Green and Coupland et al 1998, Jones et al 1998).

... to gain control

While choice and control are disconnected through the coercive nature of choice, choice and control are related in medical ideology through information: 'Information is in many ways a pre-requisite for 'external' control since having adequate information forms part of the basis upon which decisions can be made' (Green and Coupland et al 1998: 178). As I suggested above, whatever women had wanted prior to labour, medicalisation is irresistible and furthermore, most were convinced that what had happened was in their best interests (Green and Coupland et al 1998, Holloway and Bluff 1994, Machin and Scamell 1997, Shapiro 1983).

Wendy Trevathan's (1997) comment that 'only in rare circumstances can a woman act and behave exactly as she wishes during the birth process' (80) because social norms will usually decide where and how the woman gives birth, what "artifacts" will be used, how she behaves and who receives the baby, sounds a note of caution about the meaning of control and how free women are to exert it. It fragmented its meaning into a number of components (Green and Coupland et al 1998, Kitzinger 1990: 107-108) which collected around internal (self) control and external control of the environment. The notion of self control arising in part from the fear of disorderly bodies, led to psychoprophylactic techniques (see for example Wright 1964) which ensured compliance. This was transformed by natural birth discourses which espoused a more complex version of self control through attunement with bodily processes: following one's instincts and simultaneously letting go. External control over what is done by others to the self (Green and Coupland et al 1998) and the environment was seen as crucial: 'le controle sur mon environnement, ca permet d'etre plus secure'

(control over my environment allows me to be safer) (Lemay 1997: 92-93). I discuss the meanings of control through the women's accounts on page 281.

When control is infused with the values of dominant ideologies, women must attempt to take control from a position of subordination and relative powerlessness (Murphy-Lawless 1998a: 249). Curious sequelae ensue. For example, Jo Green, Vanessa Coupland and colleagues (1998) found that women wanted to be active decision-makers and wanted control over what was done to them (64-65), and that 'feeling in control is central' to their experiences (160). At the same time, they noted stereotypical views of and hostility towards women wishing natural births (19), which reconstructed the usually positively viewed, well-educated, well-informed woman, as problematic (24). Acts of control by professionals were particularly noticeable towards women who were deemed to have the strongest views: they were most likely to receive the opposite of what they wanted. The researchers suggested that 'the extreme (sic) views of these women were seen as irrational by staff and provoked an anti-reaction' (128). Similar findings (Jones et al 1998), mentioned above, associating the use of birth plans with a greater likelihood of interventions, and Diana Scully's (1994) findings that doctors expect to be in control; like compliant women who share their backgrounds and values; and dislike women who they experience as non compliant, questioning or "difficult" (91-93) are suggestive of the deeper structures of violence in which normalisation is maintained (see Chapter 10). As Scully observed, this affected the treatment of the women in their care: those who were seen as difficult tended to be ignored or even cruelly treated (130-136). Yet male-based assumptions about control and the stereotype of 'high control women' attempting to "dictate" has been refuted (Green and Coupland et al 1998: 81). On the contrary they showed:

'a picture of women who are relatively active rather than passive, who see the birth as their responsibility as well as the staff's, who have a fairly clear idea of the sort of delivery they want and who see involvement in decision-making as a necessary pre-requisite for achieving this' (152).

This is more akin to feminist debates about decision-making (Belenky et al 1986, Gilligan 1985), which showed that women place emphasis on relational ways of information gathering and discussion based on mutuality rather than control (see Chapter 10). This was highlighted by the women in my study who challenged the need for control during labour and birth but recognised the paradox, that going with the flow usually meant going along with the flow of dominant ideology.

The polarisation between home and hospital birth has led to assumptions that boundaries can be drawn between external and internal control and that the former exists at home rather than in hospital: 'it is this external sense of control which is most likely to be experienced as lost immediately a woman enters the hospital institution. Hence, for some women maintaining control may mean having their babies at home' (Green and Coupland et al 1998: 19). The different basis of the relationship between woman and carer enables her to be in control at home: 'The social relationships between the childbearing woman and her carers are different when the birth occurs in the woman's home, where she is in control and her carers are guests (Campbell 1994: 4) and when they give birth at home, 'they own the whole shop and can be in charge of the whole enterprise' (Martin 1987: 143). The debates and comparisons about control are based on a (realistic) dichotomous view of control in the home in relation to experienced or perceived lack of control associated with institutionalised birth. The women in my study suggested a more complex relationship between internal and external control, and the control assumed at home was relative rather than absolute. As Maggie Banks observes, women may indeed only be 'truly autonomous' at home, but '[w]hen one hears [home birth] women talk of "I had to ..." or "they made me ..."' (2000: 214-215), this is clearly not the case.

Moving beyond the home/hospital dichotomy lies at the heart of moving beyond the current polarised debates, which place hospital and home birth at the centre of the divide between medical and social meanings of birth, where medicalised meanings take precedence. The attempt to fuse them through the rhetoric of choice, communication and control may result in the hospital being brought into the home, as I discuss in my analysis.

In summary, one of the problems facing women and midwives is, 'the difficulty of contesting the scientific approach, for it is a deeply privileged one, deeply embedded in our culture. Therefore to stand outside that rational order may be a virtual impossibility. On the other hand, we must try to identify the sites where women can work to develop alternative definitions' (Murphy-Lawless 1998a: 45). In a similar vein, Kirsi Viisainen (2000a) points out that while feminist research has attempted to bring issues of concern to women onto the research agenda to shape another view of childbirth it simultaneously shows 'how deeply influential medical thinking has been on the western understanding of childbirth' (53). My understanding of the literature suggested that a strong alternative body of knowledge is lacking. This is not to say that it is not there or needed, but that it lacks visibility, coherence and authority.

As I gained understanding that I and the women in my study are constructed by and construct the discourses, this thesis became a way of deconstructing the dichotomies of modernity through the reconstruction of a series of coexisting ironies, causing tension and resisting closure. My next chapter therefore examines some of the issues pertinent to the construction of knowledge and how the construction of the individual in its social context and the ability to resist dominant meanings is implicated.

CHAPTER FIVE – Continuing the debates between feminisms and postmodernism: Who can know what, on what grounds, or can anyone know anything?

Introduction

My partial deconstruction of knowledge in Chapter 3 gave me a sense of what could no longer be taken for granted. It became clear that deconstructing knowledge had wider implications than those I had considered. Implications which I needed to examine in order to analyse my interviews with any authority (albeit partial/situated authority). In making claims, not necessarily grand claims, but claims all the same, I needed to know for both myself and the reader on what grounds I was making these claims and what I might be including and excluding in the process, so that once again, the reader could make her or his own decisions. But to return to the immediate issue; not knowing the level of partiality in one's work does not make it any less partial - but can promote a false sense of authority. I thus adopt a more fully-fledged deconstruction and (partial) reconstruction program.

In this chapter, I therefore explain how I attempted to follow the feminist/deconstructive project as far as I could, in order to understand the women in my study as best I could, and in order to clarify the processes of knowledge production specific to this particular piece of work. It may initially seem too abstract and irrelevant to continue these theoretical debates. But contrary to what some feminists see as a widening gap between philosophical concerns and debates and empirical research (Stanley and Wise 1990), I found that these debates were crucial to furthering my understanding about what the women told me about their experiences of planning home births. It was this continual movement between theory and the women's accounts that provided me with: a deepening sensitivity to their articulations; the confidence to follow them more closely; and more knowledge about how subjects are formed and re-formed in historically specific locations. In short it gave me a greater understanding about the complexities of emancipatory feminist politics and some of the underlying philosophical debates, which influence women's experiences both internally and externally (see Chapters 10 and 11).

I begin this exploration by considering traditional meanings of epistemology and some of the challenges to this. It seemed that some of the debates in Chapter 3, that challenged epistemic norms and exposed androcentricity, could provide a different sort of basis for knowledge and its (partial) authority. Because women's experience is central to knowledge production in feminist work, I look at what this means in the light of feminist and postmodern debates. This necessarily includes other aspects of experience such as subjectivity and language (voice). Finally I consider how the basis for knowledge could be expanded to include the muted partner to objectivity's reason, and could become embodied and impassioned as well as intellectual.

Knowledge

Epistemology (or can women know?)

While it may be common sense to accept that women know, it is clear from the previous chapter that midwives' knowledge was severely undermined and considered irrelevant to modern obstetrics, while women's knowledge was not even a consideration. Stark examples from Ann Oakley and from my own experience left no doubt as to the problematic nature of women's knowing:

'Doctor: (reading case notes) Ah, I see you've got a boy and a girl.

Woman: No, two girls

Doctor: Really! Are you sure? I thought it said ... [checks in notes] oh no, you're quite right, two girls.' (Graham and Oakley 1981)

My own experience of accompanying a woman to a gynaecological appointment gave a similarly stark example. As we sat alone in a waiting area, a nurse appeared and called for Mrs. Brown. She returned some minutes later and repeated her call for Mrs. Brown. Finally as we remained seated, she approached us, and asked if my friend was sure she wasn't Mrs. Brown. These examples are not aberrant, isolated examples, but symptomatic of the erasure of women's knowing. They confirm a body of feminist research and theory which is suggestive of a number of different issues: that women and professionals may be working from different knowledge bases, that women's ability to know is doubted, and that knowing itself may be relational - often to do with the encouragement or hostility to that knowingness (Belenky et al 1986, Jordan 1977). It seemed that in the face of other forms of (dominant) institutionalised knowledge, giving voice to women would inevitably be problematic. As Stephanie Brown et al (1994) point out, this is still not accepted in many quarters. In their discussion about women's experiences of motherhood and postnatal depression, they appealed to research showing women's high recall of past experiences of postnatal depression to claim authority for the accounts of the women in their study.

Given the marginalisation of home birth and the potentially challenging nature of what women might say in my interviews, it was likely to be even more problematic. In privileging the mind over the body and rationality over emotion in hierarchical pairs, 'classical thought thus controls the parameters of what constitutes knowledge and monitors the extent and kind of discourses that are allowed to circulate' (McNay 1992: 13). This mutes but does not erase the role of experience and emotions (Griffiths 1995). I therefore needed to provide a framework in which women could be speaking, knowing, and believed. This does not necessarily mean privileging experiential accounts and abandoning theory or my own critical faculties, but believing that women's accounts have their own authority and are as authoritative as other accounts. They form part of a tapestry of knowledge.

In the last chapter, I described the move from social to medical birth, obstetrics claim to authority over birth, and its redefinition of birth as a medical problem in which a woman was only implicated by being the physical container of a baby. As already mentioned, her experience and views about labour are extraneous and therefore irrelevant (Murphy-Lawless 1998a: 211), to the extent that her bodily experiences can be denied, even when she knows she is about to birth her baby (Jordan 1997) or has chest pains (Burt and Code 1995: 34). This is highlighted in the 'Dunne' case, in Ireland where the woman's experience of her labour (which suggested to her that all was not well) played no part in the subsequent court proceedings (Murphy-Lawless 1998a: 220), showing how women's knowledge is systematically erased from obstetrics and the wider social networks. Women fall outside the production of knowledge in what can be described as 'radical silencing' (Murphy-Lawless 1998a: 223) - but of course, as Michel Callon and Bruno Latour (1981) suggest, 'black boxes' are difficult to seal indefinitely (285).

Feminist challenges to modernity's epistemology: Is rationality the only contender?

Modernity's epistemology has been isolated, with objectivity its only companion. Here, objectivity is based on rationality and vice versa. Discourses of male reason have linked knowledge production to objectivity as defined by male, rational knowers. This sort of epistemology privileges 'knowing that' rather than 'knowing how', and that S (the knower) knows that p (the known), where only p needs to be examined. This assumes the 'view from nowhere' in which the act of knowledge production is 'neutral' (Code 1993: 17, Dalmiya and Alcoff 1993). A hallmark of feminist (and other) critical methodological theories has been the awareness that S as well as p must be brought into the field of enquiry and that 'the researcher's understandings are necessarily temporally, intellectually, politically, materially and emotionally grounded and are thus as specific as those of the researched' (Stanley and Wise 1990: 23). Hence, the subject and object of study are not fundamentally different, as both are shaped by social forces (Harding 1993: 65).

Two broad feminist/postmodernist critical projects have been to; deconstruct objectivity and recast it to produce situated knowledges from situated material positions (Haraway 1988, Nicholson 1999); or to abandon the notion of patriarchal objectivity in favour of subjectivity (Poovey 1988). These issues arose in my discussion about empiricist and standpoint feminist theories in Chapter 3 on pages 28 and 29. To go a little further, while epistemology underpins what counts as knowledge and how knowledge can be acquired, feminists asked whether or not ‘subjective truths’ qualify (Harding 1987: 3). Opening up the debate further, Mary Maynard and June Purvis (1994) suggested that epistemology asks ‘who knows what, about whom and how is this knowledge legitimated?’ (18). Louise Alcoff and Elizabeth Potter (1993) made the general suggestion, that feminist theorists have applied the term “feminist epistemology” ‘to refer to women’s “ways of knowing”, women’s experience or simply “women’s knowledge”’ (1).

The feminist debates discussed above move beyond the dichotomous objectivity/subjectivity basis of knowledge, destabilise rationality as the only producer of knowledge and by legitimately expanding the epistemic field, expand the arena from which knowledge can be constructed. Vrinda Dalmiya and Louise Alcoff (1993) suggest that ‘contemporary epistemology needs to recognise that knowledge can be found in unexpected places’ (241), thus making visible and legitimising the exploration of the possible existence of other sources of knowledge¹.

Moving beyond dichotomous thinking disintegrated boundaries, to create spaces for women’s experiences². Uncovering “emotion” as the oppressed partner of “reason”, for example enabled feminist researchers; to acknowledge emotion in the research process, thereby acknowledging the ‘experiential aspect of method’ (Williams 1993: 578); to question the use of vision as the ‘primary route to scientific knowledge (Martin 1990: 69); and to discuss ‘gender-specific experiential knowledge (Dalmiya and Alcoff 1993: 229). This brought in the possibility of not only expanding the epistemic field in terms of where knowledge could be found, but also expanding the ways in which it could be produced, from the limitations of rationality, to involving any and all of the senses.

Feminism has been instrumental in pointing to the authority of women’s accounts. It has been possible to develop frameworks and epistemological theories in which these are central, but not exhaustive. A combination of feminism’s commitment to women (in all their diversity) as subjective producers of knowledge, and postmodernism’s commitment to destabilising the grounds on which that knowledge is based begged questions about the notion of experience, subjectivity, language and voice at the very least. I had already directly appealed to the notion of voice(s) in the discourses in the first part of this thesis. As the foundations for this appeared to slip away, it would have seemed inadequate on my part not to have at least attempted to find some acceptable resolution (or non resolution) by continuing to pursue the debates between feminisms and postmodernism. In fact the explorations I carried out finally helped me to move beyond this dichotomous resolution/non resolution to one of “becoming”.

Communities of knowledge production

The sequelae to this sort of thinking includes bringing women’s ways of knowing onto the agenda and examining so called scientific, medical knowledge in the light of this; looking at the interplay

¹As Mavis Kirkham pointed out to me (2000, personal communication), the authors could have added that these ‘unexpected places’ are only ‘unexpected’ in terms of dominant ideology and its accepted locations from which knowledge arises.

²In examining this dichotomy in the light of feminist postmodernist debates, I came to understand that in examining the muted partners in dichotomous thinking, both terms collapsed into new meanings. For example, Morwenna Griffiths (1995) demonstrated that the self is created through the experience of emotion as much as reason (120) and that public and private decisions cannot be made in isolation (142).

between their knowledge, midwives knowledges and medical discourses; and bringing the researcher and researched into a more democratic, relational way of being, so that knowledge production becomes interactional, communal and relational, rather than individualised and unidirectional. In contesting the boundary between researcher and researched and respecting women as knowers, all actors become part of the production of knowledge (Code 1993) so that as Liz Stanley and Sue Wise (1990) suggest, 'the known are also knowers, research objects are their own subjects; objectivity is a set of intellectual practices for separating people from knowledge of their own subjectivity' (11).

This leads to a further challenge. Feminists have pointed to the implausibility of 'epistemological individualism' (Nelson 1993: 393) which modern philosophy has been committed to (Potter 1993: 161). Both Lynn Nelson and Elizabeth Potter suggest that it is not the individual who alone produces knowledge through observational and mental processes: knowledge is constructed by epistemic communities against a context of previous knowledge and the situatedness of these communities (Nelson 1993: 141, Potter 1993: 162). Potter urges us to acknowledge knowledge production as a communal, social affair, so that we may see 'the ways in which the politics of gender, class, and other axes of oppression are negotiated in the production of knowledge' (165). This is clear in Jo Murphy-Lawless' (1998a) critique of the development of obstetric knowledge and in Thomas Kuhn's (1970) notion of the construction of knowledge and its relative factual indeterminacy. This dialogic approach enabled me to weave the individual women's narratives into a rich tapestry of meaning. Without the concepts of dialogue and diversity I may not have seen women's alternative readings of birth so clearly.

Feminist theorists have suggested that not only is knowledge produced through dialogue, but that the environment in which dialogue occurs impacts on knowledge. Brigitte Jordan (1977) showed that women were more or less likely to know whether or not they were pregnant depending on the expectations of their ability to know or not know, suggesting that women's knowledge can be muted or fostered depending on the regime in which it is sought (Belenky et al 1986). I consider this in terms of relational knowing.

Relational knowing

The branch of feminism which provided the ground breaking work on women's ways of decision-making (Gilligan 1985) and knowledge construction (Belenky et al 1986) and paved the way for an 'ethics of care' has been criticised for locating its work in hierarchical, linear developmental patterns (Debold et al 1996, Nicholson 1999). However, this work suggested that women are disadvantaged in the knowledge stakes because of the established male styles of relating, prevalent in the formal institutions through which knowledge is provided and acquired. They raised the possibility of different forms of knowing and epistemology that included complexity, ambiguity, relational ways of interacting, intuition, responsibility, compassion and spirituality. Mary Belenky and colleagues (1986) found, for example, that women expand their knowledge through relationships, life events and community involvements, and that formal education often remained peripheral (4)³: knowledge based on voice (relational) metaphors, rather than the visual (distancing) metaphors of (male) science and philosophy (18).

³However, like Gilligan (1985), the pathways of knowledge acquisition they described, were not unlike those of Perry and Kohlberg (see Nicholson 1999) They moved from silence (where women perceived themselves as unable to give or receive knowledge), to received knowing (where women looked to "authorities" to provide them with knowledge), to subjective knowing (where women listened to their own private inner voice), to procedural knowing (which acknowledged the 'voice of reason'), to constructed knowledge (which was seen as the most integrated form of knowing: 'weaving together the strands of rational and emotive thought and [...] integrating objective and subjective knowing' (134).

Though the authors acknowledged its specificity, this earlier work based on feminist standpoint and difference theory was less able to talk about the context in which women developed ways of thinking and being. More recent work with girls and young women by Elizabeth Debold and colleagues (1996) took a postmodernist feminist stance, which acknowledged power relations, destabilised unitary identity, and provided a different interpretation about how and why women may adopt relational, caring stances. They suggested that women may have multiple knowledge positions which are rooted in gaps between their own knowledge and authoritative knowledge and that the “less developed” knowledge positions defined by Belenky and colleagues (1986) may in fact mark resistance to external authorities:

‘Girls’ conflicts between their own experience and their increasing knowledge of cultural expectations at early adolescence may lead them to give up on developing methods for knowing (that is, procedural knowing), and in so doing, either accept what authorities say as true (received knowing) or to attempt to hold onto a personal truth (subjectivist knowing)’ (Debold et al 1996: 95).

This challenged any notion of hierarchical, developmental frameworks (95) and located women’s development of knowledge, morality and responsibility in complex and diverse responses to unavoidable dominant forces. The ‘self, or subject becomes divided against its self through an incorporation of knowledge that functions as a form of power’ (87). Hence:

Women’s struggles with hegemonic representations of development can be seen as both their resistance to authorized cultural power relations and their embeddedness within a system of power that historically has excluded the female from reason’ (94)

So while Belenky and colleagues (1986) suggested that women’s ways of thinking and being are more flexible, and more able to sustain ambiguity and complexity, the work by Debold and her colleagues (1996) suggested that women have no choice, if they are to retain any sense of authenticity regarding their own experiences and that fractures will necessarily occur between thought and action, which are more to do with oppression than women’s psychology⁴.

Theories of knowledge inevitably coexist. They are far from uniform and have not developed in linear fashion (Code 1993: 17). As Linda Nicholson (1999) suggested, homogeneity is not a feature of society, and ‘even when certain patterns become dominant, older patterns linger and interact with the newer patterns to form hybrid phenomena’ (6). The ‘hybrid’ between modernity and postmodernity has been appealed to by feminists who reject the values of modernity and the apparent lack of value of postmodernity. For example, Lorraine Code (1993) argued for contextualising knowledge production, but retaining some concept of reality (21) and Lois McNay (1992) suggested retaining some normative values. The question is, whose reality and which norms.

In developing her own work in this area, Linda Nicholson (1999) located these arguments as part of the legacy of modernity whereby ‘we have inherited both the idea that culture changes and the idea that constructs that rise above such changes are possible’ (9). Rather than appealing to Lyotard’s small scale, local narratives, or retaining vestiges of foundationalism, she suggested focusing on the historical and social situatedness of any claims, and the reconstruction of rationality as open,

⁴Michelle Fine and Susan Gordon (1992) remind us that ‘contextualised research is necessary to unearth women’s psychologies, as they reflect, reproduce, resist, transform social context, hegemonic beliefs and personal relationships’ (3), but that while women change, the structures around them remain relatively unchanged. Feminist psychology has sometimes slipped into individualism and psychologism, so that problems appear to lie in women rather than in oppressive regimes. This individualises life stories and fails to situate them within the powerful structures, which shape that very psychology. It was on this basis that I attempt to provide a theoretical account of the women’s experiences in Chapters 8, 9 and 10.

inclusive and continually “becoming” (9-12), not unlike Donna Haraway’s (1988) reconstruction of inclusive “objectivity”. This included an acknowledgement of experience as a central concern to knowledge generation.

Deconstructing and (partially) reconstructing experience

As I suggested on page 28, there appeared to be overall agreement that feminism ‘generates its problematics from the perspective of women’s experience’ (Harding 1987: 7). As feminists focus on women’s experiences, to produce challenging accounts and theories, we need to be able to say more about what this means, how experience interacts with or challenges accepted knowledge, how it might generate new knowledges (Maynard and Purvis 1994) and how it interacts with theory or culture. Feminists such as Liz Stanley and Sue Wise (1993) took a clear stance on the key role of women’s experiences and the need to examine the wider structures of society from the basis of women’s everyday experiences (63). They suggested that

‘the essence of feminism for us is its ideas about the personal, its insistence on the validity of women’s experiences and its arguments that an understanding of women’s oppression can be gained only through understanding and analysing everyday life, where oppression as well as everything else is grounded’ (136).

In the light of postmodernism, it seemed important however to consider some of the challenges and limitations to privileging experience, and build in the same situatedness or partiality that I have attributed to other aspects of knowledge production. Without a degree of fluidity between experience and theory, there is no space to examine how each informs the other. As Sasha Roseneil (1996) pointed out, privileging experience inevitably leads to closure - ‘discourse is produced by actors and is at the same time productive of those actors’ (88). This notion was further developed in Joan Scott’s (1992) postmodernist critique of experience which warned against any simplistic, foundationalist acceptance of experience - ‘experience is at once always already an interpretation and is in need of interpretation’ (37).

In accepting that there is no such thing as ‘raw’ experience and that experience is contextualised and discursive (Maynard and Purvis 1994: 24), I could no longer allow experience to speak for itself. Sandra Burt and Lorraine Code (1995) capture the fine line feminists (and others) attempt to tread between ‘the old tyranny of authoritarian expertise that discounts women’s experience and a new tyranny of “experientialism” that claims for the first-person experiential utterances an immunity from challenge, interpretation or debate’ (36)⁵. Thus in the same way that experience is filtered through culture:

‘subjects are not attributed authenticity outside (dominant) culture. Instead, we can present them as finding ‘their voices’ within and through the network of meanings made available to them, including where they resist the dominant meanings ascribed them’ (Alldred 1998: 161).

Following up debates in Chapter 3 about the status of the experiences of subordinated people, and returning to the issues raised by Maynard and Purvis, and Scott above, if experience is constructed, how is it constructed? I raised the possibility of discourses being partially internalised, in the section

⁵An interesting example of these debates comes from research with women assembly workers by Miriam Glucksmann (1994), when she realised that the experiential accounts of these women provided them and therefore her, with only partial (contextualised) knowledge of their situation. It was only when she was able to research beyond their part in the work process that she was able to bring valuable interpretations to their experience – i.e., that part of their subordination was embedded in their own partial knowledge of the work process itself. Here theory and experience combined to provide a more complex, useful explanation of women’s subordination, than experience alone could have done.

on 'Focusing on women' on page 45 and Wendy Trevathan's comment on page 75 suggested that birth and birth practices are socially constructed. This interaction between experience and culture has been discussed by feminists. For example, a detailed analysis of Ann Oakley and Sheila Kitzinger's accounts of women's birth experiences, by Tess Cosslett (1991, 1994) identified how women internalised popular discourses. This suggested that the natural birth discourse (the 'female oral tradition'), as well as the 'medical expert tradition' could obscure women's experiences ('old wives tales') (Cosslett 1991: 228). Tina Miller (1998) made similar observations about the internalisation of cultural norms and suppression of experience from her research on childbirth and motherhood. Her distinctions included 'public' (professional/medical knowledges and practices) and 'private' (informal, lay knowledges) and 'personal' (as sense of *self*) in an individual's account' (66).

While medical discourses hold greater currency, and there are therefore power issues not dealt with in Cosslett's analysis, she raised the issue of how women's experiences may be shaped by competing discourses, which oppress individual experience. This was useful in raising my awareness that home birth has often been linked to assumptions that may obscure some women's views. The potentially powerful role of the researcher in constructing her own knowledge from other's stories is clear (Devault 1994) and in the same vein, Ann Opie (1992) urges us to approach research with 'an awareness that all ideology can obscure as well as enlighten' (66). As Drucilla Cornell (1995) pointed out, our assumptions, both as researched and researcher cannot be underestimated or even known, as we 'can never know the level to which we have internalized and identified ourselves with the available images of Woman' (97). Marjorie Devault (1990) suggests how to listen to women's attempts to articulate different meanings, which I consider in the interview section in Chapter 6.

Meanwhile, in putting experience through the feminist/postmodernist lens in an attempt to provide a situated subjective, yet authentic account: subjectivity, as the subject of that experience; language which articulates that experience; and bodies which are the matter of that experience need to be considered. I focus on subjectivity and voice next, language in the next section, and then corporeality.

Deconstructing and (partially) reconstructing subjectivities and voices

Liberatory feminist research and theories have relied on some kind of notion of the knowing and active subject. Debates tended to focus on how knowing and active subjects women can be, rather than on the historicity, specificity or instability of the subject itself⁶. Critics (Nicholson 1999) pointed out that Carol Gilligan's (1985) construction of women's moral development and Mary Belenky and colleague's (1986) theories of women's knowledge development suppress different voices and subjectivities. For example, Linda Nicholson argued that while Lawrence Kohlberg's theory of moral development reflected a modern, liberal, western, male world view (23) Gilligan's more cautious theory of women's responses to moral dilemmas still represented a failure to acknowledge the developmental/historicity of her claims, or the complex relationship between societal structures and gender: 'to assume that these responses are progressively more moral is to normalise the circumstances and responses of a particular social group' and 'any abstractions that cuts the human voice into two, although certainly representing a vast improvement over those abstractions that construed it as one, are much too limited' (28).

The development of feminine ethics of care and responsibility were influential in mapping out women's ways of being,, but as Nicholson and others (Shildrick 1997: 122, Flax 1990: 52) suggest,

⁶But, as I discussed on page 33, the apparent death of the subject, along with other postmodern deaths was seen as equally problematic by many feminists. Feminists who have engaged with postmodernism suggest that internalised thought patterns may obstruct moving beyond dualistic thinking.

it can easily slide into essentialism. It fails to take into account that gender is constructed in particular ways and that the "feminine" (i.e. difference) has been at least partially constructed by its place within mainstream/dominant discourses (Di Stefano 1990: 71)⁷. This deconstruction enabled me to hear the women in my study voice their different ethical/moral positions. Morality becomes more of a circumstantial process than based on fixed standards of right and wrong, where rationality is one of a number of components in decision-making (Shildrick 1997: 123).

Judith Butler (1995) made similar suggestions, by retaining some concept of the active subject which acknowledges its situatedness and discursive construction. Retaining a reconstructed 'I', like Nicholson, she suggested that the 'critique of the subject is not a negation or repudiation of the subject, but, rather, a way of interrogating its construction as a pre-given or foundationalist premise' (42). Thus the subject is both constructed and constructing. It has more in common with some of the French feminists notion of 'becoming', rather than pre-existing⁸. But as Margrit Shildrick (1997) suggested, deconstructing subjectivity and appealing to diversity need not rule out the possibility that individual women 'have sufficient similarities to make their conjunctions significant and meaningful' (133). Indeed, as I suggest, this is where the strength of my analysis resides. The fluidity and "becomingness" of the subject opened up possibilities for multiple voices and provided a framework not only for multiplicity between the women in my study, but provided a way of hearing multiplicity within or between interviews with the same woman⁹. This enabled me to avoid slotting women's views into neatly packaged theories and closing gaps through which their lived experience struggled. As their voices danced more freely, I was able to hear coherencies, discrepancies, ironies and contradictions, which forms the rich weave of experience. In other words, modernity's subjectivity mutes certain voices within the subject and arranges voice hierarchically in relation to rationality. Other voices are seen as contradictory, non consequential or distracting in an effort to provide a coherent, rational whole¹⁰.

However, the tendency towards fragmented, free floating voices and subjectivities in this sort of analysis needed to be considered. For example, Susan Greenwood (1996) identified a search for wholeness and identity among the women she worked with, which was in 'stark contrast with the postmodern fragmentation of the self, where the subject is heterogeneous, decentred and never whole' (109-110). The search for wholeness was a feature of my interviews. Part of the meaning of home birth was to do with continuity and wholeness and a rejection of the discontinuity and fragmentation associated with medicalisation and hospitalisation. But the fluidity of subjectivity is only incompatible with fixed rather than transient "wholeness"¹¹. Thus one of the tasks of postmodernist feminism is not only to move beyond dualistic thinking, but to see both the uses of and the linkages between these dualisms (Nicholson 1999: 43). The notion of historicity and situatedness enabled me to embrace Andrea Doucet and Natasha Mauthner's (1998) eloquently, articulated aim, to balance:

⁷I come back to this in Chapter 9, where ethics of care was evident in the women's accounts, but I continue to examine them in the light of their shortcomings in Chapter 10.

⁸It is at first sight akin to poststructuralist theories developed by Derrida, Deleuze and others, focused on textuality and 'texts', but as I noted on page 34, this is problematic.

⁹This had echoes with Millar Mair's (1977) 'community of selves', and Jane Ribbens (1998) 'voices' where the individual can locate different, even conflicting, internal voices. Also with Diana Meyer's (2000) intersectional identity, where the self is cross-cut by gender, race, etc. While this may suggest that 'personal identity [is] an anachronistic modernist sham' (158), it need not suggest that identity cannot be constructed from complexity.

¹⁰The acceptance of identity through multiple voices is evident in psychology (Mair 1977), and by therapists such as Ronnie Laing (1959) and Michael White (1995). Developing theories from postmodernity on schizophrenia, these therapists attempt to work with voices, rather than suppress them, as has been the practice in most medical psychiatric approaches.

¹¹This kind of transient "wholeness" was implicated in disintegration and reintegration women experienced through the rite of passage of birth (see footnote 48 on page 242), and could be incorporated into theories of becomingness.

'the multiple and varying voices and stories of each of the individuals we interview; the voice(s) of the researcher(s); and the voices and perspectives represented within existing theories and frameworks in our research areas and which researchers bring to their studies' (140).

We can thus acknowledge that we discover as much about ourselves as about our subjects, and yet, as Marjorie Devault (1994) suggests, that there are profound differences between the self and others (3). While the self provides a filter through which other's stories pass, 'they could change me as well, so that my interpretation developed as I came to know them' (3). Her construction of 'speaking up carefully', seemed in keeping with my attempt to maintain a feminist political commitment within a postmodernist framework:

:
'a voice that will be thoughtful and self-reflective - not imposingly authoritative, but clear and personal - the voice of an author who invites others to listen and respond, aiming more toward dialogue than debate. I want to write about others *care*-fully, in both senses of the word, with rigor and empathetic concern' (Devault 1994:3).

One of the main ways we have of expressing voice is through words and language. Debates in feminism and postmodernism about language and textuality, suggested that language is both mediator and mediated. I address this in the next section.

Deconstructing and (partially) reconstructing language

Of particular concern to feminist projects is that language is not only far from neutral, but, 'some have argued that a particular vision of social reality is inscribed in language - a particular vision of reality that does not serve all of its speakers equally' (Ehrlich 1995: 45)¹². Even before the poststructuralist notion that knowledge is mediated through texts, the connection between experience and language and language as a mediating factor was highlighted in feminist writings. In the same way that subjects could be said to be both constructed and critical, Drucilla Cornell (1995) draws on Wittgenstein's description of language as both limiting and expansive, 'one that both gives us our world and yet keeps us from being imprisoned in it' (76).

Dorothy Smith (1987) pointed out that underlying androcentricity alienates women from their experience by imposing male concepts and terms by which women must think of their world (86). 'Man-made' language (Spender 1980) shapes our everyday experiences of this world (Eichler 1988); prevents women putting their experience into words; and poses difficulties in documenting that experience (Devault 1990, Stanley and Wise 1993).

Language is not a transparent naming 'things' (Scott 1992). As Linda Nicholson suggested, words, such as "woman" are contentious, and therefore, to describe, is thus a 'stipulative' rather than a descriptive act, and that 'any claim about its meaning must be viewed as a political intervention (75). This may be particularly the case in relation to childbearing and women's bodies, as the dominant language is medicalised and technical (Martin 1989). As Paula Treichler (1990) pointed out:

'The word *childbirth* is not merely a label provided us by language, for a clear-cut event that already exists in the world; rather than describe it, it *inscribes* and makes the event intelligible to us. We cannot look *through* discourse to determine what childbirth really is, for discourse itself is the site where such determination is inscribed' (132)

¹²Hence the critiques of Rorty's 'conversations' on page 35. His appeal to solidarity and tolerance is not sufficient in acknowledging real differences (Code 1993: 24)

In other words, in appropriating birth, obstetrics developed its own authoritative language, which removes it from, and constructs women's experiences and how they relate to their bodies (Murphy-Lawless 1998a: 54). Despite the internalised language and meanings of obstetrics, other stories can be told (247-250), but this calls for careful investigation about the context in which women think about, decide, describe and act in terms of pregnancy, birth and motherhood. As Pam Alldred pointed out, 'The idea that any ethnographic subjects are free to present their own meanings in any radical sense neglects the ways in which the dominant culture provides hegemonic meanings' (Alldred 1998: 154)

Expanding on Dorothy Smith's earlier point above, and in a similar vein to Judith Butler's view of agency or subjectivity, Susan Ehrlich (1995) proposes linguistic manoeuvrability in 'that languages predispose speakers to view the world in particular ways, but that such a world view is not all-determining' (47). Thus, 'the motivating principle behind critical linguistics is the investigation of the role of language in the reproduction of dominant ideologies' (47-48). In particular, feminist's attempt to find 'new terms to express women's perceptions and experiences, phenomena previously unexpressed in a language encoding a male worldview' (51).

Or as Morwenna Griffiths (1995) suggested, 'language creates us, but is also created by us and [...] descriptions of experience are always revisable' (55).

Exploring some of the debates about language increased the sensitivity of my research. For example, I became more aware of how the women and I used medicalised language, and how they redefined taken for granted terms, that have been adopted into the everyday language of birth, such as "safety" in Chapter 8, "continuity" in Chapter 9 and "control" in Chapter 10. In addition, the debates about language as a cultural organiser brought the issue of oppression and resistance to the fore, and the powerful forces implicated therein. It is to power I turn now.

Power

Acceptance and resistance in context

Having acknowledged postmodernism from the 'edges' in the previous chapters, I pushed the boundaries of postmodernism further as I recognised the need for a philosophical framework, which could embrace the coexistence of women's celebratory, acts of defiance as well as their internalisation of the norms of our day. Feminist standpoint theories seemed inadequate because of their insensitivity to diversity and their limited understanding of the circulation of power within the marginalised/oppressed groups they represent. The women in the study appeared to move between alternative and dominant ideologies and defied being categorised or hemmed in by rigid boundaries. My framework still seemed incapable of incorporating plurality at the level displayed by the women themselves, and seemed unable to acknowledge the intersection of different levels and forms of oppression¹³.

Feminist accounts discuss the constant tension between acknowledging the levels of oppression which women are victims of, and the more celebratory aspect of women's abilities to disrupt these oppressive forces and be knowing, acting, resisting subjects:

'In 'woman-centred' research, women are acknowledged as active, conscious, intentional authors of their own lives. As an ideal this notion of 'woman-centred' research is appealing.

¹³The women's accounts confirmed Diana Meyers' (2000) nuanced critique of standpoint theories, based on intersectional identity. In this reading: 'the trope of intersectional identity dismantles the stark opposition between dominant and subordinate positions', because few people have wholly privileged or subordinated identities (160).

As a description of reality, however, the term 'woman-centred' is not entirely satisfactory because it seems to suggest that women can occupy a powerful authoritative and controlling position in their lives: lives often hemmed in by social arrangements and structured inequalities not of their own making' (Brown et al 1994: 3)

And as Nancy Fraser observed:

'Agency has become a problem in recent feminist theory because of the cross-pull of two equally important imperatives. On the one hand feminists have sought to establish the seriousness of our struggle by establishing the pervasiveness and systematicity of male dominance. Accordingly we have often opted for theories that emphasize the constraining power of gender structures and norms, while down playing the resisting capacities of individuals and groups. On the other hand, feminists have also sought to inspire women's activism by recovering lost or invisible traditions of resistance in the past and present. Under the sway of this imperative, we have often supposed quasi-voluntarist models of change. The net result of these conflicting tendencies is the following dilemma: *either* we limn (sic) the structural constraints of gender so well that we deny women any agency *or* we portray women's agency so glowingly that the power of subordination evaporates. Either way, what we often seem to lack is a coherent, integrated, balanced conception of agency, a conception that can accommodate both the power of social constraints and the capacity to act situatedly against them.' (Fraser 1992a: 16-17)¹⁴.

Jane Cowan (1996) also talked about the dangers of seeing women as actors and not victims. By seeing women as equals we may fail to 'situate women's strategies and powers strongly enough within larger structures of male domination at every level' (65)¹⁵. In other words, while feminism was able to articulate dominance and marginality, it was not always sensitive to the particularities of the power, tending to locate it centrally, or within powerful groups. And yet, as Diana Meyer (2000) remarked, autonomous individuals, do indeed arise from oppressive regimes (152). In explanation, Natalie Stoljar (2000) suggests that while the norms of femininity and other oppressive norms limit rather than erase the capacity for self-reflection and therefore autonomy (106-107). I needed a framework that could locate general patterns of oppression, but which could also locate the specific oppressions, as the women in the study engaged with dominant medical discourses in different ways. Like the women in Jane Cowan's (1996) work: 'Their varying stances were engendered by a complex configuration of factors: age, personality, religious persuasion, religious upbringing, political persuasion, class position and the (negotiable) effect of dominant local codes and meanings.' (82)¹⁶.

¹⁴Picking up on relational knowing and ethics of care that I discussed above on page 81, there appeared to be an added complication. Agency is based in the everyday networks of relationships focused on care rather than on abstract procedures for determining right and wrong (Gilligan 1985). But disagreement is synonymous with conflict, which can threaten the very relationality espoused (Belenky et al 1986: 70). Thus the same relationality that enabled women to expand their knowledge, appeared to restrain their autonomy:

'Even when women held strongly to their own ways of doing things, they remained concerned about not hurting the feelings of their opponents by openly expressing dissent. They reported that they were apt to hide their opinions and then suffer quietly the frustration of not standing up to others. Some women described feeling either petulant, private resentment of others or self-admonishment for being so unassertive' (84)

Although, the women in the 'constructed knowers' group were perceived to: 'balance and honor the needs of the self with the needs of others' (Belenky et al 1986: 151). As I mentioned above, I come back to these debates in Chapters 9 and 10.

¹⁵There is sometimes a tendency to idealise traditional roles and nature and identify them as complementary rather than asymmetrical (Cowan 1996: 66-67). Tradition and nature featured in home birth discourses. Some women identified with this, others attempted to distance themselves from it. The terms 'earth mother' and 'earthy' arose, and women had both negative and positive feelings about this. Feminist/postmodernist constructions of difference as well as similarities are crucial, as it has often been falsely assumed that women planning home births collect around a 'mother earth' polarity.

¹⁶Morwenna Griffiths (1995) describes stereotyping as a powerful exclusionary tactic and Judith Okely (1994) describes how, in her study of gypsies, dominant power and stereotyping converge in a powerful suppression of marginalised others. While identity construction is an important intellectual concern it can be used as a political weapon: 'the rejection of

Postmodernist feminist interpretations of Foucauldian notions of power have identified uneven, circulating networks of power relations. As Zillah Eisenstein remarked, 'power need not be seen as a unified whole to be recognised as having concentrated sites that formulate hierarchical privilege' (1989: 16). Nor does acceptance of this preclude resistance (Shildrick 1997: 94). This enabled each woman planning a home birth to describe her own experience of engaging with those representing authority and enabled me to dialogue with, rather than assume oppression, leaving spaces for resistance and acceptance:

'while some women share some common interests and face some common enemies, such commonalities are by no means universal; rather they are interlaced with differences even with conflicts. This, then, is a practice made up of a patchwork of overlapping alliances, not one circumscribable by an essential definition.' (Fraser and Nicholson 1990: 35)

Material power

Feminist interpretations of power showed that socialisation and normalisation acts directly in/on the body as well as the mind. Indeed, power relations are played out most concretely on the body (McNay 1992: 16) and bodies are 'essential to accounts of power and critiques of knowledge' (Grosz 1993: 196). Using a Foucauldian analysis, David Armstrong (1987) examined the power over bodies exerted by medical surveillance, suggesting the need to study power, 'at the more extreme point of its exercise, for it is at these points that the power is in immediate relationship with its field of application and where it produces its effect' (70). Hence, showing a rash, placing a stethoscope on the chest is 'the stuff of power' (70). In this reading, planning home births was a way of attempting to avoid inscriptive practices which claim and normalise those bodies: being 'strapped up', 'hooked up', 'tied on' and 'held down' for example (see Chapter 10).

But feminist critiques of Foucault's theories of power (McNay 1992) point out that power can be implicated in acts of resistance as well as oppression. This enabled me to hear women talk about their powerful, knowledgeable, sexual, sensual, and spiritual, pregnant and birthing bodies, as well as the violation and abuse of these bodies (see Chapter 10). As Michelle Fine and Susan Gordon (1992) acknowledge, 'women's bodies serve as a [...] platform upon which social politics are choreographed, resisted and negotiated' (27).

Working with these ideas made me realise that my theoretical framework had not yet sufficiently well understood or incorporated the "matter" of bodies. But it seemed anathema to research experiences of birth using a framework, which remained either disembodied or essentialist. In attempts to avoid essentialism, many feminists appeared to leave too little space for women's embodied experiences and thus the materiality of knowledge production¹⁷.

I thus revisit some of the debates about the embodied subject, which I had raised earlier. I described how subjectivity moved from modernity's foundationalism, towards an uneasy stability, somewhere between modernism and postmodernism, and feminist concerns about poststructuralism where apparently nothing exists outside discourse. But postmodern feminists insist that while the subject

visible local Gypsies as 'counterfeit' in contrast to a mythically 'real Romany' legitimates a policy of harassment and oppression' (27). Looking at power and stereotyping in this way provided parallels with how women planning home births were legitimised and delegitimised through obstetric risk/morality. The obstetric moral code meant that women who follow professional advice, and claim to care more about their babies than themselves are likely to be seen as more responsible and acceptable than women who do not make these explicit claims.

¹⁷Emma Wincup (1999) described the thoughts and feelings she experienced when listening to the stories of women awaiting trial. And Mavis Kirkham (1999) raised the possibility of using midwives' embodied knowledge when she wrote about the value of midwife nausea during birth.

may be unstable, it is still embodied: 'the denial of sexual difference suppresses how it is, specifically, to become a subject in a body defined as female' (Shildrick 1997: 158).

Bodies

Bringing the body back

One of the problems was that the 'paradigmatic knower in Western epistemology' (Longino 1993: 104) was not only a white, western, detached, rational male, but also *disembodied*¹⁸. The full force of the need to bring together the somewhat troubled theoretical understandings of corporeality became apparent when I considered the deeply embodied nature of childbearing and the silence in medical discourses about practices on women's bodies. Yet, women's talk was often to do with their bodies: what they were doing; what they planned to do; what was going to be done to them; and what had been done to them. Their bodies were implicated in acts of knowledge, defiance and passivity:

'if bodies are traversed and infiltrated by knowledges, meanings and power, they can also under certain circumstances, become sites of struggle and resistance, actively inscribing themselves on social practices.' (Grosz 1993: 199)

Many of the women's discussions about practices carried out directly on their bodies would have been impossible to theorise without an embodied framework. Embodying research was thus a powerful way of uncovering silences. For example, I was now able to see that the women's accounts not only brought together theoretical debates and experience, but that they were able to make the materiality of the power/knowledge dyad more visible. Maintaining a bodily distance from obstetrics by staying at home provided a space for them to articulate the potential of their bodies, as well as obstetrics' experienced and/or imagined abuses.

In considering further possibilities for the embodying of research and knowledge, I turned back to some of the feminist/postmodernist theories, which had considered a more integrated encounter between the two projects. Some had raised the matter of bodies in ways that might move beyond essentialism. For example, Nancy Fraser and Linda Nicholson (1990) suggested that, 'a postmodernist reflection on feminist theory reveals disabling vestiges of essentialism' (1990: 20). The integration of feminism and postmodernism was appealing, because it appeared to provide the means to accept corporeality, but recognised the level of diversity I sought.

Missing dialogues

¹⁸And when it does feature, it is not only 'striking that the body figures in socialization theory only as the biological, anatomical or physiological body (Gatens 1996: 11) but that in phenomenology, and the writings of philosophers such as Deleuze, Derrida, Foucault, Freud, Leibniz, Nietzsche, and Spinoza, the lived body, or the body as a site of inscription was either a distinctly male body or a supposedly neutral body, which in fact turned out to be male (see for example, Gatens 1996: 23-24, Grosz 1993, McNay 1992, Marshall 1996: 255, Soper 1990: 13). So while the sociology of the body is undergoing a revival, mainstream sociology has tended not to explore how gender interacts with corporeality and how this fits into wider axes of oppression. As Elizabeth Grosz (1993) points out, we must seek new ways of representing the female body to be able to explore the production of knowledge as that of sexually specific bodies. And while 'lived experience' is a much used term, masculine accounts of subjectivity are disembodied to such an extent that illness has been described as the 'absence of an absence' (Leder 1990). The body is experienced only in illness and restoring it to health implies its disappearance again. The implications for women and their bodily changes during menstruation, childbearing and the menopause underpin the unease about women's 'leaky bodies and boundaries' (Shildrick 1997) and the increasing medicalisation of the bodily changes women experience. Control of reproducing bodies reflects a concern to control the threat to the rigid, modernist boundary between self and other and to prevent 'unsettling ontological certainty' (34)

But if they have spoken about them at all, feminists have had a troubled relationship with women's bodies. Their equating with oppression led to a wariness, which has inhibited much needed theorising in this area. Theories that neither disappear nor essentialise women's bodies remain underdeveloped. While Elizabeth Grosz (1993), suggested that one of the challenges to feminist theory is 'acknowledging the body in the production and evaluation of knowledge' (187), she recognised that, 'there is still a strong reluctance to conceptualize the female body as playing a major role in women's oppression' (195). Those who do have been accused of biologism, essentialism, ahistoricism and naturalism. And yet, as she asserted, the consequence of privileging the conceptual, or mental over the corporeal, has led to 'the inability of Western knowledges to conceive their own processes of (material) production, processes that simultaneously rely on and disavow the role of the body' (1993: 187). Women's focus on integrating mind and body through birth¹⁹ (Rabuzzi 1994) and evidence that women planning home births may feel more in touch with their bodies (Davis-Floyd 1994) take on a more political dimension in this light.

The mind/body split is both philosophical and political²⁰. Its muting of the body not only mutes oppressive bodily practices, but the power of women's birthing bodies. It mutes embodied knowledge, embodied action and renders the body more docile and less able to resist, because where the mind/body split predominates, it is inevitably internalised (at least to some extent). And as Moira Gatens suggests, the privileging of reason has meant, that we inherit a situation whereby:

'Our political vocabulary is so limited that it is not possible, within its parameters, to raise the kind of questions that would allow the articulation of a bodily difference: it will not tolerate an embodied speech' (Gatens 1996: 26)

And yet preventing articulations from circulating does not prevent the circulation of oppressive bodily practices. As Margrit Shildrick (1997) suggests, dominant discourses shape conceptions of the body that remain unacknowledged but nonetheless generate truths which lead to actions and practices which impact on women's lives. In other words, failing to acknowledge the materiality of the body does not make it less material, in the same way that refusing to acknowledge the politics of research does not make it less political. Indeed, it leaves women's bodies vulnerable, for as Margrit Shildrick observes, the gender neutral "body" (rather than bodies) in the medical model is that of 'corporeal raw material' (13). The Cartesian duality of mind and body attributes all that is animate to the mind (16), and the body is little more than an inanimate mass, fixed, 'brute matter' (Gatens 1996: 61, Marshall 1996: 255)²¹. This goes some way to explaining the ease with which invasive practices are imposed on pregnant and birthing bodies, and women's (muted) unease about these. In imposing bodily practices, there is little acknowledgement that 'the integrity of the patient as a person may be at stake' (Shildrick 1997: 18).

¹⁹Just how the body and mind interact is elusive. Grosz (1993) provided the analogy of a mobius strip (198). But as Shildrick (1997) and Marshall (1996: 261) pointed out, the attempt to show both that the external biological body and the internal social self is both separate and seamless is problematic. Moira Gatens suggests that the body is a cultural product lived in culture - and yet distant at times:

'the privileged relation which each individual has to her or his own body does not include a privilege over its construction. We may think of our bodies as the most private of all our possessions, but in fact the body - and the way we each 'live' the body - has about it an eerie anonymity and otherness that is especially strongly felt at times of illness (both mental and physical), times at which we feel alienated from our social surroundings and times at which we are vulnerable to objectifications of others (1996: 35).

This resonated with notions of birth as a rite of passage (Adams 1994, Rabuzzi 1994), and the need to protect oneself from the invasive practices of obstetrics by distancing oneself from the body. This in turn resonated with broader issues concerning the need to cope with abuse through alienation. For example, women describe sexual harassment as though they were bystanders, outside their bodies (Brodkey and Fine 1992: 82).

²⁰Debate about mind/body integration or distancing the mind from the body, is after all one of the main contentions in most life philosophies.

²¹It goes some way to explaining the emphasis on technical proficiency, within which women struggled to articulate their own broader concerns, which are then rendered illegitimate.

Revisiting essentialism

Postmodernism interpretations of the body suggest that physiology and anatomy are unstable points of reference in the context of different knowledges and needs. David Armstrong (1987) analysed changing understandings of anatomy in relation to changing knowledges, and as I suggested on page 56, Jo Murphy-Lawless (1998a) referred to ways of “seeing” the body, which reflect general beliefs about women and birth. But physiology and anatomy have been appealed to by birth activists, midwives and others in order to challenge medical assumptions. Obstetrician and researcher, Michel Odent (2000) implied that physiology may lie before culture and that birth practices should support and reflect an understanding of birth physiology. Many of the low-tech midwifery approaches, rely on similar notions of physiological stability and our ability to “see” it unhindered by culture²². As feminist and cultural writings of the body and birth (see the collection of essays in Davis-Floyd and Sargent 1997 and DeVries 2001 for example) suggested, biology is negotiated in relation to culture. We can use alternative interpretations of physiology to challenge current medical practices, but it would be oppressive to suggest that these are stable and applicable to all women at all times. These ambiguities have remained muted while obstetric certainty has dominated, but need to be examined if we are to be able to define supportive birth practices from women’s perspectives. We need to balance body and culture through “becomingness”: acknowledging our own constructions of women’s bodies, their potential reconstruction, and that bodies are not only constructed by culture, but construct culture.

One of the praxes of feminism and postmodernism is the notion of self as a conversation between the body/social - its dynamic creation and recreation. In this view, practices on the pregnant, birthing and postnatal body not only effect the fleshy substance of the body, but are part of an ongoing dialogue which form and re-form identity. Using Morwenna Griffiths’ (1995) account of self-esteem, birth practices could be seen as potentially both liberating and oppressive. For example, practices that are: perceived by the woman as routine; perceived as being for the benefit of the carer rather than the woman; unexpected; or unwanted, tend to be experienced as particularly harmful and invasive. Those carried out in the context of a trusting relationship, which are experienced as being done out of necessity are likely to be experienced as less harmful²³.

I therefore revisited the work of some of the feminist theorists who have been accused of essentialism, and commentaries on these in an attempt to find some way out of the feminist dilemma. Helen Marshall (1996) suggests that current theories are flawed. The attempt to abolish difference mentioned earlier merely privileges the male body and disappears the feminine. Yet valorising the feminine, in ways typically suggested by radical feminists such as Adrienne Rich and Mary Daly, privilege the mind. Appeals to Lacanian fragmenting of the body disappears bodies altogether, and Donna Haraway’s appeal to cyborgs reduces bodies to texts. (Marshall 1996: 254). Both sexual equality and sexual difference are trapped in the same dualistic paradigm (Gatens 1996: 68). Some French feminists created new theories, but while Julia Kristeva is said to be opposed to difference, she is also said to invoke it, and Luce Irigaray and Helene Cixous are said to come ‘close to reproducing’ traditional male/female dichotomies, but rendering female more positive (Soper 1990: 13). Jane Flax discusses this oscillation between the reductionist glorification of the body, and the denial of the significance of bodily experience. (Flax 1990: 53). While glorifying the previously

²²Some of the work appealing to alternative interpretations of physiology have been emancipatory in obstetrics and paediatrics: leading to more humane and sensitive ways of handling babies, particularly through the use of anaesthesia during operations. Though even in 1977, after the birth of my second child I was told that light and noise were of little consequence as babies are blind and deaf at birth.

²³This raises the complex question of value; whether birth practices can and should be subjected to value judgements; whether or not value can indeed be rested from postmodernism; and on what basis judgements could be made. I address this in Chapter 11 on page 333.

lost or denigrated feminine (Barkley 1998, Rabuzzi 1994) may be tempting, particularly in relation to childbearing, this would indeed be falling back into the dualities of modernism and privileging the views of some women over others. For example, while some of the women in my study talked of celebratory acts, there were complex and ambivalent views on and experiences of being female and the bodily task of giving birth. The temptation to use the specificity of the female body to talk about women as an oppressed group (Grosz 1993: 195) leads back into standpoint theorising and the criticisms levelled at focusing on women's ways of thinking, knowing, deciding, voicing, which differentiate them from men but not from each other. In other words just as difference theory was criticised because of its dualistic and therefore oppressive, general assumptions, biological foundationalism is seen by Linda Nicholson (1999) as falsely generalising (68-69)²⁴.

Ways out of essentialism?

Feminist readings of postmodernism seemed to offer the potential for understanding bodies in less oppressive ways, rejecting determinism and foundationalism, without ignoring the sexed body. The postmodern/feminist notion of materiality: that the body is both the surface of inscription and the site of material practices each of which speaks to a sexed specificity' (Shildrick 1997: 10); and its 'refusal to read the body only as a text is crucial. Margrit Shildrick's work, based on empirical and theoretical notions of reproduction addresses both the criticisms that postmodernism fragments women and that any attempt to maintain difference necessarily falls into essentialism. Her sense of difference is one 'rooted in the 'real' bodies of women but insistent on the multiplicity and incommensurability of those bodies and their experiences (1997: 102). She suggested deconstructing essentialism drawing on theories which destabilise and create opportunities for reconstructions of women's bodies, using Judith Butler's work on dislodging the sex/gender binary and making judicious use of Luce Irigaray's challenge to the definition of biology as 'static, ahistorical and determinate' (177) for example. Diana Fuss (1992) and Elizabeth Grosz (1993) suggest using Irigaray's theory of essence, strategically to provide substance rather than emptiness for women. By providing women with undefined multiple essences,²⁵ she is able to take her place rather than provide the 'envelope' from which man emerges as the only Essence (Fuss 1992). Shildrick (1997) concluded that it would make no sense to claim that the body as sexed is of no consequence, but that this does not necessarily lead to 'fixed' gender differences' (179).

Taking this work forward, Linda Nicholson (1999) suggested moving away from dualistic accounts, which resulted in "sex identity" - a sharply differentiated male and female self, rooted in a deeply differentiated body' (63), which 'obscures the possibility that what we describe as commonalities may themselves be interlaced with difference.' (57). In this reading, the body 'becomes a variable rather than a constant', 'historically rooted' but remaining as a 'potentially important element' (57-58). 'Difference' feminism, often supported by radical feminists, is too narrow to allow for non-conformity. In other words, 'two bodies' is no better than 'two voices'. Nicholson suggested retaining what is useful in difference feminism, rejecting what constrains it, placing more emphasis on historicity and contexts, and remaining alert to where theory ceases to apply (72-73). Finally she suggested thinking about the meaning of "women" in similar ways to Wittgenstein's notion of "game", 'where the meaning is not a specific characteristic, but is found through the elaboration of a

²⁴Nicholson makes a useful distinction between social construction and biological foundationalism. Biological foundationalism differs from biological determinism because it acknowledges varying degrees of social construction, but still relies on some of the physiological "givens" of biological determinism. She thus describes it as a hybrid term which lies somewhere between social construction and biological determinism depending on the views of particular thinkers (64), paralleling some of the criticisms about feminist empirical, standpoint and radical theories.

²⁵Attempts to unify humanity across gender differences are futile and lead back to the suppression of difference and multiplicity. We need to develop theories based on multiplicity and difference but at the same time accept that dissecting peoples along the lines of gender, race, class, etc only, may be equally oppressive. A number of feminists (Fraser 1992b, Young 1997a) suggest that transient, looser groupings for particular purposes at particular times can be useful.

complex network of characteristics' (74). In the same way that Margrit Shildrick (1997) suggested, she pointed out that to move away from specific meanings is not to accept no meaning (Nicholson 1999: 74). In accepting the fluidity of postmodernism, Nicholson accepts the need for collaborative research through dialogues and that 'our claims about "women" are not based on some given reality but emerge from our own places within history and culture; they are political acts that reflect the contexts out of which we emerge and the futures we would like to see' (76).

Knowing, active, bodies: sexuality/sensuality

A number of feminists from psychological traditions suggested that sexuality is defined along gender lines where activity is attached to maleness and passivity attached to femaleness. While researching adolescent sex education, Michelle Fine and Susan Gordon (1992) found that young women were portrayed as victims of male sexuality rather than 'female sexual agent(s)' with desires of their own (32). 'The naming of desire, pleasure or sexual entitlement, particularly for females barely exists in the formal agenda of public schooling on sexuality' (35) and though their data demonstrated a possible expression of female sexuality and desire, it was barely audible. Because of an emphasis on females as passive recipients of sexuality, 'what results is a discourse of sexuality based on the male in search of desire and the female in search of protection' (45). In a detailed examination of early cultures Starhawk (1990) traces the modern definitions of sexuality in terms of the move to patriarchy and the subsequent war/protection culture in which women became possessions and sexual objects to be both desired and reviled. French feminists such as Luce Irigaray and Helene Cixous have pointed to female desire and the female body as a site for multiple pleasure, but 'that the expression of female voice, body and sexuality are essentially inaudible when the dominant language and ways of viewing are male' (Fine and Gordon 1992: 38).

Sexuality and sensuality of pregnancy and birth is discussed in some of the more recent birth literature. For example, Robin Gregg (1994) suggests that the 'pregnant body [...] is an overt symbol of sexuality (76). Feminist/midwives suggest a very different potential reading of women's bodies and birth, in contrast to the disembodiment/desexualising practices of obstetrics. This includes sexuality, eroticism, sensuality, ritual, spirituality, desire and power, to describe a connected knowing, located in the self, the body and the joy of life and creation (for example, Adams 1994, Gaskin 1990, Irigaray 1985, Kahn 1996, Kitzinger 2000, Lorde 1997, Parvati-Baker in Chester 1997, Rabuzzi 1994, Starhawk 1990, van Ophen Fehr 1999). This is not to say that they deny the pain of birth or suggest that it should be pleasurable for all women, but that the potential for this has been erased through the erasure of sexuality from dominant discourses of birth.

In Summary

I have been privileged to hear and read the words of many great thinkers, who have contributed to and profoundly shaped my thinking. Jo Murphy-Lawless (1998a, 1998b), Linda Nicholson (1999) and Margaret Shildrick (1997), have perhaps been most influential in articulating critical feminist theories in which I could interpret patterns of oppression and resistance in specific, historic locations. They enabled me to make claims, while at the same time remaining sensitive to differences and open to the possibility of further claims and counter claims that might enrich our understanding about ourselves and our societies. Thus while postmodernism does not lead automatically to the inclusion of all women, a feminist reading of it leaves a space for the exploration of difference, which need not lead to closure. It is in this tradition that I located myself and considered my interviews.

As I attempted to form a dialogue between the debates of the last 3 chapters and my extensive interviews, to produce a coherent account, it was almost with relief that I recalled Linda Nicholson's (1999) advice: that in rejecting the idea of a 'singular entity "woman"', we need not necessarily

reject the possibility of general claims. 'We can recognize that social theory requires a certain amount of abstraction and thus a certain degree of forgetfulness of the complexity of all our lives.' (28). I came back to this again and again as I worked through the interviews and attempted to remain close and true to what each woman told me. On occasions I felt obliged, even forced to suppress some of the nuances in the interests of writing coherently - indeed, in the interests of writing anything at all. The act of writing once again brought me into contact with the constraints of a language developed from dichotomous, abstract thinking. Appropriating Kathryn Rabuzzi's (1994) analogy, it frequently lent itself more easily to separation and generalities than to blendings and particularities (110).

In the next chapter, I explain how I approached this study and the methods I used to generate and analyse my data. In doing this, I attempt to weave in and develop the issues I have discussed so far.

CHAPTER SIX - Methods

Initial proposal and preparation for the study

My initial proposal was to follow a small number of women through their experiences of planning home births, by interviewing them during early and late pregnancy, soon after birth and 4-6 months after birth, to provide in depth data about their experiences.

I received approval for the study by an ethics committee. Following this, I arranged meetings with community midwifery managers in an area of Scotland and had further meetings with community midwives in the same area to explain the study to ask if they would be willing to distribute letters about the study to women planning home births. The midwives were willing to help, and I gave them letters, which they in turn gave to women booking with them for home births. The letters explained the study to the women and invited them to take part (see below).

Background to the study

The women who offered to take part in the study were mainly city dwellers in Scotland. There were also a number of women in semi rural areas, up to 30 miles from their nearest maternity unit. In most cases women had teams of 6-8 midwives, though in one area there were teams of 2-3 midwives and in another area, teams of 5 midwives. In one of these locations one midwife appeared to provide full care where possible - though this is no longer the case.

There was a policy in operation at the time of the study, that all women having planned home births would be attended by 2 qualified midwives during birth. This is still the case. Most women were attended by 2 community midwives, except when the birth happened more quickly than expected, or when a failure occurred in the call out system. As mentioned earlier, 2 women made use of the services of independent midwives. These midwives were employed and reimbursed by the women who engaged them.

The women who booked with the community midwifery teams were told that they would meet all the midwives on the team during their pregnancies and that they would usually be attended during labour by one of their team midwives. The second midwife would usually come from another team, and would therefore not be known to the woman. In the event, 2 of the women in the study had primary midwives attend them in labour that they had not previously met, and some women were attended by 2 midwives they had met before.

There was no written information about home birth provided by community midwives in the main study region, though a leaflet was available in an adjoining region and an information leaflet was being drawn up for use in one part of the main study region at the time of the study. It became available after the end of the study period. Most women were given a list of the community midwives in their team, and the hospital numbers to contact if they wanted to talk to a midwife or call a midwife during labour. Only the women who booked with independent midwives had direct access to their midwives.

Initially I planned to include up to 10 women in the study. This was due to concerns about data collection and management. It became apparent however, that while the 10 women provided a wealth of data, in order to extend the breadth and depth of the study, it would be beneficial to continue to recruit those women who came forward. In the event, I included 30 women¹.

¹33 women initially offered to take part in the study. Of the three women who returned consent forms, but did not take part, one woman had booked for a home birth before the start of the study and was about to have her baby; I was unable to

After recruiting 30 women, drawing on the notions of theoretical saturation in grounded theory (Glaser and Strauss 1967, Strauss and Corbin 1994), it was apparent to me, that while each woman was unique, a broad spectrum of views had been included. I therefore wrote to the community midwifery teams to thank them for their help, and to ask them to discontinue giving out the letters about the study.

I usually spent between 1½ and 3½ hours with each woman at each interview. All interviews were taped and each tape was between an hour and three hours long though most were about 1½ hours. I interviewed most women 4 times, as planned, during their pregnancies and after birth. A small number of women booked for home births late in pregnancy or lived outside the main study area. I usually interviewed these women 3 times - once before birth and twice after birth.

Of the 30 women involved in the study, 13 women were expecting their first babies, 11 were expecting second babies, and 6 women were expecting their third or subsequent babies. 23 babies were born at home and 7 in hospital. Of the babies born in hospital, 3 were first babies, 2 were second babies and 2 were third babies.

Around half the women were Scottish, and a range of other nationalities was represented. All the women had partners, though not every woman lived with her partner. A number of women with children, having their first home births had remarried or had new partners. (For a brief account of each woman, see Appendix 4)

I delayed carrying out most of the follow up interviews to 6-8 months after birth, rather than 4-6 months after birth, as originally planned, to provide the women with a longer period of time to reflect on their experiences. 2 follow up interviews were carried out sooner, as 2 of the women left the area within a few months of giving birth and 2 interviews were carried out a year after the women had given birth, due to my temporarily losing contact with one woman and the other woman living abroad for a time.

Recruitment to the study

Each woman booking for a home birth over the study period received an envelope from a community midwife, containing a letter of introduction (see Appendix 1). This explained the aims of the study; described how I intended to carry it out; gave some indication of the time commitment; clarified that women's anonymity would be protected; explained that participation in the study was entirely voluntary and could be withdrawn at any time; and reassured women that their care would not be affected. This was accompanied by an information sheet and a consent form. The form was completed by the woman and returned to me (see Appendices 2 and 3).

The letters appeared to be given out to most women who booked with their community midwives during the study period for home births in the area (though I was aware that one or two women booked for home births during the study, but did not receive information about it²). On receipt of the consent form, I made phone contact with each woman and arranged a suitable time to meet. Most meetings took place in the woman's own home, but on one or two occasions women chose to come to my home.

make contact with a second woman, despite repeated attempts; and a third woman suffered a serious family crisis prior to the first scheduled interview. It seemed inappropriate to initiate further contact.

²One woman heard about the study from a friend and asked her midwife for details. While the midwife suggested that there was so little interest in home births in the area that the study was irrelevant, she gave the woman the information and the woman joined the study.

The initial visit was an opportunity to introduce myself as a researcher and childbirth educator with an interest in women's experience of home birth. I drew each woman's attention to the issue of confidentiality, and the difficulties of maintaining a high level of anonymity with such a small group of identifiable women. Like Janet Finch (1984) I found women were exceedingly open and most women were not overly concerned about this issue for themselves. They were however concerned to protect the confidentiality of others they mentioned, particularly their midwives. Many women did not mention their midwives or other professionals by name when saying anything they perceived to be negative.

I asked each woman if there was any further information she would like about me, personally, or about the research. Most women had few questions initially, or said that they found the information sheet comprehensive and self-explanatory. Questions often emerged during or following interviews, and many women asked me at some point whether or not I had given birth at home. I had initially had reservations about sharing this information, but like Finch (1984) found that having a shared experience in common increased trust and commonality.

A number of women expressed concerns about their abilities to answer the questions, particularly about answering quickly and/or correctly. I therefore frequently explained that although I had some questions about home birth, which I thought might be interesting to explore, I was very keen to hear about their thoughts and experiences, and that if they found my questions not relevant, I was happy to abandon them. I also explained that if I raised topics in future interviews, I was not testing them for consistency. I was interested in any further thoughts they may have had, or if their views had changed in any way.

Interviewing: One-to-one conversations

'what are we not hearing in the words that walk past our ears' (Hunter 2000)

Interviewing formed the core of this project. I therefore looked at the range of interviews from highly structured oral questionnaires to unstructured explorations (Guba and Lincoln 1982) and considered some of the traditional approaches to interviews and interview skills. The terms structured and unstructured are perhaps a little misleading, as by definition, an interview cannot be unstructured - 'every interview has a structure For some interviews, the structure is predetermined. For others it is shaped in the process' (Ely 1991: 58). In an attempt to provide space for women to discuss their concerns, I opted for minimal structure.

In her critique on traditional interviewing, Ann Oakley (1993b) summed up that the role of the interviewer is typically to remain in control, neutral and distant, revealing nothing of him/herself of her/his beliefs - 'friendly but not too friendly', finding a balance between 'the warmth required to generate 'rapport' and the detachment necessary to see the interviewee as an object under surveillance' (223). A number of feminists offered alternative ways of talking to and listening to women, based on feminist theoretical and moral principles and their own empirical observations of working with women (Anderson and Jack 1991, Devault 1990, Finch 1984, Minister 1991, Oakley 1993b).

At a pragmatic level, Oakley (1993b) simply asked whether or not the tried and tested rules for interviewing (men) are applicable to women, whether or not they get the best results, and suggested that formal interviewing is in fact unsuitable for good sociological research with women. Echoing earlier discussions about women's ways of knowing, Finch (1984) asserted that the process of women interviewing women has the potential for a particularly fruitful exchange of information, if it models the typical ways in which women relate to each other through informal conversations, and

Devault (1990), that, 'women interviewing women bring to their interaction a tradition of "woman talk". They help each other develop ideas and are typically better prepared than men to use the interview as a "search procedure", cooperating in the project of constructing meanings together' (101).

Judith Okely (1994) however questioned the validity of one to one interviews, suggesting that these are divorced from daily practice and context (23). While acknowledging the limitations of one to one interviews, my impression from attending home birth support meetings, and running groups for pregnant and postnatal women was that the one to one setting enabled women to voice feelings and opinions that they would not voice elsewhere. For example, women discussed not 'buying into the whole natural childbirth thing' and its focus on the unborn baby, death at birth, sexuality and spirituality. None of these could easily have been expressed in a group setting. Imagination of possibilities and exploration of commonalities at home birth support meetings were sometimes richer however.

Increasing the sensitivity of interviews

Marjorie Devault (1990) and Kristina Minister (1991) suggest that comprehensive feminist ways of interviewing must be developed and Minister relates this to research on male and female communication development. She suggests that androcentricity extends into the interview framework as 'the male sociocommunication subculture is assumed to be the norm for social science interviewing'. And that male dominance takes place through male dominant and female subordinate communicating patterns internalized in childhood and young adulthood (3). Thus, in order to hear what is important to women's lives, interviewing needs to be based on how women talk.

This is no easy matter. As I acknowledged, both researchers and women have internalized a gap between the language and concepts available to them and how we experience the world. Thus a first trawl of the literature suggested that the researcher must develop awareness, skills, and ways of listening in order to help women talk, and help hear what is being said through:

- an awareness that women combine concepts and values of the dominant culture with their own experience, and where this does not "fit" with the outside world, they may be unable to express their thoughts and feelings (Anderson and Jack 1991, Devault 1990). 'To hear women's perspective accurately we have to learn to listen in stereo, receiving both the dominant and muted channels clearly and tuning into them carefully to understand the relationship between them (Anderson and Jack 1991: 11). Though postmodernism's deconstruction of the subject suggests a cacophony - as I discussed in the previous chapter and return to in a later section in this chapter (see page 110)
- providing a receptive, non-judgemental space, in order to give each woman the freedom to explore and voice her experience, especially when this falls outside the accepted norms of women's behavior and feelings
- providing sufficient time to focus on the issues arising - not only in terms of discarding the researcher's 'own research-oriented, time frame in favor of the narrators' temporal expectations (Minister 1991: 36), but also in terms of staying with the woman's agenda
- providing sensitive 'intersupport', both verbally and non verbally (Minister 1991: 37).³

³Like Nicola Slee (2001), I found that women frequently used phrases such as, 'you know' and 'I don't know'. Like her, I saw these as 'collaborative speech strategies' (26). When women used these phrases, I attempted to adopt a particularly supportive manner, leaving plenty of time for them to reflect and sometimes gently encouraging them to say more if they wanted to. I also found, as she did, that silence needed to be acknowledged as a place from which "truth" can emerge:

- probing and exploring the use of words and phrases used by women in interviews and not taking too much at face value (Anderson and Jack 1991: 14)
- listening to herself as well as women, using her responses of confusion, discomfort or over-certainty for example to guide her and explore further if the woman is willing. Anthropologist, Judith Okely (1994) suggests drawing on the totality of the experience of fieldwork and that 'it is recorded in memory, body and all the senses' (21)
- listening to what is missing, tentative, as well as contradictory in the woman's own interpretations provides insightful clues to her experience and how it differs from social norms (Anderson and Jack 1991, Devault 1990)

Beverly Skeggs (1994) and Devault (1990), suggested that tapes should be listened to more than once before the final analysis and that preliminary analyses could be constructed with the women or sent to the women for comment⁴ (see also Bergum 1989, Field et al 1994). 'Strategic borrowing' from conversation and discourse analysis in order to tune one's ear to details in talk, such as pauses, silences, hesitations and tone, and taking notes on body language, facial expressions and intensity of voice are invaluable in interpreting meanings (Devault 1990: 108, Opie 1992: 59).

Moving from old accepted ways of approaching research, to the new, where the new is undefined, in addition requires imagination and courage (Rorty 1991)

Ethical issues

It is precisely because these more flexible and less hierarchical ways of relating appear to be successful (Finch 1984, Oakley 1993b), that, ironically they pose ethical dilemmas and can be as exploitative as conventional interviewing. Where the latter could be seen as unethical in terms of its manipulative strategy and hierarchical power structure, power issues are never eradicated in feminist research and it could be that if the former is successful, women are making themselves extraordinarily vulnerable by exposure. Finch (1984) 'emerged from interviews with a feeling that [her] interviewees need to know how to protect themselves from women like [her]' (80) and asserts that it is the duty of the feminist researcher to protect those she is working with and find ways of combining loyalty to the experiences of individual women with the wider feminist emancipatory project.

Predicted ethical dilemmas can only be acknowledged and ameliorated rather than resolved. Unexpected issues must be responded to at the time. Cornell (1995) offers a useful distinction between an ethical orientation as opposed to a set of moral codes reminiscent of Gilligan's (1985) analysis of how women approach ethical/moral dilemmas, relying on a sympathetic connectedness to others, rather than the application of a set of rules.

Of course, the researcher stands to gain more from research, than those taking part in it, though some feminist researchers have commented that if this is the aim, traditional approaches could be

'The spaces and gaps in between thinking may be moments when truth is able to steal up on one unawares' (34) and 'that prophecy can begin in the inchoate sense of nameless discomfort that many women feel and can find no words to express' (35). In other words, when dominant forces mute women's voices, their utterances may be marked by stumbling, not knowing, and negativity towards what is, as well as a sense of searching for what could be.

⁴During the study, I sent all the women copies of an article I wrote about why women plan home births (Edwards 1996) and copies of a chapter I wrote for a book about the relationship between women and midwives (Edwards 2000). On both occasions I invited women to comment. Those who responded confirmed that I had represented their views fairly.

more useful to the researcher (Stanley and Wise 1993). Indeed, while some researchers commented that women often found the experience positive and rewarding, (Bergum 1989: 11, Maynard and Purvis 1994: 17, Opie 1992: 64), this is not always the case (Phoenix 1994). The researcher inevitably has an impact on those involved in the research. During pregnancy women may feel vulnerable and open to influence. While the impact of the research may clarify some of these issues and prove helpful to women, it could also interfere. I therefore look at some of the comments women made about the research process in Appendix 7.

Power issues cannot be ironed out of the research process (or anything else, as I discussed in the previous chapter), not least because the researcher retains authority over the project. However collaborative and interactive the process, she decides what is written and may misrepresent or misconstrue women's voices and experiences (Stanley and Wise 1993: 177). Liz Stanley and Sue Wise (1993) suggested focusing as much attention on the researcher and the research process as on those being researched, to even up the vulnerability levels. As I became more familiar with postmodernist views, I also accepted that my work would represent my story about the woman's stories.

I had a strong investment in my work and entered into close relationships with women. There was the danger that not only unwanted, uncomfortable, even painful issues, could be raised (Maynard and Purvis 1994: 5), but that it may be difficult for a woman to withdraw from the research or resolve painful issues, while I remained freer to leave the field on completion of my work. I have in fact been privileged, as some of the women have contacted me since the interviews, to tell me about subsequent pregnancies and births. I also supported 2 of the women during their subsequent births.

Doing the interviews

Before beginning the interviews with the women in the study, I carried out pilot interviews with two women who had planned home births and recently had their first and fourth babies, in different areas of the study region. One of the women transferred to hospital in late labour, the other woman had her baby at home as planned. I discussed the interviews with them, how they had experienced them, the appropriateness of the topics covered, and whether or not there were other areas they would have included. I refined my interview questions accordingly and describe the first interview below. Appendix 5 provides a list of typical questions I asked in interviews 2, 3 and 4.

The first interview with each woman included introductory exchanges. When the woman had no further questions and felt ready to proceed, I asked again if I could tape record our conversation⁵. While I wanted to develop an open style of interview, in the hope that the woman might take part in directing the conversation, raise issues of concern to her, and feel free to expand on these if she wished to, I did not want to cause her discomfort or confusion by leaving the conversation too open (Devault 1990), nor did I wish the initial interview to be off-putting by being too searching or awkward. I therefore asked each woman first of all, what had led her to think about and plan a home birth. Many women then spontaneously talked about the advantages they felt there would be to having their baby at home, and the disadvantages of giving birth in hospital.

Typically, I would then ask her about her own knowledge of and exposure to home birth, what information she had received and how adequate it had been, where she had sought information and support, how her partner, family and friends had responded to her plans to have a home birth, how her GP and midwife had responded to her plans, and what sorts of issues had already been discussed with professionals. Many women had limited knowledge of the community services, but I asked

⁵ Although this did not appear to present any problems for the women, it may have had some effect on the ease with which they spoke (I describe my experience of this on page 112).

them what they knew, and how they felt about the size of the community midwifery teams. I also asked women about their views on safety and risk, if they had not raised this issue spontaneously.

I did not have written questions, but introduced these topics for conversation as appropriate, if they were not raised by the woman herself. I attempted to follow the woman's interests if other topics arose⁶. For women who had children, previous experiences of birth arose frequently and were described in detail. At the end of each first and subsequent interview, I always asked women if there was anything they would like to add, or if they felt I had missed areas they would like to comment on. In the final interview I also asked if there was anything they would like to say about any of the conversations we had had that day or previously.

I began transcribing immediately, and before each second interview re-read the transcript or listened to the taped conversation, in order to re-familiarise myself with the woman's experiences and concerns, so that I could design a second, semi structured interview. Each interview was therefore designed on an individual basis, but the topics themselves were remarkably similar. The second interview usually took place a week or two before the baby's birth, though in one case the baby arrived unexpectedly early, before the second interview.

Before asking any specific questions, I always invited the woman to tell me about how her plans were going in her own words, or if there was anything she wanted to tell me. If this seemed awkward, I introduced more specific questions. Typically, during the second interviews, the women talked at length about their relationships with their midwives, how trusting they felt of their midwives how they felt about the level of continuity, how in control they felt, how they saw birth as a spiritual, sexual, emotional, physical or natural process, or a combination of some or all of these, their preparations for the forthcoming birth - this included specific points often listed on birth plans, and more general arrangements of a practical and/or emotional nature. Women frequently discussed further perceived advantages of home births as it became more of a reality. In addition, as the inevitability of birth became more pressing, any anxieties women had about their labours and births, or their care also surfaced more acutely during these interviews. There were sometimes long silences as women thought about what they wanted to say.

Most of the third interviews occurred within the first week of the baby's birth, and all but 2 within 2 weeks. These interviews focused on the woman's experience of her home birth, or in 7 cases, of transferring into hospital. Again I re-read the previous transcripts or listened to the tapes again before preparing a semi-structured interview, immediately prior to meeting with the women. Before asking any specific questions, I invited each woman to tell me about her experience. Again, although each interview was individually designed to explore each woman's interests and concerns, similar topics arose.

Typically, the woman talked about; how she had experienced those around her, how in control she felt; how she found ways of coping with her labour and birth; how respected she felt; how free or inhibited she felt to be herself; how she experienced the time immediately after birth; and any thoughts she had about the home birth service and how it operated. The interviews with the 7 women who transferred to hospital focused on how the woman felt about the decision-making process leading up to this; her experience of transferring and giving birth in hospital; the time before

⁶I also introduced topics raised by women to others in the study, to enrich the narratives. During this process of theory generation, I attempted to maintain a constant dialogue with women, between women and with the literature I engaged with. So although I have not referred a great deal to grounded theory in this chapter, as I mentioned on page 97, I drew informally from its thinking about data collection and the idea that this should perpetuate itself rather than rely on preconceived knowledge of the topic under study.

returning home; and how she felt about the services available when transferring from community to hospital care.

The fourth interviews, 6-8 months after the woman gave birth were often slightly shorter interviews, (though some were longer), and gave the woman an opportunity to reflect on her experience. Immediately prior to the final interviews, I re-read the transcripts, or listened again to the conversations with each of the women in order to re-familiarise myself with their views and experiences. I invited each woman to tell me about how she now looked back on her experience before asking any specific questions. Typically I would then ask more general questions about how she now felt about issues such as, control, continuity, her relationships with her midwives, the home birth services in her area, if she felt that her experience had affected her or her family in any way and how she now felt about home birth.

In practice, I found there was a continual tension between encouraging women to say as much as they wished about any issue, while at the same time being conscious that I wanted to raise other topics in the context of a notional hour. And while I was able to give as much time as the woman wanted, I did not want women to feel I was demanding too much of their time, and come to resent being part of the study. There was therefore an unavoidable tension between probing and moving on, especially with women who had many thoughts on many aspects of home birth.

The interviews felt searching and authentic, and I was reassured that there was a meaningful consistency and development of views. Often women would repeat their thoughts and feelings during an interview, or over the course of several interviews, sometimes using the same words and phrases while developing a story line. They also repeated similar thoughts and feelings to other women, when recounting a birth experience for example. When views changed, developed or crystallised, women were aware of this and offered explanations.

The women in the study seemed willing and able to rephrase my questions, if I seemed to have missed the point. I sometimes felt that women had views they wanted to express and that my questions served as an opening for them to do this. Often I said very little but 'yes', 'right', 'uh uh' and 'mm' for pages at a time. In the main, my intention to encourage and remain non judgemental appeared to be taken on board by women, and overcame any clumsiness or lack of clarity on my part.

The women appeared to have a robustness and clarity, which enabled them to disagree with me, if I had misunderstood, or ask me to expand or clarify questions, or rephrase questions in a way that made sense to them. When I asked if they had any further comments or thoughts, or felt I had missed areas for discussion, many women responded. Usually this was to comment further on a topic already raised, or to comment positively on the research process itself, but sometimes new topics were raised.

Adding to the interviews

In addition to the in-depth interviews, I kept field notes from before the study period began until the end of the research process. I made notes following each interview on the interview process, what the main issues appeared to be for the individual woman, how the woman seemed, and how I had felt. I also recorded any conversations I had with women between interviews, and any conversations I had with women outside the study group to do with home birth. I wrote up any home birth stories from the women attending the antenatal groups I continued to lead during the study. I heard some of these stories on several occasions as they were recounted to friends while I was present, or recounted at postnatal reunions. I wrote up how and where these remained the same or changed.

I was also invited to attend 6 home births over the study period. 3 of these births were to women in the study. These women asked me to be with them during labour because they wanted emotional support and encouragement from a woman they knew and trusted, who could be relied on to be present whenever they went into labour, and who knew about their views on birth. Quite by chance, I was also present at a few antenatal visits and several postnatal visits. Although I always offered to leave, I was invited to stay on some occasions.

I had a long telephone conversation with a birth supporter who had attended one of the study women's births, and taped a conversation with another. Both the telephone conversation and recorded conversation were carried out with the women's permission. In addition, I attended most meetings of a local home birth support group during the period of the research project and made notes following these meetings about the discussions arising.

While the focus was initially on researching home birth, planning the project, recruiting, meeting and inviting women to tell me about their experiences, as the focus gradually shifted to the analysis and writing up of this work, it became evident that this was a rather neglected subject (even in descriptions of traditional qualitative methods, this was not usually explicit or lengthy). I therefore gave it considerable attention, in order to develop an analytical framework that would complement my earlier work on the debates between feminism and postmodernism. It is to the story of developing an analysis that I now turn.

Developing a feminist/postmodern analysis, or falling back on traditional methods?

My story about analysis follows much the same lines as the stories in previous sections of this thesis. It continued the process of reconstruction and revision on the basis of ongoing dialogue between theory and women's accounts. The main difference was that it was more difficult to find parallel theoretical discourses with which to continue the emphasis on "becomingness" rather than closure.

I had consciously engaged with theoretical debates between feminism and postmodernism in order to develop a sensitive framework to dialogue with women's voices. As I focused on the interviews, my journey threatened to be diverted back to a more conventional analysis of the data. As my discussions demonstrated, there are well documented theoretical and practical concerns from both feminist and postmodernist points of view about the initial phases of research, ethical issues, entering and leaving the field and the reflexivity needed. But I found little discussion about how these concerns could be taken forward into the more overtly analytical phase of the research process. So while Michelle Fine (1992) advocates a research stance that 'constitutes activist, feminist research, committed to positioning researchers as self-conscious, critical and participatory analysts, engaged with, but still distinct from our informants' (220), how to be such an analyst remained unclear.

At this juncture, there appeared to be no alternative than to incorporate as much as I could from the debates I had engaged with, retain a feminist postmodern stance as far as possible and fall back on the well-known and respected analysis manuals. With notable exceptions, (Bryman and Burgess 1994), most of these, while clear and thorough, pay only limited attention to developments in feminism and postmodernism⁷.

Those writing about analytical processes note the abundance of literature on other aspects of the research process, in comparison to that of analytical processes (Huberman and Miles 1994: 428).

⁷I was reminded of the women in the study who planned normal labours and births and had accumulated information to support their plans, but felt obliged to fall back on active management of the third stage of labour, in the absence of supportive information about physiological approaches to birthing the placenta.

Iain Dey (1993) observed the types of comments made; 'lack of clear accounts of analytical principles and procedures', analytical procedures seem deceptively simple', conceptual aspects of analysis seem frustratingly elusive', and 'mechanical aspects seem embarrassingly obvious' (5).

The analysis of qualitative data remained mysterious and beyond words. Researchers frequently moved from gathering to interpreting data without even an acknowledgement that an entire part of the process has been skipped over. With some exceptions, in many of the theses I read, data analysis was covered in a few paragraphs to a few pages. And indeed, my experience of analysis is that it is not so easy to extricate from the whole process of "doing" research. It is interwoven from conception to conclusion and therefore difficult to isolate. Some qualitative researchers indicated that one 'lives with' and 'immerses' oneself in the data and somehow moves through a mysterious process of metamorphosis of the data. And in a sense this is true. I 'lived with' the data, pondering over each woman's story, puzzling over contradictions⁸.

Having elaborated the conceptual framework to the extent I had, however, it seemed inadequate to mention interactivism, a Dilthey-like immersion in the interviews, and an internal process of synthesis from which my story of the stories emerged. While I shared the phenomenologist reluctance to condense interviews through coding, preferring instead to develop a "deep understanding" to reach Husserl's "Lebenswelt" (Edie 1962), this still seemed inadequate in terms of an explanation to myself and others. But it seemed equally inadequate to use the menu-like approaches of managing data through coding, categorising, and theory building which was not gender sensitive. Having understood the problems associated with male-centred or so-called neutral approaches earlier, I could see how this would impact on the analytic process but remain largely hidden or obscured. This seemed particularly problematic/unethical if my aim was to produce a feminist postmodern interpretation⁹.

Initially however, my search of the literature uncovered a series of texts which fell somewhere between modernity and postmodernity¹⁰. These acknowledged the instability of truth and knowledge claims, the influential role of the researcher, and the value of reflexivity, to some extent. Most offered some kind of description about how analysis takes place and some offered more detailed descriptions of the process. It was these texts that I focused on, as their awareness of reflexivity brought them closest to what I was attempting to achieve.

⁸It was often this staying with and pondering that gave me clues and insights into deeper meanings. For example, one woman was consistently positive about her care, but interwove negative stories. It was only in trying to understand the contradiction, that I heard more about women's internalisation of, and resistance to dominant ideologies, the official and unofficial stories. I puzzled over the very different narratives of two women expecting their first babies at similar times with the same group of carers. My puzzling led me to understand the complex shifting between ideals and expectations in the same woman and between different women.

⁹Like Dey, Natasha Mauthner and Andrea Doucet (1998) observe the lack of attention paid to data analysis in comparison to other areas of research and draw attention to the lack of guidance for feminist researchers. They point out that 'the issue of listening to women, and understanding their lives 'in and on their own terms', has been a longstanding and pivotal concern amongst feminist researchers. Yet there are few examples of how this general methodological principle can be practically operationalised within the actual research process and, in particular in terms of data analysis' (120), particularly in the light of 'issues of reflexivity and power, voice and authority' (121). They see the initial phases of data analysis (identifying the key issues) as particularly elusive and intuitive. They suggest that these are rather unsystematic and 'messy' when ideas and leads are followed up. It is necessarily 'confusing and uncertain because we are at a stage where we simply do not know what to think yet. Indeed, this is the whole point of data analysis - to learn from and about the data; to learn something new about a question by listening to other people' (122) The later stages 'which tend to be structured, methodical, rigorous and systematic, are often easily described' (121).

¹⁰One of the difficulties in developing analytical processes for qualitative data seemed to arise from its roots in quantitative research and the difficulty of imaging ways out of this tradition - paralleling the dominant and minority views I had already been working with throughout the thesis.

There seemed to be some acceptance that research should transcend a common sense view of the world: 'we cannot interpret, or explain social action without critically evaluating it' (Dey 1993: 54), and that analysis is what makes the difference. Maxine Birch (1998) suggests that analysis takes sociological understandings beyond those of common sense or journalism for example and that 'strategies of analysis [...] are at the heart of the sociological text. Without such analytical devices our text could and would resemble many others' (181).

However, Dey (1993) suggests that qualitative researchers have emphasised the 'subjective sensibilities and creativity of the researcher [and] have generally been suspicious of a 'recipe' approach to teaching qualitative methods' (6). This has led to a period of relative silence on the subject, as researchers have found it difficult to develop alternative and definable methods for analysing qualitative data.

What is analysis ...

'The act of interpretation underlies the whole research process' (Kirby and McKenna 1989: 23), and 'to analyze is to find some way or ways to tease out what we consider to be essential meaning in the raw data' (Ely et al 1991: 140). This summed up much of what has been said about analysing data and while in fact Margot Ely and colleagues went some way to situating the researcher and providing a more specific account of analysis than most, 'essential' remains problematic and suggestive of truth claims, in the same way that 'raw' data, experience or language have complex meanings, as I discussed earlier.

One of the many 'circles within circles' (Ely et al 1990) of the research process highlighted by Barry Turner (1994) was that the 'process is one of interrogating the data for relevant material according to criteria of relevance which are themselves only developed during the process of analysis (209). Or in terms of the phenomenological hermeneutic circle, Danny Jorgensen (1989) and Dey (1993) suggest an ongoing dialectic between ideas and data: 'we cannot analyze the data without ideas, but our ideas must be shaped and tested by the data we are analyzing' (Dey 1993: 7) which makes 'debates about whether to base analysis primarily on ideas (through deduction) or on the data (through induction) rather sterile' (7). Dynamism and reflexivity is a feature of these accounts:

'the researcher's constant moving back and forth, between data and concepts, and between individual ideas and research explanations in order to fully describe and explain what is being researched. This keeps the researcher constantly vigilant for new understandings at all analytical points' (Kirby and McKenna 1989: 129)

A number of researchers suggested 'searching out patterns, identifying possibly surprising phenomena, being sensitive to inconsistencies' (Bryman and Burgess 1994: 6-7), or noticing repetitions of incidents or words, laughter, embarrassment or anger for example (7), as well as continuing to examine the context in which these experiences occur:

'Giving priority to intersubjectivity and critical reflection on the social context throughout the analysis ensures that we are able to hear and affirm the words and experiences of the research participants and at the same time be able to critically reflect on the structures that influence the actualities of their lives' (Kirby and McKenna 1989: 130)

There is an acknowledgement that analysis begins before the researcher enters the field (Huberman and Miles 1994: 430), with the location of the researcher herself, the literature review, the research focus, what is asked and what remains unasked. For example, Ely and colleagues (1991) point out that 'even at our most unintrusive, we influence the very phenomena we are studying' (47). All of

the above sensitise the researcher to the nuances of analysis, but stop short of acknowledging and working with the difficulties thrown up by feminism and postmodernism during the analytic process regarding the conceptual frameworks chosen to elucidate the data (Mauthner and Doucet 1998: 124).

... and how is it done?

The following provides a typical description of the analytical process described by many qualitative researchers¹¹:

‘Analysis is a breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With facts broken down into manageable pieces, the researcher sorts and shifts them, searching for types, classes, sequences, processes, patterns or wholes. The aim of the process is to assemble or reconstruct the data in meaningful or comprehensible fashion’ (Jorgensen 1989: 107).

Dey describes the ‘core’ of qualitative analysis as the ‘related processes of describing phenomena, classifying it and seeing how our concepts interconnect’ (30). While many different ways of moving through the produced data to the finished report are described, and terminology varies, there appears to be some consensus regarding the general processes of breaking data down, regrouping it to ‘generate specific and general patterns’ (Kirby and McKenna 1989: 130) and finally writing one’s own story about the stories (Dey 1993, Huberman and Miles 1994, Jorgensen 1989). There also appears to be some consensus about ‘categories’¹² and reintegrating data (Huberman and Miles 1994: 146) and that ‘the major threads are the themes running through the data’ (154) Or, as Ely and colleagues describe, ‘a statement of meaning that (1) runs through all or most of the pertinent data, or (2) one in the minority that carries heavy emotional or factual impact’ (1991: 150). Indeed, ‘how to’ analysts describe: the descriptive coding or indexing; the deeper categorising and sub categorising or charting; and the most abstract phase of mapping, interpretation, developing conceptual themes, and theory building, to move from more concrete descriptions to abstract theory (Miles and Huberman 1994). This is in essence a process of separating and sifting data. In other words the analysis is seen as the stage in research where the data is broken down and gathered together again to provide ‘coherence and structure while retaining a hold of the original accounts and observations from which it is derived’ (Ritchie and Spencer 1994: 176).

The initial emphasis on separation rather than relational aspects of analysis echoed with a number of themes in my literature review: the inherent power and violence embedded in mechanistic,

¹¹Though these accounts provide more reflexive description of analysis, they retain a modernist approach. For example: ‘Analysis is not the last phase of the research process: it is concurrent with data collection or cyclic. Both analysis and data collection inform each other. 2 The analysis process is systematic but not rigid. The analysis ends when new data no longer generate new insights. 3 Attending to data includes a reflective activity that results in a set of analytical notes that guide the process. 4 Data are ‘segmented’, i.e., divided into relevant meaning ‘units’, yet the connection to the whole is maintained. The analysis always begins with reading all the data so as to provide context for the smaller pieces. 5 The data segments are categorized according to an organizational system that is predominantly derived from the data themselves. 6 The main intellectual tool is comparison. The goal is to discern conceptual similarities, to refine the discriminative power of categories and to discover patterns. 7 Categories for sorting segments are tentative and preliminary in the beginning; they remain flexible. 8 Manipulating qualitative data during analysis is an eclectic activity; there is no one right way. 9 The procedures are neither ‘scientific’ nor ‘mechanistic’; qualitative analysis is ‘intellectual craftsmanship’. 10 The results of the analysis is some type of higher level synthesis.’ (Ely et al 1991: 177-178).

¹²Categories are movable, changing ideas which provide links and overlaps, crucial in developing overall themes and meanings (Ely et al 1991: 147). Initially the researcher may identify many categories. Identifying subgroups in categories can clarify differences in the data and connections between the categories (Bryman and Burgess 1994: 7).

reductionist processes, the subsequent, unavoidable muting of some stories in order to privilege others, and the prizing apart of lived experiences from the interpretations of those experiences. All of these spoke to me of unacknowledged gender and other biases. Without situating researchers in their own world and in relation to those they research, the need to reconcile the particular and the universal by 'reconciling an individual case's uniqueness with the need to understand generic processes at work across cases' (Huberman and Miles 1994: 435) could easily erase diversity. After all, 'knowledge and claims to knowledge are reflexive of the process, assumptions, locations, history, and context of knowing and the knower' (Altheide and Johnson 1994: 488). And despite the reflexivity discussed above, the process of fitting data into a structure of categories and shifting segments to their appropriate places seemed at odds with the idea of enabling respondents to be heard.

Reliability and validity: should this be a goal of qualitative research?

Qualitative research is frequently measured against, compared to and situated in opposition to quantitative research. This appeared to be more marked in the analysis, where, for example quantitative concepts of validity and replication may be inappropriately applied. One of the uneasy ways in which quantitative validity has been transferred to qualitative research is through the notion of triangulation, a concept borrowed from surveying and navigation. 'The underlying idea is that the wider the variety of evidence you can bring to bear, the smaller the area of doubt about your position (Porter 1994: 70). On this view, judging conclusions can be seen as a generic problem in qualitative research: 'the character of qualitative research implies that there can be no criteria for judging it' (Hammersley 1992: 58). This was frequently raised (Altheide and Johnson 1994: 485, Hammersley 1992: 58, Huberman and Miles 1994: 438-439, Lincoln and Denzin 1994: 578, Miles and Huberman 1994: 2). A broad answer suggested avoiding 'relativistic despair' (Edwards and Ribbens 1998: 4) by focusing on rigorous reflexivity and openness throughout (Edwards and Ribbens 1998, Nicholson 1999, Shildrick 1997).

Terms such as reflexivity, rigour and authenticity seem more appropriate and are gaining currency in qualitative research. Broadly speaking, discussion has focused on 'reflexive accounting' (Lincoln and Denzin 1994: 481) and the ongoing analysis of the research process itself. Or appropriating terms such as rigour, to mean 'being clear about one's theoretical assumptions, the nature of the research process, the criteria against which 'good' knowledge can be judged and the strategies used for interpretation and analysis' (Maynard and Purvis 1994: 25), leaving adequate decision-making trails (Ely et al 1991: 156). From a feminist perspective, authenticity includes an ethical orientation to uncover structures that oppress women and retain a closeness to the lives of those women being researched, so that the research is meaningful to them. In the context of multiplicity, uncertainty and transience, I have attempted to balance reflexivity, rigour and authenticity by: providing an account of my journey; discussing the role of the researcher in the section below; revisiting the notion of voices; and drawing extensively on the women's accounts throughout my analysis, sometimes providing long sections from the transcripts.

Role of the researcher

As the main instrument of research, the researcher is a priori an interactive participant in the research (Dey 1993: 37-38, Ely et al 1991: 147), from the 'devising and refining a thematic framework to 'judgements as to the meaning and significance of the data' (Ritchie and Spencer 1994: 180-182). In a more complex explanation, Maxine Birch (1998) suggests that it is difficult to distinguish between the respondents' stories and the researcher's story¹³. And yet, as Morwenna

¹³This thesis arose in part from the accounts of a particular group of 30 women and what they chose to share and withhold. It arose in part from reviewing tens of thousands of pages of texts which became thousands of pages of hand written notes. These were summarized and rearranged again and again to present a coherent account - but it is unclear how occasional

Griffiths suggests (1995) it is this very process of self-discovery that most enables researchers to avoid turning research into a self-fulfilling prophecy and to attempt to understand others' worlds: 'a profound level of self-awareness is required to begin to capture the perspectives through which we view the world; and it is not easy to grasp the 'unconscious' filters through which we experience the world' (Mauthner and Doucet 1998: 122). The researcher 'must attempt to recognise personal prejudice, stereotypes, myths, assumptions, and other thoughts or feelings that may cloud or distort the perception of other people's experiences' (Ely 1991: 122).

Part of this awareness included some understanding of one's own tacit knowledge (Ely 1991: 104), and how it interacts with that of respondents (Altheide and Johnson 1994: 492). Researchers may engage with research from their own interests and passion (as I did) and be accused of over involvement and subjectivity, especially when they work outside dominant ideology. Liz Stanley and Sue Wise (1993) wryly ask 'how many other professionals, [...] make such a fetish out of *ignorance*, elevate it into the only possible claim to professional competence?' (169). They suggested that involved researchers are in a unique position to put forward experiences and understandings of minority groups based on their own knowledge, experiences and understandings. Although in research with mature women students, Janet Parr (1998) felt that her 'background and experiences could be a double-edged sword, both enabling and limiting of women's views' (91). Her assumption about there being 'barriers' for women returning to education was not shared by all those she interviewed: the danger of over-identification needs to be borne in mind (Hughes 1994: 40). As I listened to the diverse views and experiences of the women in my study, I concluded that my tacit knowledge of home birth provided a base of commonality from which to engage with women and develop the first interviews. However, tacit knowledge is not sufficiently processed and was gradually replaced by the sustained dialogue between the women's accounts and the theory I engaged with. As Ely and colleagues (1991) comment, 'the familiar, when observed from a different stance, or a new perspective, may frequently turn out to be quite unfamiliar' (127).

And yet, there is a becomingness in ourselves, that prevents us fully knowing ourselves (Griffiths 1995). This and the becomingness through interactions between selves and others exude uncertainty and transience. It may be explained in more conventional terms as data being produced, rather than collected (Dey 1993: 14, Miles and Huberman 1994: 56). And in terms of self-discovery and political transformation may be seen as enabling rather than inadequate research. Thus what I initially saw as a problem also provided opportunities to further the process of dialogic transformation, as the following two excerpt from my interviews demonstrate¹⁴:

'But it's been, it's been very interesting for me to talk to you, because I think you've been asking me about things that I haven't necessarily formulated
N In a way that's the problem with research too isn't it, because I can put ideas into peoples heads to a certain extent and interfere with your process

paragraphs, phrases, and words were included and others excluded. It arose in part from the conversations I had throughout the process and conferences I attended. It arose largely from the person I was and am becoming and attention to my own authenticity, which meant interpreting women's accounts through a deeper understanding of the processes of oppression. It is possible that with different women, literature, and significant others, and that with less encouragement to follow my own journey, I may have written a rather different thesis from a different place on the journey. However, I am also convinced that the strands of women's multiple concerns, the importance of relationship and the support or undermining of autonomy would still have been visible. In this sense my authenticity and the women's authenticity create the indistinguishability of our stories, and yet I had an overwhelming sense of bringing women's muted voices from the margins to the centre.

¹⁴I have not given the women in the study pseudonyms in order to protect their confidentiality. Given the very small number of women who have home births in Scotland, even replacing women's names with others would have made some of them potentially more recognisable. Where I include one of my questions or comments, I insert my initial (N) at the beginning of the sentence.

It doesn't feel like that's what was happening. It's like I feel your questions have been quite minimal, so, it's like, as you're asking me things I'm thinking about them. So I don't feel like you've put stuff into my head. It's like, oh yeh, what about that then and so it does feel like it's you know, it's actually my thought process

N That's good

Yeh, yes, so I think, I mean, I do think it's quite unusual, it's certainly unusual in my experience to have somebody asking questions about the birth generally and just wanting to hear about what I think'

'N MmI think I've probably asked you the questions that I've thought of, I don't know if there are things that you'd like to add or that you've thought of?

Not really (both laugh) I've kind of.....expelled all my thoughts and some I didn't know I had (both laugh)

N That's a tricky thing about research, not wanting to put words into people's mouths or

Well, when you don't have to cos nobody really asks that many questions about what you want'

In other words, the acceptance of multiple selves and selves in states of flux and becoming makes for complex research rather than negating research. Jane Ribbens' (1998) questions are still pertinent:

'over time, I have come to realise that, even when I try to 'listen' to my own voice and to 'know' my own feelings and wants, other images and voices intervene This has raised numerous questions. What do I mean by these various 'voices' and where do they come from? Might some of them be 'imposed' upon me and is there one voice which is more 'authentic' or 'truer' to 'myself'? Are some voices external whilst others are internal? Which of these voices is actually verbalized and under what circumstances (a major question for research). Are some voices silenced even before I hear them myself?' (29).

But, our job as researchers is to reject any appeal to an essential core self, further our own becomingness, and create spaces for women to further theirs, so that more of our imaginations, as well as experiences of "what is" may be voiced. As both Morwenna Griffiths (1995) and Michelle Fine (1992) suggest, it is in the moving between the fractures of "what is" and "what could be" that new possibilities and critical reflections may arise (225-227). Movement itself opened spaces (moving between the realistic, sometimes pessimistic expectations and ideals of the women, between disciplines and theories, and between women's accounts and theories), in the same way that movement may create different possibilities during birth.

Muting or retaining voices

But thought in process or becomingness needs to be heard and acted upon. As I read the interviews more and more carefully, I began to understand that the silencing or muting I discussed in the last chapters is as much or more to do with the researcher's listening abilities and their own silencing as the women's difficulties in imagining beyond norms. In the same way that the women made themselves vulnerable by sharing thoughts, feelings and experiences that challenged orthodox thinking, the researcher makes herself vulnerable by reporting this (Mauthner 1998). Thus concern to protect women may hide a concern to protect oneself. "Being with" was at the very heart of my work rooted in feminism. Just as midwives who align themselves 'with women' are vulnerable but gain strength from those very women, "being with" as a researcher makes us simultaneously more and less vulnerable. Thus research can be strengthening, connected and political or we can risk

becoming part of the silencing mechanisms¹⁵. In the following quotation, Rosalind Edwards and Jane Ribbens (1998) described the intersection and ambiguity of dominance and resistance through public and private spaces, researcher allegiance and voices:

‘Social researchers concerned with domestic and intimate issues are involved in the social construction and material production of knowledge within the domain of public, and academic discourses. Ambiguity thus arises when we seek simultaneously to serve an academic audience while also remaining faithful to forms of knowledge gained in domestic, personal and intimate settings [...] There is a danger that the voices of particular groups, or particular forms of knowledge, may be drowned out, systematically silenced or misunderstood as research and researchers engage with dominant academic and public concerns and discourses [...] However hard the researcher tries to position herself within the marginalized culture, she faces a dilemma. As long as she is seeking to be heard by a public academic audience, she cannot evade the necessity to interpret the worlds and understandings of the Other into a discourse or knowledge form that can be understood and accepted within the dominant Western frameworks of knowledge and culture. Such Third World or Other voices cannot be heard by a public Western audience without the researcher as ‘interpreter’. This is the inescapable nature of its dominance’ (2-3)

Inevitably, while the private, personal and emotional remains “other” working in this area ‘is a sensitive process where participants and researchers can feel cautious and vulnerable’ (Mauthner 1998: 42). Drawing on Morwenna Griffiths (1995) work on public and private spaces, part of the role of the researcher is thus to dismantle the arbitrary boundaries created by dichotomous thinking and close the gap between the two so that voices and dialogues are less systematically situated through networks of power that increase the volume of some and mute and scramble others (which then appear to need interpretation).

In the previous chapter I discussed the difficulty of hearing about women’s lives through ‘predominantly male-stream public language, concepts and theories’, as well as that of hearing ‘stories which might contradict dominant feminist understandings’ (Mauthner and Doucet 1998: 137). The voices of the respondents are particularly vulnerable to being lost or appropriated¹⁶ (Mauthner and Doucet 1998: 137-139, Reay 1996). I thus continue the discussion here, in the light of some of the above debates about autonomy, subjectivities, potential and limitations. Rosalind Edwards and Jane Ribbens (1998) specifically mention that ‘while there is now a significant body of feminist literature devoted to issues of gaining access to research participants and of reflexivity within the data process, far less feminist attention has been paid to the processes underlying the retention of research participant’s voices in the phases of data analysis and writing up’ (15-16)

There are of course intentional silences (Morgan and Coombes 2001)¹⁷. This was brought keenly to my awareness when I was asked to take part in what I considered to be sensitive qualitative

¹⁵The dangers and possibilities are clearly mapped out. For example, Michelle Fine (1992) warns against using others’ “voices” to further our own theories or romanticise women’s voices (218), but equally:

‘that we fail to articulate how, how not and within what limits is a failure of methodology and a flight from our own political responsibilities to tell tough, critical and confusing stories about the ideological and discursive patterns of inequitable power arrangements’ (219)

¹⁶ Iris Marion Young’s (1990b) contention is that in some cases oppression is so endemic and pervasive, that theories of equality are insufficient to provide marginalised peoples and groups with audible voices, and merely mask oppression. My “insider” or tacit knowledge about the difficulties of expressing alternative views about birth (Edwards 1996) not only provided another strand of commonality, but enabled me to understand some of the inequities involved.

¹⁷None of the women in my study, for example, mentioned experiences of sexual abuse that might have shaped their thoughts and feelings about birth and place of birth, though it is likely that some women had suffered abuse, (whether or not this was part of their conscious memories). It may also be that women who had conscious memories of abuse chose

research. As one of a small group of people, with a minority viewpoint, I felt potentially recognisable and therefore cautious. I found myself responding to questions in a measured and restrained way and omitted anything I considered to be “radical”. I fell back on stylised responses rather than my own spontaneous speech, reminiscent of Griffiths ‘frozen’ language (1995: 161). Whether or not this is conscious, Jane Ribbens (1998) suggests that voices are frequently monitored through morality:

‘if I am doing this in relation to myself as my own moral audience, how much does this happen for our interviewees who may well be simultaneously acting as moral audience for their own feeling voices concerning sensitive private issues, as well as attending to us as moral audience?’ (33)

And as Tina Miller (1998) found:

‘The complexities and contradictions at times discernible in and across women’s accounts appear to be linked to their perception of ‘acceptable’ ways of voicing their experiences. What becomes clear is that an epistemological struggle is experienced by some women, the privileging of different ways of knowing, of different (private, public and personal) knowledges over others. Antenatally the public (medical) account is often the most dominant. This should not be surprising in a society where doctors hold the ‘privileged stories’. Voicing a public account does not appear to involve risk, women are perceived to be preparing ‘appropriately’ for motherhood’. (Miller 1998: 69).

Natasha Mauthner (1998) raised the issue of ‘moral voices’ as a way of looking at how women speak through the ‘cultural norms and values of society’ and how these ‘moral voices often conflicted with, and constrained, the mother’s concrete day-to-day experience’ (133).

As I mentioned on page 95, Nicholson (1999) advocates an acceptance of research limitations. Similarly, Mauthner and Doucet (1998) suggest that ‘we have to accept the losses and gains involved in this process, and hope that a version of our respondent’s concerns is made public, even if it is not their exact version nor necessarily all of the issues they regard as paramount’ (141)¹⁸. It is to the ‘losses and gains’ that I turn to next, as I attempted to find an appropriate way of analysing a large number of long interviews, through what may appear to be incompatible approaches: a software data analysis program and a voice-centred relational methodology, I discuss below. The ‘bricoleur’ (Shildrick 1997: 5), ‘nomadic (Braidotti 1997: 60), ‘open-ended’ (Okely 1994: 28) or ‘eclectic’ (Turner 1994: 212) approaches became even more pertinent in the analysis.

NUD*IST

Renata Tesch (1990) provided a detailed account of software analytical programs and NUD*IST seemed most appropriate in terms of its flexibility and ability to deal with large amounts of qualitative data. The dangers and imponderables of computerised analyses were also detailed: they may be used to lend authority to analysis, to appeal to objectivity, and to gloss over the uncertain analytical process, to contain anxiety (Mauthner and Doucet 1998: 123) It is unclear how standardised, computerised packages impact on the uniqueness of each research project, or how software packages may ‘condition the analysis (Bryman and Burgess 1994: 217-221). While the

not to respond to the invitation to join the study.

¹⁸All findings are in fact tentative, and I am reminded of Bryman and Burgess’ (1994) salutary claim that it is still unclear ‘how issues or ideas emerge in order to end up in the finished written product’ and further, that ‘the real problem is that we simply do not know why certain themes emerge as core elements of the report’ (224).

focus of analysis is on emerging theory, Michael Huberman and Matthew Miles (1994) suggest that software has built in assumptions about theory (423).

My own concerns about using NUD*IST were fourfold: 1) that despite acknowledgments about its limitations and reassurances about these (Richards and Richards 1994) it would lead to concrete/mechanistic rather than fluid/imaginative coding, because of the speed and ease of coding and thus become a 'data disposal' system rather than contribute to a thoughtful analytic process, and turn computer coding into data analysis (Mauthner and Doucet 1998: 129); 2) that despite the easy retrieval system, the analytical process may become more invisible; 3) that it might increase the possibility of losing the uniqueness and context of the individual woman and her life: and 4) that it may be based on and contain male-centred ways of approaching data which may be at odds with the feminist postmodernist methodology I had developed and attempted to sustain throughout the thesis.

In answer: 1) Coding was in no way mechanistic or concrete. Because I had focused on the concerns of each woman, rather than using standardised questions, there was no way of coding the data quickly or systematically. I was unable to set up a coding system or tree prior to coding and therefore laboriously devised a coding system as I moved through each interview (see Appendix 6). Each word and line of text in each interview had to be pondered over. This meant that there was a great deal of scope for imaginative ideas and flexibility. The ease with which codes and sub codes could be created and deleted built in experimentation. Unlimited space meant that as much of the interviews could be coded as I wanted and having a complex system was in no way cumbersome. Thoughts and comments could be included quickly and immediately through the memo-ing system or as annotations in the interviews themselves. As Jane Ritchie and Liz Spencer point out (1994), 'even where the analyst has been the sole interviewer, it is likely that recollections will be selective and partial' (178). Using NUD*IST provided me with a more systematic way of attending to each woman and each interview.

2) In terms of visibility, I often had the impression of sections of interviews, coding, memos, and annotations disappearing into a black hole. At any one time very little is actually visible on the screen. This introduced a sense of fragmentation, exacerbated by one of NUD*IST'S weaknesses: its reporting system which appeared to maintain rather than decrease fragmentation of data.

3) Theoretically there was no reason why uniqueness and context should be lost, but in practice the process of coding seemed to fragment both women and context. As the coding system took precedence and the women receded, their experiences receded and theory took precedence.

4) The actual fragmentation was indicative of a conceptual fragmentation which led me to abandon NUD*IST for some time, in order to re-examine the interviews from my methodological perspective. Had I continued with NUD*IST alone, it is likely that the underpinning concept of relationality would have remained fragmented. I would have perceived its effect in relation to certain aspects of the data but may not have seen its pervasiveness across themes.

While I developed a certain confidence that Lyn Richards and Tom Richards (1994) discuss in their own research (165)¹⁹, I concluded that this was partly a seductive, technological illusion. And while I was able to make connections in the coding system, I lost the connections in the interviews. The focus was on making connections too quickly within the tree coding structure while losing sight of the connections and fractures in and across the women's accounts. In other words, using NUD*IST removed me too quickly from the women and their stories so that the male-based separation ideology, that I discuss in my analysis prevailed. Thus the concerns of Alan Bryman and Robert

¹⁹They claim that 'the resultant web of meaning will certainly be more complex and more confident than the manual method would have supported, the knowledge of the data deeper and the researcher equipped for interrogating results in ways that were not possible in the filing cabinet' (Richards and Richards 1994: 171).

Burgess (1994) that there is the ‘problem of attaining a higher order of abstraction without compromising the authenticity of [the] data (that is, the views of those being studied)’ (219) and Huberman and Miles (1994) that the process of abstraction may lead the researcher away from the data (440) was increased rather than reduced. The voice-centred relational method I describe next redressed this problem.

Voice-centred relational method

I have discussed Carol Gilligan’s (1985) work, ethics of care (Ruddick 1989) and relational knowing (Belenky et al 1986) and some of the criticisms of this work in Chapter 5. Criticisms included the failure to take account of men and women’s location in networks of power and the likelihood that underlying power structures that favour men and disfavour women may play a part in constructing the very differences noted. My feminist reading of postmodernism included a commitment to enabling women’s voices to remain central as far as possible while retaining diversity, acknowledging power as a central marker of those voices, and avoiding closure. The voice-centred relational method of data analysis developed by Natasha Mauthner and Andrea Doucet (1998), from work by Lyn Brown and Carol Gilligan seemed best to complement and further this approach. At the heart of this is ‘relational ontology’, ‘selves-in-relation’ or ‘relational-being’, which focuses on the interdependency rather than the independency²⁰ of people ‘by exploring individual’s narrative accounts in terms of relationships to the people around them and their relationships to the broader social, structural and cultural contexts within which they live’ (1998: 125-126). While pondering over the interviews, I had already tentatively identified a relational way of being, which appeared not to fit with the rhetoric of choice and rights. For example, as I mentioned earlier, the women in the study were aware of their rights, but these were often perceived as secondary to relationships with their midwives. The concept of relationality enabled me hear and analyse its influence at a sustained and deeper level.

The method involved three or more readings of each interview. I followed the four readings suggested by Mauthner and Doucet and included a fifth reading to acknowledge the relationships I had developed with women as I listened to their accounts on several occasions over a 12-18 month period, and to bring this timeframe into the analysis.

First reading: Plots within plots within plots

During the first reading I listened carefully to the women’s narratives for the main events and people, recurrent themes, images, words and metaphors, concerns, hopes, contradictions and puzzling aspects. As Mauthner and Doucet (1998) suggest, I focused on my own response to the interviews; emotional, intellectual and embodied. As my responses surfaced I was able to discover more about my own location in relation to the women (126-127).

During this first reading I became aware that because of the strong conceptual framework I had developed, I had been filtering the women’s accounts through theories and structures of oppression before creating space for women to speak. The close relationship with the interviews during this reading destabilised the process of imposing theoretical interpretations before fully hearing what was being said. It was in this space that I was more able to hear women’s articulations of alternative ways of thinking about birth. The theoretical framework together with the fragmenting process of coding had led to a tendency to focus on women’s struggles, their “otherness”, rather than on their imaginations. As their imaginations freed mine, I became more aware of how I had been “captured” by medical ideology and how my ideals had been limited by constant negotiations with that

²⁰Morwenna Griffiths (1995) provides an interesting critique of the meanings of dependence and independence and the gender based, value biases located within these terms.

ideology. I also began to understand more about the different context in which I had planned home births and the greater polarisation of issues in the 1970s compared to the 1990s. This freed me further to listen to the diversity and complexity in women's accounts.

This first reading focusing on plots provided me with the opportunity to reconfigure my thinking about the so-called subplots I had been coding. I began to see my earlier observation, in practice: that these were often to do with difficulties in hearing women's alternative readings of birth, and their unease with dominant ideology together with an unease about expressing dissatisfaction. Muting was as much on my side as on the women's and ironically, their voices could have become more muted during the analysis, had I not read Mauthner and Doucet's work. In reconfiguring the notion of plots within plots, I was able to explore the possibility of multiple voices serving particular purposes: balancing the need to perceive oneself as autonomous and developing positive experiences and stories²¹, while acknowledging where this was difficult to achieve; and a protection from unyielding outside circumstances.

Overall, this first reading gave me a greater understanding of the women as individuals with their own knowledges, experiences and concerns. By paying attention to where I related more or less closely with women, I was able to challenge my own assumptions, decrease judgemental attitudes, increase my ability to be 'with' women, and move further away from medical definitions and language of birth, with them.

Second reading: Staying with women

The second reading formed a continuation of the first, but focused on listening to how women talked about their thoughts and feelings in relation to themselves and others, and in relation to the social networks around them, by tracing 'I' 'we' and 'you' and the movement between these in their accounts. 'Spending this time carefully listening to the respondent creates a space between her way of speaking and seeing and our own, so we can discover [...] 'how she speaks of herself before we speak of her'' (Mauthner and Doucet 1998: 128). As I have mentioned above, coding and categorising the interviews through assigning units of text to NUD*IST nodes rendered the women more passive. Focusing on the 'I' brought the women back into the texts as vital, active, engaged subjects. Focusing on the 'I' foregrounded women's knowledge, power and resistance, whereas focusing on theory foregrounded their suppression and silence.

Focusing on the situated 'I' gave me a greater sense of women's connectedness. It also gave me a sense of how disconnectedness, fractured autonomy in relation to social networks (familial, and professional), by reducing the possibilities of shared decision-making and responsibility, and locating women outside cultural norms. I became aware of the self being marginalised through wider social structures because of the experience of being marginalised by home birth. I developed this aspect during the fourth reading.

Staying with the 'I' enabled me to see the shifting, rather than disjointed or contradictory 'I' that I described in the previous chapter. It provided me with more insight into the possibilities and limitations of the self in relation to dominant and resisting ideologies and how the self is positioned through comparison and contrast with others selves. I gained a deeper sense of the balance between women in my study as both self-determining and marginalised (oppressed) actors²². In terms of

²¹ I also noticed that in my efforts not to bias the research or introduce any negativity, I had a tendency to frame some questions in a way that invited positive responses. This could have made it more difficult for women to express any negative views and was tied to my need (as well as the women's needs) to produce positive stories for them, rather than stories of pain and conflict around birth.

²² Women's abilities to be self-determining were often defined by dominant ideologies and therefore limited. For example,

voices, the movement between shifting 'I's and 'you's maintained space to reconsider, develop ideas and search for new authenticities²³ as new information, insights and experiences occurred. It enabled women to examine their views in relation to socially constructed paradigms²⁴.

Focusing on the 'you' enabled women to: look beyond themselves; imagine other's experiences; see things from others' perspectives; and generalise and speak for the culture. This increased my understanding of a less discrete 'I' than that of Cartesian thought. This in turn brought the 'leaky bodies and boundaries' (Shildrick 1997), of the fragmenting/separating self giving birth, into sharper relief. In dialogue with the theory I discussed in the previous chapter, I was able to develop deeply embedded themes about the embodied experiences of women, their ambiguity²⁵ about their bodies, practices on their bodies and how these can distance them from their bodies.

Third reading: Women as constructed "other"

During the third reading I concentrated on the woman's relationships and social networks - exploring the 'I' in relation to others. This located her in terms of private and public relationships, and how they affected her.

I began to see further the implications of planning and having a home birth and its effect on the network of relationships in which women were located. The distancing or proximity of social and public networks meant that these could no longer be taken for granted, and I was able to hear where women gained and lacked support. This highlighted the insensitivity of both public and private networks to birth as an integral part of the transition to motherhood. It became clearer that neither maternity services nor social networks are designed to nurture motherhood. For example, as I suggested in Chapter 4 and discuss in Chapter 9, it was clear that interactions between women and midwives were mediated by midwives' locations in different networks, their employers, and the accepted practices and policies of the institutions they worked for. Midwives could be experienced as guardians of the norms rather than guardians of the normal. And in examining women's accounts in relation to social networks, just as Andrea Doucet and Natasha Mauthner (1998) found that they were able to critically examine the theory of equal rights and equality, I found the rhetoric of choice

one woman stopped trying to engage with midwives and became self-reliant and detached from them in response to fragmented care which she felt powerless to change (see page 299).

²³I appealed to Morwenna Griffiths' (1995) meaning of 'authenticity' here. But while multiple voices could express the complexities and ambiguities of women's lives, they also sought wholeness and some degree of certainty and closure, (often open to reconsideration). In other words, the different voices of individual women was a way of acknowledging different rhetorics while maintaining some sense of integrity: that is, a way of maintaining ideals about birth while simultaneously adapting to and accepting the existing services which limited these ideals. This was not without its costs, as Chapters 8, 9 and 10 demonstrate. While I was very aware of the need to enable diversity to emerge, I had concerns about fragmenting the already marginalised position of those planning home births. However my fear of rendering women even more vulnerable was ill-founded as my analysis demonstrated. I found diversity to be the only way of breaking oppressive boundaries and stereotypes, thus strengthening the position of marginalised women.

²⁴For example, one woman talked about her view of birth as necessarily traumatic and painful. In exploring the possibility that she might have internalised this view from cultural messages, she explored the possibility of other interpretations of birth and created circumstances in which she could experience her birth as less painful and traumatic.

²⁵For example, 'I' and 'me' might or might not refer to the body - sometimes the woman distinguished between 'me' and 'my body', sometimes she was her body. This explained theoretical discussions about the disappearance or separation of the body, because where the 'I' does not include the body it may be difficult to maintain its subjectivity, or explore and resist bodily practices. At the same time, women appeared to dislocate the mind and body in order to distance themselves from invasive bodily practices (see footnote 19 page 91). This was in contrast to the separation and reintegration through the process of giving birth and the 'I' being both challenged and coming together at the point of birth. This forms the basis for some of the analytical themes in Chapters 9 and 10 where I discuss the vulnerability and power of birth and the importance of a safe external environment to facilitate the safe disintegration of the old self, and the reintegration of the new self. This notion of disintegration and reintegration around birth provided one possible explanation for the increased self-doubt and malleability I observed pre and post birth.

and autonomy failed to take into account the male-based nature of these theories. I discuss choice, rights and control in Chapter 10.

Fourth reading: Women's acceptance and resistance

In the fourth reading, I addressed the issue of how women's accounts fitted with or challenged the 'broader social, political, cultural and structural contexts' (Mauthner and Doucet 1998: 132); whether they described these as limiting and/or enabling; and how far they saw these as private and personal problems or public, socially located problems (132). During the fourth reading I deliberately made links between the woman's accounts and the theories I had engaged with to see how they supported and challenged these. Keeping in mind issues of power, resistance and oppression, this presented an opportunity to listen to how far women reflected dominant ideologies around birth and how far they imagined alternative meanings of birth: how they moved between ideologies and their own experiences and knowledge. Focusing on their multi-layered voices and ideologies, as well as experience, enabled me to hear more acutely, where women moved between these to explore possibilities and reposition themselves.

The fourth reading provided the opportunity to examine the ways in which women experience reflected ethics of care feminisms, and how their worlds shaped that experience, bringing in issues of power as well as difference (Goldberg et al 1996), which I discussed in Chapters 9 and 10.

Fifth reading: Spending time with women

Finally, in my own fifth reading, I traced how the women's accounts developed over time, across the sets of 4 interviews. This provided me with an overall sense of how meanings of birth developed as an integral part of women's lives. I gained a clearer understanding about how women engaged more deeply with issues over time, exploring apparent contradictions, moving back and forth between ideas and generally enriching their narratives²⁶. Crucially, spending time with women during pregnancy and after birth enabled us to revisit their earlier views, how these transformed through birth, and their reflections in the following months.

The fifth reading confirmed the notion of different voices or selves being used to create spaces for change and development. Views became easier to grasp, examine and enrich through articulations of different voices. It also confirmed the hesitancy and malleability I observed above in footnote 25, and the prominence and recession of different voices as women attempted to resolve the fractures between their ideologies and medical ideology. For example, Andrea Doucet (Mauthner and Doucet 1998) found that women talked about their hopes for birth differently during pregnancy and after birth, and Tina Miller (1998) noticed that women might contradict postnatally what they had said antenatally, and suggested that 'perhaps self-disclosure is perceived as less risky after the event' (68). In a similar vein, I found that in the interviews immediately prior to the woman giving birth, the women in my study were acutely aware of their dependency on midwives for support, so while anxieties about medical ideology intensified there was also more acceptance of a medical view of birth. It was in the final interviews that women were most critical and challenging of dominant ideologies²⁷.

²⁶For example, for some women, initial negativity towards individual professionals developed into a more complex critique of a system of care not designed to support some women's views on birth.

²⁷The more critical and contentious nature of the final interviews may reflect a variety of issues. Distanced from a rite of passage and the maternity services, women may have felt more confident to criticize. The trusting relationships I developed with them may have enabled them to talk more freely and openly. Developing their knowledge and reflecting on experiences may have increased critical views, and knowing that this was the last opportunity to put forward views may have contributed to women being particularly open about these.

This fifth reading of the interviews gave me the opportunity to follow women's journeys through the transformation of pregnancy, birth and after birth more carefully, noticing the development of and fractures in their narratives. In following the women's journey's, I was also able to follow my own journey with more insight, observing the parallels and differences between our journeys (see Appendix 8).

In summary, because the five readings were meticulous and time consuming I was only able to read a limited number of sets of interviews in this way. Nonetheless, I was able to bring this perspective into the overall analysis. The advantages were that it 'delays the reductionist stage of data analysis' and avoids 'fitting a person into a pre-existing set of categories, whether those of the researcher or those of established theoretical frameworks' (Mauthner and Doucet 1998: 134), bringing 'the listener into responsive relationship with the person speaking' (134-135). Although it was developed from feminist ethics of care and relationality, Mauthner and Doucet's method addressed some of the concerns about difference and power and acknowledged concerns about essentialism and the instability of concepts such as self and voice.

During the readings, three interconnected themes wove their way through the interviews: the extent to which women's ongoing meanings of motherhood were suppressed by the focus on birth as a medical event, the social nature of birth, focused on the transitional process from the woman/baby entity to bringing a new member into a family, and the thread of connection and continuity as an integral part of connected nurturing. The analytical chapters on women's constructions of safety, their relationships with midwives and the ethics of medical ideology emerged from these first embryonic threads.

Maintaining movement in the research process

The unlikely combination of NUD*IST and a relational analytical method contributed to the dynamic process of the analysis, by opening further spaces and giving me a more complex understanding than I might otherwise have gained²⁸. For example, using both confirmed that the NUD*IST coding and categorising developed from my conceptual framework emphasised women as "other", which focused my attention on their struggles rather than on the support they needed for their ideals. Their needs remained muted beside these struggles until I used the relational method. However, the further twist here is that although the relational method highlighted women's knowledge, power and strength and NUD*IST emphasised their powerlessness, the former also highlighted their vulnerability in birth, whereas the latter emphasised their power to resist. In other words the different methods focused on different aspects of vulnerability and power.

While I carried out as thorough a literature review as I could at the time, I could not foresee what might arise during the interviews. During the analysis more complex issues emerged, and I felt the need to read more about theories that might relate to these, so that I could, in the words of Christina Hughes (1994), return to the data 'with fresh vision' (42). Re-reading data with new information and concepts in mind 'we can begin to see how the analytic process involves both the reading of raw (sic) data and the application of concepts which have arisen from outside that data' (42). Looking at data from a fresh perspective around emerging analytical concepts frequently involved re-reading the interviews to find related material, which I had not recognised or coded before (see

²⁸Before using NUD*IST or the relational method, I had read and re-read my interviews, marking up a myriad of issues and gathered these into (mainly descriptive) broader categories. I noted similarities, differences, and unusual narratives to try and understand the women's accounts in dialogue with the theories that I had already become familiar with. A more conceptual analysis developed and it was at this point that I enlisted the help of NUD*IST. I then systematically coded much of my data using free nodes and from this developed the complex tree structure in Appendix 6. I then embarked on a more conceptual account of the interviews using the integrated tree structure in the same Appendix, and only then discovered the voice-centred relational method and carried out the five readings I described on some of the sets of interviews.

Hughes 1994: 44). In this way the dialogue between theory and data continued until the final words had been written and amended (see the Introduction to Chapter 10 for example).

Writing and beyond

Part of the formulation of ideas and interpretations takes place during the act of writing: 'writers interpret as they write, so writing is a form of enquiry' (Lincoln and Denzin 1994: 481). Or as Judith Okely (1994) suggested more poetically, 'writing and analysis comprise a movement between the tangible and intangible, between the cerebral and sensual, between the visible and invisible. Interpretation moves from evidence to ideas and theory and then back again' (32). Rosalind Edwards and Jane Ribbens (1998) pointed out that when writing about the private lives of women, there is always a pull towards conformity. The 'researcher in these areas cannot escape the requirement to take cultures and discourses that are peripheral to predominant Western knowledge forms, and 'translate' them into a discourse recognisable to Western public audiences' (3). Morwenna Griffiths (1995) observes a deeper structural problem, that language lags behind social change and requires particular efforts to 'melt' aspects of dominant ideology that have become 'frozen' into its structures (161). She suggests that it is unclear whether or not it can be melted 'deliberately, especially for political reasons' (162). Thus the focus on potential and the acknowledgement of limitations continues throughout the writing up of this thesis.

Paradoxically, endeavouring to represent women's experiences in writing to the best of my ability brought with it a second consideration: the better the representation the greater the disclosure. As Tina Miller (1998) pointed out:

'the potential risk involved in disclosure of experiences which do not fit those publicly defined is heightened in research around sensitive topics such as childbirth. Childbirth and motherhood are closely bound up with ideas around 'morality' and publicly defined ways of being. Research findings which challenge such notions could be used in counter-productive ways, blaming women for perceived 'inadequacies'' (62)

Pam Alldred (1998) suggests that while we 'cannot ensure our preferred readings [...] we must attempt to ward off ones we believe to be oppressive' (163). With all of the above in mind, I attempt to provide a meaningful account of the women's accounts, staying as close to their words as possible, and an interpretation that respects their voices and takes account of theoretical debates. The results must, of course be equivocal:

'I will never know the experience of others, but I can know my own, and I can approximate theirs by entering their world. This approximation marks the tragic perpetually inadequate aspect of social research (Reinharz in Belenky et al 1986: 113)

If we understand the self to be fragmented and contingent, then it might be said that we have a double tragedy. The joy is that we can encourage multiple interpretations from a position of strength rather than weakness. Acknowledging potential weaknesses, increases the authenticity of our work. Thus in the following chapter, I introduce the women in the study from their diverse locations and concerns, in the context of a culture that does not generally encourage home births.

CHAPTER SEVEN - Planning a home birth

Introduction to the findings

As each woman made her unique contribution to this study, she contributed to the whole. Not a unified, solid mass, but a network of meanings about birth; a lacework of coexisting ironies¹; birth's puzzles as well as its possibilities; how accepted definitions of birth were far removed from women's; how these definitions could oppress their knowledges and experiences; how women understood birth; and how they dreamt of its possibilities.

Often, neither I nor they had the experience, imagination and words we needed to move beyond these powerful norms and yet among the medical terms and concepts, our language, the language of possibilities and the fractures and fissures we created, we stumbled across ideas and meanings, sometimes in a flash of insight, often beginning as a seedling notion. Concepts such as birth as an integral part of woman's life journeys, the social aspects of birth, the role of the midwife, the negative intrusions of unnecessary interventions and the difficulties of moving beyond accepted ideologies were frequently returned to.

Of course women continued their life journeys through pregnancy, birth and motherhood from very different places², but the time frame to the research, provided a context in which many of the topics discussed were developed over the series of interviews. Chapters 8, 9 and 10 focus on distinct themes, but also parallel this development of threads through the broader themes of diversity and autonomy. These run consistently through the women's different constructions of safety and risk in Chapter 8, relationships with midwives in Chapter 9 and ethics in Chapter 10³.

I have integrated the experiences of the 2 women who were attended by independent midwives. Their experiences of relationships with their own midwives and the comparisons they were able to make often enriched what could only be imagined or glimpsed at from other women's accounts. I have also integrated the experiences of the 7 women who gave birth in hospital. They were often able to articulate the ethical implications of medicalisation in ways that again, could only be imagined or glimpsed at by other women.

Ironically, while women planning home births are already marginalised and assumed to hold aberrant beliefs, journeying towards giving birth at home often led them further away from medical meanings of birth. They became aware of a system of care constructed from a knowledge base which was perceived to be at odds with their understandings and concerns about their births, babies and families. And yet none of the women wanted to make decisions in isolation. If their views and those of others did not coincide, they might seek other sources of information and support. But however strongly they felt, all but one women (whose views did not challenge those of her midwives) expressed that they found it difficult if not impossible to assert themselves beyond a

¹It is through diversity that I attempted to maintain the integrity of the 120 in depth interviews I carried out with the 30 women in this study. But I tried not to fall back on modernity's binaries and merely invert them, by privileging difference over similarity. I attempted rather, to weave the two in the way they were woven in the interviews themselves, reflecting the substance of women's lives and exemplifying the "becomingness" I wished to maintain.

²For example, 12 of the women planned and booked home births as a first choice for the birth of their first babies. Other women thought about home births but were put off during previous pregnancies, and others changed their minds about hospital births during their pregnancies.

³The struggle for meaning of commonly used theoretical terms, such as rationality, subjectivity and embodiment that I addressed in the literature review enabled me to see parallel tensions in commonly used terms in the childbirth arena, and the potential for different meanings. This unlocked doors to previously unimaginable ways of following women and their hopes about and experiences of birth.

certain point. While this point was different for different women, many felt unable to express themselves freely, openly and honestly about their ideals and how these could best be supported (I discuss this in Chapter 9 on page 249). These ideals were usually tempered by what women felt they could say without causing 'trouble' or 'waves'.

Thus in essence, this thesis is about how women attempted to move through their pregnancies with some degree of integrity, dignity and control. It is about the paradox of women feeling obliged to familiarise themselves with medical knowledge, while at the same time developing alternative knowledges and alternative sources of information and support, in the hope of balancing the realities of our culture with their personal ideals. They attempted to sift through medical evidence without abandoning their own beliefs to find compromises which were not too far removed from their aspirations, beliefs and knowledges and close enough to their midwives practices not to threaten these relationships⁴. The degree of divergence between women and their midwives dictated the success or otherwise of this. Thus relationships/relationality/connection form the bridge between the different sections of the analysis.

One of the particular difficulties the women experienced was the lack of open dialogue between the different knowledges. While they experienced some acceptance by midwives of alternative views and skills which did not directly threaten or conflict with medical policies and protocols (I have called this 'stretching the medical model'), where these views clearly diverged, the system became particularly closed - as in the case of breech birth at home and meconium staining during labour at home (see page 190, footnote 94 and page 220). Both were said by midwives to necessitate transfer to hospital care, because local policies dictated that this was so. These circumstances (along with others) became symbols of the boundaries which midwives were unable to cross to be with women. Consequently, there was often a fear that midwives would be unable to complete the journey with them through labour and birth, and that they might be abandoned at a time when they felt most vulnerable and in need of support⁵.

⁴As will be seen in Chapter 9, this does not apply to those women who booked with independent midwives, and is less true of the few women who were able to get to know a community midwife well.

⁵The metaphor of journeying through birth has been identified by other childbirth researchers (Halldorsdottir & Karlsdottir 1996, van Olphen Fehr 1999), but Julianna van Olphen Fehr suggests that phenomenologically speaking, studying women's experiences prospectively provides less opportunity to reflect on these experiences. My prospective research however suggested that talking to women before and after birth, could extend this metaphor of journey to one of a journey within a journey as I suggest on page 135. This sense of journeying and transition was captured by one of the women in the study, who initially planned a hospital birth but changed to planning a home birth:

'I mean, it's just once you see it from the other point of view, you realise that it makes a lot more sense in a way, not to go away from your home to have a baby'

And again when she described how her internalisation of dominant ideology was reassessed. She had previously stated that she would always think of hospital birth first as this is the norm, but in the final interview said she no longer felt this:

'no, I don't feel that way anymore ... (laughs) it wouldn't even occur to me really to I suppose that has been expiated by, you know, the births that I've had at home No, I don't feel that I have to relate everything to what happens in hospital'

The metaphor of journey was not intended to convey a linear, progression, which women moved through. It more closely resembled stepping stones or Nancy Griffith's web (1995: 141). Though this was sometimes part of a more sustained journey of re-examining other aspects of dominant ideology - such as those on nutrition, vaccination and schooling for example. This was more marked in Robbie Davis-Floyd's (1992) study, where the technological model of birth appeared to be more entrenched. Planning 'home birth is so antithetical to mainstream American behavior' (206) that it almost inevitably entails a rejection of core technological values in favour of others. She found that women who planned home births after previous hospital births made other conceptual shifts, becoming interested in natural therapies, recycling, whole-wheat bread and so on. 'It seemed, in fact, that they were actually using their births as a means to change their personal belief systems - undergoing on an individual level what Thomas Kuhn, speaking of changes in scientific models of reality has called a paradigm shift.' (293). Confirming some of the feminist theories about women's development and cyclical time, I referred to on page 58, I found that women's journeys could be both a way of reconnecting with different parts of their muted selves and their histories, creating new identities and patterns for themselves and their families, which might embrace or reject alternative and dominant values. Thus the metaphor of journey could extend across generations:

'somehow I had a very strong feeling that because she's a girl and she might one day have babies of her own, that maybe I'd set her one stage freer than I'd been myself. Because I knew my own birth was not anything like

The fall out for the often uneasy compromise which entailed a degree of erasure or muting of the woman's body of knowledge and material body resulted in varying degrees of disruption and trauma. Internal disruption and trauma to the woman's sense of herself and her abilities to manage childbirth and effect decisions, or external disruption and trauma within the relationships between herself and her baby, other members of her family, other women in her community and her midwives (see Chapter 11). On the other hand, when women and midwives were able to come together through trust, in the woman's abilities to give birth and the midwives' skills to support her, the relationship could contribute to greater safety (see Chapter 8), increase the skills and knowledges of woman and midwife (see Chapter 9) and provide the basis for experiences of childbearing that could enhance a woman's self-esteem and her ability to be autonomous (see Chapters 10 and 11).

Chapters 8, 9 and 10 theorise the different ways in which women interacted with the public/political context of birth. In the next section in this chapter, I therefore provide a more descriptive account of women's decisions to plan home births; the social networks in which they were located and sought support; and their initial concerns about birth. In other words, as Mauthner and Doucet (1998) suggest (see page 115), I describe how the women spoke of themselves and how they located themselves before locating them too strongly in the wider political arena.

Focusing on women

For some women home birth was a first choice, others moved towards it due to an erosion of trust in medical ideology and some because of growing confidence in their abilities to birth their babies. Some women planned home births following unsatisfactory or traumatic births in hospital, or straightforward births in hospital. Some women initially went along with the automatic hospital bookings until they had the information and confidence they needed to book the home birth they wanted, some changed from a hospital booking they had previously chosen and a few decided to plan a home birth just before their baby's arrival. Having a previous home birth made the decision about where to have a subsequent baby a 'foregone conclusion' for one woman, another felt anxious about 'pushing her luck'. However they came to home birth, the reasons women gave for planning these were similar to those identified by others (see page 149). These focused on a peaceful environment in which the woman could birth her baby in her own time and way (Viisainen 2000a: 72-73).

But, as I discussed elsewhere while women gave many similar reasons for planning home births, their concerns varied (Edwards 1999). A number of women talked about previous births in hospital as being traumatic and violating experiences, which they did not wish to repeat. For these women home birth seemed to offer protection. Another woman described home birth as being part of a journey of self discovery and reclaiming her self-esteem and power, which she felt had been lost during her life and experience of earlier births. Several women had deeply held spiritual beliefs, which they felt could best be maintained in their own homes and which most thought could not be maintained in hospital. Indeed, one of the most striking features of this study was that while women planning home births are often stereotyped, there was a wide spectrum of views on many aspects of birth. Women could not and did not want to be stereotyped. Some stressed their ordinary-ness, stating that they were not 'radical', and did not want to be perceived as 'different', 'difficult' or 'making a fuss'.

her birth was. And I kind of got the feeling that I'd achieved something on that level too, especially because she's a girl, that yeh, maybe I'd broken something, a long cycle of family history of difficult labours and babies being born in traumatic ways, and maybe I'd left her with something to go on in her life with, and that was a very good feeling too'

Planning a home birth in the context of a hospital culture

As I observed on page 49, research on home birth which included women's views has been interested in the types of women who have home births, their reasons for making this choice, and their reflections on these experiences. While the social and political context is implicitly included in some of these studies, most have not focused specifically on the contexts in which decisions can be made⁶. As I discussed in Chapter 4, the social construction of birth and childbearing practices incorporate and reflect the values and beliefs of any given society. Where, how, and with whom women give birth is fundamental. They and the rituals applied to birth tell us a great deal about who holds authoritative knowledge, society's beliefs about acceptable practices and how these are inscribed. One of the most vivid examples of this is the conceptual and literal move from home to hospital:

'Your whole life is spent being told that you have babies in hospital and that just seems to be the thing that you just presume. When you have babies, you'll go to hospital to have them. So I suppose a lot of women don't even consider having a home birth, just because it seems the norm to have them in hospital, you know. It's what always seems to have been recommended and what the experts think you should do, or so-called experts think you should do'

If for any reason this has not been internalised, societal norms become apparent:

'I think I've been quite surprised that other people have been so surprised. Like people at work have been so surprised that I'm having a home birth. Really, as if they've never heard of anybody ever having a home birth before, which I didn't realise it was so unusual. Really, I mean it doesn't bother me that it is, but, I wasn't expecting it to have quite that (laughing) that effect on people'

Planning a home birth in the context of women's own social networks

It was in the context of her own social network that each woman first negotiated her plans to have her baby at home. While it is impossible to determine from my research just how decisions were made⁷, and how complex influences impacted on these decisions, there was evidence that the

⁶Robin Gregg's (1995) analysis provided an in depth exploration of the context in which women make decisions regarding antenatal testing.

⁷For example, I observed that all the women had had contact with home birth, through family members, friends, communities both here and abroad and antenatal groups. For many women this was a close connection, through mothers, sisters and close friends and was part of their life stories, as in the quotations in the main text below. For others this was a more tenuous connection, and for two women, videos seen in other contexts seemed influential. While it is difficult to ascertain the significance of contact with home birth, recent qualitative research suggests that it may be of some import. Researcher, Banyana Madi presented a paper on decision making about the place of birth, at the 4th International Home Birth Conference in Amsterdam in March 2000. She found that women planning hospital births reported not knowing other women who had had home births and not knowing that it was a possibility. My own observations suggested that it is a complex process. The pull towards hospital is so strong that even when women find that medical ideology contradicts their own, even when they hear other women's views and even when they have support for home birth, few women plan a home birth. Birth has been appropriated to the extent that, as one woman remarked recently in an antenatal group:

'Even though I was born at home and my brother was born at home, and my mother said, oh, no problem, I couldn't do it the first time. And now of course I realise I could. But I didn't know'

In the following chapter, I have elaborated on women's decision-making by looking at their changing views in relation to risk and safety.

influences and responses of those around her mattered, and that the existence of counter influences and cultures portraying home birth as normal and/or acceptable provided a supportive context:

‘the feeling of, you know, my mum having been born at home and my grannie having been born at home. It means something to me, to have that continuity. I think my mum must have given me a very positive message about it, in a way that I don’t really remember but it was never a question for me, it was an assumption that I would have a home birth’

quite a lot of my friends have had babies at home, and their friends had had their babies at home, so I think probably because of that culture being around, in my friends, that it certainly makes me more positive about it’

However, these influences interacted with dominant ideology in complex ways. As one woman pointed out:

‘my mum had me at home and my brother at home so I’d always thought of home birth as being sort of like something that was normal, but being a nurse I then had the other side where I knew a bit too much, and with my first child I just thought that I felt safer myself going into hospital to have her’

But while planning her second hospital birth, this woman visited a close friend a few hours after the friend’s home birth and then decided to plan a home birth:

‘this time round I was thinking of doing pretty much the same thing, just going in [to hospital] and sort of staying overnight and coming back out again, until I went to visit a friend who was planning on a home delivery. And it was just I think the whole atmosphere. We were there the day she actually had the baby and it just felt so, I think, normal and part of everyday life, and their other wee girl was there and everything felt like that’s how it should have been, you know. Nothing was taken out of place, you didn’t have to be going out travelling somewhere and taking children out, you know, upsetting other children in the family, so that’s really what made me change my mind’

But even when the woman’s own microculture was supportive and she wanted to plan a home birth, she may not feel supported enough to do this⁸. Because of the widely held, medical beliefs about birth, it was exceptional for women not to need some external confirmation for their decisions. For example, one woman who had wanted a home birth for her first baby had been told by her GP that this was not possible. In her second pregnancy, her GP repeated that a home birth would not be possible. On this occasion, she arranged a home birth by contacting the community midwives herself. One of the differences she pointed to was her discovery of a network of support from other women who had had home births:

‘knowing that I wasn’t the only person (laughs) in the city that was opting for that [home birth] was a support in itself’

Given the prevalence of the nuclear family and that 20 of the 30 women were geographically distant from their families of origin or had lost their own mothers, their partners’ support was crucial to

⁸We know that, even in the present political climate, many more women would consider a home birth than plan one. A number of surveys suggest that this might be from 8-22% (Department of Health 1993, Scottish Health Feedback 1993). And where home birth is already supported, as many as 23% of women will give birth at home (NCT 1999). The women in this study reported that where they had wanted a home birth previously, it was often a GPs negative response that had put them off.

most. The reality of women's lives meant that all but two women stressed that they would not have gone ahead with their plans to have home births without their partner's agreement.

Women's partners

Some of the women's partners were keen to have a home birth and actively initiated or encouraged plans for a home birth. As Maggie Banks (2000), describes, men can be equally traumatised following hospital births in which control was rested from their partners and themselves (200):

'he was determined I was having it at home, because he hated what I went through in hospital, and he just said, you know, I don't want you having all that interference and everything again, and, I'd rather you had it at home'

The majority of partners were not opposed to home births, and supportive of the woman, being the prime decision-maker, on the basis that she would be giving birth:

'my partner thought it was a good idea. I think his main concern was that I felt confident. He was happy with it from the start. I mean, he was as far as I know. It was basically what I wanted, since, I mean, I was the one giving birth'

A number of partners were however apprehensive until reassured by: research; knowing that there was a community service; knowing that similar others might make the same decision; and experiencing the impersonal hospital services themselves:

'speaking to my partner about it [home birth], he started off from a very sceptical sort of position. I think his sort of belief was that, you know, all hospitals are good things and doctors are good things. So I think having to be clear about what I was saying to him so that he knew what I was thinking was very useful and he's come to fully support me and think that it's definitely the right place to give birth, at home'

'when I first suggested it to [partner], you know, he was like - a home birth? Oh! You know, it wasn't until he realised that, you know, they bring equipment and the midwife's here, and you know, until he realised all this, he was a bit unsure himself'

'I then started thinking about it [home birth]. My husband wasn't terribly keen. I think he thought I was a bit mad, and he obviously thought it was you know, dangerous and things. And then we started going to antenatal classes and there was one couple there who had planned a home birth and they were both nurses, and I think that was what convinced my husband that it's not weird people with sandals and joss-sticks in the corner who had home birth but actually people who could actually assess the risk'

'he instantly said, oh no, I mean, cos he's very sort of working class and just said, we need men in white coats there for it to be a proper - sort of half joking - and then he's also very tidy, so he said, what about the mess. So that was his concerns [...] Well I got the feeling that he wanted some sort of facts and figures about what are the risks and all that sort of thing. But actually he's come round very quickly and, I don't know, I think, just going on these hospital visits, he just has felt so kind of marginalised and really not respected'

For one or two women who had had traumatic experiences of hospital births, avoiding a similar experience was so crucial, that the plan to have a home birth was negotiated before the woman felt able to have another child:

'I think when [partner] and I started talking about having another baby, the first thing that came in to my mind was, I can't bear going through all that antenatal care. It made me angry, and going into a labour ward and, okay, I might not know what's going to happen, but I'm still going to feel very disempowered and suspicious that (sighs) nobody's listened to me, and that was, even before I got pregnant. I really felt that had to be sorted out [...] and I was voicing lots of doubts about being in hospital to my husband and he just said, out of the blue one night why don't you have the (laughing) baby at home then, you know. And I thought, hurrah (laughing) because I had been really scared to mention that to him, cos I thought he'd just go, oh no way, I couldn't possibly cope (laughing) with that'

Women's close family

For some women, responses from their parents and parents-in-law were important. This was often the case when they planned to provide practical help and support around the time of birth. Responses from parents were as varied and as open to change as those from partners. Some of the women's mothers were positive, on the basis of their own experiences:

'my mum was great. She said, oh you'll enjoy it. She said, I had you at home, you'll enjoy it. She didn't like hospitals'

For others it raised mixed feelings:

'I mean my mother, in some way I would say that she's delighted at what I'm doing, but I think tinged with - not jealousy - but because her births were just awful, you know'

And yet others were against the idea altogether:

'My own mother despite two particularly unpleasant births in hospital for myself and my sister is not happy about my decision'

Just as women wanted the support of their partners, a number of women felt concerned about the lack of support from their mothers, but found that like their partners, they usually became more positive over time:

'my own **mother**. And you see, she's been against it from the start, and she tried - I think she thought initially that it was me that was wanting to go ahead and that my partner wouldn't be interested, so you know, she took him aside one day and she was at him, and he put her straight. He said, look, you know, it's both of us - we've talked about it. You know, we've discussed it at length for months now, before I was even pregnant and she's still not coming round to the idea at all [...] I mean obviously I've got a lot of books out on home birth and my partner and I did quite a lot of reading before I was even pregnant, so I said to my mum, well look, have a look at this, you know, but she wouldn't even read one of the books. You know, it's her grand daughter or grandson I'm going to bring into the world and she wouldn't even read a book'

In a second interview with this woman, her mother's view had changed

'she's read the books and she's changed her mind quite a bit. She also got speaking to some lady in her office who thought it was a wonderful idea [...] So I think that's helped my mum, and reading the books and I think as well, seeing how happy and healthy I've been [...] I think reading the books she's said to me that she was quite surprised. I think she'd never heard of it before. I think this is what the problem was - she'd never heard of home

births. She'd never heard of anybody who'd had a home birth and she just got it into her head, you know, my daughter's being stupid, she's just taking silly chances here. And it wasn't till she started reading the books and started talking to other people about it - and then they would say, oh I think that's great, or, oh I know somebody that did that - and I think that's all helped. So yeh, she thinks it's a great idea now (laughs) so she's completely come round, which helps me because she was a wee bit stressing me out, cos I was so keen on it and I wanted her to be really keen on it, you know, and she's like, oh, I've got my doubts and ooooooh. But na, she's great actually'

Women's friends and colleagues

Responses from friends, colleagues and acquaintances, were equally mixed, but positive responses were experienced as supportive and encouraging:

'there was this very positive encouragement from my best friend who had a home birth and I mean, when hers went well - she was three months ahead of me - anyway, when hers went well and I got her account first hand, I mean it certainly increased my confidence and I was looking forward to it'

While negative responses usually had less impact than those from closer family:

'they [friends] think it's shocking that I'm even considering having a home birth, you know, what if anything goes wrong, and, you're putting your baby at risk, and, I think it's terrible. So we've decided to drop the subject [...] But I'm a bit disappointed in everybody's attitude'

Friends often showed the same movement over time as that shown by family members:

'they're all coming round [...] I think it must have been. Because it was like she's having a home birth, you know, and folk were like - well what's that, you know, what does that involve and is she taking risks? And I think everybody thought it was a risk to the baby and maybe to myself. And it wasn't until, you know, obviously the more I read, the more I was able to tell them - well look, you know, there's the proof that there's less this and less this or whatever when you have a home birth, and I was actually able to show them the statistics and things. I think that slowly but surely brought them round'

The general feeling was that when family and friends were unsupportive of home births, it was often through lack of knowledge and/or experience of home birth. Most people, as Charlotte Williamson (1988, 1992) pointed out tend to reflect dominant health ideologies. Many had unquestioningly accepted the view that hospitals are safer for birth, but when this was challenged by a woman in their own social networks, most were prepared to question their own assumptions and move towards the woman's views. The metaphor of journey could thus be expanded to include those around the woman. Many of those in the woman's social networks moved through similar journeys to those of the women's and like them, moved through these journeys from diverse positions of resistance and acceptance of dominant and alternative ideologies. Their journeys also demonstrated women's abilities to influence social constructions through the kind of dialogue which relies both on male-based language and the language of sensuality. This evidence of women's effective subversiveness confirms some of the theories of resistance through relationships and social groups (Fraser 1990, Meyers 2000).

But the coexisting discourses of support for home birth struggled to move from the (hidden) personal to the (visible) political in the context of dominant medical ideologies. A potential

exception to this is the more organised resistance of lay groups, such as AIMS, NCT and local home birth support networks. These not only provide emotional and practical support, but often politicise the issue of home birth by providing alternative perspectives and written material. For women who were already considering or planning home births these support groups could provide support which made a difference, as the quotation above on page 124 suggests.

The concerns and hopes, which influenced women's decisions to plan home births were socially constructed through the personal and political networks in which their beliefs were shaped and experiences occurred. The underlying, often hidden, dichotomous world lens, which I discussed in the review casts home birth as "other" in relation to hospital birth. This meant that many of the women's concerns and hopes were intimately bound up with the (local) social construction of hospital birth. The disadvantages of hospital birth and the advantages of home birth were somewhat polarised⁹. Whether or not these are intrinsic to place of birth is somewhat equivocal. On the one hand, accounts of births in Birth Centres (Saunders et al 2000), one-to-one care schemes (McCourt and Page 1997) and home-from-home settings (MacVicar et al 1993) disrupt any clear boundary, yet, as Ruth Wilkins found (2000) the women suggested that there are aspects of home birth that cannot be transferred to hospital. Obvious examples include moving during labour, which many women felt would be stressful and increase their experience of pain, and that general hospitals signify sickness, dying and death, which is not conducive to the creation of new life.

How women discussed the advantages and disadvantages of home and hospital birth

Women's descriptive concerns included: reducing the likelihood of invasive interventions and routine practices such as vaginal examinations; reducing the potential for being attended by strangers who may not appreciate their beliefs, hopes and concerns; avoiding feeling anxious, intimidated or embarrassed; and reducing the likelihood of being separated from their babies and partners. The following quotations express some of their initial concerns:

'just being afraid actually, of surrendering myself to other people who might not know what's good for me actually. Also because I didn't feel they knew me very well or that they were in touch with my body [...] In hospital you're just one of a crowd'

'and then it's - we've sent your husband home, you're going to have a long labour, it's going to be through the night, we're going to put the television off, put the lights off and we want you to lie down and try and get some sleep - you know. And you know, how am I going to sleep, you know -and you're lying there. So he got sent home (said incredulously) and it wasn't until a few hours later, you know, I said, look, no, I'm not happy with this, you know, go and phone him, I want him back here [...] I think as well, at the time when she said to me, you know, you have to rest, I thought, well, they're midwives and they deliver babies all the time. They know what they're talking about. And it wasn't until I'd lain there for sort of an hour and tried to suffer these pains in the darkness and I thought, no no. I don't want this, I don't want to be like this. And then you think, oh, I don't want to be a burden. I don't want to be a pest to these nurses. But then it's your birth - you want your birth to be the way you want it, you know'

⁹None of the women had experience of Birth Centres or other arrangements, which might have crossed the home/hospital divide. Though it is clear throughout the analysis that the women's experiences were often less polarised than expected, because of a tendency for midwives' policies and practices to bring aspects of the hospital into women's homes. There was a pervasive influence of medicalisation and hospitalisation. While I specifically asked each woman if she perceived any disadvantages to home birth, most felt there were none. One or two wondered if neighbours might be disturbed, but this was dealt with by them warning neighbours that they had planned home births.

'just the, main thing is just the lack of sort of control and respect that I feel and the number of people you have to relate to, you know, over and over again - and say the same things. It's just so tiring when you feel - like I was really distressed and they're just not trained to address that part of what's going on at all'

'I mean it's those things - noise and lack of privacy - and also that you become an object and people feel it's **much** more difficult to say no to things that you don't want. I get very disempowered around doctors generally, because they start treating my body as if it belonged to them instead of me. Or that's how I feel. Aaaah, I hate the idea of going into hospital for a birth'

'freedom from technology in hospitals I think is another reason'

There was a sense from many of the women, that in a hospital setting they would be captives of normative policies and practices and that the locus of control would lie (both literally and metaphorically) in the hands of those within the institution (see page 170, for example).

'Well being strapped down you're not in control, and you have no I can't even remember if you were physically strapped at the birth, I think I was, cos I think I'd have fallen out otherwise but I had a definite feeling of being strapped down and if somebody's (laughing) got you sitting in some seat that you can't get out of then .. you have no control at all'

Their perceptions were of inherent problems of impersonality in large institutions, compounded by those of uniformity and regimentation inherent in a mechanistic model of birth, which could be avoided at home. It was this conformity to an abstract process (see the section on 'Obstetric discourses' on page 57), which the women wanted to avoid by staying at home and which they felt could not support or respond to their individual and unique ways of giving birth. When women talked about their expectations of home birth, many of the problems associated with hospital birth were reversed. On the whole they expected to: have greater control and privacy; receive personalised care from known attendants who would provide continuous support; feel listened to; feel relaxed and free to respond to their own needs, take their own time; have more control in decision-making; feel more active and assertive; avoid separation from their babies and other family members and friends; feel more confident, safe, uninhibited, comfortable and at ease; create a loving and nurturing environment for birth; avoid interventions and invasive practices; enjoy the advantages of being at home after birth (cleanliness, good food, rest and quiet); be able to get to know the baby, establish breastfeeding in privacy; and avoid imposed routines:

'I felt that the care that there would be at home would be more personal and more concerned with me and that at home, people would be more willing to listen to my point of view'

'I suppose at home, it all just feels more a part of you - and the baby as well - because it's your environment and the baby's born right into that environment'

'Just a lot more relaxed, a lot more, kind of - I don't know - a nice lively. I imagine a nice lively, colourful kind of event - more like a celebration really. In hospital it felt more like a chore going through labour - but at home I'd like it to be a lot more ... Just a joyful celebration really¹⁰ [...]. It'll just be a lot more relaxed basically, and I can have a bath or a shower whenever I need to'

¹⁰This sort of expression was mentioned by several women and illuminates Starhawk's (1990) exploration of life forces

'I read a book on home births and it was basically people's own experiences - from wonderful - to people who gave birth at home because it just came on too quickly - to people who'd had sad experiences who'd been taken into hospital. It went through the range - and the last two were women who'd given birth and their babies were dead or dying - one - I can't remember the name of it, but it's where they've not got a brain and she didn't realise - nobody realised until the actual head appeared - and I just said to my husband - if that was us, then home **definitely** is the place to be because she said she cuddled her baby for like three solid days - and you just wouldn't have done that. That baby would have been whisked out of your arms'

'I'll be so much more relaxed and comfortable in my own environment. I'll have my own things around me. I won't have to worry about making sure I've got all the things with me that I want to have and this'll be my house and I'll be much more in control than I would feel if I was in hospital. [...] That's the main thing, that I'll be much more comfortable here. If I'm relaxed it's bound to all go better and also I think it will be much easier for me as a first time mother - never having looked after a young baby before - to start doing that in my own home rather than under **scrutiny** in hospital with all the other pressures that there would be in hospital. And it will be much easier for my partner to be the father to the baby if he doesn't get sent off home just after it arrives'

'my home's a place I feel relaxed and I feel that I would be able to follow my instincts there. It's a space I've got control over where I can, you know. I've sat in the sitting room thinking, ooh, yeh, I'll have the fire on and, you know, that candle that we've got. Someone gave us a beautiful candle, and yeh, we can move the sofa back and it'll be quite comfy, and what will my partner sit on and it's like, I can actually see it happening in this room'

'there's the environment - being at home with people that I care about and who care about me is very positive. Labour is quite an emotional time, or a trying time. It's a time when you need supportive people and an environment that you know and like - and that makes **such** a difference. I think it certainly makes a difference to my labour because I have freedom from limitations for - well, for all three stages really. Sometimes they limit time in hospitals. Limitations on freedom of movement - I'd be very unhappy, you know'

'I like the idea that they're here all the time as opposed to in hospital where, you know, you're on your own, and you've got to press the buzzer and nobody might come for ages if they're busy. So I like the idea of having your own captive, personal midwife that is there. I find that quite reassuring'¹¹

Planning a home birth was thus about connectedness rather than separation, continuity rather than severance. Birth was seen by many women as deeply rooted in family life¹², potentially connecting:

and the suppression of these in patriarchal ideology and institutions. As one woman put it: 'it [hospital] just seemed to take away my dynamism'.

¹¹This notion of "capturing" a midwife was complex as women not only had different needs for support, but when ideologies between women and midwives diverged the woman could feel a "captive" in her own home. The quotation was also made in the context of the local hospital services, where there appeared to be an unacknowledged shortage of midwives. There were abundant anecdotal stories of midwives providing care for several women at once, and women and their partners being left alone for periods of time when they would have preferred more support.

¹²The connectedness often focused on by woman was with her partner and their baby. In a society structured by the nuclear family rather than by communities, it is perhaps unsurprising that the woman's partner was the key figure for many of the women. One of the key reasons for planning home births was for the woman, her baby and her partner to be together throughout. There was concern about the possibility of imposed separation and distress about previous

the woman to her body and her baby; the baby to the family; grandmothers, mother and daughters; women and nature; and women and sexuality and spirituality. In these women's accounts, home was a metaphor for control and connection and hospital a metaphor for loss of control and severance, through its ideology, organisation, policies, rules and spatial arrangements. A mechanistic approach was seen by many women to leave little possibility for birth as a sacred, powerful or creative act on their part (Adams 1994, Rabuzzi 1994).

While nurturance was one of the axes around which women's views collected, not all the women saw birth as a necessarily positive experience in its own right. Acknowledging these women's views and experiences enabled their hopes and concern to collect around another axis: that of protection. This encapsulated the views of all the women in the study. Focusing on the notion of home birth as a protective decision brought to light many related issues of muting, erasure and violation that I examine in Chapter 10. These different meanings of birth destabilise accepted meanings and form the possibility of very different constructions of safety, supportive relationships and ethics in Chapters 8, 9 and 10. While attempting to create (transient) generalities from the particular, I attempt to maintain the uniqueness and diversity of the women in the study, throughout. I thus describe this in more detail in the following section.

Women's diverse beliefs about birth

Beneath the apparently similar reasons for planning home births lay different emphases and beliefs which impacted on how the women saw the role of birth and home birth in the context of their lives. The detailed, wide ranging and somewhat unusual pages of Kathryn Allen Rabuzzi's (1994) book gathered together many of the ways in which birth can be interpreted. Her work enabled me to see further just how unique these women were, and how the reasons they gave for planning home births, such as control, avoiding hospital, or maintaining connectedness were deeply implicated in their belief systems and what they hoped to achieve by having their babies at home.

For example, there were women in the study who valued birth as a powerful experience in itself, and saw home birth as offering the potential for birth to be a sacred, spiritual, sensual and empowering process. Some of these women expected the transition from pregnancy to motherhood to provide opportunities for positive growth and transformation. A few women, like some of those in Marie O'Connor's study (1992) saw birth as a necessary (often painful and/or traumatic) transition from pregnancy to having a baby. As I have already mentioned, these women did not necessarily value birth as a positive experience in itself, but thought that medicalised/hospitalised birth might increase the level of pain and trauma they expected. Home birth was thus a way of minimising potential harm to themselves. For some of these women, there was a precarious trading between the challenge and pain of childbearing and the need to avoid anaesthesia and bodily invasion, which would entail being in hospital and loss of control (see the quotation on page 334 for example). For some women, the family unit was sacred. They believed that life could be enhanced by living it through the family/home rather than through institutions. Some women focused on the baby as a fully conscious, highly sensitive, defenseless individual. Its experience of birth was paramount¹³. These women saw home birth as providing the gentlest, most protective circumstances for their babies. For some women, hospital and home birth did indeed appear to represent a set of beliefs which expanded beyond birth into other parts of their lives and were associated with a general trust in and affinity with nature and natural home-based processes and a general distrust of

experiences of separation. Given the predominance of the nuclear family, the widespread disintegration of extended families, and the greater expectation that men will be involved in nurturing their children, the need for bonding between father and baby is more of a necessity for the woman.

¹³ Work by obstetricians, Frederick Leboyer (1977) and Michel Odent (1999) and an overview of research in this area by psychologist David Chamberlain (1998) have influenced thinking in this field.

and unease with technology and institutions. For others this was more ambiguous, and home birth was a means for achieving particular needs - avoiding a caesarean section or other interventions for example. Many women held varying combinations of these beliefs and overall aligned themselves with nature rather than technology, but challenged the notion of discrete boundaries between belief systems and described these in terms of unhelpful stereotyping.

In summary, the women in this study had expectations that home births rather than hospital births, could potentially fulfill their hopes and ideals. But this was tempered by the experience and knowledge from a variety of sources that there may be constraints to how supportive of their ideals, individualised and woman-centred their care may be. In the following three chapters, I attempt to explain why this was inevitable. Often, the first tangible evidence that care might have prescriptive, abstract, and medicalised overtones came from the very first meetings with midwives, where one of the main agenda items was that of risk. Women became aware that there were risk criteria already in operation, against which their pregnancies would be measured (see page 207).

As the literature suggests, the reconfiguration of safety and risk was crucial to feeling confident enough to plan a home birth (see page 68). As I discuss on page 140, most women sought out research and were convinced that home birth was not irresponsible or risky. Many came to the conclusion that despite the view of many professionals, home birth was in fact often safer than hospital birth (see page 143). On reaching this decision, women wanted support from those around them, and their midwives and doctors to increase their confidence and enhance the likelihood of a safe home birth. It is to the question of risk and safety, how women negotiated obstetric meanings, and how they provided very different definitions of these terms from their own concerns that I turn to next.

CHAPTER EIGHT -Towards well-being: Deconstructing risk/reconstructing safety

Introduction

It is clear from the literature review that any discussion about risk and safety is set in its own historical, social and cultural milieu. Safety in childbirth has been reconstructed in the Western context of; better overall health which has reduced mortality rates of women and babies; changes in childbearing practices in response to the development of obstetric ideology and practices; and changing views about the role of chance and our ability to manipulate this through risk discourses. The women's accounts and my analysis are located in a relatively affluent country, with a high level of sophisticated medical services. In Scotland, relatively few babies die and even fewer women die (Scottish Office Home and Health Department 1994). Death is rare enough that women in this study, although aware of its possibility, expected to survive. The impact of this on women's views and experiences and its influence on constructions of safety and risk are profound and I can only attempt to imagine, what it may be like to live, as many women do, with the constant reminder that death occurs all too often during childbirth. So while uncertainty is ever present, as I discuss below on page 152, women did not generally fear for their lives or those of their babies. At the same time, the greater emphasis on risk and assumptions that it can be reduced through medicalisation and hospitalisation, also meant that women entered the childbirth arena with the pervasive message that hospitals are safe and homes are risky places in which to give birth¹. The juxtaposition of birth being less risky in terms of mortality and the greater cultural focus on risk has meant that the actual decrease in danger has not been complemented by a focus on potential. Thus, those women who most reject technology are most likely to be accused of placing themselves and their babies at risk, despite evidence to the contrary.

The coerciveness of obstetric risk

As I suggested in the literature review, the concept of risk, definitions of what is risky and the construction of safety through the avoidance of risk are so emphasised and legitimised in our present culture generally, that the fear of risk and danger is pervasive and deeply coercive. In contrast, the concept of safety and its creation is under-defined and unless related quantitatively to risk management tends to carry less weight. As I described in the section on risk on page 61, risk, morality and responsibility have been rolled together in ways that incorporate the general subordination of women and the particular constructions of how pregnant and birthing women should behave through the assumptions of obstetric ideology². It is also clear from the various critical analyses I referred to (Murphy-Lawless 1998a, Smythe 1998) that maintaining more than a modicum of fear³ and infusing childbirth with highly emotive connotations about morality make

¹A risk culture generates a high level of "free-floating" fear (Kirkham 2001, personal communication). As research with women of other cultures (Chesney 2000, Kitzinger 2000) suggests, even though death may be more likely, fear tends to be replaced by faith through ritual, trust and acceptance. Some of the quotations in this chapter suggest that women in this study were more trusting of the birth process than professionals. This is a complex area, and I am not suggesting that we should accept all deaths as an act of God or nature. Clearly, from a global perspective, it is possible to create safer circumstances for women and babies. But my discussion about the unlikely, but possible death of a baby at birth on page 172 suggests that we need a space for this that does not detract from the creation of safety.

²Yet different values are attributed to risk depending on the activity in question. For example, as I observed on page 65, in footnote 51, Celine Lemay (1997) examined the positive role of risk taking in other areas of life - namely in sporting activities (90). Those who take part are often described as courageous, powerful and heroic. While childbirth has similarities to this sort of thesis, it has been defined through medicalisation and the view that women's bodies are weak and unreliable rather than able, strong and powerful. So while heroism and medals are the concepts and language of sport, heroism in childbirth is reconstructed as martyrdom and women are told that there are no medals for avoiding pharmaceutical pain relief.

³Indeed, competent and confident women and/or midwives may be perceived as a threat to medical ideology as can be seen in some of the quotations in this thesis. How many of us have heard women observe that they felt happy and confident before an antenatal visit but left feeling deflated and anxious. One woman described how she approached

definitions of risk and safety particularly susceptible to being placed beyond question and therefore particularly challenging to deconstruct⁴. Indeed, in the context of the general perception that home birth adds greater risk to an already risky situation, risk was perhaps the most difficult of the medical terms and concepts which I attempted to examine, deconstruct and redefine from the women's perspectives.

One of the most coercive ways in which medical ideology and practices exerts control over women to conform to the notion of medical risk is through attaching value judgements to women's compliance with, or resistance to medical advice (see page 167). Attributing labels of responsibility to the former and irresponsibility to the latter powerfully imposes the "coercive contract" described by Jo Murphy-Lawless (1998a) that I refer to throughout this analysis⁵.

Staying with women

Under the influence and guidance of the feminist/postmodern theories I engaged with, this study became very much centred on women's accounts. Yet following where they led on the issue of risk and safety and reconstructing safety from their points of view was a decisive moment in the analysis: an act of faith. Andrea Doucet and Natasha Mauthner's (1998) adaptation of a relational voice methodology that I discussed on page 114, was instrumental in being able to put the theoretical framework I had developed into practice⁶. It provided an analytical framework and practical tools that enabled me to stay with women, when it might have been easier and less uncertain to take a more detached stance based on conventional analyses which often fragment and reassemble data at one removed from the people who supplied it (see page 107)⁷. This decisive moment enabled me to take a dialogic approach to my interpretations of the women's accounts and

antenatal visits feeling confident in her abilities to look after herself and experienced these as a 'slapping back down' (Edwards and Sullivan 1994, unpublished interview).

⁴I have already mentioned the concept of black boxing on page 79. This describes how dominant ideology maintains its belief systems in the face of other knowledges, and the critical analyses which suggest that medicine is particularly introspective and maintains a closed knowledge system (Davis-Floyd and Sargent 1997) or predatory system (Saks 1992) on page 44. A similar parallel is apparent in Marilyn Friedman's (1999) discussion of relational autonomy, when she suggests that 'even an autonomy-idealizing culture may shield certain norms or values from critical scrutiny' (44-45) protecting the beliefs and privileges of certain social groups.

⁵This highlights the difficulties women have in making decisions that are not in keeping with the culture, their own social networks or the professionals involved in their pregnancies and births. (I discuss this in view of some of the theoretical concepts about women's decision-making and autonomy in Chapters 9 and 10). The coerciveness of medical morality also harnesses their desire to do the best they can for their babies and families in ways that persuade them to override their knowledge, instincts, intuitions and bodies. For example, one woman, described a conversation with a doctor during a previous pregnancy:

'it's, you know, like have I considered that was it when or if? When this baby's brain damaged - this baby could be brain damaged, you know I should be considering this, and don't I think I'm being a little bit selfish ... in not considering how my mother ... and my brothers and sisters my other two children I have will feel about this'

⁶Of course, questioning authoritative meanings provides a challenge. As is clear throughout, our meanings of birth are not only powerfully shaped by dominant discourses, but my questions and the women's accounts confirmed tensions identified by feminists regarding the difficulties and possibilities of moving beyond accepted meanings and practices. Focusing on how women talked about themselves, their experiences and their views in the ways suggested by Doucet and Mauthner (1998) showed me just how far women were able to create their own meanings. In providing the conceptual and practical tools for balancing holism and diversity within individual women's accounts, the voice-centred relational method opened the door to a kaleidoscope approach, where each woman was able to contribute to the construction of women's concerns. The contrast between their accounts of safety, and the mechanistic management of risk in obstetrics developed the concept of relationality that I had discussed on page 81, and consider in Part 4 of this chapter on page 180. I look at relationships in Chapter 9 in the light of theories of separation and connection. On the basis of the ambiguities thrown up by this, I theorise, the ethical and practical implications of relationality in Chapter 10, following closer examination of the feminist/postmodern debates about ethics of care, subjectivity, embodiment and autonomy.

⁷Women's voices and their attempts to be heard were ongoing themes throughout the thesis. But as I explained in the literature review women's voices are easily delegitimised. Liz Stanley and Sue Wise (1993) have been particularly articulate in suggesting that even in feminist literature this may be the case.

the theory I engaged with, in keeping with my central project of becomingness. Letting women lead me into hitherto unimagined realms led me into further theoretical debates with which I might not otherwise have engaged⁸. They led me to concepts of risk and safety which are invisible within dominant obstetric ideology, but which are nonetheless authoritative and crucial if we are to find ways of developing alternative approaches to birth, which carry within them the means to assist women in childbirth safely.

Whatever their concerns, it was clear from the lengthy, in depth interviews that the women were passionately concerned about their and their babies safety and that there was no question about abandoning safety as a central concern. But questions arose about what constitutes risk and safety. As I observed earlier, obstetric risk provides only one way of constructing the meaning of birth (Lemay 1997: 94), based on questionable statistics (Murphy-Lawless 1998a). Women discussed how it could be created in different ways, and the constraints they encountered. It became increasingly clear from their accounts that the concepts and language used in a medical approach to birth distilled complex issues in positivistic, narrow ways that muted their concerns. As they discussed the advantages of home birth and the disadvantages of hospital birth they created a broader discourse about the qualitative aspects of birth far removed from the limited risk discourse of modern obstetrics. While the main body of research on place of birth concerned itself with mortality and latterly morbidity (see pages 18 and 66), birth outcomes for these women included their and their families emotional health and their embodied, spiritual and sexual integrity, as well as their and their babies physical health - all of which needed to be considered in the longer term context of having a baby (I discuss these multiple concerns in Chapter 10). I have termed this broader concept of health, well-being. Their definitions of safety identified qualitative aspects of birth, which dissolved the dichotomous divide between short-term physical health and longer-term aspects of well-being. It was through seeing birth in the context of their lives, as journeys, within journeys, that enabled me to acknowledge their concerns more fully, and understand the different values they attributed to risk and safety. I attempt to explain that the narrower focus of obstetrics was in contrast to the women's broader aspirations to create a more holistic safety, where physical safety is not disconnected from other concerns.

So while this chapter forms a discussion about risk and safety in its own right, it is simultaneously a precursor to Chapters 9 and 10. Deconstructing the medical terminology of risk and safety, exposed how it enables the circulation of dominant concepts while disabling the circulation of other potential meanings. This set the scene for highlighting and theorising women's concerns and ideals on their own terms. That is to say that by examining the potential meanings of risk and safety from the women's perspectives, I develop this kind of deconstruction of medical meanings more broadly, and transfer this deconstruction process to the meaning of relationships in chapter 9 and in relation to ethical issues and the potential abuses of women and their power through birth, in chapter 10. So while this chapter somewhat artificially separates risk and safety, the following chapters develop many of its themes, reuniting risk and safety with women's concerns by focusing on well-being and integrity and how these could be maintained or violated through birth. In other words, this chapter forms the basis for shifting the focus from the dominant medical meanings of birth, to the diverse concerns of the women in this study.

Substantive themes: Engaging with obstetric risk/creating safety

In part 1 of the 5 parts that follow, drawing on feminist and sociological analyses, postmodern uncertainty and the lack of coherence within obstetrics' own logic I examine challenges to the

⁸While I move between literature and women's accounts throughout the study, the format of a thesis did not allow easy scope for making this more visible. I thus provide an example of this in the introductory pages of chapter 10, as it becomes evident that I needed to develop a more nuanced theoretical approach, to understand the women's accounts and contribute to debates about feminist understandings of beingness.

construction of obstetric risk and how women engaged with this. This returned to the earlier issue of the research agenda and the focus of its reported outcomes, and how policy and research have been closely connected through patriarchal discourses and institutionalised mechanisms of control, which largely excluded women's concerns. In part 2, I explore where women located risk.

As many of the women in my study found, challenging dominant medical beliefs about safety in childbirth, inevitably raised the issue of death at birth. This forms the focus of part 3. Women were aware of the limitations of attempting to erase death at birth through the policies and practices in current obstetric use; that death cannot always be avoided; and that attempts to avoid it at all costs may impact on them and their families in ways that need further examination.

In part 4, I attempt to reconstruct safety, from the woman's accounts and some of the critical literature I reviewed, in order to provide a more complex view of safety, based on women's concerns rather than on the limited generalities of obstetrics. Using Elizabeth Smythe's (1998) theoretical construction of a 'semblance of safety', in part 5, I examine the obstacles women encountered. This includes discussion about procedural definitions of safety and risk, the level of autonomy women were able to exert in attempting to create safety, and the difficulty of moving from a semblance of safety, to a safety which can be both created and felt by women and midwives during the woman's journey through childbearing. This raised the issue of midwifery skills and alternative ways of developing safety, which rely on different forms of knowledges and relationships rather than on risk management (see Chapter 9). As Smythe (1998) observed, these alternative ways of creating safety focus on individual women's circumstances rather than abstracted generalities which depend on the practitioner's abilities to extrapolate from a broad experiential and intellectual knowledge base:

'Learning that has achieved the alchemy of wisdom melts down all the moments of understanding and blends them together to become something more, something deeper and something more open to new understandings' (226)

But as the women's accounts demonstrated, medicalised care relies on abstracted generalities; fragments birth, relationships between women and midwives and thus midwives' knowledge and experience; and undermines their abilities to extend their knowledge and practice. It may prevent them learning from women in ways that would enable them to generalise from their own experiential knowledge, and generate fear rather than confidence:

'the midwives should be confident Even my midwife who'd delivered loads [of babies] had never delivered first and fourths. So she was confident in delivering babies, but not firsts [...]. And when she was saying, I think maybe we should think about going into hospital I thought, she's not confident in doing this. She doesn't know She saw it as going on unmapped territory'

In the next part I suggest that deconstructing meanings of risk and safety involves dismantling the obstetric safety package and challenging authoritative knowledge and the beliefs on which it rests. Because of the close weave between beliefs, moralities, authoritative knowledges and social structures, this challenges layer upon layer of our mainstream cultural heritage. The obstetric construction of risk and safety is dependent on holding authoritative knowledge in place. Its deconstruction depends on challenging its authority. Thus every part of my literature review is implicated in this process.

Part 1 Challenging the authority of authoritative knowledge

Can normative practices be challenged?

The construction of risk in western childbearing practices is cast in a number of interacting patriarchal discourses, some of which I discussed in Chapter 4. These are neither uniform nor static (Bartky 1997), but nevertheless tend to reinforce different aspects of patriarchal beliefs. The construction of risk is therefore deeply implicated with belief systems and thus morality (Douglas 1992). It contains within it a range of normative practices which generate and support normative behaviors (Foucault 1977)⁹ and as I mentioned above, maintains an ethos of closure or seizure towards competing knowledges.

Collecting up different threads from my review suggests that the obstetric construction of risk and its insertion into the culture as authoritative was one of the inevitable outcomes of the increasingly patriarchal foundations of society where a need for certainty and control prevailed. A powerful network of dominant structures and mechanisms developed from positivistic, patriarchal beliefs in which these beliefs are simultaneously embedded and reinforced. These contribute to holding authoritative knowledge in place and developing strategies for rejecting challenges to its authority¹⁰. As I discussed in Chapter 4, developing elitist knowledge based on supposedly verifiable scientific truths managed through professionalisation effectively: removes it from the ken or control of women; controls resources; and directs the research agenda and the development of practices and sophisticated technologies. On a day to day basis, obstetrics maintains control over the kind of knowledge women have access to. It introduces quality standards, which are based on its own measurements of success and reflects its own concerns rather than those of women. In attempting to impose normative values and practices, competing ideologies have been largely suppressed, women's and midwives' voices have been muted, their experiential knowledge largely negated, and irrepressible competing "incidents" dealt with in such a way as to focus on wayward individuals rather than on a problematic, hegemonic ideology¹¹. My discussion on page 43, about government

⁹These practices inevitably vary historically, to reflect changing concerns and technologies, but may continue to be underpinned by deeper patriarchal motivations. As I discussed on pages 39, 42 and 193 (footnote 99), capitalism has underpinned the health agenda. At the beginning of the 20th century for example, the focus on health was in response to imperialist motivations and a perception of unlimited resources. In the early 21st century, longer life spans and a perception of diminishing resources continue to shape the health agenda through capitalism by focusing on the maintenance of a healthy workforce. Influenced by a continuing belief in rationalism and individualism, this has focused conceptually on promoting normative, risk avoiding practices. I am not suggesting that individualism has no place, or that it is wholly disadvantageous to women. As Linda Barclay (2000) suggested, there have been clear benefits. It has provided opportunities to question cultural, community, religious and family norms of women's servility and/or abuse. One of the problems focuses on the construction of individualism and how the needs of individuals and communities are balanced. Individualism is often limited to its (oppressive) patriarchal definition (see page 264). Barclay provides a stimulating, readable discussion about how relational autonomy could be constructed from a feminist point of view.

¹⁰It would be difficult to explain the extraordinary suppression of midwifery and other research showing the potential range of benefits for women and babies of a social, midwifery approach to childbearing and the potential harms of medicalisation, other than in terms of power relations. However, when these disruptive findings cannot be more widely introduced, alternatives are unable to develop. There are few places in Britain for example where home birth forms part of a cultural norm either for women or professionals. So despite research findings, there continues to be a lack of practice and experience with which to transform alternative knowledge into alternative practice. Few midwives are able to develop the kind of 'birthing culture' described by Maggie Banks (2000):

'The home birth midwife's confidence in a woman's ability to give birth comes from a deep conviction that where she is well nourished, healthy and follows a healthy lifestyle, the continuum of a woman's childbearing will seldom be problematic [...] as she practices solely in the home birth setting, it is not difficult for her to maintain that belief. She sees women birth time and time again, seldom with problem. That is the home birth midwife's birthing culture - her reality' (132).

¹¹One of the few, notable and shocking exceptions is the New Zealand cancer story (Paul 1988) where women with signs of cervical cancer were not treated because of the beliefs of an individual doctor. Unusually, this story dislodged the foundations on which medicine rests and acted as a catalyst for the eventual move from a medical model of birth towards a

reports and policies on place of birth during the 20th century demonstrates how “outdated” or competing discourses are managed, and dominant discourses reinforced and incorporated into the fabric of society¹².

As I discussed in my literature review, diverse analyses by feminists and others suggest that knowledge pathways are anchored through dominant belief systems and that knowledge is generally sought to confirm those beliefs rather than necessitate their reconstruction in ways that might alter the societal balance of power¹³.

Challenging authoritative knowledge

Drawing on the various sociological perspectives (see the section on knowledge on page 78), which undermine the stability of the knowledge on which obstetric practice is based, as well as their own experiential knowledges, women challenged authoritative knowledge at many different levels; its logic, assumptions and ethics. Women were aware of the cultural, geographical and historical arbitrariness of obstetric certainty, and how this might influence definitions of home birth, and those who plan it. For example, in global terms, birth at home is often the only option available for most women. In some cultures it may be an acceptable alternative to hospital birth, and in others, it is even more marginalised than it is in Scotland:

‘I mean, I’m just trying to, you know, keep the ... emotional temperatures around as low as possible and just(laughs) I don’t know ... I guess I’m just young and rebellious still. If I were a bit older then (laughs) maybe I wouldn’t feel so much that I had to prove a point In my own country, certainly I wouldn’t feel that way, because they’re much I mean, my mother’s now married to a man, and his daughter had her baby at home and it was a very relaxed affair and no-one batted an eyelid (laughs) apparently. But, you know, it’s the

midwifery approach to birth (Guilliland and Pairman 1994: 7). This was unusual because it contributed to changes at a systems level. “Horror” stories emerge in Britain from time to time, but the professional response to these “incidents” is to restore public confidence by isolating the negligent practitioners. Ever more sophisticated procedures are then introduced in order to identify these individuals, so that medical ideology remains intact.

¹²For example, until 1992, the Government maternity services reports over the course of the 20th century reflected the gradual medicalisation of birth and midwifery. Jean Donnison (1988), and Iris Marion Young (1990b, 1997a) and Anne Witz (1992) among others, provide nuanced debates about the marginalisation of competing discourses, through patriarchal constructions of democracy and power, which systematically support dominant ideology and deny women and other marginalised groups access to policy-making. Until the successful suffragette movement, this was literally only through powerful men (Witz 1992). The long struggle resulted in women over 30 years of age being able to vote in the 1918 election. It was only in 1928 however, that women over 21 were able to vote. The Mayfair Picture Library produced a picture postcard. The background shows the Houses of Parliament, and in the foreground a policeman clutches a behatted, respectable looking older woman. The caption reads:

‘This is “THE HOUSE” that man built.
And this is the policeman all tattered and torn
Who wished women voters had never been born,
Who nevertheless
Tho it caused him distress
Ran them all in,
In spite of their dress:
The poor suffragette
Who wanted to get
Into THE HOUSE that man built’

I look at some of the political theory debates in relation to equality and rights on page 270. It is clear that having a vote does not ensure that women’s concerns will even reach the political agenda, let alone be heard and responded to empathetically. Feminists and other minority peoples continue to be constrained by the dominant ideologies, concepts and terminologies of the day.

¹³As I have suggested elsewhere, focusing on domination does not negate the power of resistance, but in this section I examine the ways in which authoritative knowledge is held in place.

usual thing there - and just a very sort of matter of fact approach to birth, whereas here, I do feel it's quite dramatic'

'I mean in my country, you just don't think of having home births. It's very unusual. I mean, in Europe in general I think ... there's more an acceptance of home birth, or it's not so alien to have one

N Does it feel like that?

I think so. I mean, in my country there would have been no question of not going into hospital really. I mean, if I'd moved back and I said I wanted a home birth, they would probably have looked at me as though I was crazy or it would have been so hard to organise, you know, because, there's also this problem of who takes responsibility and malpractice suits and who's responsible for what. I mean, it would have been really hard. Midwives aren't - I don't think they're trained to the extent they are here as well, and the doctor takes centre stage. And probably a doctor is too busy to come out to your home, so that the whole routine, the whole concept of (laughs) what happens when you have a baby, just makes home births almost impossible. So I'm glad I'm here (laughs)'

Despite research findings, the women in this study were left in no doubt that in planning to have babies at home they were transgressing powerful cultural norms and understandings about risk and safety¹⁴. Thus in planning home births, they challenged both the construction and certainty of risk management, which emphasises short-term physical outcomes and de-emphasises all other concerns. In the next sections, I therefore examine the series of questions that women raised about the assumptions underlying the obstetric thesis of risk.

Challenging certainty: 'They just don't know loads of things really'

Their discussions about statistics, were often located against the background of experiential knowledge which challenged the assumptions about just how knowledgeable, skilled and certain medicine is in general. Women were often aware of its shortcomings through previous experiences:

'I was rushed in for an appendicectomy and it turned out not to be appendicitis and I just had a horrendous sort of six months after that with antibiotics and tests and trying to find out what it was. And ... and I just thought, they just don't know loads of things really and in terms of women's gynaecology, aren't that interested. And so I think around maternity it's kind of similar really. Like you know, well, we just don't know why you've been bleeding, let's just hope it settles down (laughs), you know. And if you're going to miscarry, well, you're going to miscarry. There's nothing we can do, and you know, that that kind of attitude which, maybe medically is all they can do. But ...[...] I don't have a basic attitude that I think some people do, that they're almost gods that can do anything So I guess my willingness to take risks, if you like to call them risks by having a home birth without doctors present, doesn't feel like that much of a risk to me'

They were equally aware of control issues and the fact that women's health has not been a priority in modern medicine:

'I don't know about the rest of medicine you know, but I mean, I think childbirth and pregnancy is something which is very individual and to sort of brush over that, I find that really offensive You're almost victimised. It's made into an illness, which I don't like. I

¹⁴As I discussed in the literature review, reasons for this on the one hand cluster round maintaining power relations, protecting a belief system, and managing bodies and birth appropriately in late modernity. On the other hand, midwives themselves have largely accepted a medical construction of birth and have remained ambivalent about their role, skills and confidence in relation to birth, especially home birth.

mean, you might not feel well but it's not an illness. It's not an affliction they want to cure you of. They have to help you to get through it. They should assist you, but you know, I think you should be the main person to make the choices and to know what's happening. And I'm sure that it's, you know, it's a control thing So I think, you know, I think that definitely is a big issue, which does definitely concern me a lot, you know. Not just childbirth, but you know, issues surrounding it. You know, postnatal health for women, I mean, even contraception you know. I feel that all these things are done with a lot of disregard to ... women. You know, even in the case of drug research, which I'm now sort of aware about. I believe it's done mainly on males, which is not fair. So, I think it is important, you know, it's important'

Using medicine's own terminology, they frequently challenged its apparent certainty by suggesting that even within its own frame of reference, this cannot easily be claimed:

'I would like to challenge some of the things people say Like for example that the monitoring machine is completely safe Nobody knows. You can't say that. They use it and any doctor will say it's safe to use. And they have no right to say that. What they should say is that there's inconclusive evidence, but as far as they know it's okay'

And that within its own framework of rationality and objectivity the standpoint of obstetric risk could be exposed as illogical or contradictory and that different perspectives could lead to different interpretations. Thus, from the woman's perspective, the interpretation of risk appeared to depend on what was at stake, and the "correct" decision in specific circumstances:

'I mean, what he [obstetrician] said to me was that there's - I can tell you, there's a definite 5% chance that your uterus will rupture. And I said, that's fine isn't it, cos there's a 95% chance that it **won't**, you know (laughing). So where's your argument then. And it's like, you know, if I was coming to have an operation that might better my life or not, you know, you'd be going - but it's 95% effective wouldn't you, you know, and and so what's the difference. So I can't see why they can't be positive about my birth'

One of the initial ways in which women challenged authoritative knowledge was thus through its own internal logic. The research on place of birth provided one of the more obvious fractures with which to dislodge dominant views. Although decision-making processes are complex and women planned home births in diverse personal/social milieus, all the women engaged with obstetric risk and referred to research findings to support their views. This was most visible in the accounts of those women who had planned hospital births during a previous or current pregnancy on the grounds of safety. In other words, at some point, the women in this study rejected the current normative beliefs about the greater safety of hospital birth.

Women's changing views on safety and risk¹⁵

12 of the women in the study reported that home birth was their first choice and that they had made plans to organise this in early pregnancy. The remaining 18 women had planned or had had previous hospital births. A few of these women had considered a home birth but had been discouraged, but most of them said they chose hospital births because they had assumed it to be safer than home birth, and had subsequently changed their minds:

¹⁵ The series of interviews I did enabled me to hear the becomingness of women's views based on the changing nature of their knowledges and experiences over time.

'I thought the safety of hospital in case anything went wrong [...] My mind was changed. My views changed or developed - evolved'

Having previously adopted the dominant view that birth is safer in hospital, they moved to the position that home birth would be as safe, or safer and would confer a number of advantages. Their views changed when they had reason to reconsider previous assumptions, typically in response to negative experiences in hospital and/or exposure to alternative views¹⁶. As their views changed they began to feel that the perceived risks of having their babies at home were acceptable and outweighed by the advantages:

'we sort of thought that those risks [of the baby not breathing or the woman haemorrhaging] were not negligible of course but, risks that were sort ofwe could take. And ... you know, we thought we wouldn't put ... the baby or myself in any sort of undue danger with things, so you know, we were quite happy on that account'¹⁷

In the following quotation we can hear the combination of influences: other knowledges and views about birth, the woman's increasing experience of the fear embedded in medical approaches, and her gradual move from fear to confidence from risk to potential as she defined birth in terms of the quality of the experience as well as the physical outcome:

N Do you think I could ask you what led you to planning a home birth, or thinking about a home birth?

Um um, I don't know what it was, at first. At first I thought, no. There's, you know, there's no need to .. to have anything different, you know. I'll just go through the normal medical procedure. But as things went on, I think it was a combination of gaining confidence in the fact that ... childbirth is is something fine, is something natural and something beautiful. And this I got particularly from, I think from being in (country) in my early pregnancy with my husband. The culture there is entirely different, you know For them it's a very natural thing, a very beautiful thing, and they like talking about babies. They like knowing about ... about a woman's pregnancy, and for them everything's going to be fine, and everything's going to be beautiful, you know. So that gave me a lot of confidence, which I think, I've realised since, that some other women don't have So I started to feel less that it was a medical procedure and more something that could be .. a really wonderful experience. And I think then the second part was actually going to hospital antenatal classes (laughs), which .. I found very difficult. And really, I always came away feeling ... quite really quite depressed from them. I found them ... I found I couldn't relate to the atmosphere there, which was very much fear orientated, and talking about how many drugs we can fill ourselves with, and how we can blot out the whole experience. And I think in the end I just felt ... there's no point in me going through that. It seems so foreign to me, and the home birth seemed just a far more sensible thing to do, as long as it was medically viable. And when I talked to people, you know, to my GP and so on, there seemed to be no medical

¹⁶Negative experiences of hospital care during pregnancy, birth or postnatally were particularly influential in future plans to have home births:

'As soon as I'd had my first (laughing) one, even before I was pregnant, I knew that next time round I'd be having it at home'

¹⁷All the women held positive views about home birth, but as they gained information and confidence, all without exception (including the 7 women who had their babies in hospital), described becoming even more positive about home birth over the course of the interviews (i.e., in later pregnancy and postnatally). Many described themselves in the final postnatal interviews as being more politicised and proactively in favour of home births than they were in early pregnancy.

reasons why I shouldn't. Apart from obvious a few obvious risks, which were, you know, weren't insurmountable ... so that was why I decided in the end'

Thus in the next section I explore how women engaged with dominant medical ideology.

Engaging with statistical research:

Can 'the master's tools [...] dismantle the master's house'?

So while the women's concerns were broader than statistics, dominant ideology dictates that this is the currency through which debates about home birth take place¹⁸. Most appreciated confirmation that their decision was reasonable. But given the predominant views about home birth they felt obliged to develop their knowledge of research in order to 'arm' themselves to meet potentially hostile responses to their plans, and demonstrate the concerns and abilities deemed necessary by society to be seen as responsible mothers. Whatever their reasons for planning home births, their discussions frequently started with statistical evidence. And while some women searched out more research than others, all of them talked about the necessity of meeting the selective empiricism and beliefs about home birth embedded in obstetric ideology with statistics, for themselves as well as for others:

'I think the things that I found useful were studies that I read that were very clear about it's no safer in hospital than it is at home. I think that I'm a great (laughing), believer in well conducted studies and good statistics and things. So I'm well convinced by things like that. So I think that sort of very statistical information helps'

In the same way that research challenging obstetric beliefs has tended to use the same concepts and tools as those of obstetrics, many of the women in this study challenged the apparent risk of home birth by using the same logic and knowledge that had supposedly legitimised obstetric belief. They quickly identified one of the paradoxes in obstetric ideology: that even using obstetrics own tools, logic and figures¹⁹, the statistical research on place of birth appeared to demonstrate to them, that home birth is safe for healthy women and babies (see page 19). Thus if questioned about risk and safety, all the women responded through the accepted discourse of statistics, and pointed out that medical ideology rests on beliefs that its own research does not support:

'I mean we often talk about it with friends etc, because they'll comment - you gave birth at home, oh it wasn't very safe. And I'll say - well you won't find a statistic that will tell you

¹⁸ As I said in my methodology chapter, the first interviews with each woman included a question about her views on risk and safety. Although I wanted to raise topics of conversation to enable women to discuss their concerns, inevitably, in a culture that emphasises medical risks during childbearing and de-emphasises other components of safety, the discourse most readily available to us was that of quantifiable and measurable definitions of obstetric risk. As the quotations show, my initial discussions with the women about risk and safety often focused on statistics. As I became more sensitive to the limitations of medical concepts and terminology and where and how women created spaces to develop their own meanings of safety, I was able to put the theoretical spaces I discussed in my literature review, into practice by: asking more open questions about safety; asking what made birth safe for them; and listening to how and where else they talked about safety.

¹⁹ Marilyn Friedman (1999) challenges Audre Lorde's (1984) well-known paper on this, and suggests that, 'with all due respect to Audre Lorde, the "master's tools" *can* "dismantle the master's house" (Friedman 1999: 47). It is clear from the literature review that there is some disagreement within feminism generally about how far the tools of patriarchy in any form or field can disrupt and reconstruct oppressive patriarchal society, and how far we can conceive of creating alternative tools. Clearly, we cannot step outside our cultural heritages, but equally, feminism and postmodernism have disrupted dominant philosophical and social norms and practices. The difficulty remains that using the ideology, concepts and tools of the dominant societal group tends to contain and limit debate. It may prevent deeply coercive beliefs from being challenged, and may focus research, thinking and developments on current constructions rather than on the development of alternative constructions. Their views are not necessarily mutually exclusive. The 'master's tools' question the belief that birth is safer in hospital, suggesting that Friedman is correct, but these tools are limited and cannot provide understanding about what safety means or assist in developing understanding about women's concerns and experiences, supporting Lorde's analysis

that it's safer to give birth in hospital - oh I don't - no, no, listen to me. You **won't** find a statistic. You cannot prove it is safer to give birth in hospital - oh, they'll say - right - so you know'

'I didn't actually have the facts'

For those women who had approached birth sharing the dominant cultural assumptions about the greater safety of hospital, planning home births involved rethinking these assumptions, and engaging with research and alternative views. In the same way that women described those in their personal social networks, not knowing about home birth, many women described this as part of their own journeys:

'then I started sort of reading books and finding out a bit more about it, and actually a lot of the books were saying that you're actually safer off having your child at home than you are in hospital - the risks are a lot less

N So have your views on safety changed? You said that you felt safer being in hospital the first time

I think (sighs) maybe cos I've read some of the books about it. I didn't actually have the facts the first time round, if you know what I mean. I didn't actually know about what the facts were. You're just always told that it's safer to have your baby in hospital and the risks are less and all this. But actually reading the books, the actual research doesn't seem to prove that. It seems to point towards, actually that even if you're a high risk mum the chances of having your baby are actually - you know, you have much better chances of having a baby that's okay. So I think the medical profession likes to hide behind figures and say - oh you're much better off in hospital, because they can have more control over things'

'N Have your views on safety changed a bit since you had your son [in hospital]?

Um yeh, yeh, they have, yeh, .. Because I hadn't done any reading about home birth or anything like that before I had [son]. So, I mean, it's definitely an automatic assumption that hospital is the safe place to have the baby. When you actually start reading about it, you realise that's because Well, I've been talking to my neighbour as well, who used to (laughing) deliver babies in the 40s at home, and in the 40s, when the hospital system came in mums used to have to book the hospital themselves and so it was the less organised (laughing) ones, and probably the less middle (laughing) class ones who **weren't** doing that, and who were then having their babies at home and were probably more badly nourished etc, etc, and in worse conditions. So it was then the case that home birth wasn't as (laughing) safe as hospital²⁰, but that was because (laughing) of the way that they had to refer themselves I think (sighs)

N Had you assumed that hospital was safer?

I think that assumption has grown up, yeh and I ... I would just automatically fall into it. Yeh ... if you don't do any reading, then I think you do, you know (laughs). But before I really finally made the decision about having the baby at home, I mean, I definitely sought and read statistics on home birth, in comparison to the risks. What's her name, Marjorie (laughs)

N Tew, Marjorie Tew?

Yes, her. Well, I just read the AIMS leaflet on that, and was very pleased to see really that the mortality rates for mid [middle] risk is less at home than it is (laughing) in hospital

²⁰ Jean Donnison (1988) suggests that the outcomes for midwife-attended births have been consistently favourable, but that there were skilled and less skilled practitioners amongst both midwives and doctors. Julia Allison's research (1996) points to very good domiciliary outcomes from 1948 to 1970 among women living in relative poverty, when attended by midwives in their homes.

... Because at the time I was still sort of considering myself to be possibly, well, not low risk. Maybe sort of low to mid risk because of my previous history and because I'm (laughing) overweight. In fact it doesn't seem to bother the community midwives at all (laughs) so, you know they're quite happy (laughs)²¹

Many women did not isolate or dwell on risk in the way that dominant medical ideology would have them do. Nor were decisions made in the positivistic way, indicative of obstetric definitions. As I have suggested, safety was a central issue, but was defined in more complex terms. None of the women in this study made decisions to have home births on the basis of statistics alone. Rather, research supported their experiential and intuitive knowledge during their deliberations:

'I like to read about things and find out a bit more first before I make a decision [...] I think you know, having thought about it you know. I thought it feels right. I then wanted to check that I was going to feel happy from a safety point of view. You know, chances were that everything's going to be okay and the more I looked into it the more I thought, yes, you know, there's no reason why there should be problems any more than if you were in a hospital. I mean you've still got a midwife there and you know, it's not as if you're on your own'

Clearly, good statistical analyses can give us invaluable information about generalities and trends in populations. As Mary Maynard (1994) points out, quantitative research on violence against women, poverty and inequality, for example, increased knowledge about the extent of the problem (13). But it was the additional qualitative research that informed us about the nature of this violence. Thus, while statistical research was seen to be useful, it needed to be contextualised and combined with other knowledges and interpreted through women's concerns as well as those of obstetrics²².

²¹Confident midwives, open to home birth, intuitively sensing the woman's unspoken or hesitantly spoken desires might also contribute to their changing views becoming a reality, as these were developing and forming during their pregnancies:

'the home birth came, I think through a combination of things. But it was suggested. I mean, I didn't demand it or anything

N Would you have thought about it?

Oh I would have liked to have had it

N You would?

Yeh, but the current thought was (laughing slightly) and I mean I nearly fell into the trap, and in fact I did. I fell into the trap .. of thinking, first birth?, at home?, far too dangerous, far too risky, you know. They [midwives in another area] wouldn't even let me have a domino in my first birth, so why would I want to ask them [for a home birth] ... And that's the reason I didn't. And that was a big mistake on my part

N So what changed your mind about that. What made you think it wasn't so dangerous after all?

My midwife offered it to me, and as long as she was confident to do it ... What I didn't want was to have a midwife who wasn't confident about me having it at home, who was grudging me having it at home. That would have been ... That would be also a very anxiety sort of building thing. So that also wasn't an alternative mm, yeh, I think .. I needed to have everything in place with everybody happy doing what they're doing'

N Do you think you could tell me how you came to change your booking from a domino to a home birth?

'Yes, well, on the domino, I had said several times to the community midwives who were visiting, every other week or so, I'd said oh, but if the head's hanging out and I'm still at home, you won't move me will you? Or you know, if I'm doing really well at home maybe I could just stay at home and little comments like this. And they'd said several times, if you want a home birth, just say, and we'll get the equipment in. That's the only difference. It's the same team, and we're happy not to move you, but we would like to have the baby resuscitation stuff, and all the right equipment. So, I'd sort of, I suppose, unwittingly I'd identified that that's what I secretly wanted'

²²This is not to suggest that we should abandon research-based evidence. Rather it is to suggest that we need to examine how research-based evidence is currently limited by its epistemological assumptions and practical tools. As I discussed in the literature review on page 79, if the epistemic field is not expanded to include other forms of evidence, evidence-based practice remains as empty and oppressive as many of the terms I explore in this chapter and Chapters 9 and 10. Elizabeth Smythe's synthesis of knowing (see the quotation on page 136), suggests engaged ways of knowing that are more complex than drawing on research evidence alone.

Limitations of positivistic research

While the appearance of articles on qualitative research in medical journals suggests that it is gaining some acceptance within medicine, the emphasis is still on quantitative research and the privileging of RCTs. Despite criticisms, these are often assumed to provide certainty²³. Taken at face value, the findings of RCTs suggest that the majority of people respond in particular ways to identified treatments or interventions. The RCT cannot take individual circumstances into consideration or tell us how to distinguish between majorities and minorities. However, as it uses the language of science (probabilities and statistical calculations) by a rhetorical sleight of hand, its uncertain knowledge is transformed into certainty. Women's knowledges are defined as unscientific and therefore remain uncertain and delegitimised (Kirkham 2000, personal communication). Feminist and postmodern debates about knowledge, that I discussed earlier suggest that so-called scientific knowledge may in fact be less certain than individuals' knowledge, because the former discounts a range of sources of knowledge, which individuals may draw on, which are specific to their contexts. In other words, how we define what counts as authoritative knowledge not only impacts on what we then discount from knowledge claims, but limits the authority of those claims²⁴.

Holding onto authoritative knowledge: Labelling women 'selfish, experience hunters'

And yet in a curious twist, medicine ignores its own internal inconsistencies and continues to promote its belief system. Thus, based on their own readings of research, women became more aware of what they saw as the underlying obstetric agenda to promote hospital birth and discourage home birth, which shaped what was being said to them. They began to mistrust those they saw as promoting an ideology based on fear, focusing risk on place of birth and defining them as irresponsible. They pointed out that parents do not usually place their children in danger, but that medical responses are often limited to medical beliefs and lacking in openness to other views:

'I wouldn't do anything to risk damaging my unborn baby obviously. But I'm doing what I think is right. And sometimes that's not what everyone else thinks is (laughing) right'

This limits the potential creation of safety based on respectful interactions between medical beliefs and those of individuals. Women often found that medical practitioners were unable to engage with other beliefs and at best, might accept divergence: and at worst dismiss those who resisted medical ideology as 'silly', 'foolish', 'ridiculous' and 'stupid'. In other words, irresponsible or immoral:

'I found him [obstetrician] very insulting in his approach. He directly said I was being foolish. And when I went [to hospital] the second time, that was how he referred to me - 3

²³Martin Shipman (1988) provides a straight forward but enlightening critique of research in general, including the potential practical drawbacks of RCTs. Recently, Mavis Kirkham and Helen Stapleton (2001) provided a more sophisticated critique based on their qualitative investigations during a RCT trial. Their findings uncovered not only practical problems which could not otherwise have been detected, and which limited its findings, but also dominant cultural beliefs which questioned the trial findings. Their work raises questions about what could usefully be the subject of RCTs and what (if anything) a RCT alone can tell us. A number of other researchers (Gyte 1994, Johnson 1997) have suggested that while RCTs should be carried out, they should also be subject to scrutiny, and that placing them at the top of a research hierarchy may be unwise and misleading. The practice of meta-analyses has also been the subject of criticism on the basis that it is difficult to find trials which are similar enough to combine, and that any flaws in the individual research studies used may be compounded, or disappear during the process of combining them (Gyte 1994, Macfarlane 1997, Olsen 1997).

²⁴The interpretation and presentation of obstetric research is based on the constructed obstetric priority of obtaining live babies and women at birth. The potential and actual physical damage sustained by women and babies usually remains muted. As I observed on page 67, outcomes between groups of women are frequently said to be similar, despite the fact that women who had home births or births with midwives in birthing units had fewer interventions, their babies had fewer problems and there were other advantages.

or 4 times in the conversation - I think you're being very foolish. And he implied that I didn't care about the safety of my baby. I don't know where you get your research from but if I thought home births were safe then I'd be advocating them. And he just gave me no credit for being an intelligent woman. He didn't give me credit for having read in the field or for the fact that it's me that's having the baby and of course the baby's safety is paramount to me'

'he [GP] just told me I was being ridiculous and stupid not to get them [vaccinations] done (laughing), you know. Like, you can't really tell people that, cos they're not going to willingly risk the lives of their children'

Women firmly rejected the view that they were deliberately taking risks. However, they acknowledged that statistics can be appropriated in different ways, and neither they nor the professionals they met claimed that birth is either risk free or always hazardous. Their accounts focused on a different set of risks, located in medicalised and institutionalised birth environments and practices:

'policies and practices that are supposed to protect women from the risks of childbirth, have often created another set of risks to their physical and emotional well-being.' (Aspinall et al 1997: 3)

So while women were told that:

'it [home birth] would be a silly risk to take - unnecessary risk is the other quote they [professionals] used a lot - home birth is an unnecessary risk'

Their concern was to avoid unnecessary interventions during birth:

'I'm less likely to be subject to unnecessary medical and surgical intervention in my own home So that is the ... most important aspect of safety that I'm concerned with'

The dichotomous view of birth outcomes in dominant ideology has led some practitioners to consider themselves to be more responsible for babies, than women themselves. The separation of physical outcome from experience, and the muting of women's definitions of safety through obstetric morality and terminology allows medical risk discourse to redefine their concerns in terms of selfishly desiring "nice experiences". This redefinition of women's concerns as frivolous and irresponsible in comparison to the serious and responsible concerns of obstetrics allows the coercive contract in obstetrics to retain currency, in a culture defined through patriarchy and expertism:

'the obstetrician must respect the wishes of the mother and father, but only as far as it can be done without risking the health of the mother or the baby. Finally the obstetrician must be the expert who dares to set limits on "experience hunting" and take full responsibility for the birth' (Rutanen and Ylikorkala in Viisainen 2000b: 796)

In Part 2 of this chapter, I examine the various elements of risk identified by the women in the study. Like studies, that I discussed earlier, these include: a focus on fear; generalities; rules; time limits; birth technologies; inappropriate space and material surroundings; the presence of strangers; and lack of privacy. Looking more broadly at the women's accounts, these were to do with being controlled in time and space as well as being subjected to the unknown and the unexpected. The resulting fear, loss of control and inability to exert agency (which I examine in chapter 10), contradicted the dominant risk discourse:

'I think that the hospital environment imposes risks of its own which I find much more terrifying because I don't know what they are (laughs) ... I know the risks of the home environment, so I'm better prepared to cope with them whereas in hospital your risks are incompetent people or people who don't know you, or are not in contact with you, or are unwilling to listen to you and ... who maybe do things before before it's (laughing) absolutely necessary, I don't know, and thereby, you know, create a whole ... series of problems (laughs)as far as I can see [...] There's less risk of infection andand you're just cared for much better at home'

While appealing to research remained within the framework of dominant ideology, much of the following discussions moved beyond this.

Part 2 Where women located risk: The risks of medicalisation and institutionalisation

Opening up the discussion

The sociological debates about risk (see page 64) provided different perspectives in which to examine it²⁵; for example, focusing on the risk of technology, questioning its values and logic, identifying risk as a mechanism for social control, and locating different values attributed to it in different settings. While it has been suggested that conventional sociological debate has tended to focus on challenging the location of risk, shifting the gaze so to speak rather than examining how the gaze is constructed (Lane 1995) and that medicine had been largely exempt from even these deconstructive practices (Scambler 1987), it has provided a basis for questioning medicine within its own terms of reference (Enkin et al 1989, Strong 2000), as the Cochrane database demonstrates. For example, those who claimed that the medical management of labour developed to protect babies can increase risk, as in the case of routine, continuous electronic fetal heart monitoring can now appeal to accepted guidelines to support this view (RCOG 2001).

These sociological constructions of risk have been incorporated into the social/midwifery approaches to birth, (see page 69) which focus on the potential of birth and view medical technology as a threat unless it is required²⁶. It is this openness to potential that the women's

²⁵As competing sociological discourses on risk circulate and balances of power change, fractures arise in unexpected places. For example, one of the premises on which the Expert Maternity Group (Department of Health 1993) based its conclusions was that safety is not an absolute concept (10). As Mavis Kirkham (1999, personal communication) pointed out to me, the significance of this statement that lays the foundations for potentially different readings of safety, in a parliamentary document on childbirth has not been widely recognised or elaborated on. The tentative suggestion that there may be qualitative meanings of safety moves away from the medical definition of physical safety, to a broader definition which encompasses the meaning of birth in terms of potential - as an 'enriching' (23) experience for example. Exemplifying both resistance to and acceptance of societal values, and a pragmatism appropriate to a Conservative Government, the report stopped short of deconstructing risk and safety, and instead promoted choice through the provision of midwifery models of care. Thus the meanings of safety remained underdeveloped. Without providing a conceptual framework for alternative approaches to birth, which integrate safety, these alternatives remain open to dismissal on the grounds that they are attached to women's choice rather than safety. For example, the report emphasised continuity of carer. But as I discuss on page 208 in chapter 9, while relationships are linked to choice rather than understood as integral to safety and well-being, research focuses on women's preferences, rather than on its embeddedness in safety and its wider implications of power and control. So while the Report (Department of Health 1993) attempted to include women's concerns, the ideology behind this was only partially constructed. Its attempt to transform the medical model of birth into a social/midwifery approach has been largely unsuccessful in the light of the competing medical discourse on risk. Risk assessment and management continue to feature prominently and are embedded in the fabric of capitalist societies, where risk and insurance have formed a powerful alliance (Cartwright and Thomas 1997). For example, points are awarded to hospitals that demonstrate compliance with linear, rule-bound, medical protocols, while independent midwives are unable to obtain insurance that can encompass a social/midwifery definition of safety.

²⁶Robbie Davis-Floyd (1992), for example suggests that the broad purpose of a technological approach to birth is to do with socialisation and a simultaneous demonstration and inscribing of societal values - i.e. a normalising process to maintain dominant ideologies across a broad spectrum of life concerns which attempt to shape how we live our lives and how we relate to others and our environment (Starhawk 1990). But any approach to birth, risk and safety can have

accounts aligned themselves with. A focus on the riskiness of birth seemed to them to generate unsubstantiated fear that could undermine their confidence and thus paradoxically increase risk. And while women accepted that babies, and rarely women still die during birth in Scotland, they rejected the conflation between catastrophic incidences which occur when “natural” birth takes place in the context of poverty, long-term ill-health and lack of access to equipment and expertise when it is needed, with their own circumstances. As reports into maternal and perinatal deaths suggest, they believed that death could lie within and outwith obstetric knowledge and expertise and that uncertainty exists wherever babies are born, whether or not it is acknowledged²⁷, as a recent article (Waterstone et al 2001) examining the number of ‘near misses’ exposed.

The riskiness of focusing on risk: ‘Their focus was very much on fear’

The medicalisation and hospitalisation of birth is inextricably linked to obstetric risk discourse (Murphy-Lawless 1998a, Smythe 1998). While the management of birth on this view, relentlessly searches out signs of risk, in order to manage it, the women wanted to maintain an optimistic, attentiveness based on confidence, and the reassurance that if all is well, they are likely to continue to go well²⁸:

‘I don’t seem to worry about things that haven’t happened really’

They were well aware of the risks identified by obstetrics, but like the women in Lemay’s (1997) study, risk was part of an integrated set of considerations based on the belief that birth is a normal, life process²⁹:

normalising, oppressive influences. On the one hand, the normalising influence of technology has been made visible by feminist deconstructions in terms of the patriarchal fear of nature and women’s bodies and the management of male fear/instability, where women threaten to undermine patriarchy and the ideology on which it is based (Murphy-Lawless 1998a, Shildrick 1997). On the other hand, as I also discussed on pages 48 and 64, feminists have argued that natural philosophies of birth can be equally oppressive (Cosslett 1994, Diprose 1994), if these prevent women from valuing and accessing appropriate technologies, obscure women’s experiences, or prevent women from exerting their own autonomy and thus meanings of childbearing. I discussed the complex issue of the oppressive home-natural/hospital-technological dichotomy, within the context of dominant cultural values, and the apparent valuelessness of strong postmodernism in Chapter 11.

²⁷Work on deaths and near deaths in countries with high maternal mortality rates, is attempting to track the events leading to this by taking a holistic view. Researchers carefully gather information from different sources - the woman herself, if she survived, the members of her family, hospitals and medical practitioners (if involved). Part of the aim is to develop strategies for low level technologies or interventions and skills which could be used by traditional or trained birth attendants, and to define what sort of higher level technologies/expertise may be needed, when and where. Another aim is to look at the level of skill needed to provide potentially lifesaving interventions, with a view to making caesarean section for example, more accessible, acceptable and affordable. In other words, moving beyond expertism, to determine what knowledge and skills may be needed (Jo Murphy-Lawless 2000, personal communication).

²⁸Their understanding about the need to reduce fear and increase confidence was articulated through the rhetoric of relaxation. This was so frequently referred to that I spent some time examining what women meant. In looking at their accounts and focusing on how and where they discussed ‘feeling relaxed’, I came to understand that in the same way that they identified fear as a risk, being relaxed was part of their construction of safety. As Lemay (1997) observed, a focus on risk feeds fear and accentuates the danger rather than the potential of birth (85). I therefore look at relaxation in more detail on page 180.

²⁹The women in Lemay’s (1997) study described fears as ‘peurs normales’ (95). Research cited in the nursing literature suggests that these normal fears (or worrying) are part of a preparatory process and may assist people in meeting challenges (Kirkham 2000, personal communication). I come back to this on page 186, where I discuss the importance of relationships between women and midwives as a contributing component of safety. Midwives are more able to distinguish between normal fears and ‘announcings’ (see page 194) of possible complications, in context of relationships and/or woman-centred care (Smythe 1998, see also, Daviss in van der Hulst and van Teijlingen 2001: 170, Woolford 1997). In the context of medicalisation and fragmentation, it is difficult for women to express their fears (see page 228) and difficult for them or midwives to distinguish between ‘peurs normales’ and ‘announcings’. As one woman commented, ‘my experience of antenatal care was that they make you anxious and then try to reassure you’.

'I would view it [birth] as something that you do naturally. So why would it be dangerous sort of thing, rather than a dangerous occupation. And, you know, you've got to make everything okay, you know. So I suppose I looked at it that way and that's why I don't have a great worry about the safety of it'

They wanted practitioners to journey with them, with confidence, rather than dwell on the pervasive rhetoric of risk, which implies 'disaster at any moment':

'I just think I'd like to take a step away from all the technology and I just think it's a natural part of life. It would be nice to bring a child into a room ... that's warm and ready for it rather than a hospital room with all, you know, like heart monitors, thinking that there's going to be a disaster at any moment. And I know there can be, but ... you know, most times things are okay ... I suppose it feels like for me - it feels like a positive step, to think, well, you know, like, I have the power to have this child in the environment that I choose'

Yet, as I discussed earlier, midwives are located in power networks that have decreased their confidence and knowledge in birth. There is no reason why they should feel any more enabled or powerful than women in general, and yet women needed midwives' confidence³⁰. Paradoxically, some women felt that they had to inspire their midwives' confidence. The following quotation was made by a woman who's long previous labour ended with a forceps birth:

'I always feel they should be more confident and they should make me not have any doubts myself (laughs). But I always feel I end up trying to encourage them to think it's going to be alright. And this time round, I suppose it's harder, given the experience I had the first time'.

While focusing on risk provides the basis for obstetric safety, this fear-based medical focus seemed to women to present a serious risk to their abilities to give birth at home safely³¹. Their accounts were marked by shifting priorities, and while their focus was on the potential of birth, if they or their baby seemed unwell, this would take priority³²:

'what I feel is, just sort of read the signs and ... stay with what's happening and try and deal with each ... moment at a time. I suppose [...] I suppose safe is that you can trust in the moment and deal with it appropriately ... and that ... if there was a need for medical intervention then that choice would be open'

³⁰A story told by Irish midwife, Philomena Canning, at the European Midwifery Congress for Out-of-Hospital Births in Aachen, Germany, Sept/Oct 2000 demonstrated the contagiousness of courage and the need for midwives to be courageous in the face of obstetrics' threats, that women and babies will die, and its threats to midwives' knowledge and livelihoods. A woman expecting her sixth baby with an unstable lie and low lying placenta at term went into hiding when an obstetrician contacted the police, with a view to forcing her into hospital. She contacted the midwife, who felt that there was no reason to intervene, but at the same time felt unable to document her opinion in the woman's notes in opposition to that of medical opinion. On reflection, she decided her knowledge was as authoritative as that of obstetrics and that to side with her profession and women, she must document her opinion. The woman gave birth at home as planned.

³¹Both fear and confidence arose frequently in the women's accounts. They described not only their own fears and confidences, but how confident or fearful they experienced midwives to be. Smythe (1998) suggests both trust in and fear of birth are needed (9) to evoke alertness, carefulness and caution. Through listening to, and watching midwives who trust in birth and regularly attend births at home in various circumstances, I observed that they combine a relaxed attitude with a moment to moment alertness. I concluded that the 'mindfulness' described by spiritual leader, Thich Nhat Hanh best portrayed the kind of watchfulness that allows neither undue fear nor over confidence to obscure their vision.

³²This did not mean that they thought that other aspects of birth should be cast aside. And, like those parents in Kirsi Viisainen's (2000b) study, to a certain extent 'when actual risks were detected, the parents would [...] judge the medical opinion against their own experience and intuitive knowledge in the final decision (802). As Smythe (1998) observed, it is crucial to maintain what matters to women as far as possible. Women have most concern, and indeed, their deeper concerns filled their accounts. Responding to complications need not mean turning away from women's concerns, and imposing others (as footnote 88 on page 155 suggests). It is this separation of concerns, the inability of medicine to understand shifting concerns and the assumption that obstetric concerns should take priority that troubled women.

The emphasis on risk and the transformative influences of fear and confidence are palpable in the following quotations:

‘there’s this big sort of worry that seems to surround it [birth] most of the time. Oh, you know, something could go wrong. But it seems to be, you know, a sort of all pervasive, you know ... Most people seem to have that attitude to it most of the time. And, you know, I suppose you sort of get into that yourself’

‘there seemed to be this big emphasis on prevention - well it's better that you take this drug in case this disaster happens. Or it's best you come in hospital cos we **don't** want a tragedy, was a quote from the consultant. You know, it was like their focus was very much on fear, which I found completely disempowering. It made me think well maybe I can't deliver a baby. Maybe I haven't got the energy to do this you know. And maybe I do need their help, and you know, maybe I should be grateful that they're all wanting to help me. And I just found myself ... with a very weak sort of attitude suddenly.³³ And ... it was my husband who noticed it more because he said I'd been very sort of strident all along and here was I suddenly going very mouse like and saying, maybe I should go in for a six hour delivery and be a good girl you know. And he said .. what's happened today (laughing) you know. He was quite shocked. And I didn't notice the effect it was having on me. But they really meant well you know. They kept telling me it's my right and I can do what I want. But they kept sort of worrying on my behalf, you know, about all the things that could go wrong. So I thought, if they don't believe it's safe and if they ... don't have the confidence to deliver this child then it's not going to be a very relaxing atmosphere to be having a home birth. Which was when both my sister and my antenatal teacher suggested an independent midwife. And suddenly I felt a weight going off my shoulders. I suddenly realised I had a choice and that money wasn't the issue at the time. The issue was how worried I was getting ...at feeling that I'd have to hand over this birth to the authorities, It's what it felt like, you know, that all my grand ideas of sort of being in control was just ... they were silly fantasies or something, you know. ... So when I suddenly, you know, spoke first to my sister or to my antenatal teacher and then to the independent midwife, the confidence came surging back. It was like, no, this wasn't a figment of my imagination. It is possible to have a home birth. It is possible, you know. There are alternatives to all these disaster stories, you know. And these disaster stories happen in hospitals as well, you know. Like people seem to want a guarantee. I've noticed in the local antenatal class, they assume that the drugs in the hospital ... will give them a one hundred per cent certainty and I know that isn't true. So why bring out all these negatives when they talk about home birth but not when they talk about hospital birth, which is what they do’

Respecting but not dwelling on risk

Limited by the same dualistic thinking that separates woman and baby (see pages 41 and 306), women's optimism was frequently pitted against obstetric's pessimism through the concept of morality, suggesting that women's optimism was a sign of lack of morality, responsibility, caring and concern.

³³ This is reminiscent of a talk given by midwife Caroline Flint at the AIMS 25th Birthday Conference in London, in 1985, where she discussed the contagiousness of fear. She began her talk by listing a series of highly unlikely disasters that could befall members of the audience either in the auditorium or on their way home. She demonstrated very effectively, just how fear is generated, the inappropriateness of focusing on risks that are unlikely to materialise, and the potentially damaging impact on confidence and decision-making.

However, for the women, focusing on risk was experienced as counter-productive to the confidence they needed to birth their babies safely. On this view, as the quotation below suggests, their focus on optimism was a responsible moral position, based on; a concern to develop ongoing strategies to develop confidence (rather than rely on medical formulas) that could promote safe birth; the knowledge that birth usually unfolds straightforwardly; and the belief that skilled and trusted midwives increase the likelihood of a safe birth:

‘N [...] what are your views on risk, is it something you've thought about in relation to home birth?’

Um it, it might sound funny, but I try not to think about it, because ... because you can drive yourself crazy. I mean, there's always a what if, but there's a what if, if I cross the road and I'm not looking. It's that kind of, I suppose intellectual approach to risk, you know, or intellectual, [said questioningly] but if you actually sit down and think about what is risky and what isn't, you'd be surprised at the risks you take everyday - and you think, well, this is part of living [...] I'm brave with pain, but I'm not brave with risk and if I ever felt that something's wrong or I don't feel well, I would call the doctor. I would say, take me in. I would prefer to be next to the machines and a consultant you know, who could possibly help me better than a midwife could at home. But risk, I mean, I know of the risks ... in the sense of what would prevent me from having a home birth. But the risk of things going wrong Again it's from what I've read and what I've talked about with midwives and so on, that the risks that you take are ... basically the risks you would have in hospital anyway. If the cord's round the neck, if the child is facing the wrong way, if there's any kind of distress. I mean, I don't know what else can go wrong during birth, you know, specially if you've done it before (laughs). I mean with each birth I've grown more confident if you like. So I know, the basic risks, and I mean I am concerned. I mean, even, now and again I think, but gosh, what if I have meconium or what if, you know, they find that the cord's wrapped 3 or 4 times round the neck or what if they discover that the baby's not breathing properly, when she comes out and ... I mean these things do occur to me, but I have a sort of ... faith in the success of the birth (laughing). Maybe it's misplaced, I don't know. But if you are going to look at statistics, I suppose the births that go well and are straightforward are the majority. I mean, you always hear about this happening and that happening but actually, I mean some millions of women give birth every year and I can't imagine that every other birth has a problem, you know, we wouldn't survive as a race if there were always problems (laughing) at births, I mean even taking a too simplistic attitude. But you know, if I'm feeling alright and everything is alright then I feel at ease and my mind's at rest ... and I think also the midwives they would decide whether I go in or not. Maybe if I'm unaware of something [...] if I'm okay but the baby's in distress, I would rely on their expertise to, you know, do the right thing, which is probably just to take me in to the hospital apart from other things they might do for me at the time. But ... that's how I view risk (laughs)'

Paradoxically, medical ideology, the professionals women met, and the books they read reinforced the general consensus that the main two risks at home are of the woman bleeding after birth and the baby not breathing at birth, even though these are less likely to occur at home following normal births:

‘there's basically only two big things that can happen. The baby won't breathe or I would bleed, you know. These as we understood, and as I still understand now are the main dangers that can happen, you know. You haemorrhage or the baby won't breathe'

There were few indications that women were able to engage with uncertainty in more meaningful ways in discussion with their midwives, but in response to these two risks, women felt that their individual circumstances did not suggest that these were likely to occur, and that if they did, they

believed that they could be dealt with at home sufficiently well to resolve the problem, or stabilise the situation before transferring to hospital:

‘having looked at all the potential problems, I don’t think there’s anything that couldn’t be dealt with or couldn’t be covered. It’s not a worry to me’

While dwelling on risk was seen as counter-productive, a readiness to respond to concerns was always present. Unlike some of the women in Kirsi Viisainen’s (2000b) Finnish home birth study however, most women saw no need for more antenatal ‘checking’ visits (see page 243). They felt that more routine monitoring could not contribute to greater safety. However, as I explain, they would have welcomed the opportunity to meet with their midwives more frequently, or for longer periods if these meetings could have provided opportunities to discuss their views and feelings about birth and find out more about their midwives views and practices. But their wish to avoid unnecessary medicalisation did not exclude concerns with facilities for potentially increasing safety during labour. Women considered the presence of midwives and the ability to transfer into hospital as the main ‘safety-net’ available. Some spontaneously raised the idea of having ambulances on standby for their home births - based on the perceived Dutch system of care, or because their midwives had talked to them about flying squads (which according to the midwives were available in theory, though not necessarily reliable).

Is the only certainty, uncertainty? ‘There’s nothing in life that doesn’t come with a risk’

The women’s acceptance of living with what they considered to be unavoidable uncertainty was in direct contrast to what they saw as the medical attempt to remove uncertainty (when it cannot be removed) by imposing inappropriate risk management procedures:

‘I suppose for me, I thought, well, you can’t guarantee anything in a (laughing) birth. In a way, you take a risk everytime you enter into it’

In their view obstetric risk management could have harmful consequences and could reduce the potential for creating a broader meaning of safety, and the empowering potential of birth³⁴. In other words, while they felt that having home births created advantages for them and their babies³⁵, their accounts portrayed knowledgeable acceptance about uncertainty, from the planning to the outcomes of these births:

³⁴In was in this vein that women deemed to be "high risk" in medical ideology might plan home births in the context of previous technological births, which impacted negatively on their well-being and/or relationships with their children. Smythe (1998) suggested that some ‘high risk’ women chose home births because they held broader meanings of safety, and felt safer at home with known and trusted practitioners (20-21). In the next chapter, it becomes clear that the women who were more likely to have complications were in fact least trusting of NHS professionals and were not able to obtain care from either known or trusted carers. From their point of view, holistic, continuity of care would have been ideal, but because of the greater likelihood of medicalised care in hospital and the uncertainty of who would attend them in labour wherever they gave birth, they felt it all the more important to stay at home and avoid going into hospital.

³⁵Women positioned themselves through the complexities of medical ideology and their own internalised acceptance and resistance. They demonstrated the ‘splitting’ discussed by theorists (Belenky et al 1986, Debold et al 1996, Gilligan 1985, Hamer 1999), locating themselves on a spectrum of risk through both obstetric definitions as well as their own perceptions of risk. This was balanced against the risk of invasive obstetric procedures and the benefits of being at home in the knowledge that there is confusion between potential and demonstrable risk. One woman observed that:

‘that’s probably my biggest risk - that I have had small babies. I still smoke. I’ll have another small baby [...]. You know ... statistically, I’m in the social class, you know, like, you know, it’s not good from my ... social standing. I’m more likely to have dead babies and things, you know Whatever that means, you know. So I’m aware of like, how they’re [doctors] looking at me’

But despite seeing herself through the gaze of medical ideology her experience of the coerciveness of medicalisation in hospital described by others (Machin and Scamell 1997), the level of fear in practitioners there, and the disruption to relationships between herself and her previous babies, this woman felt she would be safer in her own home.

'it's always tentative when you're planning it [home birth] because also, you don't know, you know, if there will be medical implications for going into hospital or whatever'

'things can happen to you, you know Or more likely can happen to the baby, you know I had a friend who had a home birth and she delivered a still-born child and nobody knew it was. It just happened and had died previously, during labour at some point. And nobody knew, nobody realised. And I mean, you know so you know, it is still possible. That's why, you know, if there was any doubt about the safety, I mean, I would quite happily transfer to hospital. Although I do realise ... I mean, that women died giving birth in the hospital, you know So obviously I mean, you know, mortality is quite low these days, but I mean, it [birth] is quite a major thing to happen'

They were aware that uncertainty crosses the home/hospital boundary and saw the attempt to empty hospital of risk and locate it in the home, as if birth only contains uncertainty at home, as misleading. They felt that birth contains uncertainty by its very nature wherever it takes place:

'Everyone kept saying - it's safer to have a baby in hospital, which I thought was disputable, you know. And I thought, there's nothing in life that doesn't come with a risk, you know. Driving to the hospital itself is a risk, and crossing the road is a risk and for them to try and imply that a hospital birth is no risk was, you know, misleading'

Women's accounts of uncertainty created a crucial space between obstetric "certainty" and impending "disaster" in which to explore the inevitability of risk wherever one gives birth, and other potential responses. It was sometimes difficult for women to articulate this space through the pervasive language of risk, but in the quotation below, the woman attempted to explain uncertainty, potential and possibilities beyond medical management:

'N Mm can I ask you what you think about safety and risk
Um

N Is that something that you've thought about?

Oh it is. I mean, I have the feeling like with the midwives that ... that their risk levels were very (laughs slightly) low. And I'm not saying that I wish to harm myself or the baby, cos obviously I wouldn't. But I just feel that there are some things in life that happen, that we can't always make the way we want them (laughing slightly) to. And like a birth is a risky thing, and sometimes, I wish that they [midwives] would feel more willing to take more risks than they do. Because yeh, I still don't know if I was being prudent, if we were all being prudent last time [transferring into hospital during labour] or if we could have pushed me further. I still don't know that. And what the real limitations and boundaries are. And some people seem to say - I mean my friend has had the experience where she felt people were taken into hospital prematurely. Things could have been handled at home. Even having a cord wrapped round the baby's neck doesn't necessarily mean a death So I wish that they would have confidence to deal with things that are risky, cos they are risky in their (laughing) nature'

Reducing women to statistics: 'I'm not just anybody'

Like those women who planned home births in other studies (Davis Floyd 1992, O'Connor 1992, Viisainen 2000a, 2000b), women in the study spent time reading and considering statistical findings on place of birth. But they saw the need to differentiate between the stereotypical woman in research findings and individual, embodied women, like themselves:

‘they [professionals] use statistics and I know statistics can be used and abused in many, many ways. They use the ones to illustrate what they want and I thought that was also unfair, because I said - I’m not just anybody, you know. I am above average health and fitness probably. My diet is a lot better than most people’s. My confidence is probably a lot higher, and my knowledge of birth. And to bunch me in with everybody else without looking at me as an individual, I thought was a very unfair thing. To say that 33% of women need intervention without looking at everything, you know, individually. I thought they were being very sort of unfair. But then that’s what systems do, you know, you aren’t an individual at that level’

In short, they did not think that statistics and rules could be applied to individual women in any direct or meaningful way. They appreciated the research findings because they gave them more confidence in the face of adversity. They lent support to their plans, and helped gain the support of partners and other family members. However, many of the women’s decisions appeared to be based on a sense of moral rightness, for which they sought supporting evidence. This moral rightness, based on experiential, and embodied knowledge has often been supported by research at a later date, as in the case of routine enemas, shaving, inductions, EFHM and episiotomies for example.

The risk of subjecting individuals to general rules³⁶: ‘It’s about you and your baby’

In addition to the problem of focusing on risk, the women identified problems arising from the application of the generalities of obstetric risk assessment and management to individual women, which results in safety being defined through a series of abstract rules. They did not think that a mechanistic view of birth, which the rhetoric of statistics and rules appeals to could account for the complex interaction between mind, body and spirit:

‘I can’t help thinking that giving birth is ... it’s not just a physiological thing. It’s a psychological thing and I don’t think that’s taken into account ... And I think that the mind overcomes practically everything ... if one is in control³⁷ ... And I think any woman who’s not in control of her birth is not going to have a good experience I really don’t believe they can because it’s what it’s about. It’s about you and your baby. It’s not about anybody else. The only reason other people are there is to facilitate it, you know. And I just don’t think that that’s acknowledged (laughs slightly) So I feel amazingly confident, and my partner does too ... I mean it may turn out dreadfully. We don’t know. But certainly at this stage I feel great about it. I have no fear ... at all about it, and that feels really great. I feel great. I look forward to it. I’m in control, and the fact that I don’t have to go anywhere is great’

Their accounts concurred with Maggie Bank’s (2000) observation that:

‘When the labouring woman is supported by patient attendance, the time frames and experiences of physiological labour for individual women teaches us that there is only one rule that can be taken with any certainty. That rule - *there are no rules!*’ (145)

From this perspective, being subjected to rules was likely to interfere with their abilities to give birth rather than enhance them. Thus, in the same way that the women challenged statistics’ ability

³⁶In the following section of this chapter, I examine rules from a safety perspective. However, while women described how rules might obstruct their births and therefore safety in their terms, they also described how rules disrupted their relationships with midwives. The two issues necessarily overlap, but I continue the discussion about rules and relationships in Chapter 9.

³⁷I examine the complex notion of control and what this means for women in Chapter 10, page 281.

to differentiate between the general notion of risk and identifiable complications, they also challenged the definition of safety through rules. As I discuss below, how to move from the generalities of risk criteria and management is far from obvious and throws open searching questions about the balance between risk and possibility, the definitions of normality and abnormality, and how decisions could be made about whether to act or wait, (see Part 3 on page 172³⁸). And yet one of the most striking features about the interviews was that whatever the women's beliefs, wherever they positioned themselves in relation to birth ideologies and whatever they discussed, they stressed over and over again, the desire to be understood as individuals and the need to avoid general policies and practices. Women knew that a different meaning of safety could be created by focusing on the individual³⁹.

Policies or rules which derive from generalities, seeing the body in mechanistic terms, and the emphasis on moving women through labour in predetermined patterns, leaves little possibility for focusing on individual women, or inactivity. Thus the medical model espouses a rhetoric of individualised care, but this individualised focus is already filtered through an ideology that measures women and their bodies against norms, and rules to maintain these⁴⁰. Women who

³⁸ The issues that arose from the women's accounts following this line of questioning included how material complications are responded to when they do occur. Many women felt that complications could be dealt with in less medicalised and less invasive ways. (see pages 158 and 168 for example). For example, Jane Evans, independent midwife in the south of England recounted the experience she had while helping a woman with obstetric cholestasis. The woman concerned had had this condition in a previous pregnancy which had resulted in problems. During her second pregnancy she and Jane worked closely together drawing on medical and alternative knowledges. The condition remained stable through a dietary approach and was carefully monitored by the judicious use of blood tests. This type of use of medical knowledge and technology to support alternative approaches opens possibilities for moving beyond the boundaries between technological and holistic approaches to birth, which support the individual and protect women from both the harm of complications and the harm of invasive procedures. Medical knowledge and expertise was combined with a holistic approach to the woman, her concerns and beliefs to create the best outcome in terms of physical and emotional well-being. In this case, an independent midwife practising from a holistic perspective was the key person in facilitating the woman as an active agent during her pregnancy and birth, by integrating different knowledges, the woman's concerns and her own midwifery skills. It appears from this and other sources (Clarke 1995), as I describe in Part 5, page 187, that risk criteria and rules undermine the ability of community midwives working within the NHS to support women to have home births. They are unable to develop their own autonomy and increase their skills which could enable women to stay at home safely rather than transferring into hospital. Midwives practising within the NHS are obliged to engage with general risk criteria which direct the focus towards reasons why women should not have home births, rather than on finding ways to support their plans. There is an increasingly troubling and conflicting discrepancy between rights and choice ideology and the management of health services, where the emphasis on audit and review have more in common with rules than autonomous practice, and where choice is undermined by medical definitions of best practice. The immunisation debate exemplifies this conflict between choice, autonomy and what medicine "knows" is best (see for example Bedford and Elliman 2000). I discuss some of these issues in the section on choice on page 272, and rights on page 278.

³⁹ The interplay between generalities and the individual appealed to by women was more akin to the decision-making processes of birth attendants described in other cultures by Brigitte Jordan (1993). Their attempts to question midwives about how they would respond to certain circumstances were suggestive of generalities grounded in experiential knowledge rather than the theoretical generalisations based on statistics in current obstetric practice. Thus women's accounts confirmed the feminist/postmodernist critiques of knowledge I discussed in Chapter 5 by pointing up the limitations of knowledge claims, both epistemologically and through the inherent problems of generalising from populations and trends, to individuals.

⁴⁰ It is perhaps a misconception to use the term individualised care in a way that suggests that care is tailored to the individual. It would be more realistic to suggest that individualised care refers to a humanising project in obstetrics whereby good obstetric care is brought to individual women, through an emphasis on good communication. But the ideology and practices remain relatively intact. The focus on individuals can be emancipatory, when women and midwives work together, within more holistic meanings of birth, to create safety for the woman and her baby, while relying less on standardised policies and practices. It can be oppressive however when it is defined through the individualistic self care/management ideology, if there is an expectation that individuals must take responsibility for their lives, in a culture that undermines the autonomy of women and other less dominant groups (see page 193). Responsibility which appeals to individualism can exacerbate oppression in ways described by Jenny Harding's (1997) research on women's health discourses (see page 54). The focus on the individual, de-emphasises the oppression of social groups (McLeod and Sherwin 2000: 259). Additionally, responsibility in the context of limited autonomy is problematic (Benson 2000). While women had some autonomy in planning and having home births, they had less autonomy in relation to the services available to support their decisions. I return to these issues in Chapters 9 and 10.

transferred to hospital became particularly aware of this. On assessing the transition from a planned home birth to an emergency caesarean in hospital, one woman suggested that, by focusing on her situation, it may have been possible to avoid it, or to have made the decision that it was necessary without moving through 'all of the steps [interventions]' of actively managed labour⁴¹. Her account suggests that women's experiences of childbirth are largely constructed through rules, but her observations suggest that complications could be responded to by balancing activity and inactivity with individual circumstances, so that the minimum number of interventions are used:

'I think..... I maybe went in [to hospital] too early..... but I think..... I didn't have..... If I'd have had ... an expert there saying, you can do this... then that would have made the difference, but because they [midwives] were being anxious, I became anxious I think ... because it completely ... I mean... my husband says that it completely changed the way I was looking at the situation. Up until then..... I was coping and then suddenly I was like.... no..... I just want it taken out. I just want to go. I want to you know..... [...] So that's ... you know, that's what I'd like to have done if I could have ... I don't think it would have done any harm if I'd spent a few more hours at home anyway.... Well I do believe, you know, there wasn't any great time limit on the whole thing ... until they started intervening and it was their interventions possibly that put that time limit on ... I don't know in terms of the like the caesarean. I don't know whether if they'd left me longer ... they wouldn't have needed to go through all of the steps before that ... you know If they'd come to the conclusion I'd needed one then you know Because the position [of the baby] was different I think is it? They could have found out the position and so on without having to you know, break my waters to give me all these things to induce me and you know ... have all the monitors and everything that they did in-between - put me on a drip you know ... If I really needed a caesarean because of the position then.... they maybe should have made that decision earlier mmmm..... you know I don't know. I mean, I don't know what their procedure is and how long they have to wait for these things and why suddenly it was an emergency to you know.... have a caesarean I don't understand that'

As I described on page 58, time is the mechanism through which obstetric management (control) of birth is applied. It meshes a number of modernist agendas: managing uncertainty, increasing speed and efficiency and meeting training needs, all of which may conflict with women's needs. It has become a metaphor for safety in the sense that it has come to represent the boundary between risk and safety. Different constructions of time form the hallmark of different approaches to birth. While clock time is one of the main bases for decision-making in obstetric ideology, in more holistic approaches to birth, nature's time is respected. Clock time may be one of a number of considerations in certain situations, but is not the basis for decision-making. Thus, from the women's perspectives, adhering to time rules posed another risk.

Authoritative time

Safety in hospital rests partly on disconnected clock time, which fragments both the birth process and the care provided. Safety is neither circumstantial nor relational, but a fragmented response to isolated events in the body⁴², providing what Smythe (1998) termed, a semblance of safety (see

⁴¹ It was the definition of necessary that was at issue here. By planning home births women questioned obstetric ideology. In the event of complications, the women's accounts posed questions about whether or not there are other ways of working with the body which are as safe, in terms of preserving life, but avoid the invasive/harmful effects of obstetric technology.

⁴²This observation contributes to the discussions about the disembodied nature of obstetric management of birth and the

page 196), which denies women's time. As Erin McNeill (2000, personal communication) suggested, we need only to look at the definition of labour to see that women's knowledge of the beginning of labour is systematically denied through obstetric time and its concept of 'false' labour (when women describe being in labour but are told they are not) and 'active' labour (when medical ideology decides that they are, and begins to time the process of birth)⁴³.

I suggested that bringing the literature from diverse fields on time and place together indicates women's bodies have been construed in dominant ideology as matter out of time (Adam 1992) and place (Braidotti 1997, Douglas 1966). Indeed, the women's accounts suggested that they were constricted as much by the construction of space through clock time, as time itself: having equipment and personnel to hand to intervene in response to the dictates of time as it 'run[s] on and out' (Adam 1992: 161). The arrangement of labour rooms and the physical restriction they discussed was in contrast to the rhetoric of freedom to move, labour, and birth their babies in their own time and ways.⁴⁴

Time limits: 'The clock started ticking'

Thus, not surprisingly, obstetric ideology and women's views diverged on the issue of time. Managing birth through time in medical ideology is seen as crucial to decreasing risk. Yet women felt that denying nature's time and managing their bodies through clock time would greatly increase the risk of obstetric interventions being advised and used. Basing decisions on the passage of clock time alone seemed illogical to women. For example, the uniformity of defining the parameters of safety for home births through time (usually from thirty eight to forty two weeks of pregnancy) seemed particularly restrictive and limited to inappropriate, preconceived generalities rather than individual circumstances:

'she [midwife] explained that they would be basically available for me, for the two weeks before the birth date and two weeks afterwards. After that time, I was in hospital. That is what I was told

N Right. What did you think about that?

No, that sounded a bit sort of like cut off time, you know. Doesn't it depend, surely how I feel and what's happening with my body at that (laughing) time. Cos, you know I mean, some babies just don't want to come out ... on time Yeh, no, that was a bit - I found that a bit annoying really It sort of made you feel like you were on a tight schedule, you know, and (laughing) sort of like you don't fit into this⁴⁵,

Rushing

Confirming the research on time that I examined on page 58, a sense of external urgency featured strongly in the women's accounts of previous or imagined experiences of hospital birth. Midwives

ethics involved in this, in Chapter 10.

⁴³But safety can break down when no-one is relating to the individual woman, or heeding her knowledge, as the Dunne case demonstrated (Murphy-Lawless 1998a: 214).

⁴⁴Time's partner, space is integral to the management of birth and risk and I discuss the wider implications of this in relation to territory, power and control in chapter 10 in the section on 'Holding things steady', on page 287.

⁴⁵The strength of feeling about this issue in the accounts may also have reflected the fragmentation between community and hospital midwifery services. Most women were told by their community midwives that because of the lack of resources, they could only be on call for women for a limited period and that if their labours started before thirty eight weeks or after forty two weeks they would have to go into hospital. In practice, some of the midwives attempted to attend women if their labours started just before or after this set period. But for women, there was always the anxiety that if they did not give birth within the time frame allocated, they would not only have to give birth in hospital, but would also be attended by midwives they had not met before. But it also reflected a general awareness about the impossibility of resisting clock time as a measure of progress and need for intervention, in a hospital setting.

were frequently described as 'rushing' or 'running about' and babies were 'whisked away' There was talk about 'sudden emergencies' and things happening 'quickly' and 'suddenly'. The prominent 'clock on the wall' was the symbolic visual reminder that birth takes place through a series of measured events and that short labours are preferable to long labours:

'I was quite isolated in the [labour] room for quite a long period of time. And they also at that time had a clock on the wall, facing you, which I thought was quite an awful concept (laughs).

It is difficult to capture in words just how clock time impacts on birth, and the behavior of the woman and those around her, when she and they feel under pressure of time. When women and midwives lacked authoritative alternatives on which to draw, this lack was as implicated as cultural norms in obliging most women to engage with obstetrics' powerful risk/time/intervention chain.

'There's nothing to be gained by waiting'

For example, one of the women had some concerns about her baby, but was equally concerned about the effects of having an induction. She felt her baby needed to be born, but had no sense that this needed to be immediate. She wanted help to find an alternative solution to the use of syntocinon. Within the model of care available, there appeared to be no alternative to either staying at home against medical advice or having her birth induced in hospital and relinquishing her own needs and concerns. Her attendants were unable to practice outside the obstetric time frame and were fearful that she might reject this. As the excerpts below demonstrated, time was deeply implicated at every point of decision-making and her concerns could not easily be heard or met:

'we'd arranged to go into the [main hospital] to have the placental scan thing. Before I went however I had a rather upsetting phone call from someone at the hospital whom I don't remember meeting. But, you know, she sort of introduced herself as, oh we met yesterday and I was expecting to see you with your baby born. You know, really if it had been me I would have had this baby by now and you know, really there's nothing to be gained by waiting. And I said, well we've actually already spoken to the registrar and you know, he's in agreement that we should do it this way and this is our decision, you know. I mean, I was really really upset. And she said well, you know, they're not going to tell you any different really, you know. It's almost like wasting time and you need to be in here having this baby. Anyway I put her off and said, well I want to go with our decision that we've made already and I'll come down to the hospital and we'll speak to the consultant'

[following induction of labour] 'well we sort of were in early labour for about four hours and only sort of went about a centimetre (laughs slightly) which was a bit depressing. And then, you know, the clock started ticking and, well by 12 o'clock, if we haven't gone a bit more we've got to do something about this Which is, I mean, (sighs) exactly what happened last time. And it's just such an arbitrary thing. It's like they take this four hours out of the air and, you know, dangle it in front of you which just makes you anxious, I think. So I was really, really anxious. I did not want to go on this drip. So, you know, that coupled with everything else that had gone on in these five hours, I wasn't in a great frame of mind ... I just really needed to keep my mind on the job. However, nothing really happened so at twelve they put in the drip. And the midwife knew I was scared cos I'd been on it for like six or seven hours the time before and it was really hard going. And I just thought I can't, I just can't, I just don't want it, I cannae do it. Which is not really like me. I'm usually much more kind of positive about it. But I just felt that my anxiety was kind of spoiling it a wee bit or, you know, stopping me from being able to cope better. Anyway she spoke to me. You know, full on the face, she says we're going to get this baby

born and it's going to be as natural as we can and you can do it and we're doing it now and (laughing) you know, no messing. So, then it was full on really from there and it was agony. And I groaned and I (laughing) screamed and everything I didn't do last time because I was thinking, I know what this is like. It's horrible'

'It's a strange kind of situation because you realise what an arbitrary thing obstetrics is. It doesn't seem to fit into anything. Probably medicine in general actually - the way we in the West to do it. But it seems to create these situations of decision making that possibly don't really need to be made. Maybe give nature a chance. But at the same time, as the midwife said to me. She said it takes a very, very strong person to say no, I'm going to do it at home in the pool. And I wasn't prepared to make that decision, you know, and possibly put the baby's life in danger. So, you know, in that sense it was my decision to be in hospital'

'Maybe if they'd suggested, well, why don't you bring your pool with you and then, you know, to begin with you can start with that. I think they thought that I was going to be really, you know, obnoxious and demanding and things. So if they'd known a wee bit more about our situation and been a bit more welcoming about it or inclusive rather than, you know, oh, that's not happening therefore you're doing it this way. That would have been better'

So while women and professionals might share similar concerns, there could be profound divergences between them about how to respond to these. As the quotation above suggests divergences often centred on the construction and role of time and on the level of invasiveness needed. While the medical model may believe that 'there's nothing to be gained by waiting', women might believe that there is a great deal to be lost by not waiting.

Time between safety and danger/home and hospital

While the safety relationship between place of birth, clock/nature's time, complications during pregnancy and birth and obstetric intervention is unclear⁴⁶, assumptions about time and safety are embedded in the risk discourse on home birth:

'the midwife [...] really hammered it home, you know. You do understand that this may well be a small risk, but it's still a risk. And if something happens, it's ten minutes to get somebody here and less than thirty seconds or whatever in hospital'

Women who lived close to hospitals were able to appeal to dominant beliefs about time and safety as an additional lever to support their plans:

'I think one of the main things was that we were in [city] and to get from here to the [hospital] in an ambulance would take you probably about 15 or 20 minutes at the very most. And then somebody said, you know, to get the theatre done for an emergency section takes 15 minutes anyway. So, you know, we didn't really see - I mean you know, if we'd lived in the middle of nowhere, I think we would have thought about it very carefully I think my husband would have been much less inclined to agree and I wouldn't have done it if he didn't agree with me⁴⁷,

⁴⁶ For example, as services become more stretched, I hear more stories from women who have been prepared for forceps births or caesarean sections but go on to have spontaneous vaginal births during the wait for medical staff or theatres to become available.

⁴⁷ This woman in fact transferred to hospital for the birth of her baby because the baby had not arrived in the time allocated by medical ideology. She had an emergency caesarean section, because following amniotic rupture of her membranes, her baby turned into a malpresentation. Subsequently, she had a home birth in a more rural area - 'in the middle of nowhere'.

Women who lived further away from hospitals were obliged to engage with the time/safety assumption in different ways. Their trust in midwives skills as well as the birth process and the belief that they would still be able to transfer to hospital quickly enough, should it become necessary, was more overt:

'they [doctors] were just sort of - it was really just the whole time factor of getting from here to the hospital. And you know, if there was any difficulties with the baby, you know, everything's at the hospital, nothing's at home was their attitude, you know. All the equipment's in hospital, but at home you've got nothing. But I mean, I don't know. I mean, you have the oxygen and, I don't know, the midwives are very good you know. I mean a midwife in hospital's no different to a midwife at home who's going to cope with the cord round the neck or any of these problems. So, but, it really was just a time factor that they pushed from here'

In other words, women in this study resisted the assumptions that clock time is the essential and only link in the complications/treatment chain to provide safety; or that nature's time and midwives' skills are necessarily less safe. Part of their trust in birth, as I discussed above, derived from the belief that emergencies are unlikely to occur very suddenly or that the move from safety to danger may be without warning and catastrophic:

'it's funny. I'm doing a course at the moment, and on it are three nurses And when I said, I went in, and I was really excited about it, and I said, hey girls, I said, I'm going to have a home birth (pulls serious face) Home birth?, (laughs) **oh boy** So very open minded people, but, first baby - home birth tut, tut, tut So, you know, it's against the medical thing. Oooh, taking a chance there, oooh, what if it goes wrong I mean, if it does go wrong, and something happens, how am I going to deal with it. I mean, that's something I have to think about If I don't get to the hospital in time
N What have you thought?

I'm just too confident that it won't happen And I'm just too confident that we'll detect anything really serious beforehand. I mean, I have agreed to, as long as it's clearly explained, I have agreed to go with the wisdom of the midwives and their professional opinion And that's importantyeh. But having it at home far outweighs that⁴⁸,

For the women, safety resided as much in skills as technology. They believed that midwives' knowledge, skills and equipment could mediate between danger and safety to maintain safety and protect women and babies. In other words that safety is more embedded in knowledge, skills and a deep engagement between woman and midwife (see page 182 below) than managing birth through time:

'N Yeh, yes were there any risks beforehand that you had been particularly concerned about?

Um I don't know, I suppose it's things like after the baby's born. Things like postpartum haemorrhage and things like that. But having read the books, it's not actually such a - I mean okay it can be a major thing. But it's something that can be started off being dealt with at home and you can be transferred to the hospital for a blood transfusion or whatever you need. So it's not something that actually is necessarily life

⁴⁸Despite the undermining differences in ideology, which I describe in Chapter 9, women had faith in their own abilities and those of their midwives to detect any complications that might arise, quickly enough to be able to transfer to hospital. Ironically, obstetrics (in particularly antenatal care) is based on the premise that it can predict and detect complications during pregnancy. Research suggests that this is not the case (Strong 2000). Hence its tendency to view all women at risk. Parallels can be seen in mental health services (Petch 2001).

threatening within five minutes of it happening at home. So I think you know, certain things like that, or retained placenta. Again it's something they can transfer you to hospital for a problem with that. So I think there was only sort of three or four things that were mentioned in the books, that actually would need you having to be admitted to hospital for dealing with. And I thought, well all of them, I thought well, you know, fine, but if you were in hospital you'd need to be dealt with. If you're at home you just get transferred. Obviously it would be a bit of a hiccup to the system if you had to get transferred, but I mean, you know, you could deal with that. But there was nothing that seemed to be too major that you couldn't deal with it, you know'⁴⁹.

As I have already mentioned, it seems likely that some complications may not be amenable to treatment regardless of time or obstetric management, wherever birth takes place, though there are clearly time implications during birth. Excessive bleeding after birth for example, needs to be treated quickly.

Fragmented clock time/extended relational time:

'My responsibility is to form a relationship'

Obstetric ideology and women's accounts further diverged over the notion of birth as an isolated event in linear time, rather than the day to day cyclical experience of being pregnant, giving birth and raising a child (Gregg 1995, Murphy-Lawless 1998a). While the former focuses only on a live baby and woman at birth, women's 'criteria for success' includes the 'ongoing experience of being a mother to a child' (Murphy-Lawless 1998a: 47). It is this ongoing nature of the whole experience that most radically differentiates the meanings of birth and the concerns of obstetric ideology compared to those of women and their different concepts of time⁵⁰. The linear, fragmented time in dominant birth discourses muted how women connected birth to parenting through relationship. Pregnancy, birth and parenting are frequently disconnected through the muting of women as active agents. For women, the ongoing decision-making during this time brought them into relation with their babies as part of the process of becoming a parent. In other words, women located risk in the ideology of separation as well as fragmentation:

'Yeh my responsibility is to form a relationship. I don't know, it's almost like that the birth is a rite of passage in a way, and by the end of it you've been through it together and you're in relationship to the baby, you know It's sort of, the baby is what comes at the end of the (laughs slightly) the process of giving birth, and it helps to I think the more connected I am with the birth, the more connected I am with the baby ... mm and maybe my responsibility is to be open to having that (laughing slightly) connection with the baby'⁵¹

⁴⁹This quotation provides a typical example of how women responded to the obstetric assumption that safety is embedded in obstetric units because of the supposed, immediate availability of medicine and technology. As the next quotation in the main body of the text clearly demonstrates, elaborations on safety included the presence, skills and equipment of midwives. However, as other quotations show, the issue was rather more complex about whether or not midwives and their practices and equipment provided safety, if they also brought an attenuated medical ideology into women's homes (see page 165). The discussion in this chapter about death at birth and whether or not life should always be preserved, also speaks to this issue. Given the views of some women, that midwives' skills to support normal birth at home are underdeveloped and their policies and practices too closely aligned with medical ideology, there was some ambivalence about just how far they could provide the kind of safety women wanted.

⁵⁰This includes not only how women experienced the potentially harmful aspects of obstetric technology, which as I mentioned earlier, may stop at nothing in order to secure a live baby, but that of the baby. There are suggestions that the woman's emotional health and obstetric care may impact on the baby's health. This broader meaning of safety suggesting that the relationship between how a woman is cared for and the development of her unborn baby may be crucial (Teixeira et al 1999) and that obstetric technologies may impact on the baby's mental health in later life is now entering mainstream literature (Jacobson and Bygdeman 1998, Jacobson et al 1993).

⁵¹The focus on relationship as procedural rather than fragmented, contrasts with the relatively new "bonding" rhetoric. The

To this end, women were not only concerned about the relationship between themselves and their new babies, but the ongoing relationships between themselves and other members of their families:

‘With my second child, one of the reasons that we decided to opt for a home birth was so that my eldest child didn’t have to do without meIt would have been terribly difficult for her to not only not have me around anymore for the first time in her life but also for me to come home with this strange little person, that she’d then (laughs) have to get used to. So in the end it was a very positive experience for her as well

N Yeh..... I think you mentioned last time that you in deciding to have your second baby at home, that you were taking into consideration the whole family Yes, absolutely. It seems to me unnatural to split up a family when there’s something so important happening and such a natural event happening’

The context of women being expected to focus on practical parenting skills or tasks reflects a disconnected medical ideology of motherhood rather than birth as part of a more complex journey through parenthood. Thus in contrast to the frequent observation made by practitioners and others, that women cannot see beyond birth, women’s accounts were filled with examples of how, unlike medicine’s narrow, time-bound focus, they were thinking about the hours, days, weeks, months and years ahead of them, and the need to be physically and emotionally well to look after their babies:

‘I think it will probably be safer for me not to have the drugs and too much medical intervention. Even though it’ll be much worse at the time, it’ll be safer in terms of all kinds of knock on effects and the catheter and all that stuff that goes with the epidural They make you feel ill afterwards’

And connect to their babies in a variety of different ways :

‘I think I probably just had a sense that having it at home would be nicer in lots of ways. But it’s not till it’s happened that I’m clear about what those are. And actually they’re much more about positive things than just avoiding hospital. And I’m much clearer about how awful hospital would have been, I think, for me [...] I just think it feels more like you’ve given birth and so it’s your baby. Whereas if you feel that you couldn’t have done it without this **huge** building and all these people and instruments and drugs, you know, then it’s almost not so much yours is it But I did feel she was very much mine’

Their accounts demonstrated how the immediacy of clock time in medical ideology takes only short term, limited consequences into account. For them, the experience of birth was not seen in isolation, but as part of a transitional process with potentially life-long consequences. Thus safety entailed a balancing of needs in both the short term and the long term⁵²:

obstetric meaning of ongoing relationships has been reduced to the woman and baby spending a short time together after birth with a focus on ‘skin to skin’, as long as there are no medical reasons to remove the baby. Even at home, women were sometimes distressed that the weighing, measuring and checking of their babies prevented them from having the peaceful, unhurried time together after birth that they felt was so important. In the women’s accounts, bonding was replaced by their ongoing relationships with their babies, during pregnancy, birth and after birth. This was intensified during and after birth, but not confined to the narrow, time-bound meaning attributed to it by medical ideology.

⁵²This issue of relational time in terms of consequences on the self and others is strikingly demonstrated by a description of decision-making in an American Indian community. In making decisions, the group considers how these might affect the community in seven generations time (Starhawk 1990). The long-term emotional and physical effects of birth remain largely unexplored and undocumented, even though the physical impact and memories of birth stay with women, as I noted on page 19). While it may be difficult to attempt to research the complexities of the social impact of birth, it remains crucially important.

'I think it [home birth] has contributed to the sort of seamlessness of a new baby coming into our family, and it's probably affected the way we've been with him since his arrival
N How do you think it might have affected your way of being with him?
[...] that we've somehow been able to accommodate him very easily and very confidently. And I am some distance from the birth now, but I remember close to the time having a feeling of sort of like, well if we can do that we can do anything, you know. And so there was a sort of sense of confidence in our abilities to look after him because we'd brought him into the world at home'

Which some women felt, laid the groundwork for enhancing their journeys and abilities as mothers:

'I feel I've got more into mothering this time, and being with my family, with my children [...]. I think it's because I'm finding a sort of satisfaction ... that I'd like to get into more, you know, and have more time to get into. And, I mean, that also seems to fit in with a sort of feeling of ... I don't know, getting something natural that I've maybe got into more deeply through the home birth, through feeling ... more confident this time around. It's almost like, ah yes, I can see what this is about, you know, and I'd like to go further into it'

In essence, clock time forms the basis for decision-making within obstetrics, and the passage of time leads inevitably to interventions. Given the women's commitments to giving birth without medical intervention, imposing time restrictions was seen by them to be risky because it diminished the likelihood of them being able to birth their babies in their time and increased the likelihood of invasive procedures being imposed on them. Through their accounts it became clear that medical interventions could present not only physical risks to their bodies, but emotional risks to their integrity and family life (see Chapter 10).

Risks and costs of interventions

Concluding an extensive review of the research on place of birth, as well as his own research on outcomes of births in California from 1989-1990, sociologist Peter Schlenzka (1999) suggested that the material and social costs of the obstetric model is such that 'the already apparent disadvantages of the obstetric approach have such large order of magnitude, that in any clinical trial it would be considered unethical to continue with the obstetric "treatment"' (175). Obstetric interventions have potentially long-term negative impacts on well-being of women and babies but remain muted. Emotional effects are even less well documented. Research and commentaries indicated that there are multi-faceted consequences (Banks 2000, Green and Coupland et al 1998, Kitzinger 1992, Lyons 1998, MacArthur et al 1991 Ogden et al 1997c, 1998, Schlenzka 1999, Simkin 1991, 1992). Emotional effects are potentially difficult to research and can tend to focus on women's psychological vulnerabilities, but are nonetheless crucial when women are confirming that they have experienced long-lasting, life-changing consequences following birth - especially when these include lowered or enhanced self-esteem⁵³.

⁵³The crucial interconnection between safety/well-being, and ethics, which women made, enabled me to develop what I considered to be a different level of analysis. Understanding some of the potential affects of medical ideology's prioritising of some risks and the muting of others, from the women's perspectives showed a very different side to the apparently ethical stance of obstetrics' almost exclusive focus on babies. In attempting to understand women's embodied, as well as emotional experience of medical ideology in practice, I make connections between feminist analyses of the medicalisation of childbirth and women's health and the feminist/postmodernist analyses of the subject in the section on 'Bodies' on page 90.

'Looking at surgical intervention as a violation of women's bodies'

Like women in other home birth studies (Lemay 1997, O'Connor 1992 Viisainen 2000a), these women talked a great deal about avoiding the dangers of unnecessary medical intervention. While women acknowledged the potentially life-saving attribute of medical knowledge, procedures and technology, they felt that when they are overused, they detract from safety. They described the simultaneous reduction of the contact and attention given to them by midwives when care relies on technology and it becomes the focus of attention. Being in hospital therefore had the double disadvantage of increasing reliance on technology and de-emphasising other forms of support (see chapter 9, page 242), thus making interventions more likely:

'freedom from the technology in hospitals I think is another reason I don't I'm wary of hospitals. I'm wary of their dependence on technology unnecessarily. Technology is good if you need it But it's wholly unhelpful if you don't because I think, one of the reasons is because their [practitioner's] attention is divided You don't get their attention because it's, you know, with the machines. And I didn't want to be at risk of being strapped up or being injected with anything (laughing)'

The above quotation also alluded to issues of control and coercion. Women began to redefine obstetric technologies as invasive rather than benign; the material means to appropriate their bodies, control, restrain and work on them, in ways that could impose physical and emotional pain and damage. The following quotation for example moved from the usual risk discourse of medical ideology to a very different discourse of the risk of violation. It exemplified the divergence between medical discourse and women's concerns, which formed the basis of Chapter 10:

'I'm less likely to be subject to unnecessary medical and surgical intervention in my own home so that is the ... most important aspect of safety that I'm concerned with I'm not convinced at all that there is a safety argument to be made ... and the statistics - well, there have been various critics of the statistics, but a very recent one pointed out that births at home which were problematic were sometimes not supported. You know, there was no-one there. There were people having a birth on their own with no midwife and nobody around. But they're also included in the general statistics

N In the?

In the general statistics on home birth - which is perhaps inappropriate

N Yes ... yes when you said you don't think there's necessarily a safety argument to be made, can I ask you to say a little bit more about that, in what sense would you say that?

Well, the book I read has a critique on how some of the statistics have been gathered and how the information has been presented, which I think is quite convincing. So I don't believe that one is less safe in one's own home ... On the contrary (laughing) I feel that there may be a case to be made that home births could be considered safer, if you want to start looking at surgical intervention as a violation ... of women's bodies'

A number of women talked about the feel of instruments against flesh and the 'hardness' and potentially 'hurtful' nature of obstetric instruments and interventions:

'the thought of having an injection or a piece of equipment going in and helping you in a way, I just feel is alien to really The feel of metal inside of you or something like that - it doesn't, you know - it doesn't seem - it's completely unnatural'

'I mean first they tried to convince me to have a domino delivery. That was just before I actually booked for a home birth, when I tried to change my booking. And that was one of the midwives who showed me the [labour] ward, to give me an idea of what it would be like. And I suppose one look at it (laughs) and that was it. I was so shocked. Yeh well I mean, you know, it looked like a dentist's apparatus. All these gleaming instruments you know. I don't know if you went to this maternity exhibition recently but, I mean I went there and it put me off totally. All these sort of metal, bright things looked like they would be hurtful'

Can 'this equipment frighten you', or do 'they really have everything you could need'?

Because of the dualistic thinking, which frequently polarises technical and natural birth (Cosslett 1994), it was difficult for women to discuss medical technology outside this dichotomy. However, the women's accounts suggested that feeling safe or unsafe was to do with how far the woman could remain autonomous in relation to medical expertise and technology, or how far she was objectified and rendered powerless by it. When women have holistic beliefs about birth, the artifacts and visual impact of medicalisation can be particularly threatening and dangerous:

'but, you know, I think this equipment can frighten you, if you're (laughing) in labour. It's daunting. I didn't actually get to see it, but I didn't look for it. Yeh, things like..... cylinders of air, or, you know. Perhaps contrary to some other people, I don't find those things at all re-assuring and, you know, when I first saw the rooms in which women are in labour in hospital, that really brought it home to me (laughing). Put me off the whole idea of going to hospital because we did parentcraft classes at the hospital, before I had our first child. And I'd never seen a labour room on the inside. But you know, just these gleaming sort of instruments. I mean, I just, I don't (laughing) think I would have - I would just be so frightened (still laughing) of what they might be for, you know (laughs)

N Did you see instruments in the room?

Well, I don't know. It was some things, I mean, even just fixed to the wall. I don't know for drips or whatever. Some kind of tubing and dials and knobs, and (laughing) I wouldn't be able to tell you really what they are. And just the way the bed looks and the room is very small. It's like, it's like a cell. I mean, (sighs) it's really like going to jail (laughing) or something you know, you can't just walk about. I mean, I suppose you can walk about, but you're in other people's way if you do, I imagine, if you leave your room'

The ideology, visually represented in hospital, symbolised management of the birth process through restraint and painful interventions, representing women's limited role during birth and the central role of experts and technology. In other words, they saw safety being defined symbolically through control. In their own homes they were able to arrange soft furniture, soft lighting and other visual symbols which reflected their own beliefs about birth and which were suggestive of creating safety through enabling their birthing bodies rather than restraining or invading them. (I have discussed space in terms of territory in chapter 10 on page 287)⁵⁴.

But even at home, some women felt that the community midwives' equipment symbolised moving the hospital into the home which maintained a risk/control focus, whereas others saw it as part of creating safety through being prepared. This depended on where women placed midwives on the medical/holistic continuum, the level of congruence between their beliefs, and the level of trust that it would be used only when necessary rather than part of a coercive, normalising strategy:

⁵⁴Indeed many women "see" the conflict between their needs for a conducive environment and the clinical appearance of most hospital labour wards. Superficial changes such as pretty wallpaper are clearly not the answer. Many women remain unmoved by this window dressing and continue to read the underlying visual messages of medicalisation.

‘But, I mean, I don’t know you know. I really don’t see how the equipment and the professionalism and the training (laughing) really adds in some ways I mean some people talk of it as a safety net and that it’s reassuring. But I don’t really see it that way. I mean, I find it quite sort of frightening that, you know, this possibility (laughing) that things are going to go wrong (laughs), that you need a big oxygen tank or something (laughs), you know (laughs). And would it really help if something did go wrong, you know’.

‘when the midwives leave the packs and things, they leave an entonox cylinder. They leave a little oxygen cylinder in case the baby needs some oxygen after it’s born, you know. So they bring all the things with them. They also bring - if you do want pethidine or anything like that - they do bring that with them as well in case you want it. So I mean, they really have everything that you could need at home’

But whatever their misgivings about the community services, at home, women felt protected from the full impact of medicalisation. Transferring to hospital was thus seen as another potential risk. Because women felt more secure at home, they were often concerned that despite the fact that they might be advised to move to hospital for safety reasons, that transferring would signify moving from the safety of their own homes to the danger of the hospital, for all the reasons I have discussed so far.

‘When you have to intervene, you have to’

The women in this study did not discount the possibility of going into hospital or the use of medical or technical assistance during pregnancy and birth. Like those in Lemay’s and Viisainen’s studies women were attached to their babies and families rather than ideologies:

‘c’est sure que quand il faut intervenir y faut je ne veux pas courir apres une ideologie’ (Lemay 1997: 92) (when you have to intervene, you have to. I don’t want to chase after an ideology).

And there was a general consensus in this study, as in others, that prioritising the baby’s safety may become inevitable if complications occurred:

‘I mean, I’m not going to be, you know, if the baby’s distressed and they say, well, look, you know, we really think we’ll have to go in, I’ll just go in, you know. I’m not going to risk ... the baby or myself just because I’m so determined to have a home birth’

Risks of hospital: Moving into danger?

However, similar to other research (Green and Coupland et al 1998), many of the women’s descriptions about hospitals included loss of autonomy and control over their bodies, babies and concerns. Being face to face with medicalisation rather than one removed, changing environments and often being handed over to strangers induced a feeling of danger rather than safety (Viisainen 2000: 804)⁵⁵. The women’s concerns about unnecessary, invasive procedures were underpinned by the knowledge that loss of control is usually (but not inevitably) implicated with medicalisation and hospitalisation:

⁵⁵As I discuss on page 213, this was exacerbated by the organisation of maternity services, whereby women were often transferred, not only out of the community, but also out of the community services (see also Walker 2000b).

'the consultant had said to me... you know, you don't need to bring a birth plan because... if you come into hospital it won't be taken into consideration'

The power imbalances between women and professionals are apparently equalised by choice, consent and rights, but as I discuss in Chapter 10, dominant views on safety and their insertion into morality restrict this potential. Thus planning home births was a way of disengaging from negotiating or resisting the unwritten 'blanket' notion that women will consent to anything deemed necessary in order to obtain a live baby. In other words, staying at home was a way of retaining control. In practice, as I suggested, this was more complex and equivocal than might be imagined. While many of the women avoided some of the potential conflicts and negotiations that occur in hospital, consent in the home setting focused on gaining consent that the woman would transfer to hospital, if advised to. So while they believed that there are legitimate reasons for transferring to hospital, one of their greatest fears was of being persuaded to transfer to hospital for inappropriate reasons, such as (flawed) policies, or rules, about meconium staining or lack of progress, the midwife's feelings of insecurity or lack of skill, her allegiance to colleagues, or fears of litigation.

The troubling issue of consent

In order to ensure consent, medical ideology tacitly brackets home birth women into responsible and irresponsible categories, and introduces the notion that only women who accept professional advice can be deemed responsible, with no acknowledgment of the power relations in which this occurs. Women might then internalise the limits set on them by medical ideology by taking on board these categories⁵⁶. Thus it is possible to see that a contract is established, whereby, responsibility is traded in for compliance through medical morality⁵⁷:

⁵⁶Not surprisingly, it was my observation that the women who least challenged medical definitions of risk and safety experienced fewer conflicts with the services they engaged with, than women who overtly challenged medical ideology.

⁵⁷A view expressed by one of the women in the study highlighted how most women's discourses are constructed through the coercive expectation that responsible mothers place their baby's safety above other concerns. The following quotation was striking because of its non compliance with this ideology. In making the contrast it created a space to acknowledge that while some women challenge the medical approach to birth, few overtly challenge the underlying premise that women and babies are separate and that the woman's responsibility for her baby is not only separate from her responsibility to herself, but should be privileged:

'I guess my attitudes are slightly aberrant in that I think of there being a maternal/fetal unity. And until ... the fetus has become a baby, I see it very much as an extension of myself, that I should have complete control over. I don't actually feel that I have responsibilities to a baby at this point (laughs) ... But I appreciate that's probably a minority opinion It's not a popular way of conceptualising it and it's certainly not a point of view that's reinforced by the kind of baby books that I've been reading'

I came back to this in the second interview with the woman towards the end of her pregnancy:

'N I was interested in one of the things that you said last time, that you see your baby as an extension of yourself, and that you should therefore have complete control over it, and that you don't see yourself as having responsibility to a baby, whilst there's that maternal

Fetal unity, mm

N I wondered how you felt about that now

Well on an intellectual level I feel the same way. But I have become aware during the course of my pregnancy - mainly through my interaction with the midwives I have to say - of the kind of social pressures that are on women ... Well, I mean, they use the word baby for example. I mean, for a long time they've been talking about the baby - is the baby moving. They don't talk about the fetus, or the maternal/fetal unity. So, I mean, actually there are a number of assumptions about the separateness of the fetus embedded in the kind of language they use And there have been times when I've been sitting in the pub with a pint, where I've been waiting for the tap on the shoulder, and the American accent, you know. I think they are about to come over and say - do you know what you're doing to your fetus (laughs). But, you know, it's never happened but I think it's - yes it's that palpable. And also, yes, I mean, people have so many expectations - oh so you'll not be drinking. I mean, I have come across that relatively little. I mean, we are in a culture which is immensely unhealthy But I occasionally, every now and again, I come across people's expectations about what I should be doing or shouldn't be doing with my body, because of my pregnant state. And that's been okay actually. I mean, again it's mainly my interaction with the midwives that has made me feel uncomfortable

'my consultant readily agreed [to a home birth] [...] and I'm sure that she felt that I was sensible enough to know that if something did go wrong, I'd go in [to hospital] fine'

'they [professionals] feel responsible, you know. They feel they have to point out the risks. But since everything went smoothly the other times, they had no qualms about my having a home birth ... And also, I made it clear that, I mean, if anything seemed to be going wrong, I wouldn't resist going into hospital. I know some women are, you know, adamant it's going to be a home birth and that's that'⁵⁸

As long as this "agreement" is gained, the coercive contract women are drawn into when pregnant remains relatively intact. If women agree to transfer when advised, they can be subjected to the same rules of obstetrics as other women, as suggested by the rather blunt, but perhaps honest quotation about birth plans not being taken into consideration on page 166 above.

Consent takes place not only in the context of definitions about safety and responsibility but also in the limited possibilities for responding to complications. Thus women are to a large extent, obliged to accept medical definitions as well as medical morality. For example, rules about the length of pregnancy imply that babies should be born at home within the allocated time limit, or be induced in hospital. The tension between the definitions of safety in the context of persuasive medical ideology and lack of support for alternative meanings forces women (and practitioners) back onto medical explanations and solutions, whether or not these are supported by research or other belief systems:

'I wouldn't have even thought of not having this one at home. Just purely for the fact, you know, comparing my two [previous births], I know which one I preferred, you know Obviously if there had been any complications I would have, you know - you just automatically do what's best, don't you [...] You know it was funny. I went to the clinic on the Thursday and the other midwife was on that day, and she put on my care plan, "fed up waiting". And when my midwife came on Friday I said, you know, I says and it isn't so much fed up waiting, I says. It's wanting to beat the deadline. You know it was very much uppermost in my mind that I had to have this baby before the Monday because I did not want to go in and get induced

N Would you have done that if she hadn't been born by

Well I don't know. My husband told me I should just tell them to get stuffed and that I'm not coming in. But then, you know you've got to think, well You've got to think of the baby's sake and if the placenta's still working properly or not or things like this. To me you know I'd felt that date wise it was the sixteenth when she was due going by my dates which I was really sure of. So you know technically she was a fortnight late anyway. So so I don't know. I mean if they'd said she really does need to be delivered, I probably would have just gone along. I mean you've got to do what's best for them but ... it was very uppermost in my mind to beat my deadline and not go back for my overdue appointment. So thankfully we did it I probably would have been very disappointed. It probably would have ruined the whole thing if I'd have had to have gone in and been

..... My social interactions with people have felt okay'

As I acknowledged on pages 83 and 87, it is impossible to know how far competing discourses are constructed in relation to dominant discourses. But nevertheless, these fissures created by dissenting views are crucial in highlighting where and how discourses may be constructed by deeply held, less visible norms.

⁵⁸In the 25 years I have supported women during home births, I have not met a woman who has refused to transfer to hospital under any circumstances. Any disagreement is about necessary reasons for transfer and who makes the final decision. While women may be accused of being more attached to the experience of natural birth than to their babies, some professionals claim that they have only the interests of the woman and baby at heart. Authoritative knowledge is so embedded in culture that it often hides the attachment of those who adhere to it.

induced, cos right from the start I was, you know, I was wanting my home birth [...] But you've got to think of their well-being above your own'

Medical policies and consent place women in the invidious position of moral acceptance or immoral resistance - both at a cost - without being able to examine the possibility of creating a different sort of safety based on the individual woman and baby, what matters to her, and her ability to retain and exert autonomy. In Smythe's (1998) terms, women cannot feel safe if their concerns are of no concern to those attending them, and if they are likely to be overridden. Their observations and experiences raised the issue that women need to feel safe wherever they give birth. Even at home, feeling safe might be only relatively speaking, and only as long as they remained at home. Their feeling of safety is only a semblance of safety if it relies on remaining at home and if planning home births is to avoid feeling unsafe in hospital.

In considering safety, women were concerned about the possibility of emotional harm as well as of physical damage to their bodies and babies. The risk to personal integrity underpinned their discussions about risk and safety, and forms the basis for a more theorised discussion in both chapters 9 and 10 about the relationship between women's integrity and the medicalisation of birth.

Risk to personal integrity: 'I am such a good person I do what they ask me to'

As women were aware, part of the risk of being in an institutionalised environment is how it affects the individual in terms of compliance and resistance. This involves the risk of; not being oneself; not being able to stand up for oneself (see page 249 and page 250); becoming 'infantilised'; the greater coerciveness of an ideology in its own setting; and our socialised and gender learnt responses to institutional power (Belenky et al 1986). As Morwenna Griffiths (1995) observed, these can form the basis of lowered self-esteem. The quotation from Kirsi Viisainen's (2000b) study below exemplified how women's integrity and thus safety may be at risk in an institutionalised setting:

'I do not want to go into hospital because of what happens to me there. I am such a good person. I do what they ask me to. And they will ask a lot. 'Let's have an enema, let's examine, all right lady, let's stay still, we'll listen to the baby's heartbeat, we'll put this strap here and this string here, and let's break the membranes.' I do not want that. I want my birth to progress in peace on its own ... I have to relax and concentrate: I cannot fight with them at the same time' (805)⁵⁹

Women in my study drew similar parallels from their experiences of institutions, to comment on how their learnt responses and those of others influence how people relate to each other. They described how they might be less able to exert their autonomy and keep their concerns in the foreground if their agendas and that of the institution diverged, because institutionalisation requires professional allegiance to itself and its ideology, rather than to those it serves⁶⁰:

'When I went for my first visit at the antenatal clinic, we walked into one room. There was a midwife and she said ... It was like her seat, and then two seats, so she sat down in hers and my partner sat down in that one and I had a bag, just a little bag with like all my papers and stuff. And she said, put your bag on the chair ... and I thought, if I put my bag on the chair ... So I remained standing thinking, oh she wants to measure me or something. And

⁵⁹This quotation also raises the issue of the potential tension between the physical and emotional opening, to giving birth and the need to remain alert and on guard, if women are unable to trust the ideology and practices of those accompanying them on the birth journey. I discuss this paradox in Chapter 9 on page 238.

⁶⁰I discussed professionalisation in the literature review on page 72 and examine some of its implications for women and midwives in the section on professionalism in Chapter 9 on page 229.

then she just started talking (said incredulously), like she started reading our papers and just talking. And I just thought, am I meant to be standing up (again said incredulously, half laughing). And it took me a minute. I mean like in a normal situation I'd just react much more quickly to that, but I do fall in to that infantilised position and it took me a minute till I said, is it alright if I sit down, and she said, oh yeh. So I mean, I don't know why she said, put your bag on the chair. Maybe it was just a sort of throw away, or she meant put your bag down or, I don't know. It was very odd, but it's just that kind of thing that can happen

N How do you think that happens in hospital?

How does that happen. Um I guess I had to go into hospital a lot when I was a child, so, and not as an adult. So maybe that's been the bulk of my hospital experience, has been as a child [...] And, you know, even then I felt like they weren't really talking to me, they weren't really finding out what was going on for me at all [...] And then when I was about 19, I was rushed into hospital, they thought I had acute appendicitis and like I can really remember having two anal examinations like you know, [...] and I was just in agony. That sort of thing. It's just done in such a light way. I mean maybe there's not a more pleasant way to do it, but you know, things like that I guess that just mount up in your experience, that make me quite frightened I think, in hospital, which is why then I'm quite submissive I think And I suppose that I work for a big institution, you know, and I sort of I find people quite irritating (laughing), if they sort of come in and are very anxious and ask loads of questions when it's ... when it's something I'm going to get to, you know, and explain. So I guess I had this naivety that they're going to explain (laughing) things to me which is what I try to do in my work'

'it's just a completely different attitude which is inevitable⁶¹ [...] Like just now I'm still working [at home], because I'm self employed so I have to. So I'm working to a degree. But if I go into the office and I'm working in the office in a work environment then you're going to get a very work orientated me .. But I actually had an architect phoning [me at home] this morning. I'm like, oh, right, hello, how are you. And he's like, oh I'm fine (laughing). Very chatty this morning (laughing), you know (laughs). It's usually, right, well. You know (laughs) your attitude is different, so just by going into a work place and relating to people on a different basis. I think that's maybe what the whole thing's about, They're [practitioners in hospital] relating to you on a different basis. Here [at home] they're relating to you as ... a person in their own home who's quite relaxed and comfortable [...]. I definitely think that people working within a hospital environment, especially where there's a lot of teaching going on. They have a completely different attitude towards you, that you're somebody that they're learning off, or that they're teaching off or whatever [...] So in a hospital [...] it wouldn't matter if I was assertive or not, the hospital couldn't change their procedure just to suit me' (my emphasis)

Inevitably, women found it difficult to engage on an equal basis when the underlying hospital structures are based on the same sort of general, societal structures and inequalities that increase the power differential between people. This was compounded by the woman being the object of medicalisation: a medicalisation which is insensitive to her qualitative concerns (Shildrick 1997), during a vulnerable rite of passage.

Muted, but powerful stories about personal integrity in the context of safety and danger circulated and alerted women to the possibilities of this being breached in the name of safety. From the woman's point of view, the narrative below, demonstrated the difficulty of protecting women's

⁶¹Just how inevitable this is, is a central question.

safety and all that matters to her, and exerting any kind of autonomy in the context of medical ideology:

‘I do know somebody who had really, really been wanting a home birth and ... had ended up having to go to hospital. And ... I was actually seeing her. She was a client of mine. I was doing therapy with her and she was recovering from it [the birth] 2½ years later. And it was almost like a rape really - what had happened to her. It was so devastating. And she couldn't she couldn't equate those two experiences of having had a hospital birth - which is a normal thing - and her feelings of complete violation⁶² Well, you know, everything that she had wanted, had just been swept aside and I'm not sure exactly what had happened. I think she'd had a forceps birth. And she was really worried that the birth had damaged her baby. She'd been so aware of the process from the baby's point of view as well and so kind of sensitive to ... to that whole side of the experience and was left with just a whole lot of feelings that she she was still really dealing with two and a half years later

N How does that make you feel?

..... (sighs) I think I find it quite shocking. I think Yeh, I think the whole experience of listening to her and hearing what her experience had been. And then also thinking about myself - because at that point I was also very aware that that would be something that I would be doing at some point in the future Just the kind of strength of her feelings and how long they'd lasted and also the fact that she **had** been so disempowered. But it just kept on cropping up. I think I've gone back to thinking about it ... since I've been pregnant. And at the time it wasn't something that she was necessarily dealing with [in therapy] a lot, but it came up in two or three sessions. And I remember always feeling like, wow, there's a lot in there. But she she hadn't made those connections. It was still quite a disjointed experience for her. So yeh, I think I'm putting it together just now, as well'

Risk of alienation: 'If it's someone else's house, you do what they do'

It is clear from the feminist literature on embodiment that I examined in Chapter 5, that alienating women from their own embodied knowledge can be detrimental to their sense of self, their self-esteem and their abilities to be autonomous (as I discuss in chapter 9). Murphy-Lawless (1998a, 1998b) and Smythe (1998) make connections between decreased safety, self alienation and the alienation of women's embodied knowledge from medical knowledge. In alienating women from their bodies and excluding their knowledge, they suggest that a primary source of knowledge is lost. Smythe's 'semblance of safety', could equally well be applied to knowledge, where often only a semblance of knowledge prevails.

I discuss the women's observations about the risk of alienation from their own environments, support systems and ultimately themselves in Chapter 10. But I have included a quotation here, from a woman who made a direct comparison between the risk of home birth (as usually defined by medical ideology) and a reinterpretation of risk through her experience of alienation during her previous birth and her experience of alienation generally:

‘we'd had friends who've had home births and things, and we'd thought it was, just cos they're a bit hippy or something, you know. We'd listened to their stories about how wonderful it was and everything, but at the same time, the sort of sensible side of us had thought, that's a bit silly, it's not very safe. And, you know, cos I'm rhesus negative, we

⁶² I have raised the issue of violation here in relation to how women's safety could be in danger from their perspectives - but examine women's feelings of being abused and/or violated in more detail in chapter 10 on page 307.

thought for some reason that there'd be some risk of not being in the hospital. But that's not true at all. I really thought .. I'd rather just stay at home and remove the temptation to do it the hospital way and have the epidural. Which you do, you know. It's so overwhelming, you sort of forget how .. painful it is, and, you know, you do suddenly want anything that's going to stop this pain, and defocus, and not rely on yourself. So I wanted to remove that temptation and try and .. help myself get focused⁶³ in, my own system, my own environment, and not feel that I had to give myself to someone else's system. And that's very much ... if it's someone else's house, you do what they do. And if you're in the hospital, you do what the hospital does. And you try and fit in and be very polite and obliging everywhere you go. But in your own home you can just do your own thing. So all these added up I think and made me think .. I'm going to do it here'

From the women's perspectives, the potential of home birth and the risks of hospital birth were many fold. These perspectives were based on their readings of research and a sense of moral rightness, which, as I discussed above, did not shy away from uncertainty, risk, or the possibility of babies being born dead, dying, or severely damaged⁶⁴

Part 3 Can death be part of the discourse of birth? At what cost?

Unpacking the 'immortality strategy: 'All you want is a healthy baby, don't you?'

Discussion about death at birth and the possibility of negative consequences of preserving life is particularly muted and threatening.⁶⁵ Thus, as I have mentioned, the obstetric challenge to defeat mortality is not easily reconstructed. And yet the women's accounts suggested that while the obstetric project creates a strong quantitative demarcation between life (success) and death (failure)⁶⁶, for women, these form a continuum through their quantitative/qualitative attributes, and there is a need for autonomy in relation to both life and death⁶⁷. The dichotomous thinking involved in obstetric demarcations provides no way out of this dilemma. In the same way that qualitative aspects of birth are systematically emptied out of medical concerns, so too are the qualitative aspects of death. It was only in the women's accounts that spaces opened up. Their questioning of the categorical "no" to death, implicit in obstetric ideology led into little known and difficult territory.

The accepted view that death is the worst outcome is so endemic that when Smythe (1998) opened up the issue of safety to its many different meanings, she returned to the dominant position that the

⁶³I discuss the importance women placed on 'being focused' on page 292.

⁶⁴While I asked women about their views on risk and safety, I did not specifically raise the issue of death or damage to the woman or her baby. Of course asking about risk and safety implicitly raises this, but I did not consider it appropriate to initiate this topic directly with pregnant women. However, many women spontaneously told me that they had considered the possibility of their babies dying or being severely damaged. Given the pervasive risk/death pairing in our culture, it would have been surprising if women had not thought about it. The following (tentative) section on death at birth is therefore based on women's (semi) volunteered accounts about these issues.

⁶⁵As Margrit Shildrick (2000) commented, part of the concern to erase death reflects the patriarchal unease regarding vulnerability and uncertainty. This is one of the bases of modernity's ethics and politics which I discuss in chapter 10.

⁶⁶The distinction between success and failure is far from clear when obstetric ideology can extract a high price to produce a healthy baby.

⁶⁷Death was an acknowledged potential outcome of birth, as life and birth exist in relation to death and are therefore inevitably cyclically connected. The woman's quotation about her death experience while giving birth to her baby provides an example of how life, birth and death might be deeply connected in symbolic and complex ways:

'I think I would have to say that it [birth] was quite a spiritual experience, although I have a very sort of diffuse sense of spirituality [...] But within the realms of spirituality would be the sort of life cycle and birth and death and what happens when we die and before we're born and things like that. And I suppose the experience I had was very much about life and death and existing and not existing. And I've also felt that it may have been almost like reliving my birth .. and the complications of my own birth and it almost feels as if it was completely outside time'

life of the individual woman and baby is paramount⁶⁸. The women in the study certainly shared the view that the preservation of their babies' lives was of ultimate importance:

'I've made it very clear to them [midwives] that I'm not rigid. I'm really flexible about anything. If there's good reasons for anything then I want to talk that through, and you know, that I'm not going to sort of say, absolutely not. Never say never. I mean, I may have to transfer to hospital and have every medical intervention known to woman. And if I do, that's just the way it is. And it won't be the end of the world, because ultimately all I want is a healthy baby. But if I can do it my way, then well and good'

And yet, when women had suffered the consequences of the exclusive focus on the baby's physical life, to the exclusion of the whole experience, they questioned the narrowness of this view:

'all you want is a healthy baby don't you? You know I didn't realise that it meant feeling ... you know I didn't realise any of that. I didn't realise you know. I thought it would just be the same, I mean I thought, you know, like, it didn't matter if you got one off a supermarket shelf or something. I mean, it was just the same wasn't it? If you wanted a baby, you had one, you know But it's not (laughs). It's definitely not. You know, even now, my relationship with my daughter is totally different ... I just can't get on with her. That's how I feel. I just can't ... get on with her. It's just, it's an awful sort of strain, you know I don't know why. It's just something

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⁶⁸There are alternative views, which are embedded in relational community structures. Groups of Aboriginal women in Australia and Inuit women in Northern Canada for example, no longer leave their communities to give birth. This different weighing up of risk and benefit is documented in Betty Anne Daviss' (1997) account of birth practices among some of the Inuit peoples. The different concept of well-being was made collectively by this community and embedded in a political decision by their tribal council to return birth to the community. In coming to this decision, the well-being and therefore survival of the community was seen to be as important as the survival of individual babies. The argument was that the occasional death of a baby was acceptable in order for the community as a whole to survive. 'We are willing to include that [the possibility of death] because sending birth out of our villages is killing our society. We need to birth with our people in order to survive as a culture and we will take responsibility for any losses' (Complete Mother 2001: 22). On one level the debate continues to mirror the medical arguments around safety and risk within a different hierarchy of needs, because the death of a baby was not considered to be as devastating as the death of the community. It is community-centred rather than baby-centred. On another level, these decisions raise the same questions as the women in my study, about removing death from life and the community. Midwife Helen Stapleton (2000, personal communication) suggests that the death of a baby may be experienced as more acceptable in a community setting, and that it is the loss of community and the isolated, hospitalised experience of birth which makes death more unacceptable and unbearable. At the same time, there is no evidence to suggest that babies are less likely to die if women are removed from their communities or more likely to die if they remain there. The medical view cannot easily acknowledge the social construction of birth. By not seeing birth as a part of the community's life, it limits itself to seeing only what happens inside its hospital walls. Even premature and precipitous births, which are more likely to happen in the community fall outside its remit - and thus limits the provision of safety. Recent research in Finland also noted an increased mortality rate following the centralisation of services in remote areas (Viisainen et al 1999). Accounts of the !Kung women in Africa (Biesele 1997) suggests that the heart and strength of communities may be profoundly affected by its cultural approach to birth. The skills and autonomy continually passed on to women and those involved in birth practices sustain the community in ways that may be difficult to understand, but may nonetheless be crucial to its survival. As Jo Murphy-Lawless reported at the European Midwifery Congress for Out-of-Hospital Births, in Aachen, Germany, Sept/Oct 2000, in a community in Bolivia, the people rejected the opportunity to trade their skills, knowledge and autonomy in their dealings with life and death, for what they saw as disempowering and thus inappropriate medicalisation. The theme of autonomy and what it might mean for women underlies my analysis, but I focus more overtly on this in chapter 10.

⁶⁹ Women understood the complexities of life influences, but felt that difficult relationships with their children, or postnatal depression for example, were linked to negative experiences of birth, where their feelings had been overridden, they had lost control, or had been manipulated (see page 242 for example). Indeed, Green, Coupland and colleagues (1998) noted that the women most adversely affected by their birth experiences, were those who had had interventions they felt were not necessary. Looking back on her previous caesarean, the woman talked about how matters were compounded by the ongoing separateness of mother and child, and care from strangers in the context of an institution:

'I remember thinking, oh God, I can't cope with this, you know, and I remember the midwife saying to me,

But even when women appeared to share the obstetric goal of 'at all costs' one might still question the costs involved and the chasm between 'getting through', compared to feeling empowered:

'I think I always knew that no matter what happened as long as we both came out of it alive we'd be..... we'd cope. Because I think I'm quite a grounded ... person, I can sort of get through most things'.

Debate is embedded in the value placed on women. As Starhawk (1990) suggests, when women are undervalued no price is too high to pay for the live obstetric product (the baby)⁷⁰. There is a sense in which patriarchal obstetrics gives rise to "anything goes" in order to obtain a live baby. But this limits how women can speak about and prioritise their concerns. The medical view of life at all costs troubled some women because it involved their loss of autonomy over decisions to preserve life, which could involve aggressive/invasive techniques and long-term consequences for them and their babies⁷¹. By leaving a space in which death could be acknowledged, women could consider these crucial material and qualitative issues, that could impact on their lives.

Autonomy over death: 'I would want to make that decision'

While the dichotomous 'immortality strategy' severs the continuum between life and death, some women saw home birth as providing the potential to rejoin these and retain some control over decision-making about life and death⁷². Staying at home provided them with more autonomy over the quality of death (and resisting mechanistic practices) as well as of life. In other words, the issues involved for women about how death is handled in medicalised institutions or at home held similarities to those involved in how birth is managed or facilitated⁷³:

oh my God, you've got one there. Cos she was like, you know, always crying. And not the sort of baby they wanted born to a caesarean mother because (laughing) she was crying all the time and they had to keep coming. And I picked up on that as well - that it was making them annoyed. And it was making me annoyed, you know, that this baby wouldn't settle. And I couldn't hold her, because somebody'd have to be in the room ... And they took her to the nursery and she cried and cried and cried, and I remember going, oh no, and like thinking, if I buzz to bring her back, they're going to be annoyed aren't they, you know, like - and just basically telling me that they have lots more things to do than walk around with my baby [...] so hopefully this [birth] will be ...'

As hospitals become busier and staff shortages more acute, women receive less support and help. Paradoxically, while the woman's family and friends are often pleased to "hold the baby" and support the woman, they are often discouraged from doing so, as they apparently disrupt hospital routines and pose a security risk. The irony of the continuity/strangers debate was brought home to me by an article about a pregnant woman who planned for her mother (a trained midwife) to be her midwife. The woman and her mother/midwife were put under pressure to abandon their plans because it was not deemed appropriate by senior midwives for a relative to attend a birth (Ann and Heidi 2001).

⁷⁰ Apparently, not even precipitating the death of the woman, as in the case in America of an enforced caesarean in 1987, where the woman, Angela Carder was dying of cancer and likely to die during the operation (see Hewson 1994: 5). In this case the caesarean operation was carried out against the wishes of the woman and her family and both she and her baby died. Following a number of enforced caesarean sections, it seemed that this was generally going too far for both lay and medical communities, as debate (Dolan and Parker 1997) and commentaries, (Goldbeck-Wood 1997) demonstrated. While emotional coercion may be part of day to day practice, enforcing treatment is not only unpalatable, but challenges the notion of the bounded subject of contract politics underlying the principles of liberal democracy which I discuss in relation to choices and rights in Chapter 10 on pages 272 and 278.

⁷¹The implicit assumption that doing everything medically possible reduces the likelihood of death is not borne out by research, but nonetheless a double standard is maintained. That is, when medical ideology relies on and imposes its beliefs and values, there is an acceptance that some babies will die, but when women and midwives want to rely on theirs, the death of a baby signifies faulty ideology and practices.

⁷²In fact women were sceptical about the likelihood of having any say in decisions of this nature. They expected that institutionalised morality and practices to preserve life would take precedence and Jo Murphy-Lawless' (1998a) work confirmed this.

⁷³This brings us back to whether or not death in the community can be different to death in an institution that I raised in footnote 68 above. There is a question here about how institutions impact on autonomy and self-sufficiency. The

'I think I would maybe want the option to say, well if I do have the baby, I don't want you to support it. You know, I'm not saying don't feed it or whatever, but don't If it would naturally have died then it should naturally die rather than having it on life support systems and whatever for a long period of time So I would want to make that decision'

The quality and dignity of life and death: 'Just let the baby die in your arms'

The obstetric severing of death from birth and life, attributes only negativity to death: death as intolerable. While the death of a baby is devastating, a number of women talked about the importance of being able to hold and cuddle their babies. As in other birth accounts, (Banks 2000: 179, Noble 2001, Wesson 1990: 184, WHIC 2000: 141), this precious time with their babies could comfort and integrate the experience in a more tolerable way. Many of the women in the study stated that if their baby was going to die, they would prefer it to be at home, where the baby would be less likely to be 'whipped' away and subjected to harsh, invasive treatment, and kept alive when it should have been enabled to die with comfort and dignity:

'I don't want to dwell on you know, anything that goes wrong. Although (partner) and I have sat and we've talked about it and I think it was important initially to Like I was quite keen to take the responsibility if anything went wrong⁷⁴. But I was a wee bit concerned about my partner because obviously I was scared in the beginning that he was just agreeing with me because you know, (own name) knows, she knows what she wants and I'm quite happy just to go along with her. So...I did say to him you know, look make sure you read all about the complications and you get everything sort of straight in your own head because I think it's a responsibility that you both have to take, if anything goes wrong. And I think what I find as well, if there's anything wrong with the baby, you know, quite often prolonging its life in hospital. I mean I don't agree with that anyway. So, I think if anything really was seriously wrong, I think it would be so much nicer just to let the baby die in your arms or you know. So for that reason as well that was sort of one of the reasons. I mean I can't think of anything worse than your baby being rushed away and its body battered to try and bring it back to life, and do this and do that, and it may be

institutionalisation of birth concerned the women in this study, and some expressed unease about the institutionalisation of other parts of our lives. There was an intuitive feeling that institutions cannot replace communities and that the potentially oppressive impact of living our lives through institutions contributes to the destruction of communities which the Aboriginal and Inuit peoples attempted to avoid:

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'I feel very strongly that we sterilise our lives now. That all those things that (thinking sigh)that are really important to us somehow, you know, birth and death are shoved away. They're taken away and everything's made clean and neat and tidy andsomehow unnatural ...you know. Weput our grannies in homes and we send our labouring women alone to places where they don't feel comfortable. And it seems to me that these things are part of our natural lives and part of our natural experience. So home birth fitted well with...with that idea It worries me (laughs) that we do that and I'm not quite sure why we do it...you know. Are we so busy thatwe can't fit these important parts of life that are common to us all into the pattern of our lives'

'some people are very comfortable in groups and actually like to belong. For me it's very difficult to actually understand that (laughs), you know, they like to be with people that are in the same situation as themselves - you know - other women giving birth or something you know, as part of that whole set up - that whole network of institutions that you lead your life through. And you're also quite happy to end your life in an old persons home because that is just, you know, part of your institutional way of thinking'

Of course communities can be institutionalised and as oppressive as institutions, but we need to look at the impact of replacing one with the other: the exclusionary/inclusionary aspects of both (Griffiths 1995).

⁷⁴This quotation also demonstrates that women's reluctance to dwell on risk, did not mean that they had not considered the notion of uncertainty and the possibility of death at birth. On the contrary, in exerting autonomy and taking responsibility for birth, a number of women included allowing a dying baby to die with dignity as one of their reasons for planning a home birth.

severely handicapped or whatever, you know. Well we don't agree with that anyway so.....that's not really something you know - we're quite keen that if anything is really wrong we don't want any intervention. if the baby's going to die well, you know, it will do it in it's own house. Our son will be here and we'll be here ...so. But I know, I mean I know they [midwives] bring breathing equipment and things with them anyway [...] But I've no reason to think that there is going to be anything wrong so you know. That's not really anything that we're really worried about'

'maybe a brain damaged child wouldn't be resuscitated or kept alive as long as it would have been I'm sort of ... I suppose I'm of the school of thought that (said with slight sigh) if, if I have very badly damaged child, I would ... be happier for that child to be allowed to die naturally, than to be on .. machines and things in hospital and survive longer and add to the survival statistics'

'we talked about you know if the baby ... cos I suppose it's something you have to talk about if the baby was born very badly handicapped or died shortly afterwards, how we'd feel about it. And I said well I'd probably prefer to have a baby at home in that situation because you can be with the baby. The baby's not whisked away to special care or to rhesus or whatever, where you're suddenly separated and you haven't got those few minutes. And also if the baby is very badly handicapped and isn't going to survive do you really want someone to intervene and keep the baby alive when it really shouldn't be alive, you know. And we discussed that and we both felt that we were happier at home in that situation⁷⁵,

If the project of obstetrics is to avoid death "at all costs"⁷⁶, the medical ideology could seem threatening to women who questioned 'at all costs'. Having little or no control over life and death decisions threatened their values: how a baby lives or dies and its quality of life could not be divorced from life and death decisions for parents. Nor could it be divorced from the implications

The burden to women, of life at all costs

As the quotation immediately above suggests, some women observed that the burden of care derived from a mechanistic view of life, which sees death as failure and has a series of procedures in place to avoid this, would fall on them:

I did think the other day, that if I had you know, if I had a difficult birth or something went wrong, or (sighs). You know (sighs) it would be nature taking its course in a way. That might sound really hard but ... you know, perhaps too many children are actually born and live ... that ... maybe they shouldn't be born, or maybe I mean, if it's taken out of your hands at some point and they give the baby oxygen that is not doing well, or not

⁷⁵The 'whisking' away repeatedly referred to symbolised the decrease in women's autonomy, the lack of acknowledgement of the woman/baby relationship and of the baby as the woman's to care for. It reduced the complex qualitative experience of the birth of a new person to simplistic mechanical events embedded in separation ideology which has (inappropriately) appropriated life and death from the lifeworld into medicine.

⁷⁶And yet in early pregnancy women may feel coerced into aborting their babies. The illogicality of this suggests that there are other interests than the preservation of life at stake. The hidden burden of technology personalises its costs (see for example, Gregg 1995, Katz Rothman 1986), which oblige parents to make choices, but often steer women to aborting babies with abnormalities according to the tests. What may look like a technical success in dominant ideology, could take on a different meaning when viewed from a more holistic ideology (Katz Rothman 2001). The utilitarian ethics which have enabled enforced caesarean sections to be carried out, are oblivious to women's concerns and quality of life issues at the beginning of a person's life trajectory which impacts on the family and wider social network trajectories. (I discuss the untenability of overriding parents ideology and autonomy on the basis of medical ethics in Chapter 10).

thriving or something. Then (sighs) you know, as a parent you maybe feel afterwards that you have a burden that otherwise you wouldn't have had'

The cost of challenging obstetric morality: 'You'd naturally feel guilty'

But the women's acceptance of uncertainty was not without its costs, in the face of the responsibility and morality infused into obstetric certainty and the persistent dominant message that desiring a home birth means prioritising the woman's experience over the baby's safety. Although women felt that they planned home births to create safety for their babies, themselves and their families, this drew on meanings of safety that are not generally acknowledged or accepted, and thus did not necessarily decrease the sense of guilt women might feel when they explored the possibility of their babies being injured or dying at home⁷⁷. The negative attitudes towards parents who plan home births is so powerful that it is almost inevitably internalised, so that 'if anything did go wrong you'd naturally feel guilty':

'I mean, even with (son) you know, the first thing I wanted to know, you know, did he get ill because I wasn't in hospital? But that is a guilt which I get because society's conditioned me to have my children in hospital. Or is it because you know, generally it's more safe in hospital. I think the statistics say it's actually not safer in hospital but I don't know. It's difficult to say'

One woman who had experienced the death of a young child described the typical responses parents have. Her experience gave her a profound understanding that however and wherever a baby or child dies, our risk/blame culture is such that parents experience an overwhelming sense of guilt as well as loss. Her reflection and integration about this, as well as her experiences of birth in hospital, enabled her to plan a home birth in the context of the lack of safety she felt in hospital, and her acceptance of death:

'and I feel that, you know people can't understand. You know ... [they think] I'm taking a big risk mentally, I suppose, with how, you know, if this baby was to die, I'm going to feel responsible because I had a home birth and all of that, you know. And well, you know, for me, it's like, I've had a baby die, it doesn't matter how they die, or what they die of. You've still got that - if only I hadn't done this, or if only - you know. Every person that's lost a child has got ... has got to go through the - was it my fault, you know. That's what it was all centred on [...] And people even blame themselves when it's a straight forward - you put your baby to bed, and ... you know. And I was going, yeh, I can totally understand why, you know, because ... And that's how I feel about, you know, it's like you know life, isn't it, you know. And and if there's any powers that be and they want to do that to me again, you know, what can I do about it, you know. Because you know, I don't believe in ... God or anything, so you know I just have to believe in nature, and I just can't believe that it's anymore dangerous because I don't think I'll have the same fears'

This acceptance of death is relatively unusual in our culture. Modernistic ideals appear to have impinged on natural phenomena to the extent that when any death occurs, unless it is managed culturally appropriately and in expected ways, in the appropriate setting of hospital, hospice or nursing home, it may be viewed with suspicion.

The costs of challenging obstetric morality: 'I'm doing what I think is right'

⁷⁷I discuss wider implications of guilt in relation to women on page 252 and 289 for example, but the notion that hospital is safe and home is unsafe is reinforced by coercive value judgements about death at home. The implication is often that death at home could have been avoided in hospital even when this is unlikely to be the case.

In attempting to erase death from life, the obstetric project simultaneously evokes and reinforces the patriarchal culture of fear, blame and guilt from which litigious society has developed. Modernity's profound dis-ease with death, combined with dichotomous thinking creates its own boundaries between avoidable and unavoidable death. Negligence and blame is then apportioned to individual parents or practitioners⁷⁸. Both are located in a parallel culture of blame and it becomes almost impossible for either to subscribe to anything other than the dominant 'strategy'. As Helen Stapleton and colleagues (1998) found in their study on midwifery supervision, survival strategies in blaming cultures depend on deflecting blame onto others⁷⁹. In taking responsibility women suggested, moving away from blame towards doing one's best in the context of uncertainty, appropriate structures of care, knowledge and skills:

'There's risk. I mean, women still die in childbirth and that can still happen, but it doesn't put women off having babies does it. So, I don't know. I think you can just sort of try your best really. I don't think, I don't feel particularly scared by it, no no And I wouldn't do anything to risk damaging my unborn baby obviously. But I'm doing what I think is right'

As I discussed in Chapter 9, while many found that midwives could move towards this ideal within their policies, most found that the level of fear amongst midwives was usually too great for them to be able to negotiate mutual responsibility rather than mutual blame outside those policies.

Can we move beyond medical definitions of safety, risk and death?

It became clearer that the attempt to erase death from birth and the morality attached to this has implications for parents and practitioners which are little explored and which form part of the more hidden risk agenda - an agenda which attributes blame and guilt to parents and/or practitioners who deviate from normative beliefs and practices (Viisainen 2000a). If death continues to be the spectre of medicine, the burden of life falls on the practitioner, making for a potential conflict of interests over the life and death of a baby⁸⁰. The potentially very different consequences of the death of a baby for parents and practitioners make it difficult for them to work together in an attempt to make decisions about a dying or very ill baby, but power relations are seldom acknowledged. Even Scully's (1994) deeply critical study on the 'miseducation of obstetricians-gynecologists' fails to acknowledge that the professional/ethical basis of medicine, can never be free of other investments and that power is necessarily implicated in decisions about life and death.

⁷⁸The bounded construct of avoidable and unavoidable is lacking in complexity. These terms do not usually include social circumstances, the relationships between women and carers, the woman's concerns, or many of the circumstances preceding birth. They do not enable society to examine the structures of care in which death occurs. For example, when a baby dies because of practitioners working beyond their sphere of competence, the death may be assigned to the unavoidable category because correct procedure had been followed, or may be attributed to the avoidable category because care was substandard. Either way, the power relations embedded in structures of care which focus on professional and training needs described by Scully (1994) which allow practitioners to work beyond their level of skill and knowledge remain relatively unexamined. My own experience on the UKCC Professional Conduct Committee often left me feeling uneasy. It seemed to me that inappropriate structures of care, contributed to individual misconduct. While the individual could be held accountable, the structure in which he/she practiced was not.

⁷⁹There are a number of layers to the risk culture here, which link into the notion of the closed system of obstetrics I referred to earlier. Both women and practitioners are involved in the chain: Policies and protocols are created, consent is assumed, bullying takes over where consent fails, and blame is apportioned to those who challenge. Ruth Hadikin and Moira O'Driscoll (2001) found similar patterns in their study of bullying within the NHS.

⁸⁰The question about how much should be done to preserve life rests on a morality that is based on a complex fusion between beliefs and ability. The specific question posed by the accounts of some of the women in this study was whether the preservation of life at birth in modern obstetrics has overridden other moral positions and beliefs and lacks sensitivity to how resources are deployed.

The profound moral dilemma posed by obstetrics' uncertain knowledge about whether a baby would die whatever is or is not done is institutionalised by doing everything medically possible in all cases with little consideration for the quality and dignity of life, or implications for living family members. Yet the women in this study did not usually talk to midwives about their views. As the following quotation suggested, these discussions cannot easily arise outwith relationships:

'I think this has a lot to do with the relationship between the woman and the midwife. It was a subject frequently raised by women when I worked independently. It was rarely raised by women when I worked in the NHS and I don't think it was simply because of the changes I underwent in the process' (Stapleton 2000, personal communication).

As I discuss in Chapter 9 conversations were unable to reach the level of intimacy, depth and detail needed to discuss sensitive issues in fragmented systems of care. Thus life and death decisions can be removed from the agenda and the immortality strategy prevails. As can be seen from the quotations above, there was a spectrum of views on decisions about life and death. But the women's accounts suggested a need to reunite life and death, and a need for practitioners to reject the myth of immortality and move towards some acceptance of uncertainty. The attempted erasure of death from birth/life creates the context in which appropriate attitudes and behaviors of women and practitioners are constructed. Thus relationships between them are constructed and limited through the myth of life without death. It is only by attempting to change this context that different spaces might open up in which different concerns might emerge. Indeed, the women's accounts opened up many spaces in this under researched and complex area. Their diverse and circumstantial views, as they responded to the changing emotional and embodied processes of pregnancy and birth suggested that trusting relationships built on partnership are crucial. Their accounts also suggested that a changing framework needs to be based on the assumption that they are the people most concerned about their and their babies' well-being and thus needs to increase their autonomy and responsibility to promote all that is safe.

They challenged the dichotomous view that safety is located in hospital, technology and professional expertise and that danger resides in women's homes. Their view of safety located it in their own bodies, knowledges, and abilities to birth their babies and the transferable safety of the midwife's knowledge, skills, and her ability to relate to women and their knowledges. But birth at home in medical ideology is perceived as out of control. If all goes well there is sense of relief which I described as a currency of luck on page 68:

'my local midwife, when she came out, she's the first to admit that she hasn't done a home delivery for four years and although she did quite a lot in training she's not up to date with and doesn't feel that it's something she does often enough to feel particularly confident in [...] And her reaction's been that anybody that delivered a child at home would then go away and breathe a sigh of relief if it all worked out well. So she said to me, any midwife would then leave and breathe a sigh of relief'

Through the eyes of medical ideology, the woman's home seems emptied of all that contributes to safety and reduces risk. Those attributes of the home that increase safety and decrease risk are invisible in medical ideology - unless the home becomes a (less adequate) mini hospital. It is seen as very basic in the hierarchy of technology and medical personnel. So while "[b]eing safe' is more complex than any risk management is ever likely to be able to accommodate' (Smythe 1998: 257), obstetrics attempts to move its ideology, policies and practices into the community - taking the hospital home. Yet this is exactly what women were attempting to avoid by staying at home. It is clear from the women in this study and other home birth studies (Lemay 1997, O'Connor 1992, Viisainen 2000a)) that planning home births involved simultaneously avoiding the perceived disadvantages of hospitals as well as benefiting from the perceived potential advantages of home.

Through the eyes of the women, their homes embodied all that was safe for them. But unless the meaning of safety is expanded to include their concerns, their definitions cannot easily emerge or be legitimated.

Part 4. Women's reconstruction of safety: Being safe/feeling safe

The weave of safety

In describing safety as circumstantial and relational, safety was not seen by women to exist either at home or in hospital as a prior or separate entity. In the same way that Elizabeth Smythe (1998) described, they saw it as a process of becomingness, created from the social fabric of all that contributes to each individual birth, rather than applied from a package of prior calculations based on generalities. Thus, I came to understand that all the perceived advantages of home birth that women discussed were to do with safety. Every aspect of the environment and how they felt could contribute or detract from their sense of safety and confidence. So unlike the fragmented safety of obstetric ideology, women's meanings of safety formed a continuum; a weave of connecting strands, in which safety had many attributes. There was a profound understanding that birth exemplifies the power and fragility of a rite of passage which is influenced by a complex interaction between psychosocial, physiological and environmental factors. To move through it women focused on creating the sort of safety which could connect physical and emotional security. The following quotation perhaps exemplified the interconnectedness of these different facets of safety: the need to avoid the medical gaze and its attendant routine interventions; the need for a conducive environment where the woman can feel trusting, private and confident; and the centrality of woman's time rather than medical time. Those aspects typically attributed to a "nice experience", in medical ideology were crucial contributions to safety from the women's perspectives:

'N Yeh, yeh can you say a bit more about what makes it [home] safe?

.....Well there's the environment, being at home with people that I care about and who care about me is very positive. Labour is quite a an emotional time or a trying time or a It's a time when you need supportive people and an environment that you know ... and like And that makes **such** a difference. I think, it certainly makes a difference to my labour because I havefreedom from limitations on me during the labour, limitations on time for the first, well, for all three stages really. Sometimes they limit time in hospitals Limitations on my freedom of movement. I'd be very unhappy - you know, when I was in labour with my second child, I was all over the place you know. Walks outside. Coming back home. Going from room to room. Not being followed by anyone. People being supportive - and that's so important, it meant that the labour went terribly, terribly well. My second child was ... occipito posterior and so I spent a lot of time in different positions and finding comfortable positions and helping him to turn. And I felt far more at ease choosing these and getting into these without strangers about. Without people, you know, seeing what I was doing andI think that that really helped the labour progress'

The women were convinced that how they felt would contribute to how birth unfolded and that if they felt relaxed and secure, the process was likely to go well⁸¹. In the same way that emotional and

⁸¹As I noted on page 148 in footnote 28, and describe in chapter 10, the word 'relax' was a key word in all the women's interviews, which I came back to again and again. Women frequently moved from my questions about risk to their focus on 'feeling relaxed'. In talking to Mavis Kirkham (2001, personal communication), it became clear that relaxed meant feeling emotionally secure, removing obstacles to feeling safe and being able to let the birth process unfold. It was an articulation of the trust/safety pairing which women focused on. There were physical/bodily connotations to its meaning, i.e. women wanted to shed extraneous physical tensions which they thought might interfere with the birth process unnecessarily. However, it was more to do with creating circumstances that would generate a sense of emotional security

physical aspects of birth were seen as interdependent, feeling safe contributed to being safe. This view is not widely accepted, and women's beliefs and knowledges about the need to feel secure and relaxed are often relocated through the currency of luck I referred to earlier⁸². Despite their hesitancy in making claims about their own knowledge, they were convinced that mind and body cannot be divorced from each other:

'I knew this was the only place for me, definitelyIt's just the way birth is meant to be. And I suppose you could say, well I was lucky because my birth went well. But on the other hand you could say well, I'm sure it went well because I was so relaxed you know. There was nothing I had nothing to do except [give birth]. I was in my own house, you know. It was, to me, it was just perfect'

Their beliefs about safety were more aligned to holistic birth ideologies (see page 69) based on a concept of watchfulness: a readiness to 'leap in' or 'leap ahead' (see footnote 53 on page 245). It neither looks for nor denies danger, but attempts to be open to recognising it as and when it arises. This is the procedural, circumstantial approach described by Smythe (1998). It rests on the premise that while we cannot erase uncertainty, we can develop responses to meet its challenge. At the very heart of meeting this challenge to create safety, lies the trusting relationship between the woman and her midwife⁸³. In this view safety and relationship, which are separated by obstetric ideology are reunited:

'If a relationship is such that the practitioner does not listen, does not come to know the hopes and fears of the woman, does not respond to her anxieties, then the mode of care can only be one of leaping-in, and can only be based on the semblance of what the practitioner thinks should be happening. It lacks attention to the things that are 'mattering'. It traps the woman into a passive role of accepting inappropriate, unsafe care, rather than freeing her to involve herself in the accomplishment of personalised care that promotes all that is safe' (Smythe 1998: 202)

Because of the divergences between women's beliefs and the policies of their midwives, the birth environment was as persistent a theme in their accounts, as that of relationships. While the attributes of familiarity and control in women's own homes were crucial, and cannot easily be replicated in hospital settings, they were perhaps all the more important when women felt unable to trust their midwives wholeheartedly. I thus briefly discuss environment in relation to safety in the following section before discussing relationships below, and returning to the more general aspects of environment in Chapter 10.

and safety, through the woman's physical surroundings, those around her and the need to trust, in order to 'let go' in the way described by Tricia Anderson (2000). In other words, two of the main components of 'relaxed' for women included not having to worry that their integrity might be at risk, and feeling at home and trusting enough of those around them to be themselves. 'Feeling relaxed' was the way in which women proactively reduced risk and increased safety. As Maggie Banks observes: 'The sensual nature of birthing demands a birth scene that resembles the intimate environment in which the baby was conceived. It is this environment, which **frees the woman from her need to be vigilant** and ensures her maximum relaxation' (2000: 147-148, my emphasis). Of course not all babies are conceived in intimacy, but this does not detract from the need to give birth in an intimate environment.

⁸²The obstetric notion that when home birth goes well, it is fortunate (see the quotation on page 179) suggests that not only is the process risky and unpredictable but that women and midwives have little to contribute to safe outcomes.

⁸³In the following chapter I discuss how every aspect of the woman's experience is influenced by the relationship between her and her midwives.

Safe environments: 'Feeling safe is to do with feeling comfortable in your environment'

Obstetrics has incorporated the notion of conducive environment and imbued it with its own meaning which excludes that of safety. Women's accounts reconnected environment to safety:

'I mean, I think a lot of feeling safe is to do with security and feeling comfortable in your environment and if that can help things to go well then that's you actually making as much You're kind of creating a security and a safety for the birth, just by making sure that your environment's right'

'my home is **hugely** important and where I am ... is hugely ... Where I work - the office that I'm in - **terribly** important for me to feel safe in it. And so that was one issue'

Familiarity and safety remain disconnected in medical ideology. But feeling safe and relaxed in their own environments, over which they could retain control, compared to the impersonal, often disorienting hospital environment, over which they felt they had little control, featured in all the interviews. The 'uneasy compromise of flowery wall paper is the inadequate surrogate for the constellation of factors, comforts and rhythms women have at home' (McNeill 2000, personal communication) in which familiarity in medical ideology remains far removed from women's needs to feel safe:

'Mm I think safe means sort of like familiar. Mm, sort of mmmm. I suppose, yeh, I mean in your own house, you know where things are. You know what the normal things are that are going to happen in a day. You've got your normal sort of familiar routine and in that sense it's safe - in the sense that it's known The fact that you knew that during the day you'd be getting some lunch ready, you know. My daughter would be coming home from school. Then it would be teatime and at some point during that day things were going to be changed because you were having a baby and you wouldn't be able to do all these things. But to know that there was sort of like a normal routine going on, normal things were happening round about you and it wasn't ... it wasn't like you were suddenly being taken into another environment where everything is alien'

While part of women's concepts of safety was located in the control of the environment - making a safe place in which to 'let go' (Anderson 2000), safety was strongly invested in midwives. The midwife's experiential knowledge and competence, her trust in the woman's ability to birth her baby, and her ability to focus on the individual woman, was seen as the bridge that could unite feeling and being safe. It is to this relationship that I turn to next.

Locating safety in institutions or individuals?

As I noted on pages 44 and 70, the conceptual tool embedded in a medical concept of safety is risk management, and that embedded in a holistic concept of safety is relationship. While this is an over simplification, each depends on different definitions of trust (Giddens 1991), in which safety is defined and safeguarded. While medicalisation and hospitalisation is justified through abstract trust in faceless individuals and prescribed management, women discussed the need for individual, competent midwives in whom they could place their trust. (I discuss more about what women meant by trusting relationships in Chapter 9). It was precisely because women felt that they would not be safe with strangers and the restrictive rules of an institution that they planned home births. But trusting relationship is only the key to safety, if the midwife's knowledge, skills, confidence and

presence make it so⁸⁴, and if the trust is mutual. While I discuss this in Chapter 9, I raised it here because women identified this as the main component of being and feeling safe.

The focused presence of a trusted midwife: 'Your own personal midwife'

Many women located safety in the continual, watchful presence of midwives where they would be the focus of attention and the midwife would have few distractions. They thought that this was more likely to be the case at home and that any problems would therefore be responded to more quickly:

'I mean anything can go wrong anywhere with anything, so And it can go wrong in hospital and as I said before, you might not have the attention you might get if you've got a midwife with you, your own personal midwife at home with you'

'they're with you [...] You know, they're with you, whereas in the hospital they leave the room, or they put you in the room and leave. So to convince them that there's something going on takes a little while anyway. And even if they're there with you they're still not always listening, cos they're busy doing all sorts of other things as well, you know. I'm not criticizing them, but they're not listening to what **you** are feeling or what you think's happening. So it could be twenty minutes before anything's picked up anyway. By which time you know, we could drive into hospital in that time and if they're **with** you then, I don't think that even if there was a major panic, I don't think that they would have anything sorted out all that much quicker'

In discussing the watchful, skilled presence of midwives, women described a procedural safety which could acknowledge and respond to the uncertainty they identified.

Competence: 'They're here to guide me through a safe birth process'

While it was usually difficult for women to judge individual levels of knowledge and skills, competence was seen as a crucial ingredient for safety:

'they're [midwives] here to guide me through a safe birth process and to give me the benefit of their training and wisdom and whatever, to make this delivery happen as efficiently and effectively as possible. So a good working relationship's the most important thing ... and the requirement'

Women identified different spheres of competence. Broadly speaking these were to do with the skills to support women to give birth at home, and the skills to safeguard the woman and her baby if danger arose. While many women discerned a lack of supportive skills, unless the midwife herself questioned her competence, the women assumed that the midwife would respond appropriately to any complications⁸⁵. It was specifically because of this that the women who considered not calling

⁸⁴Over the course of this study, I frequently pondered about safety, relationships between women and midwives and the different experiences of the two women who engaged independent midwives, the few women who got to know and trust their community midwives and the majority of the women who received their care from teams of midwives. While continuity was crucial to women's experiences (see Chapter 9), it became clear that whether or not women got to know midwives, their community midwives were limited by obstetric policies and rules of employment. Women's experiences with known community midwives could be very positive, especially if there was little divergence between their ideologies. But as employees in a medicalised climate, midwives are unable to develop their own ideologies and practices in any other way than subversively ('doing good by stealth', to use Mary Cronk's phrase), which as Sally Hutchinson (1990) observed, has its limitations and costs. While the community midwife's responses are limited by the policies and practices she works within, the autonomous practitioner has more freedom to respond to individual women (see footnote 92). The midwife's greater or lesser autonomy enables women to be more or less autonomous (see Chapter 11).

⁸⁵As I discussed earlier, women wanted their midwives to be able to discern the boundary between danger and safety, from

midwives during labour because of their divergent ideologies, decided to call them. These women felt unsafe with midwives because they believed that their presence would increase the likelihood of transferring to hospital unnecessarily and receiving interventions that might harm them or their babies (see footnote 34 on page 329), but they wanted someone present who could respond to a serious complication. Their competence, was to some extent judged through their confidence:

'I wish that they have more confidence themselves, so it isn't a risky thing to have baby at home, I don't always get that feeling that ... that's the case, there's always at the back of the mind, this back drop of the hospital and ... and the contact there'

The women were well aware of the interrelatedness of competence and confidence and that the midwife's confidence derives from a feeling of security which rests on her knowledge and skills:

'I think that the the midwives should have more much more experience of it [home birth] really ... And I think that they should be much more much more confident in their own abilities And that's most of the problem really'

Their accounts identified that midwives were hampered by restrictive rules which did not enable them to develop their knowledge, skills and experience and thus confidence. When midwives practise according to rules, rather than autonomously, they create different parameters of safety (see footnote 92⁸⁶).

Essentially, women hoped that midwives would be able to provide safety by; protecting them from hospitalisation and medicalisation; avoiding rules and expanding the parameters of safety; protecting them from danger if serious complications arose; and providing skills and support to enable birth to remain normal. They hoped that in their own homes, midwives would be more able to focus on them and less on their rules. But it became clear in the following chapter that while the home could at least attenuate the distractions of medical policies, practices and allegiances, some of these crossed the home boundary.

While being safe was more to do with the midwives' skills, feeling safe was often to do with the attributes of the midwife herself. Until the cultural changes in westernised societies that led to the professionalisation I described on page 72, midwives were usually women with grown up families who had developed skills in helping women give birth and who were usually part of the communities in which they served (Allison 1996, Donnison 1988, Leap and Hunter 1993, Marland 1993, Tower and Bramall 1986).⁸⁷

a position of knowledge rather than fear and from a perspective of holistic midwifery care rather than obstetric ideology. They wanted their midwives to know the difference between difficult births and complicated births and be able to support them when birth was difficult but not complicated (see the quotations on pages 153 and 188).

⁸⁶There is the further problem here, that, as midwives are socialised and disempowered during their training, they are less likely to question policies and may come to accept these as absolutes, rather than guidelines. They may even believe that these have legal standing. For example, while supporting a woman during a planned home birth, a midwife arrived during her second stage and informed me that the woman would have to transfer into hospital as there was a legal requirement for 2 midwives to be present at a birth, but the second midwife may not reach the woman's home because of snow. Similarly, women have been led to believe that midwives cannot attend them at home if their pregnancies last more than 42 weeks, or if the baby passes meconium. When midwives are unable to expand their knowledge and skills and thus the parameters of safety, they become anxious if asked to. Thus women are forced to weigh up their understandings of safety, and their need to remain at home with the midwife's anxiety and subsequent decrease in safety.

⁸⁷As in other cultures today, the role of these women was more fluid and the boundary between them and the woman's family and friends less marked. For example, in Margaret Chesney's (2001, personal communication) work with women and dais in Pakistan, the only task that the dai must carry out is the removal of the woman's placenta. All other tasks are negotiable, depending on the skill, knowledge and willingness of those with the birthing woman. Professionalisation has defined a less negotiable role for the midwife, which largely excludes women's family and friends. Nicky Leap's (2000) work in this area has attempted to reunite birth in the woman's social networks by re-involving the woman's family and friends (see page 248).

Feeling safe: 'Someone who's been through it before ... who knows'

As the next chapter demonstrates, the knowledges, experiences, personalities and attitudes of midwives was crucial to women. Being and feeling safe were woven together through the competencies and attributes of midwives. For some women, the presence of someone 'who knows' and who has been there before was a necessary component to feeling safe:

'some midwives who are a bit older and who have had several children I suppose it's that sort of a role. But I mean, again because [birth supporter] was there, I felt that she could sort of provide that as well. In the way [that she was] someone who'd been through it. I mean, I did feel that looking back, you know, when she came that I could relax in a way, like now I could give birth. Whereas if I had just been alone with my husband, I wouldn't have felt nearly so confident or comfortable about actually letting go and giving birth (laughs). I think it really does help to have someone there who's ... who's been through it before and yeh, who just has children, who knows'

For some women, it seemed crucial to feeling safe and able to give birth, to have a 'motherly' figure present (Michel Odent (1999: 31) and Sheila Kitzinger (2000) discuss the value of a motherly presence at birth⁸⁸). Not having someone 'who knows' from personal experience would have interfered with this, as is evident from the depth of feeling in the following quotation:

'you don't have living proof that it can be done (laughing) and, you know, that it'll be alright. And you need an example don't you (laughs). Something to live towards'

Women located safety in relationships and elsewhere. For example, contrary to medical ideology which locates risk in the body, as I discussed earlier, women identified their embodied knowledge as a potential source of safety. I raise this issue in the next section and develop the theme of embodiment and embodied knowledge in Chapter 10.

Women's embodied knowledge as an (unacknowledged) source of safety: 'I think I would feel it within myself'

Like the women in Smythe's (1998) study, many of the women believed that their own knowledge of themselves, their bodies and their babies would interact with and contribute to the knowledge of those involved in their care and thus contribute to safety. While alienation from themselves was experienced as risky (see page 171), staying in tune with their bodies was seen as a source of knowledge and safety. Some women suggested that birth ideology has changed more than the nature of birth, so that women's inherent knowledge about safety and danger is now muted. The quotation below suggested that obstetric ideology constructs birth as more risky than it is, and moves to a more women-centred discourse, which locates the woman and her body as a source of safety:

N Yeh, yeh what do you think about the safety of home birth?
Mm I don't know. I think the safety of it, to me - I think if anything's going to go wrong, I think you're aware of it or it'll become aware I think before any kind of major danger. Maybe that's not true, but I think I would feel it within myself. If I really suddenly felt things don't feel right and I want to be somewhere where they have got lots of equipment and they can do things then you know, I would bring it up ... But I think on the whole, I think home birth is a lot more relaxed, so there won't be the same need hopefully.

⁸⁸This has parallels with my discussion about midwives having or not having children in chapter 10, footnote 59 on page 247. Having the common experience of giving birth may be reassuring in the context of lack of continuity and divergent ideologies.

You know, I think I'm..... coming from that point of view It just seems like a very safe ... I mean birth has been happening for so long in all kinds of situations. It's only since the fifties or something that it started getting so hospitalised It just seems crazy But yeh, we've managed so long to have births in all kinds of places yeh, I'm not worried about the safety aspect at all really'

'I mean, I would feel I might know first if something was going wrong'

Many women felt that their bodies would be more able to give birth if they felt at ease and in tune with them and that, as many mentioned, the home environment would influence this:

'N Right, right what are your views on safety?

Um well my experience of me in hospital is that I'm much happier out of it, and that generally my sort of natural body processes happen much better when I'm not under stress. So for me, I see it as in that respect a safer option because I think(sighs) I mean, it's a funny process giving birth. [...] I mean I really believe that the more in tune people are with themselves and particularly with their bodies and what their bodies are needing, the more healthy they're going to be and [...] I would hope in my labour that I actually am really able to listen to my body and almost just do what it's telling me to'

And that their bodies might interpret sensations more accurately than practitioners :

You know, I said to her, I mean, it was a few minutes later, I said, I feel the baby, I feel the baby really low. I said, I feel like I want to push and she's like, you're only 5 cms. And she had a look and his head was there, and a few good pushes and out he came'

It was also clear that in the context of the general alienation of women from their bodies and trust in their own feelings, that they could not always rely on their bodily knowledge and intuition and thus valued the interaction of knowledges between themselves and their midwives, as well as reassurance for their general anxieties (the 'peurs normales' I noted on page 63 and in footnote 29 on page 148):

'I really admire people who seem to know, and I think there are times when I know and there are times when I don't know. I can see that I have got limitations. You know, there are ways in which I'm in touch with myself physically and there are ways in which I've become more in touch with myself physically but some of the time, I'm not [...] but I certainly think that that should be listened to'

'it's so hard to separate your intuition from your fears. Like everyone has fears that things'll be wrong'

The notion that women are able to provide crucial information about themselves and their babies and may be more able to develop their knowledge in favourable circumstances is significant in terms of how women are listened to and thus how safety and continuity are inextricably linked. In this scenario, trusting relationships form the basis for safety, and medical ideology poses obstacles to this through its imposition of rules (which disregard individual women), and its structure of fragmented care.

Part 5. Obstacles to the creation of procedural/relational safety

Rules

In Part 3 of this chapter, I described the potential risks from the women's perspectives of: too narrow a focus on risk; applying a limited immortality strategy; imposing rules in relation to clock time; hospitalisation and medicalisation; fear; coercion; alienation; blame; and guilt. In part 4, I described their creation of safety as: an ongoing process of being and feeling safe through trusting relationships with skilled and supportive midwives; conducive environments; and the ability to contribute to safety from their own knowledge. From the women's perspectives, despite the fact that they and their midwives were committed to safe birth, obstetric ideology formed a barrier to moving from risk to safety. The possibility of community midwives moving from the medical policies and practices based on generalities, to a more nuanced focus on the individual woman and her circumstances was limited, even in women's homes.

The bounded, truth claims about risk, making it amenable to rules and regulations meant that discussions about safety and decision-making remained stylised. The initial discussions about risk and responsibility which I describe on page 207 suggested that the framework in which NHS community midwives worked prevented them from being with women from the first moment of contact, particularly if the woman had a listed risk factor which in medical ideology would preclude her from having a home birth. In Smythe (1998) words:

'Political tensions may dominate possible relationships and set up conflict before the relating even begins' (184)

Women felt that for some midwives, moving from the hospital environment and its rules, in the absence of support inevitably increased their level of anxiety and fear.

Fear: 'The midwives were so much more comfortable in hospital'

So while women might feel more secure at home, some felt that their midwives felt more secure in hospital:

'it's still something that I feel, even after the experience that I had, because of course I don't deny that I had a difficult birth. That I certainly will say. But I can still see at points where things could have happened differently. Maybe I would still have ended up in hospital, but maybe things wouldn't have come to the point they had done Because I had this overall feeling, as I said that the midwives were so much more comfortable in hospital than they were at home. Maybe they were worried about my particular case. I don't know. Although I didn't show any abnormal signs .. just a long labour, and I was tired. Those were the two factors. But there wasn't anything .. excessively worrying. There had been no meconium .. the heartbeat was always perfect, there was no sign of stress from me or the baby But I realised, you know, once I got into hospital they all of them put on the hospital garb ... and they just were so different. They were so much more confident and comfortable and happy (laughs). They were much more tentative in our house. And though we always sort of offered them food and drink they sort of kept more of a distance, which I could understand too'

Limited skills: 'They wanted to be supportive'

The woman continued to talk about her experience below, demonstrating the arbitrariness of safety, and the complex trading of midwives' experience of safety for women's, due to the impact of

medicalisation on midwifery. She explained that despite the midwives' positive intentions, their practices were limited. So while they could empathise with her meanings of safety and what mattered to her, they were unable to come 'towards' her⁸⁹. As I discuss in Chapters 9 and 10, much of this discussion rests on the midwife's skill in being able to support the birth process. Not unlike the woman I referred to on page 156, this woman believed that she was advised to transfer, not because of any underlying danger, but because her midwives' skills remained undeveloped, leaving little alternative than to adhere to the medical policies and practices, in which the time/progress pairing remains a motivating factor for decision-making:

'They were also being objective I think ... But I think it was more this attitude that I always found of let's wait and see. They never sort of came towards me [...] I found with the midwives, they just sat all the time, and they never said (laughing) anything. And then they would just say to me we'll wait and see. That's literally what they said, all the time, we'll wait and see. But in such a way that I didn't feel encouraged at all. And I never felt that I had a good gauge of where I was or what was happening to me. And I actually think that was the mental exhaustion. The physical exhaustion was physical, but that was mentally very exhausting .. Whereas I felt if they'd really come towards me as a person, it might have all gone very differently. And I thought they must see so many women and they must begin to understand people's characters a little bit and they must see how different people go into labour and get more the feel of what I particularly needed. But so from that point of view, I always felt at the back of their mind, they were more comfortable with safety always. And I suppose for me, I thought, well, you can't guarantee anything in a (laughing) birth. In a way you take a risk everytime you enter into it, so ... And I so much wanted this baby to come at home, and not to be interfered with. And it was like a ... a terrible disappointment. But they did realise that in time and in the end I felt they were really very supportive in their own way. They just didn't ... that was just how they were (laughs slightly). And I think some of them felt bitterly disappointed for me (laughing) as well. One in particular was really disappointed ... She really wanted me to be able to have the baby at home but didn't maybe couldn't have supported me in that way They were very good to us afterwards, and they all came to visit us and were very kind and yeh, in a way they wanted to be supportive, they certainly did. And I tried to handle things homeopathically afterwards as well, which again they didn't know anything about. And some were more wary of it than others, but they tried to respect it, and I just always remembered thinking it was sad they didn't have more things included in their (laughing slightly) training that they could just feel more supportive. Cos they wanted to but And I think in a way they admired the fact that we tried so hard'

These sorts of observations destabilised the term "necessary" and suggested that different ideologies generate different criteria and skills, which impact on what is deemed necessary and unnecessary. In other words, as I suggested on page 56, the same situation or physiology may take on different meanings and require different responses depending on the ideology through which it is interpreted⁹⁰. This in turn impacted on decision-making, which takes place in the context of patriarchal libertarian rights (see the section on choice in Chapter 10 on page 272). From the women's perspectives, rules and limited skills formed another barrier to safety. The standardising of risk and its management, combined with the professional's expectation, that they would take

⁸⁹Midwives who feel safer in hospital tend not to see the woman and her ability to give birth, or her birth companions' knowledges and support as a source of support for them. The more they practice by rules, the more removed from women and birth they remain and the less they develop midwifery skills to support birth. So while the woman feels more able to draw on her resources and skills in her own home, and more restrained in hospital, the midwife feels more able to utilise her skills in hospital and less able to contribute in the woman's home.

⁹⁰This also clarified women's contradictory comments that practitioners were 'doing their best', but not meeting their needs. Women did not question that the 'best' was being done; they questioned the conceptual framework in which the 'best' was constructed.

decisions about risk and safety, impacted on how knowledgeable, responsible and autonomous women could be in relation to giving birth safely to their babies. It is to these issues that I now turn.

Loss of autonomy: 'I'm losing control over my responsibility to the baby'

The usually brief discussions at antenatal visits precluded meaningful discussion (see Chapter 9) about how decisions about risk and safety might be reached. Women were informed about predetermined risks and told that if these arose they would be advised to transfer to hospital care⁹¹. Jo Green, Vanessa Coupland and colleagues (1998) found that women had different expectations about their role in decision-making and that some women assumed that only professionals could assess risk and make decisions. Even when women expected to make decisions, there were powerful norms in which some decisions were attributed to professionals. For example, midwives assumed the decision-making role in the event of risk and hospital transfer, which left little scope for dialogue⁹²:

'they [midwives] said that what generally happens is if they think that there's any risk at all, then they'll ask you if they can take you to hospital, and they said that you know. I said, oh that's fair enough, if there's any risk I'm quite happy to go into hospital. But on the whole if there's no risk I'd rather be here. And they said that if you do go to hospital they'll then phone the hospital and depending on what the problem is, either they'll send out an ambulance or take you in, or they'll send out a flying squad which will come here'

For women who did not expect to relinquish decision-making, and held different views about risk and safety, this was a constant, irresolvable anxiety which could result in a break down of trust and the woman having to 'hope for the best' or 'wait and see' (see footnote 43 on page 237). As I discussed on page 239, these women worried that the advice they would receive might be advice derived from a medical view of birth which did not concur with their own, and it seemed that midwives worried that women would not take their advice:

N How do you feel about assuring them [midwives] that you'll transfer into hospital if they say you should?

..... Well, I guess I've said it on a sort of trust basis that you know, they do know that that I do want to be at home and that unless there's really good reasons (laughing) whatever they may be, they wouldn't encourage me to transfer, but when it came to it, I don't know

Yeh, yeh I'm sorry to dwell on that, it seems quite a difficult conflict really

It's quite good, cos it's getting it a bit clearer in my mind as well, cos .. it's either been like, no I don't want to hear you, I don't want to hear this stuff ... because it's been just designed to make me say, yes, yes, I'll go to hospital Or I've or I've just been trusting

⁹¹ The patriarchal emphasis on boundedness and separateness, which I discuss throughout the next two chapters surfaced on the issue of these isolated risk indicators. The implication that there is a clear boundary between safety and danger and that the move from safety to danger is definable, not surprisingly, has similarities with the patriarchal notions of the more bounded male decision-making process, compared with women's procedural, and connected decision-making processes (Gilligan 1995). Women often considered a bounded view of risk as somewhat illogical. They accepted uncertainty, and therefore that there are degrees of safety and danger. They wanted midwives to be able to work with uncertainty and to be able to think through their individual circumstances rather than apply generalities. An articulation of this process in a childbirth journal, involved a woman with diabetes having a home birth, where during her pregnancy she continued to gather knowledge about her circumstances and on the basis of this, continued to make decisions. Some of the practitioners she engaged with found this procedural approach to birth alien and disconcerting (Lawson 2001).

⁹² I am not suggesting that there was no dialogue between women and midwives when hospital transfer was advised. I am suggesting that the dialogue that took place was to do with explaining the risk and why transfer to hospital was necessary rather than dialogue which might question the construction of risk.

that everything will go okay and I won't need to worry about it, and yeh, there's something that is unresolved in in me or between me and them. I'm not sure what it is, but I guess it's probably between me and them. But we haven't really talked It's always, oh we will, yeh, you will meet the midwives and ... and we will all talk. But .. I mean, it's only a month away now, so I guess ... it ought to be happening soon, shouldn't it'

'if there was a good reason for me going into hospital, I wouldn't trust that it was for a good reason, because I wouldn't know that she [midwife] wasn't just panicking or plotting to get me away'

Many of the barriers to safety were underpinned by ideological differences and the different shape of safety, depending on whether it is defined by rules or principles. Both women and midwives found that attempting to move across incompatible ideologies, or mesh holistic care with medical policies created mutual confusion, distrust, fear and danger:

'If if there seems to be a problem, I don't want to hold out and have a bloody natural childbirth and a dead baby, or a really unhealthy baby I'm just - I am really anxious that they'll kind of panic and want to take charge really quickly And the other thing was about cutting the cord, where I didn't feel quite so happy, because I was saying that I wanted the cord to be left until it had stopped pulsating And I do feel quite strongly about that. And she was saying, oh well (said slightly severely), you know, if it comes out and it's round the neck and it's very tight and we can't get it off, then we'd want to cut it right then. Is that okay? (said slightly menacingly). And ... and I don't know. Yes, if the baby's in danger, then of course, do anything. But I suppose it's just if I don't know I'm coming from the same value basis as somebody, then I don't know if they're going to be making decisions on the same basis as I would And I wrote something after speaking to them. I wrote something at the end of the birth plan that was about kind of the medical model, and you know, how wonderful it was, and also how it could really get in the way and not be helpful (sighs). So I still haven't actually sent the birth plan to them, because I'm still not happy with (laughing) what I wrote, because I was trying not to be accusatory, and I was trying not to put them in that camp, when that may not be where they want to be. But at the same time, I wanted to articulate something around a basic value base I suppose, And it's, and it's very difficult to know what to say or how to say it to people'

Neither women nor midwives could create safety or feel safe when they were unable to find common ground. Differences in ideology reduced the availability of both their knowledges, closed off information and reduced both responsibility and autonomy. The following excerpts exemplify the danger and divisiveness of preventing women from creating safety in their terms and demonstrate the difficulty of dialogic decision-making across ideologies⁹³:

⁹³For the women who wanted to create safety on a procedural, dialogical basis, and wanted their individual circumstances to carry more weight than obstetric generalities, decision-making across ideologies presented a rather intractable problem. Meconium staining provided a good example. The women found that in the event of meconium staining, NHS community midwives were required to transfer them to hospital immediately. The women who booked with independent midwives found that in the same circumstances, their midwives would discuss the best course of action with them at the time, as there are indications that it need not always be a reason to transfer to hospital (Page 2000). The contrast between the two following quotations provided an example of how relational responsibility could be achieved and where policies could be divisive, confusing or potentially dangerous when they became entangled with "choice". They showed how the midwife's autonomy, or semblance of autonomy could impacts on the woman's autonomy:

'I knew that she [independent midwife] would tell me if there was anything wrong and if she was ever really worried about the baby you know because it was a long labour and, you know I did have meconium staining at one point and we carried on. Whereas, definitely it seems to me that with the community midwives that's it,

'Well, I don't feel like anyone's talked to me in an open way about risks. People have given me the fear trip .. which I don't feel is talking to me about risks, because I'm just totally defensive and saying, well I want to have a home birth. But I don't feel like anyone's really said to me like I don't really know what the risks are. So I don't know
N Is she [midwife] one of the people, when you talk about fear trips, is she one of those people as well or not?

Yeh But I can't even remember what she said, because I think I just closed off my mind each time, cos I didn't want to hear the thing again Yeh, I mean they would try and get me to assure them that if something was going wrong that I would go into hospital. That I wouldn't be saying, no, no I have to be at home And I think that's been their way of talking to me about risks ... But I don't really know what the risks are ... And if it arrives prematurely, they were wanting me to go to hospitalBut I can see that, cos if it's really premature, then you need loads of equipment don't you. But I don't know how premature that was'

'Mm I feel a bit sort of in the dark about it [risk and safety] all really, cos there seems to be such a huge margin of what's normal. Like for some people, like one woman, she had a show and then nothing happened for ages. Or some people, their waters break and then nothing happens. And I don't know what a normal childbirth is. Like even the idea of a normal childbirth doesn't seem to exist so I don't really know what's risky or what's not. And so I find the whole thing quite difficult to think about'
N Right, yeh, mm Does that affect the way you feel about the midwife's role?

Well ideally it would be ... that ... someone can ... someone does know what is risky. And so I'd feel really good that there's somebody there who I can trust, who'll reassure me ... if everything's fine but just taking a long time or whatever, and say, no, this is okay, don't be worried and if there's something wrong, now hold on, we should be doing something now, and this is what's possible. And I'd trust them. The problem is that I don't, so I don't feel - I

you're just into hospital. And she knew I didn't want it so she said "mm the heartbeats fine, I think we're ok" and I thought well we must be I never thought that when I was in the bathroom that she would say to [partner] "look another half an hour and that's it, we're going to have to go". I never felt there was any subterfuge. I knew that she was respecting me and telling me the truth the whole time which I mean, later she said to me there were a few times when she was a little worried but not much you know. So if you like it was good, cos she made me confident and ... she never lied to me. But she was able to manipulate that a little bit in a positive way you know. I trusted her so much that I let her take the worry, one or two times when there was a wee bit of worry, she absorbed that without me knowing which is really good'

'they [midwives] said that meconium staining .. they said the baby was in distress, I mean I think you know, looking back on it, I think I should maybe have made the other decision [to stay at home] but they said that the baby was in distress and that they were going to phone the ambulance on those grounds and then they said that the heart beat was a hundred and forty, which was as it had been from the very beginning, so it sounded as if they thought there was meconium, however the baby was well and the baby wasn't bothered so the two of those things don't don't seem to combine for me, but anyway they said that it would be advisable to, to go into hospital [...] and so my husband and I said okay. My friend said I think they need a few minutes to make up their minds, so they left the room for, oh it must have been at least thirty seconds [...]. They were very keen for us to make the decision **immediately** [the midwife] came back in and she, you know, she came up to me and she was at the very most a foot away from me, and she was being very directive and saying, you know, that we should be going to hospital bla, bla, bla. And then she said at the end of all that, of course we'd be very happy to stay here and deliver you at home and I thought well if you are worried - in hindsight - if you are worried then surely you wouldn't be saying that. Surely, (laughs) surely you should be saying something else. So although they I felt that they'd tried to indicate that there was a sense of urgency, I felt that that particular thing that they said meant that they weren't all that worried that's what struck me about saying that to me [...]. One of the things I said was I really feel we have no choice and she said, oh yes but you do have a choice, oh yes but you do (laughs slightly)'

guess in that way I feel I feel like I feel like maybe I'm losing control over my responsibility to the baby .. I don't feel able to exercise that in some way, because I don't really know the situation and I don't know how far to trust the midwives to be doing or understanding what I want So yeh, I feel quite confused about all of that stuff⁹⁴,

Limited control over the creation of safety

Of course, birth is likely to go well, and as pointed out, 'care may be safe if there is nothing to make it unsafe (just as the day is fine if it does not rain)' (Smythe 1998: 233). But the idea that "luck" rather than safe care effects a safe outcome seemed inadequate to women⁹⁵. And yet, as the quotations above articulate, they often felt that they were restricted in their efforts to create safety. Safety has become packaged and professionalised and taken out of the hands of women (Smythe 1998: 34). For example, women had little influence over midwives' competence or confidence, and little option but to rely on their midwives' judgements, even when they had serious misgivings⁹⁶:

'there's quite a few women around and abouts here who have had home births, and I think they've had the local midwives and it's all been fine. So I sort of thought I'd just trust to that (laughs). But, yeh, it's not it's sort of, it would just be like giving up in a way, because I'm not completely happy about it ... So then I guess if something did go wrong, I would feel like I hadn't maybe done my full responsibility towards the baby, cos I'd sort of been overwhelmed by all the difficulties'

Even when they knew that safety was not being created, they were unable to influence the situation beyond a certain point, (yet were still deemed responsible). Sometimes, their own midwives had told them that they felt lacking in skills, experience and confidence. One woman reported that even senior midwives expressed concerns about the community services. But in the face of institutionalised responses, individual women felt powerless to create safety for themselves and their babies:

'like they [senior midwives] don't like the system. They're trying to change the system [to improve the skills and confidence of community midwives] so they obviously feel the system doesn't work Yet when I say my worries, they say, we can understand. But they are qualified midwives. And it's like, well, I know they're qualified, but that doesn't, you know [...] So I feel like they know. They do understand why I'm pissed off and they want to change it, but somehow they're not prepared to do anything to make it slightly better. I don't see why they couldn't have a midwife from the hospital come out, except that it's not procedure, you know. It's just the bureaucracy thing [...] It's like you've got community midwives on a rota for you and you know, you should be happy with that.

⁹⁴As Mary Cronk (2000) suggested, if professionals do not trust or encourage women to retain responsibility during pregnancy, birth and postnatally, the opportunity for women to develop the abilities and skills needed to care for their babies and children is undermined.

⁹⁵The safety/risk agenda and who is the subject of protection has been clearly visible in recent months when women have attempted to book home births with community midwives, where Trusts have wanted to reduce this service in an attempt to deploy resources in different ways. Or, when women have planned to have breech babies or twins at home against medical advice. Even when community midwives, or independent midwives have been willing and competent to attend a woman, some Trusts have resisted making appropriate arrangements for home birth and have insisted that she give birth in hospital - and that a midwife could not be made available.

⁹⁶Women were well aware that some midwives were more experienced, knowledgeable, skilled and supportive of home birth than others, but because of the rota system, had no influence over who would attend them. There is thus a potentially unacknowledged conflict between the rhetoric of institutionalised trust (in which professionals are interchangeable), and women's experience of difference.

Even though we're not happy with it, you should be which isn't really making much sense⁹⁷,

Constructions of responsibility that limit women's autonomy

Given the marginalisation of home birth, and the emphasis of hospital birth, responsibility is attached to place of birth: women planning home birth are irresponsible and therefore obliged to be responsible for their actions, and women planning hospital births are responsible, and can therefore relinquish responsibility:

'often when I speak to my contemporaries, their comment is, oh, you just want to get into hospital into a safe ... and sort of hand over responsibility, you know. And you think, mmm, (laughing) do you? (laughs). Whereas to me, handing over responsibility is just ... not at all the way it's meant to be. I mean you have to take responsibility'

This is predicated on normative beliefs about safety which have constructed responsibility through "responsible" mothering which encourages compliance with medical ideology through the limited currency of choices, rights and control (see Chapter 10). In the absence of other constructions women are thus steered towards relinquishing responsibility or obliged to stand alone as the quotation below suggests. This dichotomy rests partly on women's location in a patriarchal society that disconnects autonomy from responsibility and thus mutes the problem of limiting women's autonomy and demanding responsibility; and mutes the relational aspects of responsibility (Benson 2000). This reading suggests that both women and midwives need to be autonomous in relation to, and responsible to, each other⁹⁸ (see Chapter 11).

You're on your own'

The structural underpinning of the relationships between women and midwives was one of separation and segregation of responsibilities for safety, rather than one of connection and mutuality, in the quest to create safe circumstances. Women were expected to follow their midwives' advice, but in the unlikely event of a poor outcome, to accept responsibility. The

⁹⁷In areas where few home births occur, women reported that midwives seemed unwilling to provide a home birth service because they were unable to develop competence and confidence. But from their accounts there was also a sense of resistance to improving the service. Is it possible that the assumption that safety is located in hospital creates a paradoxical tendency in those co-opted into medical ideology to be less concerned with the safety of women who plan home births and the midwives who support them? There are also parallels here between women's autonomy and responsibility described by Paul Benson (2000) and that of their midwives. Predictably, medicalisation decreases midwives' abilities to be autonomous and therefore responsible in much the same way as it does women's.

⁹⁸Separating women and midwives' responsibilities, rather than developing relational, connected responsibilities, de-politicises the issue of autonomy and responsibility. I have already suggested that the often internalised concept of individual responsibility for health can hold within it burdensome, externally imposed moral beliefs and obligations, as well as questionable practices, which de-emphasise the limitations on women's lives. Like the women in Kirsi Viisainen's study (2000b: 802) lifestyle choices, self-reliance, and self-care were believed by nearly all the women to be integral to increasing the likelihood of birth going well. Eating well, exercising, reading and gathering information, preparing for birth through yoga and other practices, using alternative therapies, and reducing stress were seen as ways of reducing risk and maintaining good health and exerting autonomy. While this may be the case, drawing on critical literature in this area and listening to women, this focus could have other, more limiting meanings. The move towards self-management and self-care is partially based on coercive, capitalist strategies to maintain the wealth of the nation for some, rather than the health of the nation for all. There is additionally no guarantee that self-care regimes are either beneficial or harmless, and many of these regimes, as I suggested are exclusive to dominant groups in society (Harding 1997, Lane 1995, Peterson 1997). For women planning home births, focusing on their own health could de-emphasise the focus on the political nature of home birth. In other words, it was equally or more likely that medico/political factors would interfere with her plans to have a home birth, than her own health. The emphasis on individual responsibility for health also feeds into the view that women are responsible for any adverse outcomes of home births.

midwives' responsibilities were to follow correct procedure and transfer women to hospital if their procedure deemed this necessary:

'she [midwife] sort of explained, you know, that if there was an emergency, she said, you really would have to sort of psychologically gear yourself up, thinking - you're on your own. You've got to cope. Although we would, obviously do everything we could to get you both to the hospital safely⁹⁹,

In making women overly responsible when they are able to exert only limited autonomy, the potential for coercion, blame and guilt increases. It allows practitioners to continue to focus on monitoring the physical aspects of pregnancy without necessarily engaging with women at a deeper level, but as I discuss in Chapter 9, women wanted to take care of themselves and their babies in the context of relationships with midwives, rather than in isolation. It is in this context that women's knowledge ('announcings') could contribute to safety.

'Announcings': Not drawing on women's knowledges

'It is the woman who will be most sensitive to subtle changes in her being-of-pregnancy, yet she is the one least likely to understand what the changes might mean. Safe 'concernful' practice is open to announcings. It heeds the woman. It gets as close to the announcings as it is able, bringing the wisdom of knowing' (Smythe 1998: 195)

I suggested earlier that self-alienation decreases a potential source of knowledge and is thus detrimental to the creation of safety. Alienation between women and midwives similarly decreases sources of knowledge and potentially increases danger. Both are obliged to fall back on their own interpretations of safety and risk, without the benefit of the other's knowledge, in the cultural context of women having already been alienated from their own knowledge. Women wanted midwives to 'know what is risky', based on shared values and trust (see 'Trust' on page 236). But often the woman attempted to make decisions in one belief system with information from a conflicting one. She thus lacked the knowledge and the support to carry out or revise her decisions.

Smythe (1998) suggested that the two main aspects of safety are the knowledge and skills of the practitioner and the relationship of trust between the practitioner and the woman. This relationship enables the woman's knowledge to surface as 'announcings'. These 'announcings' can then be interpreted and may notify her midwives of danger:

'This reminded me of my time as an independent midwife and what was so powerful was the knowing in women's voices when they phoned. I often knew from the tone of their voices whether or not they were okay or in pain or frightened - or not, because I knew those voices, probably as well as I knew their bellies or their partners or their children' (Stapleton 2000, personal communication).

The literature I discussed in the section on knowledge on page 78, about women's knowingness located it in relationships, appropriate contexts and expectations (Belenky et al 1986, Jordan 1977). It might be experienced bodily or intuitively, but its meanings hidden as suggested above, and by the case of Catherine Dunne and the tumultuous contractions she experienced before her twins

⁹⁹ The underlying assumption suggests again that safety is an entity, contained within a hospital setting and that the home is risky. The midwife's responsibility in this view is to transfer the woman to hospital as quickly as possible. High blood pressure in pregnancy or labour provides an example of how constructions of risk shape beliefs about the location of safety. In medical ideology, women may be hospitalised, monitored frequently and their labours induced. Alternative views suggest that women with high blood pressure may be safer in their own surroundings, as high blood pressure may be exacerbated by the stress of being in hospital, frequently monitored and having their labours induced.

became compromised (Murphy-Lawless 1998a: 214). Thus the midwife's encouragement and expectations of women's knowingness forms the appropriate relational context:

'It is the climate of trust and of knowing that the practitioner is most effectively able to leap-ahead, discerning what might possibly lie in the darkness. It is in this same climate that the woman is also free to give voice to her intuitive knowing of what she perceives lies in the darkness' (Smythe 1998: 188)

Lack of space for 'announcings': 'They should have listened more'

However, many felt that there was little meaningful recognition or place for this knowledge within obstetric ideology (see the quotation on page 254). The women were often unable to make their 'announcings' in ways that could be heard, elaborated on or acted upon. While of course there were fine examples of midwives encouraging women to draw on their own knowledge, listening to them, and combining their knowledges to influence safe outcomes (see page 233), this depended on individual women and midwives negotiating barriers to safety and finding their own meeting places. An ideology that has no concept of safety being located in the woman herself systematically mutes this knowledge¹⁰⁰ as in the quotation below:

'like I was saying before about **feeling** him [baby] not to be engaged and **knowing** that he wasn't as other women had described it They should have listened more to that because they constantly asked me if I felt this pressure and if I had an urge to push. And I kept saying I kept thinking, well maybe I should ... maybe this is an urge to push that I'm not really recognising. Or you know I was questioning it, my own feeling which in retrospect I just didn't have. It wasn't there And I think they should have listened to that and if they'd been more experienced they'd have known from that you knowThey'd know, you know. Not just from internals, but they should have known from what I was saying that it wasn't happening And I think I'd I'd say the next time I'd have faith in my body to ... to say, this has got to be sorted out first mmmm ... And I think I'd discuss it with [partner] you know Things like the idea of making me push and stuff like. And I'd make sure that he outrightly refused that I did that if I didn't feel the urge (laughs) to because it just wasn't going to happen And there was no benefit to it except to make me even more tired and probably probably a lot more internal bruising or whatever it was that was going on you know [long pause] Yeh, I think they could they should maybe talk to you more about how you're feeling at each stage, about what ... you know, what the contractions are feeling like and so on. And they could maybe discuss it with you a bit morebecause they pretty much left me to just feel them and and maybe there's more in the way they're [contractions] feeling than in the way they're changing and that that would indicate more to them I don't think that they generally I don't think - I think they're looking for physical... signs like, centimetres dilated than ... you know the different feelings ... pressures and different I don't know, I don't know'

Being the 'model patient'

In the context of the political background and lack of continuity through which midwives relate to and listen to women, there may be little access to creating safety through the woman making 'announcings' and illuminating the darkness. The quotation below demonstrates the intersection between knowledge and relationship, the interdependency of relationship and safety and the

¹⁰⁰This of course has parallels with midwives' knowledges, which are equally disregarded in a system of care that relies on risk management.

disadvantages of lack of continuity when midwives may already be listening to censored versions of women's feelings and knowledges. It demonstrates the fragility of relationships, the need for a robustness that can only develop within the context of knowing and trusting another person¹⁰¹, and the difficulties facing women who attempt to exert autonomy (see chapter 10):

N How easily do you feel you can raise any concerns you have?

[...] I suppose with things that I feel will be disapproved of, I suppose I haven't necessarily felt comfortable about raising them as issues. I only want to raise things that make me out to be the (laughing) model patient, and, you know, an easy, straightforward case ... obliging and not difficult

N Does that mean, you've kept some things to yourself?

Um I don't think there's too much troubling me other than just things that I know are to do with my obsessive behavior. I mean, I'm not technically obsessive, and I wouldn't be classed as obsessive. But I, you know, I just get a bee in my bonnet about something and have to work through that. I have to sort of get so sick ... take it to it's extreme, and work through it. And that's the way I deal with things, rather than presenting them to people I'd be more inclined to talk to (partner) a lot about it, or to read about it, or to find out from other sources, than risk the relationship I'm having with my midwife [...] You know, mostly I would .. wash my dirty linen elsewhere (laughs) and that's all part of this need to be accepted I'm sure a lot of women feel that. That they crave acceptance and I'm sure that's why a lot of women end up doing exactly what the doctor wants or having the full medical thing .. because they don't want to cause trouble'

In essence, many women experienced a rhetoric of safety that was not necessarily matched by the practice of safety. They experienced a series of rules that could not provide them with the safety they needed. 'Fixed, rigid beliefs and routine practices, even if validated by research findings, have little to do with making 'being safe' possible' (Smythe 1998: 228). Women and midwives could not get close to safety. As one woman articulated, it leaves women 'in the dark about it all really [...] I don't really know what's risky and what's not'. It is this 'semblance of safety' (Smythe 1998) that I explore next.

Semblance of safety¹⁰²

If, as women suggested, relationship is a key component to being and feeling safe then the semblance of relationship that develops from lack of continuity, (see Chapter 9), is a major component to this semblance of safety. If this is exacerbated by conflicting ideologies, both women's and midwives' ability to look into the darkness, to meet uncertainty, and maintain safety is decreased (Smythe 1998). Both are alienated from their own knowledge and feelings by the policies and practices the midwife is expected to abide by. Smythe suggest that facelessness and lack of

¹⁰¹This is not to suggest that women should be expected to share all their thoughts and feelings with professionals, or that mutually self-disclosing relationships should be the goal, (though relationships require a certain level of disclosure in order to work). Rather that continuity may provide opportunities for women and midwives to get to know each other well enough, so that women could feel safe enough to share their feelings if they chose to. It is interesting that this woman raised this issue with me in the context of a relationship, but appeared not to talk intimately with her midwives - she described the relationship, in a quotation above on page 183, as a 'working relationship'.

¹⁰²Where negative attitudes towards home birth prevail and there is an emphasis on hospital birth, women may also feel less inclined to transfer to hospital, even when it might be safer to do so:

'all the way along I'd said - if there's a problem, I'd love to go into hospital. And I think if there's an emergency, I'll be very grateful for it. And I said that all along. But then it became a ... Then it felt like a battleground and now I feel if I go into hospital I feel like they've won and I've lost. And it would be - I told you so - which isn't a very healthy thing either'

I come back to this quotation in Chapter 10 on page 300.

responsibility undermine safe care in institutions (214). The deployment of resources and resulting midwifery shortages prevent practitioners from engaging with people and obliges them to fall back on medical generalities, distrust, lack of knowledge, and insufficient dialogue, to be able to cope. The quotation below, from one of the 7 women who gave birth in hospital, exemplifies the paradox of safety when it is focused on routine, risk-based policies, which disregard individual women and babies:

'now let me think to get this right. My [community] midwife sort of got us set up [in the postnatal ward]. She went away and suddenly, I was sort of half asleep and this nurse appeared and I saw her wheeling out my baby ... And I said, you know, where are you going. I mean, obviously people steal babies and things as well. I mean, it could have been anybody with a nurses uniform on. And I mean, you've just had a baby, you're so protective against this baby as well. And she said, we're taking the baby to the nursery. And I said, well, I don't want the baby to go to the nursery, you know. I want the baby beside me. That was something that I was really ... that was one of the reasons I wanted a home birth as well, because I don't really believe in a mother and baby being separated after birth ... So she said, oh no, we'll have to take it away. And I said, well, no I don't want you to take the baby away. And it was going to get to the stage where it was like, yes I am, no you're not. And I said, no. You're not taking the baby away. So she sort of huffed away and she went away out. And then some more senior nurse appeared and said, well, really because of the meconium, we really feel that the baby would be safer in the nursery, just so that it's got constant, you know - somebody constantly looking after it ... and I thought, ooohhh. And I was like, you know, I didn't want - I didn't want to put my baby - I didn't want to wake up and him to be sort of struggling for breath or anything. I didn't want ... So I said, right, okay, fair enough. But as soon as the baby wakes up, I want somebody to come and tell me, or somebody to bring the baby back to me. Well of course I couldn't sleep. You know what it's like, you know. And I didn't have my baby beside me and it was really getting me down. And I thought, well, I can't sleep, I might as well go and sit in the nursery myself. So I went to the nursery and there was no staff in the nursery. And I thought, well. You have just told me that the reason the baby couldn't be beside me was because I would be sleeping and there would be nobody looking after him. And yet he'd be safe in the nursery. I walk into the nursery and all the staff were obviously on a wee break and having cups of tea and there's nobody in the nursery ... So I just got him and wheeled him back through to me, and nobody came back and said anything I mean, I suppose there was staff in and out, but it just so happened that when I was in, there was nobody there and that was the whole point that she persuaded me to take him into the nursery'

The intended goal to increase safety may not easily materialise when policies take the place of thoughtful practitioner engagement with the self and others.

In conclusion: Safety has meanings beyond survival

Through their different readings of birth, women assessed risk in very different ways from the usual tick list of medical criteria (see Stapleton 1997) and thus perceived home birth as potentially safer than hospital birth, for all the reasons I have discussed above. Safety was described by them as integral to the quality of their lives and those of their family, rather than limited to survival. In other words, unless the baby's life was under threat, safety had many meanings beyond the immediate physical health of the baby at birth, and included the ongoing complex processes of family life.

Because of their beliefs and experiences, they aligned themselves more closely with circumstantial safety associated with holistic approaches to birth, than with the conceptualisation of birth through risk management embedded in more technological or medical models of birth. But as they and their

midwives found, attempting to merge ideologies that had potentially conflicting views about safety was not easily able to provide it. As in other studies (Lemay 1997, O'Connor 1992, Viisainen 2000b), the women in this study were mindful about the uncertainties of birth. They saw potential and uncertainty as coexisting attributes, which need not generate fear, and yet, the language and meanings of obstetric security have been specifically conceptualised in relation to risk and fear (Lemay 1997: 82). So while women clearly did not reject medicalisation out of hand, or wish themselves or their babies any harm, their focus on increasing safety through confidence was perceived as a responsible, ethical stance in relation to the belief that they would in all likelihood be able to give birth safely from a position of confidence rather than fear. As other studies (Lemay 1997, Smythe 1998, van Olphen Fehr 1999) have shown, the relationship between women and their midwives was fundamental to this confidence and potential for safe birth, where "safe" encompassed the women's multiple concerns. But midwives were only able to take on board the women's concerns about safety so far as they did not conflict with their policies and practices and in so far as they were able to get to know the women's concerns within the constraints I have described.

As I have suggested in this chapter and explain more fully in the next two chapters, to feel and to be safe require high levels of midwifery skills and trust, so that both women and midwives' knowledge contribute to a circumstantial, procedural safety. This requires a fundamental change in birth ideology, based on feminist's constructions of autonomy and responsibility based on support rather than blame. It requires an acceptance that safety is not an absolute concept and that safety cannot be guaranteed (Smythe 1998: 249). At present women and midwives lack autonomy, but are obliged to take responsibility, which leaves them too vulnerable to being blamed for "unsafe" outcomes¹⁰³.

Given the political backdrop to midwifery and home birth, mutual fear and distrust often developed: women felt that their integrity may be breached through what they saw as the over medicalised practices of their midwives. Midwives felt that women wanted support for situations, which might take them outside the "safety" of their policies and practices, for which they had been unable to develop adequate skills. Thus the flow of procedural safety was fragmented on the rocks of risk management and conflicting safety agendas. Barriers between women and midwives caused mutual fear, and alienation from what was safe and what was not. In this view, medical ideology (or indeed any ideology which prevents practitioners focusing on and engaging with individual women's meanings of birth) could be interpreted as a locus of risk.

Both the women's accounts and the literature I drew on, suggested that there was no such bounded entity as safety and no way of packaging it with any certainty despite attempts to do so. Rather there are principles, which can contribute to safe outcomes and constraints, which limit their likelihood. As Smythe (1998) suggested, safety is an ongoing process affected by the: current ideology; physical health of the woman and her baby; emotional feelings of the woman; women's knowledge; professional's knowledge; accepted knowledge of the day; localised policies and practices; resources; levels of support within the general system of care; development of relationships between women and carers; presence or absence of trust in these relationships; and undoubtedly other influences. Treating the pregnant and birthing body in fragmenting and mechanistic ways, imposing the general onto the individual, ignoring other knowledges, and refusing to acknowledge the importance of trusting relationships cannot ensure safety or eliminate risk.

¹⁰³ As I discuss in Chapter 10, and as the quotations on page 280 demonstrate, women sometimes felt they had no option than to follow professional advice; not because they felt it was necessarily the safest course of action, but because they knew that they would be blamed for any untoward outcome, and were unable to create trusting relationships with midwives or gauge the skills and support they would be able to provide. So while they were aware that focusing on potential increases responsibility, and were prepared to accept this responsibility, they were unsure if their midwives could meet them in this regard. In other words, the feminist theories about relational autonomy (Mackenzie and Stoljar (2000)) were borne out by these women's accounts.

The deconstruction of risk and the reconstruction of safety suggests that birth needs to be located in social/midwifery philosophies, drawing on wider knowledge pools, than the limited epistemological basis of mechanistic models. In other words, women's meanings of safety depend on openness to experiential knowledges and its assessment in the context of their lives and circumstances. Risk management relies more heavily on one source of knowledge. The women's accounts pointed out the limitations of scientific knowledge claims, both epistemologically and through the generalising from trends/populations to individuals. While poverty, lack of support, and location, for example, will continue to influence every aspect of women's lives and impact on the safety of childbearing, a growing body of literature suggests possibilities for maintaining safety during childbirth. When women's circumstances are taken into account and responded to, even those most vulnerable to complications remain healthier (see for example, Davies 2000, Evans 1987, Rooks 1997).

Women in this study articulated the need to open up a space between normality/abnormality by rethinking power relations involved in the arbitrary demarcations between medicine/technology and midwifery. But given the assertions of commentators in diverse fields (Bruner quoted in Goldberger 1996: 342, Davis Floyd and Sargent 1997, Kuhn 1970) that authoritative knowledge mutes other knowledges. And given the power relations in which Belenky et al (1986) asserted that 'girls and women have more difficulty than boys and men in asserting their authority or considering themselves as authorities' (5). And given the medical appropriation of normality, and its definition of birth as normal only in retrospect, these articulations were necessarily tentative and incomplete. Nevertheless, in providing a site of resistance, they form the basis for examining possibilities outside dominant meanings of birth.

This chapter avoids certainty and stops short of coming to any definitive conclusion about risk and safety. To some extent, this mirrors the uncertainty of birth. It also reflects my commitment to the "becomingness" that I developed in my review. This becomingness enabled me to understand that dominant debates on risk and safety are so taken-for-granted, while alternative debates are so elusive that it requires further research, thinking, and processing to advance these debates. It will depend on many factors, including: how midwifery/social thinkers and practitioners combine their knowledges to develop theory and skills to create safety in birth; midwives willingness to focus on trusting relationships; and an understanding that ideology is profoundly implicated in the integration or separation of safety and relationships. It will depend on women's trust in midwifery, on the values attached to birth and women's bodies, and how power relations play out over time.

But, it is evident from this chapter that the system of community care developed from a medical model of birth can only be attenuated by the ingenuity and commitment of women and NHS midwives. It provided a formidable obstacle to them being able to experience feeling and being safe together. Social readings of birth suggest that obstetric rules of the day not only impact negatively on birth, but the women's accounts suggested that they also had devastating effects on the relationships between them and their midwives, as they erase individuals: their knowledges, desires, abilities, creativities and vulnerabilities. The next chapter examines these relationships, developing the themes that have already arisen around safety, continuity, support, trust and control for example, in the light of dominant ideology¹⁰⁴.

¹⁰⁴I used the coding network I had designed with the help of NUD*IST to examine emerging themes and then reintegrated these in the light of the voice-centred relational methodology I described on page 114. This holistic approach to the narratives helped to ensure that the women remained the central players rather than the themes. This mirrored the emphasis on relationship, which was so prominent in the interviews.

With Woman

Will you be 'with me'?

No, I mean 'really' with me?

**I can feel this power, rising up within, sweeping along on
huge waves.**

I need someone, you see, because I am frightened.

I am also exhilarated to be on such an ancient journey.

I am tired to tears of people who will not listen and

I barely have the strength to protest

At their formulaic phrases and litanies of self comfort.

I cannot bear to be reduced, a product of tunnel vision.

**Not now, not when I am at my most powerful, my most
dangerous, my most**

beautiful.

I am incredibly sensitive. Your body does not lie and

When you touch me

I will know if you are not really 'with me',

if you do not respect me.

Do not insult me with platitudes

or falseness for convention's sake.

I would rather be alone.

Sanctify me. We are equal.

Do not collude with those misguided,

or more sinister still, those who would masculate me.

You are powerful and so am I. Touch me gently.

Share the power of life with me honestly, let me be me.

Jenny Green (1999: 8)

CHAPTER NINE - Re-forming relationships: Relationships between women and midwives

‘there’s so much potential for it [the relationship between women and midwives] and for whatever reason, it’s not being realised’

‘it feels like there’s quite a sort of cultural gulf between the women who are choosing home births and the women who are providing the service’

In this chapter I attempt to draw together somewhat disparate ‘pockets of knowledge’ (Belenky et al 1986: 140) from my review in order to examine the sociopolitical and personal processes through which relationships between one group of women (childbearing women) and another (midwives) are mediated¹. This dialogue focuses as much on the women’s imaginations and aspirations as on the materiality of their experiences².

Introduction: The resonances between separation and connection in theory and in practice

In looking at the deeper structural layers of society, both Kathryn Rabuzzi (1994) and Alice Adams (1994) observed that separation rather than connection is the main organising concept through which life, birth and motherhood are constructed. The fundamental reconstruction of the motherfetal relationship as separation, all the more visible since the advent of technologies which have further developed the male ‘gaze’ (Adams 1994, Duden 1993, Katz Rothman 2001), is mirrored by a series of separations. The problem is not so much the issue of separation itself, but the way in which it has been privileged through dualistic distinctions at the expense of connection. Thus connections were not initially self-evident, but became evident in the women’s words and in the gaps between them.

Feminists’ search for authentic, if transient meaning, in patriarchal societies, which alienate women from themselves, resonated with the women in the study’s simultaneous claims to diversity and search for wholeness. Thus the dialogue between separation and connection forms a fitting framework for this chapter and enabled me to look at: the parallel but different alienations of women and midwives; how both could be compromising and compromised; and the cost of this. But in trying to move beyond dichotomous thinking, I attempt to hold open the possibility of understanding these women’s experiences through a concept of networks, as well as considering what a space at the praxis of separation and connection might look like. I look to birth itself as a symbol for collapsing boundaries between separation and connection - thus rejecting the male definition of birth and motherhood as separation alone.

¹Of course, while I witnessed midwives at work, my research focused on the women. Thus my understandings of midwives came largely from the women themselves. I was therefore more aware of how women approached birth from within their own life stories, than vice versa. Midwives too were located in their own personal biographies. These included their location within the shifting milieu of power networks as well as the socialising affects of professionalisation that I described in Chapter 4. But the focus of this thesis was on identifying women’s experiences of their relationships with midwives. I locate these within the beliefs and structures of the society they were part of, to avoid psychologising relationships in ways that individualise socio/political dilemmas.

²The women were able to identify and comment on how the limitations of medical ideology imposed on midwifery, limited their abilities to develop their own meanings of birth. Listening to women through a series of interviews, hearing their experienced and imagined comparisons between home and hospital birth, and using a voice-centred relational method enabled the movement between women’s idealism and realism to emerge more clearly to create what I have termed a potential/reality gap.

Methodological concerns revisited

Bearing this in mind, I returned briefly to issues of methodology. As Ann Oakley (2000) and others (Maynard 1994) suggest, attempts to dichotomise between quantitative and qualitative methods of research are unhelpful and problematic. Not least because issues of judgement cannot be erased from quantitative methods, any more than a numerical base can be erased from qualitative methods. Indeed, as I suggested on page 144, moving across the quantitative/qualitative divide can provide detail in quantitative research that would otherwise have remained hidden, and can highlight the extent of issues in qualitative research that may equally well have remained hidden. In addition, lest we become too dogmatic about the superiority of one or the other, each approach demonstrates the shortcomings of the other. As the research vignettes that Oakley (2000) quotes demonstrate, whatever method is chosen, any certainty should be replaced by caution - in keeping with the fluidity I wanted to maintain.

Thus, using the software package NUD*IST to assist me in my analysis, it became apparent that in the majority of the interviews with the 30 women in the study, in a large proportion (at least half or more) of each interview, women were talking about their midwives. It was of course impossible, if not undesirable to draw discrete boundaries around topics, because women's discussions contained within them many overlapping views about birth. However, I focus this chapter on how women discussed their relationships with midwives. Continuing the ideas of dominance and muting, separation and connection which run through this thesis, it is about both what could and could not happen between women and midwives, in the context of powerful beliefs, assumptions and forces. In other words, by connecting different 'pockets of knowledge', I attempt to examine these relationships in the sieve of social contexts through which they pass. My intention is to provide a useful and plausible explanation about how these relationships could develop and work, and why difficulties could arise, in a way that avoids judgement or blaming of individuals - women or midwives. This move from blame to understanding is a crucial step towards alleviating disempowerment of women and midwives³.

The theoretical concepts of knowledge and co-existing belief systems from a feminist perspective documented by Brigitte Jordan (1993) and Robbie Davis Floyd and Sargent (1997) provided me with the broader, structural framework in which to understand some of the convergence and discordance described by the women. At the same time, discussions between feminists and postmodernists about subjectivity and its emphasis on 'becomingness' reminded me to avoid ascribing fixed identities or beliefs to women or midwives, as I attempted to maintain the flow of becomingness⁴.

Setting the scene

In Chapter 7, I explored some of the initial influences women described within their own social networks (their partners, family and friends) and then within the wider social networks. This chapter forms a continuation of one aspect of these earlier explorations: the meetings between women and midwives during the women's pregnancies and the development (or otherwise) of their relationships. In the context of assumptions that "qualified" help is needed for all births, and that this is mainly provided by midwives, these relationships formed one of the main context for how

³Though I did not want the personal to be entirely swallowed up by the political. Feminists have been instrumental in providing concepts and language for demonstrating the relationship between the personal and the political. This has enabled women's experiences and knowledges to enter epistemological discourses (Griffiths 1995).

⁴The prospective/developmental aspect of the research enabled me to be more aware of the "becomingness" than single interviews could have done. Through the series of interviews I was able to trace this flow, and hear some of the internal and external dialogues which demonstrated this continual reconstructing of the self

women experienced planning and having home births or transferring to hospital. It was within these relationships that women attempted to develop their knowledge: about birth; their local maternity services; how their ideals fitted or challenged the midwives' practices; and how far midwives could and would subvert authority if the women's ideals challenged dominant ideology. It was in the light of these relationships that women developed their views about relationships and discussed some of their meaningful components such as continuity, communication, trust and support in ways that challenged current definitions of these concepts.

It is clear from the review and Chapter 7 that the general cultural expectation was for women to give birth in hospital. It is also clear from Chapters 7 and 8 that home birth was viewed by people in the women's own social networks and some professionals providing maternity care, as unnecessarily risky, and irresponsible. Responses from doctors were often particularly discouraging of home birth. As I suggested on page 139, women were left in no doubt that they were transgressing contemporary cultural norms in planning home births. It was also clear in Chapter 7 that women approached planning home births from multi-faceted positions (Cronk 2000, Edwards 1996, Robinson 1999). Thus meeting midwives for the first time was already set within a complex network of influences.

Given the deeply held current assumption that birth must be attended by an expert, women looked to midwives to support them. They hoped that midwives could provide a buffer between them and obstetric services and could make having a home birth a reality. Implicit in this was the expectation or hope that midwives would be on the women's side and would protect them from the medicalised practices of birth which they saw as prevalent in hospitals, and which they wanted to avoid. The paradox clearly evident in the review in Chapter 4 was that the women needed midwives to be powerfully and resolutely "with" them, yet midwives were located in the same layers of power networks as other women, that attempt to oppress and mute them as individuals and oppress and mute their collective knowledges (Kirkham 1999 Stapleton et al 1998). Gendered power relations distance women (and other potentially subversive individuals) from each other to prevent collective thought and action, which may undermine the fabric of patriarchal society⁵. Making connections between theories on relationality and power (Foucault 1980, Mackenzie and Stoljar 2000, McNay 1992, Murphy-Lawless 1998a, Shildrick 1997) enabled me to look at the deeper consequences of conflicting ideologies and how these are incorporated, usurped and negotiated by women in their attempts to reconcile imposed internal 'splits' (Belenky 1986, Debold et al 1996) and maintain emotional, spiritual and bodily integrity (rather than unity).

On the basis of previous experiences, negative reactions, stories from friends, and birth accounts in books on home birth, many women approached the community midwives with trepidation as well as expectation and hope. They hoped that midwives would respond enthusiastically to their plans to have home births and be able to provide positive support for their ideals throughout pregnancy and birth - and at the same time, would be able to give them reliable information if problems arose. In other words that they would be both competent and confident. As I discussed in Chapter 8, there were reasons why they were often anxious that midwives might side with the body of opinion that was uneasy about home births, or that they might not be confident in a non medicalised setting, and would therefore find reasons to suggest transferring into hospital.

⁵ As I mentioned in the review, Alice Adams' (1994) analysis of birth literature suggests that women and midwives pose a particular threat, as it is the definition of reproduction and motherhood on which current power relations rest

The context in which relationships were located

Constraints

Reflecting on the initial catalyst for the study: women's sense of struggle, it was apparent from the literature I examined in the section on midwives on page 51, that midwives continue to be engaged in their own parallel struggles: struggles for survival, recognition and empowerment. Both acceptance and resistance to being subsumed by medicine, nursing, as well as employment constraints have been documented (Kirkham 1999). As we have seen, there have been ongoing attempts to retain, develop and formalise midwifery skills and knowledges that could be differentiated from a medical approach to birth. The questions about how they could coexist for the advantage of women and midwives are also being posed (see for example, Annandale and Clark 1996, Campbell and Porter 1997, Cosslett 1994, Murphy-Lawless 1998a). However, as we have also seen, this midwifery knowledge has been largely suppressed. Lacking a formalised conceptual framework, midwifery has been less able to assert its own authority in the knowledge stakes⁶. While I discussed some of the impact of this in relation to safety in the previous chapter, this had a profound effect on all aspects of interactions between women and midwives.

As I discussed earlier, midwives appear to have absorbed obstetric ideology, and now respond to each other and to women in ways typical of oppressed groups (Freire 1972, Hadikin and O'Driscoll 2000, Stapleton et al 1998). For example, in order to survive emotionally and professionally, it appeared to the women, that their midwives seemed unable to question the ways in which they were expected to practice. But both they and women demonstrated the kind of complexities found by Debold and colleagues (1996) where 'splitting' occurs in order to accommodate conflicting knowledges (Shallow 1999) and respond to perceived powerlessness in the face of an unchangeable system (see the quotations on page 299 for example).

One of the themes that arose from the various discourses in which midwifery is located, is that of compromise.⁷ This compromise inevitably had a limiting and compromising effect on women. In (even partially) accepting their limited role as immutable, it was difficult for midwives to respond positively to women's challenges to their practices. Yet, they are charged with the responsibility of responding to women from a woman-centred perspective (a perspective systematically denied to them) and expected to empower women from a disempowered position (Kirkham 1999). In other words, they are expected to respect, when they are frequently disrespected; nurture without being nurtured themselves; fling wide the gates of choice when they have few choices; and provide "unbiased" information (as though this existed) which they cannot then act upon because of the strait jacketing policies which constrain them. As we have seen, the midwife has become the 'piggy-

⁶I use Davis Floyd's term 'authority' here to comment on the lack of acceptance of a clear midwifery philosophy, rather than any lack of credibility or validity. As I observed earlier, a growing body of knowledge suggests that midwifery has an authority of its own, and can provide the same or better health outcomes as those provided by a medical approach, and that morbidity in particular may be reduced). Its full potential has yet to be explored (Schlenzka 1999), and could be increased through emphasising the woman/midwife relationship (Kirkham 2000).

⁷ In order to weather threats to survival within the networks of power in which they negotiated this survival, midwives were somewhat coerced into accepting an increasingly limited role in childbirth along strict demarcationary lines, defined by medical ideology in the form of policies. At present, in Britain, the only midwives practising somewhat outside these limitations are the few independent midwives. Midwives practising in the community, in midwife-led units or in Birth Centres often work within rigid criteria. While they develop their own resistances and flexibilities, as I suggested in the previous chapter, only independent midwives can base decisions on individual women's circumstances. When challenged, the edges of midwifery practice and the status of policies seem unclear, but it is those midwives practising independently who are both most powerful and most vulnerable as they frequently engage in widening the parameters of midwifery practice and challenging (inappropriate) policies. Just as home birth is often the site where power relations in birth are most fervently played out, so independent midwifery practice is the site where power relations in midwifery are most forcefully played out. My discussion in Chapter 8 led me to conclude that policies (rules) are incompatible with women and midwives' autonomy.

in-the-middle' (Jo Murphy-Lawless 1991) between women and obstetrics. She is caught between the demands for allegiance to medical ideology and employers, as well as advocacy and support for women. From a constrained and limited position, the midwife is given the onerous, if not impossible task of bridging women's diverse expectations within the medical ideology of sameness.

Limitations to evidence-based care

As I suggested in Chapter 8, while evidence-based care has unravelled some of the limitations and harmful effects of inappropriate obstetric birth practices, which can assist midwives in developing their own midwifery practices, even in an institutional setting (Central Sheffield University Hospitals 1998), it can all too easily suppress other knowledges. As Rachel Clarke (1995) pointed out, this contradicts the current rhetoric of rights and choices, and gave rise to the 'steering' analogy in Valerie Levy's (1998, 1999b) research that I refer to, where the midwife attempted to maintain an equilibrium between the different players. The midwife's task is to marry beliefs, which systematically disadvantage women with woman-centred care, by socialising women not to be disruptive - in a caring way. There was thus an underlying muted power struggle, as women attempted to claim agency. Muted because, both women and midwives tend to shy away from assertiveness and conflict in the ways described by Mary Belenky and colleagues (1986) which I discuss in the section on 'Revisiting relationality' on page 248.

Professionalisation

As I suggested on page 53, midwifery has aligned itself with dominant notions of professionalism. It became apparent in this study that the maintenance of distance between the women and their midwives (through lack of continuity) ensured the midwives' allegiance to other professionals rather than to the women. So while women attempted to align themselves with midwives in an effort to establish relationships, midwives were more likely to align themselves with each other⁸.

A further consideration arising from the literature was the caring/nurturing aspect of midwifing women (see page 71): the qualities attached to these in nursing and midwifery theory and practice; and the consequences posed by the gendering of caring work and its subsequent invisibility. In examining this, I consider the present conflict between professionalisation and personalised caring work and women's views on different aspects of caring relationships on a spectrum of axes: for example, from continuity to discontinuity, support to lack of support, trust to distrust and empowerment to disempowerment.

Rights and choices/ethics of care

Finally, I elaborate on issues raised in the review and the previous chapter about the relationships between women and midwives being embedded in male medical discourses, which stress medical conformity based on male rationality, and rights and choices based on male autonomy. Through planning home births, many of the women in the study were actively resisting medical conformity and demonstrated ways of relating and decision-making, which were more akin to an ethics of care and relationality. This balanced complex needs of their own, their babies, and partners, other family members and those involved in their care. It was through these concepts that I was able to elaborate

⁸The relationships between team midwives seemed stronger than those between midwives and women and midwives appeared to the women to be reluctant to cause conflict within their teams in order to meet their needs. The following was a unique example of a midwife aligning herself with a woman and providing her with information that she could request not to be attended by another team midwife:

'In fact, I think she must have realised because she did say to me, you know, a lot of women do find her bossy, she says, but you can ask for her not to be there. So I didn't realise that you could actually request, you know, that I don't want this midwife in the house or whatever. But I mean, I wouldn't do that, I mean, if it comes that she's here, well, fair enough, you know'

on the importance of relationships and women's discussion about approaching birth with fear or confidence, as being intimately bound up with how their midwives responded to their views and needs.

The taken-for-grantedness of the woman/midwife relationship

The above caveats provide some of the power/knowledge context in which I explore the woman/midwife relationship. But in terms of power/knowledge and relationality, perhaps the most deeply embedded and therefore least accessible/visible attribute of the woman/midwife relationship is the assumption I mentioned above, that it necessarily exists. Murphy-Lawless' (1998b) work with women in Bolivia, which she discussed at the Aachen Conference (see footnote 68 on page 173) for example, provided a useful contrast. She suggested that women's knowledge and therefore autonomy around reproduction has been muted in the West and that women are thus dependent on "experts". Unlike women in other cultures, they no longer decide if and when they need assistance, and have little influence in shaping that assistance⁹.

This enforced aspect of the relationship with midwives, set in a context of obstetric morality, guilt and blame, together with the location of midwives, inevitably and profoundly affected these relationships.

The need for supportive relationships

Relationships by definition are about connections between people. When it is between women and midwives, there is an implicit assumption of support. Whether that connection is in the form of a therapeutic relationship (Siddiqui 1999), caring encounters (Halldorsdottir 1996, Halldorsdottir and Karlsdottir 1996, Mander 2001, van Olphen Fehr 1999): whatever qualities are found to be desirable or undesirable (Halldorsdottir 1996, Halldorsdottir and Karlsdottir 1996, McCrea et al 1998), midwifery literature focuses on the empowerment of women. While support is widely considered to be beneficial, the markedly different forms it has taken belie that how, when, and for what it is provided is dependent on the beliefs and context in which it is defined. For example, 'active management' of birth promotes continuous support for women during labour and birth. But this is in the context of a managed approach to birth that demands compliance with its ideology and methods. Support is thus both to retain control of the woman and to assist her to remain in control of herself and avoid the kind of scene described by Elizabeth Baines, when her heroine, 'Zelda' rejected this control as she began to understand the meaning of her compliance (in Adams 1994: 53).

As I described previously, other forms of support have been provided by midwives for women who have had premature or low weight babies (Oakley 1992, 1996) and those living in poverty (Davies 200, Evans 1987), in an attempt to counteract the effects of stress and poverty. In other settings the effects of doulas have been shown to decrease the length of labour and decrease the need for interventions (Mander 2001, provides a detailed review). Few practitioners have considered forms of support, which engage the woman's own network, in the way Nicky Leap (2000) describes. Yet this was raised by women in my study. By listening to how women experienced the unique relationships between them and their midwives in terms of support, its inclusions and omissions, I hoped to increase understanding about women's own definitions of what they need support for and how it could best be provided.

⁹As I discuss in Chapters 8 and 10, this lack of autonomy is embedded in the patriarchal institutions of both medicine and law, and reinforced through a specific definition of selflessness in relation to motherhood. It is therefore particularly coercive.

Focusing on women

An introduction to what women said

Through analyses of research literature, and women's words, I explore how different ideologies of birth developed different responses to pregnancy, birth and motherhood. It is the points of convergence and divergence between these women and their midwives that provide illuminating insights into how women defined their needs during this life transition. They also demonstrated the limitations of some of the theories I had explored - challenging theoretical interpretations to remain open enough to the diversity of women (Nicholson 1999) and showing their abilities to forge their own agency through the complex interactions between dominant ideology and their own experiences and knowledges¹⁰.

The journey of meaning making for women began with the first meetings between them and their midwives. Thus in the first section of this chapter, I examine how women experienced these meetings and what they conveyed to them about the midwives and the beliefs in which their policies and practices were located. I continued these explorations through their ongoing meetings, and how these were experienced. Keeping in mind the overall framework of relationality, I focus on communication or 'real talk' (Belenky 1986). Through defining the kind of support women felt they needed, I redefine childbearing in terms of their priorities and meanings and suggest why medical ideology could not entertain the kind of meanings and support women articulated. I then examine how the theoretical limitations to midwifery played out in practice, through dominant ideology and its influence on relationality. In doing this, the substantive issues of Chapter 8; trust, confidence and fear, arise again.

I begin by looking at the first meetings between women and midwives. All the women initially booked with the NHS community services - most with teams of 6-8 midwives. Some of the women had experience of this service from previous pregnancies and a few women had met some of the individual midwives in their current teams during previous pregnancies and births.

Meeting midwives for the first time

The time immediately prior to first meeting midwives was often filled with both anxiety and hope for women. In the context of the marginalisation of home birth, this was anticipated to be an important gauge for how supportive they could expect midwives to be and how likely it was that their plans for a home birth would materialise. Thus women often focused as much on the political (what they could glean about the services and its priorities) as the personal (the individual midwives and the qualities they brought to these meetings).

Because of the recruitment to the study, all the women had already booked to have a home birth with community midwives prior to joining it, but there was still a spectrum of views about how far they initially experienced midwives to be supportive of their plans.

The potential/reality gap I identified earlier arose almost immediately in the form of anticipatory 'splitting' (Debold et al 1996). The ideal response hoped for by women was unreserved enthusiasm and support for home birth. A realistic assessment from their own experiences, and/or the experiences of others meant that they were unsurprised (but still disappointed) if this was not the case. Many women expected a 'fight', thus if the midwife was not actively against home birth, they were often pleasantly surprised. In other words, their perceptions were contingent on their

¹⁰ I discuss theoretical perspectives about agency in the context of the interviews in Chapter 11.

acceptance that this was a marginalised activity, in which case, any response which was not overtly hostile to home birth could be interpreted as positive.

As I suggested in Chapter 8, midwives were obliged to begin to spell out the 'rules of the game' (Kirkham 1999, personal communication) from the very first moments of meeting - to begin the process of steering women through pregnancy and birth in accordance with their limitations. One of the immediate constraints to unreserved enthusiasm on the part of the midwife was embedded in the medical model's response to home birth - that it is inadvisable because of the supposedly greater risks, and that the woman must take responsibility for her decision. It appeared to be a requirement that each woman should be told about the risks of home birth, to ensure that she understood that she would be responsible:

'She [midwife] said she had to tell me about the the dangers. Well, maybe that's not the exact expression she used. But ... you know, what the problems may be should they arise. She said, I have to tell you this, just to sort of let you know. It's in my job description and if I don't tell you, I'll be sort of breaking my contract. I suppose, almost like that you know'

'she [midwife] was pointing out the sort of dangerous side of it and I was getting into a sort of argument with her [...]. But then again, you see, I think she was just doing her job [in relation to the policies set out for her]'

Having complied with their policies, midwives often then qualified what they had said, by reassuring women that they had not had problems in the past, and by being more positive about home birth. Some women expected this sort of response, and expected to have to agree to assuming responsibility for their decision. But women also made judgments about which midwives were generally supportive of home birth despite having accepted the policy of spelling out the risks and responsibilities as defined by obstetrics, and which midwives were less confident about home birth and were conveying their own limitations through these discussions. Because of women's assumed reliance on midwives, if women felt that they were unsupportive of their plans to give birth at home, this could be undermining:

'I contacted the midwives and one of them came out to see me [..]. That was my first very disappointing experience. I was very disappointed because prior to that I hadn't expected much. I hadn't expected much from my GP, but I thought, right this is one of the community midwives. This is someone who could deliver my baby. These are the people that I need to speak to. This is my lifeline and I knew from books that I was likely to be dissuaded, as it was my first baby. And actually that's exactly what she did'

The initial focus on risk criteria and women's responsibility, indicated to, or reminded women that home birth is situated within the limitations of medicalisation where midwives practice within constraints that limit their abilities to make their own judgements and support the women's plans to have home births. Most women experienced a combination of caution and support, which many described as positive, but which some experienced as 'lukewarm' or unsupportive. These women began to feel distanced rather than engaged with midwives, and felt that they might have to take responsibility for their decisions in a rather more isolated way than they had hoped¹¹.

All that I have discussed in the thesis so far suggested that there was obvious potential for discordance between women's beliefs, hopes and ideals and their midwives policies and practices¹².

¹¹I discussed this in relation to safety in Chapter 8 and further in this chapter. Making decisions in isolation was not how women usually made decisions.

¹²I create a deliberate distinction between the beliefs of the women on the one hand, and the policies and practices of their

And yet, it was clear from my interviews and the quotations in Chapter 8, that all the women in the study were deeply committed to the best outcomes possible for their babies, themselves and their families, and believed others were too. Any divergence was about how best outcomes could be achieved, on what basis judgements could be made, and who should have ultimate responsibility for deciding this. Though as I also observed earlier, the women challenged any attempt to draw discrete boundaries around birth ideologies, by moving between some of the belief systems described by theorists and commentators in this field, and describing their midwives as doing the same.

I was able to expand on the issues I raised above, and others as women continued to meet midwives during their pregnancies.

Continuity

Continuing to meet midwives: In context

The provision of NHS community midwifery services was mainly through teams of 6-8 midwives. This was perceived in the locality (as it is in many areas of Scotland) to be providing continuity. Occasionally women described receiving all or most of their care from one or two community midwives and 2 women received one-to-one care from independent midwives. While team midwifery was most prevalent, the experiences of the women who had different forms of care provided a valuable contrast.

As I discussed on page 70, there is no consensus on what continuity means, but within team midwifery, the idea was that at each antenatal visit the woman would meet a different team midwife, so that she would have a “known” midwife with her during labour and birth. The emphasis was on continuity of care rather than continuity of carer. It became clearer that in dislocating continuity from relationship, the medical model has appropriated the term continuity and redefined it through its own beliefs; both constituted by the beliefs from which it arises and a symbol of those beliefs. Thus despite the rhetoric of continuity, relationships were not a central organising factor of care. The distinction arises over care and carer: continuity of care emerged from a medical belief system, while continuity of carer reflects beliefs that relationship is integral to effective care. Through listening to the connections women made between continuity and support I redefine continuity and re-embed it in relationships.

Getting to know midwives or recognising a ‘familiar face’?

Having met their midwives, for the first time and, having been told about some of the perceived risks of home birth, women were then usually given basic information about how their antenatal care was likely to proceed. One of the first issues that many women observed and commented on was the arrangement of the community midwifery services in terms of numbers of midwives allocated to their care and the pattern of that care during the childbearing period.

The women reported that a group of 6-8 midwives could not be said to be providing continuity, if continuity is defined as getting to know midwives. But there was a spectrum of views on team midwifery¹³. Because women’s assessments of the service were often made in comparison to

community midwives on the other. This is because it was unclear to the women (and therefore to me) how far the midwives themselves believed in the policies and practices within which they worked. These may be no more in accordance with their beliefs about birth than they are for women. But they may feel less able to question these (Kirkham 1999, Stapleton et al 1998).

¹³Though the continuity that women hoped for is usually no longer a feature of urban midwifery in Scotland, (but still occasionally exists in rural and semi rural communities) women were aware that this is a recent phenomenon, and one which they had many doubts about:

‘I said to my partner. Look, can you not imagine what it would be like in past centuries if you said, well, I don’t

hospital services, where no continuity was provided, their own views and needs were often tempered by this. Thus a typical view was that it was paying 'lip service' to continuity, but that it was an improvement on hospital services:

'continuity will have to be better because in hospital there's a never-ending stream of trainees, students - anybody and everybody'

'I mean 6 is a lot, but it's better than just going up to the hospital and not knowing who you might get'

A realistic assessment was that the system reduced lack of continuity by focusing on meeting midwives and providing familiar faces:

'You know who they are and they've been in your home and I suppose that helps, but it's not like you've been able to talk through it all and explain exactly what you want - or how they felt about things or whatever, or what their experience was. You know, it's a bit half-hearted really'

'so what they try and do is get you to meet all of them before you actually have your baby, so obviously they've got faces that are familiar, even if you don't know them very well - but they're faces that are familiar'

But this was unsatisfactory to many women:

'you know it's just chopping and changing all the time, and you might meet one at the very beginning and then not see them at all and then find that they come for the birth or something'

The strongly expressed needs for continuity increased rather than decreased during women's pregnancies, but even in early pregnancy, nearly all the women expressed concerns about what they defined as the lack of continuity. They challenged both the unacknowledged issue that most meetings were in fact first meetings and the implicit assumption that meeting midwives is the same as getting to know midwives:

'it does unnerve me that I have not got one person who I'm going to get to know quite well over the period of time'

'you just get a faceless professional really, pretty much faceless because, you know, even in the community midwife system you're pretty well talking about seeing them cold. You've seen them, but that's pretty well it'

'it's quite a lot. I mean, I certainly don't know all of them, you know. I've met all of them'

Inevitably, in the face of no obvious alternative, the emphasis on meeting a series of 6-8 midwives over the course of pregnancy, became a preoccupation for women as well as midwives. Given the women's expressed needs for relationships, the irony was that in order to have the unsatisfactory 'familiar face' during labour, they had to relinquish their need for relationships during their pregnancies. In other words, the arrangement of team midwifery imposed an unsatisfactory paradox for woman:

:

know who but they've been well trained. They'd go, my God, how can she do that'.

'you see the problem is, if you see a different one every time you get to know them all, which is what you want, cos you don't know who's going to be at the birth - so you do want that - but you don't because you're not seeing the same person every time'

'there's quite a strong feeling in me that I would like it if when I went for my next appointment that it was [midwife] again, you know. So in many ways, in practice, I'm quite happy reinforcing that relationship and yet obviously if there are 6, you know. I don't want to end up giving birth with somebody I haven't met before, you know, so I do need to meet the others'

'I've got a really good relationship going with [midwife] but as for the other ones, I will feel like a stranger's sort of coming in'

In some cases, the preoccupation with meeting midwives could detract from the care and support the woman needed, particularly towards the end of her pregnancy if for any reason she had not met them. It could feel as though the priority was on meeting midwives rather than meeting the woman's needs:

'you know it was like days before the baby was due and still desperately trying to meet the last one of the midwives'

'I'd rather have had some support than just a series of ladies rushing in to sort of present themselves to me and go out again, having ticked themselves off the list'

Sometimes women called midwives during labour, but were unsure from her name over the phone which 'familiar face' would arrive. Thus the main advantage of meeting midwives briefly on one or perhaps two occasions, cited by the women, was that they could check that none of the midwives were 'very unpleasant' and that there was not going to be a 'personality clash'.

Women intuitively knew that the kind of continuity provided could not replace relationships. While ongoing, supportive relationships are potentially transformative, continuity of care provides basic care, which is empty in terms of this potential. Even if midwives align themselves with women ideologically, this cannot replace knowing something about the woman and her life context (Wilkins 2000). Some women felt they would have been more able to express themselves (see page 250), had they been able to get to know a midwife, and those who were most critical of the community services, felt that if they had been able to get to know a midwife during their pregnancies, their difficulties could have been lessened:

'my criteria for what that person would ideally be like could be much broader and much more malleable if I could get to know somebody. I could get round the little quirks or whatever'

'I still think if I'd known all along who it was going to be, I could probably have engaged more with the person, even if I hadn't liked them all that much'¹⁴

¹⁴ This was confirmed by a story told by one of the women:

'I think it's 6 [midwives in the team] or whatever. However many they are, it's far too much. It's too many..... You can't really build up a rapport with your midwife.... which I think is the important thing really.... That's what you're looking for.... because you're in such an emotionally vulnerable phase in your life... you just need somebody to cling to and that is your midwife... at that point... Or should be.... And it should be one midwife or two you know..... So I think that, you know, that one-to-one thing..... like my friend for example - that's the friend who did it [the one-to-one scheme]. She said you know initially she sort of like wasn't that keen on her midwife..... but in the end she just like..... thought she was absolutely fantastic and she was wonderful and she said she really sort of like got to know her'

Inflexibility: By design or default?

In parallel with the women's experience of inflexibility, the services seemed equally inflexible for midwives (though it remained unclear whether or not midwives could influence the organisation of services)¹⁵. Even when women and midwives saw each other more than once and found that they particularly liked each other, or when the midwife had attended the woman during her previous birth, there appeared to be no structural mechanism to facilitate their relationships. Instead, it appeared to prevent any possibility of the midwife providing all or most of the woman's care during pregnancy, labour and postnatally, even if the midwife indicated that she would like to provide this. Some women felt very strongly about getting to know midwives. Comments included:

'to me it's anathema to have someone you don't know and if you're lucky it might be the person you like. I wouldn't do that to fix a car'

'I think any number would be horrible - would create the same problems - even if it were 2, because you still wouldn't know who's going to come. That's the point'

And even when women felt so strongly about getting to know a midwife during pregnancy that they pursued it with senior midwifery managers, apparently, it could not be arranged in practice:

'I actually saw [midwife in charge of community midwives]. I had an appointment with her because I had strong feelings about the fact that I would like to get to know, and I would want the person delivering the baby to get to know me prior to the birth so that we could be fairly clear about my wants and needs, and opinions on various forms of intervention and drug use and she agreed that 3 midwives would be allocated to my case. She couldn't guarantee who would be at the birth, but she could guarantee that 1 of 3 midwives would be at the birth and that I could get to know the 3 over the forthcoming months This arrangement broke down almost immediately with appointments being kept by completely strange midwives (laughs) without any prior notice being given to me. So it seems clear that they are unable to accommodate me Well they are unable to accommodate me, but they're even unable to accommodate the compromise that they suggested to .. try and make me feel more comfortable'

Though the system of team midwifery could not ensure that women and midwives knew each other, midwives made efforts to ameliorate the situation, by asking women at the end of their pregnancies if there was any midwife they would like to see again, or visiting a woman in early labour to introduce themselves if they had not met before, for example. But even though women felt strongly about getting to know midwives, there was little choice but to resign themselves to what they described as lack of continuity:

'I suppose I feel a kind of acceptance that that's the way it works. And yet, you know, I'm not happy with it'

The rota system also meant that neither women nor their midwives could affect which midwife attended which woman in labour. Again a few women and midwives attempted to exert some control over this. For example, one woman reported that a midwife accepted as many shifts as she could during the week of her expected date of birth, but the baby arrived in the following week. Women often requested a copy of the rotas so that they could at least know which midwife was on

¹⁵This inflexibility suggested that enabling women and midwives to form relationships may indeed be threatening to dominant ideologies and arrangements (see the section on 'Possibilities of relationships' on page 253)

duty when they went into labour. Some women thought they might be able to delay calling a midwife or call one out quickly, depending on which midwife it was. One woman took a homeopathic remedy, in order to try and have her baby when her preferred midwife was available¹⁶. As I discussed in the review, women's agency was limited by structures that deny it. They were thus obliged to adopt what one woman described as 'little strategies' to create space in a confined place. As Debold and colleagues (1996) observed, adapting to inflexible structures can involve reorganising the self and its knowledge.

Adapting to inflexibility

On realising the impossibility of getting to know one or two midwives, some women redefined their own knowledge about the centrality of relationships and became drawn into the rhetoric available to them; narrowing their hopes and expectations, and attempting to prioritise their needs in terms of the acceptable expectation of continuity of care rather than carer¹⁷:

'I would rather havea midwife. Or 2 midwives even would be fine, that I knew and I mean I don't think Does it matter to me that I know them very well? It, it almost doesn't. What matters to me is that I know their views on home birth, on their.....on their ideology I suppose, on how happy they are with home birth, how confident they are, if they're experienced and what procedures that they are likely to follow'¹⁸

In excerpts from the first and second interview, one woman discussed the internal process of redefinition in the context of women's socialisation, and the difficulties of rejecting this:

'I was only going to be seeing them twice for 15 minutes if I was lucky. That was me getting to know them. And not only that, but that was called getting to know them. That was considered, that was sold as a lovely cosy alternative, and I just thought, I just think this is quite dishonest because I just, you know, I'm not going to collude, I can't collude with you and pretend that that's acceptable. I think at first if somebody says to you, here's a lovely cup of tea, you know, (laughing) that is encouraging you to believe that you're receiving something good, and if you're ignorant, you know, you kind of go along with that for a while, then after a while I thought, actually this is really unsatisfying. I won't know these women at all'

'I nearly thought, it was fine and dandy, 1 of 6 and I can still probably accept it, but for a minute I thought, wait a minute, wait a minute, this is weird'

'I think it shows you just how ... disassociated we are. We don't expect very much, we don't expect any of (laughing) our needs to be met ever. People just go, well fine, I'm happy to be getting what's given .. you know, and it's As I say, I can compromise, but that's a different thing from thinking it's perfectly fine and I'm quite happy ... and I think knowing that I'm making a compromise somehow makes me feel better than when for .. almost for a second I had to snap, I thought, wait a minute, this is weird'¹⁹

¹⁶ Rotas are no longer given out in some areas because women were apparently taking homeopathic remedies in one district, when it became known to women which midwives were more likely to be supportive during a home birth and which midwives were more likely to transfer women to hospital.

¹⁷ Even though they questioned the concept of continuity of care, being provided by diverse individuals (see page 230).

¹⁸ The issue of finding out about midwives' practices was a crucial one. I return to this on page 220.

¹⁹ Her refusal to internalise the split and 'collude', led her out of the NHS system to an independent midwife: a shift many women felt unable to make because of the cost, an ideological commitment to the NHS, or because by the time they had unraveled the mysteries of calling a medicalised service woman-centred, they felt it was too late to change their arrangements.

Within the NHS services, the only control that women apparently had in this area was the right to refuse to be attended by individual midwives. But as I discuss on page 249, many women were unwilling to judge or offend others and felt unable to be assertive, particularly during pregnancy²⁰:

‘I’m basing my assessment of people on little comments because you know, I saw that women at the clinic for 15 minutes. I’ve no idea what she’s like at all’

‘I don’t know if it’s because you are more vulnerable when you’re pregnant and you do take more of a back step I think and let people boss you about more. And then you think, why did I let her say that to me, or do that to me just because I was pregnant [...] I don’t know, some people come across differently and I would hate for somebody to say to me, right I don’t want you to be my nurse, I would hate for somebody to put in that they didn’t want me involved, I mean, that would be quite devastating, so for that reason I’d give her another chance [...] I just, you know, just for her feelings really, I didn’t want to (laughs) be horrible’

In the rare circumstances when a woman attempted to exert this right by informing a senior midwife that she did not wish to be attended by an individual midwife, this was discouraged, and her request was not respected: ‘they actually just ignored what my stated request was’. In any event, this could not address the fundamental issue, which was of getting to know midwives.

Women were aware of the constraints under which their midwives practiced and usually attributed difficulties to the system of care in operation rather than to individual midwives. They frequently talked about midwives as ‘well-intentioned’, ‘friendly’, ‘nice people’, but at the same time, strangers: ‘I mean, the midwives are lovely, but they’re still, you know, it’s quite a lot of strangers’

While continuity from midwives during pregnancy was frequently discussed by the women, separatist ideologies influenced the structure of community midwifery services in other ways. A related but different aspect of continuity was the way in which the community services were located in the overall maternity services. I therefore discuss how this affected women, especially the 7 women who transferred from community to hospital care

Structural continuity: Transferring from home to hospital

Many women discovered that if they had their babies before 38 weeks or after 42 weeks, or if for any other reason they transferred to hospital care during pregnancy or even during labour, that they would be attended by hospital staff. Apart from the time pressure to have their babies in the window allocated for them (see page 157), this caused some disturbance or holding back, as women felt a need to engage with their midwives, but at the same time knew that they might not be attended by them. There was always an element of uncertainty about birth, but this introduced an element of uncertainty regarding their care:

‘N What sort of things have you talked about with the midwives at the different visits that you’ve had?

Em I think I asked most questions when they were here the last time, cos obviously that was when I felt things were sort of definitely happening. That I was really having it at

²⁰ I come back to the issues of discordance, conflict resolution and assertiveness below, as these seemed inextricably linked into preventing, potentially powerful allegiances between women and midwives and reducing women’s and midwives’ abilities to extend their own agency.

home. So I suppose up until the 38 weeks I thought I was to go into hospital anyway if the baby came before then, cos it was too early'

Gillian Creasey's (1994) research on the qualitative experiences of women who transferred from community to hospital care during late pregnancy or labour suggested that women who were accompanied by a known carer found their experiences to be more positive than those women who were not. My study reinforced this view, and additionally located it in power/knowledge networks which decreased the likelihood of community midwives accompanying women into hospital. For example, not only did the structure of care de-emphasise relationships, so that continuity between home and hospital care is conceptually and materially unsupported, but power relations within maternity services de-emphasise the community midwives' knowledges and skills (Shallow 1999, personal communication). Community midwives may find it all the more difficult to retain any allegiance to women transferring to hospital. It may be easier for them to distance themselves from these women. Thus when women transferred to hospital, some felt abandoned by their community midwives. This was clear in the following quotation from a woman, considered to be in week 43 of her pregnancy. The value of reconnecting with her community midwives in coming to terms with her experience reinforced the value of ongoing relationships:

'I just felt really like they'd completely abandoned me and I just thought, well it would be really nice because now when I'm so anxious why don't they give me a ring and sort of give me a bit of emotional support and I thought ... this is where this whole system just falls apart you know ... and I was really really disillusioned by it I must say ... you know. I think I'd just started to be disillusioned (slight laugh) by it beforehand but that just really I just thought... this is the time I really need to speak to them ... and I don't need to see them you know. I don't want you know, hours of their time ... Just give me a phone call I felt like I'd already been given over to the hospital almost. That's how I sort of felt you know it was really ... It was really awful I really really did feel like that So it's been really nice afterwards you know [Midwife] has come to see me in the hospital a couple of times and she came to my house and ... yesterday and ... [midwife] who's my sort of other favourite one came yesterday. She's actually due today as well ... so you know you don't feel totally abandoned ... They've been both quite supportive ... [Midwife] was really good yesterday. She had a very long chat with me as well and things So ... so they've you know they've been they've actually now been quite, very supportive I must say But you know when I was waiting ... when I was really... (deep breath) tense... I sort of I could have really done with just the odd phone call you know ... I mean I didn't want that much... you know, just sort of, how are you getting on, you know'

Set within the lack of structural continuity and the demarcation between obstetric and alternative ideologies, the disjuncture between home and hospital and the transition from one to the other was all the more marked (see also Walker 2000):

'probably what I experienced were the two worlds [...] so all the preparation was the home stuff, and then actually being in hospital at the end, I could see how the two were not really living together terribly well [...]. I can remember going in the morning after speaking to them at the [hospital] and going up to the [hospital], it was almost like a sort of journey away from what I'd been expecting, you know, from home and it was almost necessary to have that journey..... from one world to the other [...] and different rules for both and all that sort of thing'

Dominant obstetric ideology and economics combined to disadvantage and incorporate community services:

N What, what do you think about the home birth services and how they're organised?

(Sighs) um ... they're a bit (laughs) they're a bit haywire really, um They're not really properly set up. They don't have the personnel. They don't have the resources behind them and I feel that there's two systems really, working there. Andit's like when one doesn't work then the other one steps in instead of them working together which would be more satisfactory. I suppose for them too, because it's not like they're dropping a hot potato, you know, and moving onto the next one [woman] sort of thing'

'but when I had to go into hospital the midwives weren't with me. None of my community midwives were with me ... So ... the first time we [self and partner] went in, when I went in for my diamorphine we both saw 4 sisters, 3 consultants goodness knows how many nurses [midwives] ... All in the space of one day on different shifts, all having different opinions ... I was having to relate our story and they were coming up with different you know, feelings about it (clicks tongue). So it somehow, I just felt that the whole thing didn't fit together that well, you know. And then when I had to go back in, my midwife came in for about an hour with me, which was really nice of her. But she was very tired. She'd done the whole night long. But none of the other domino midwives that I'd been with would follow that on. And I kind of felt that I would have preferred for at least one of them to have been there, who knew me and could work with me. So I was left to a new nurse [midwife] to start up a new relationship. And when you're in pain, and you want to ask questions, and you have to explain the whole thing over again and you're confused you know. The continuity wasn't there'

This could be particularly distressing where women had formed relationships with 2 or 3 midwives who they expected to attend them, and were unaware that if they transferred to hospital during labour that they might be attended by hospital staff rather than their community midwives.:

N Had you realised that if you transferred into hospital that your midwives might not be with you. Is that something that you'd talked about with them?

No because ... I'd understood that if we went into the hospital that it would be a domino, you know, like the domino. They would come in and do it for you ... I didn't realise that .. And at one point for example, one of the midwives, not my main one but another one said, if you go into hospital, we have nothing more to do with you and I thought, well, why not. I thought the domino service offered, you know, you went in with people, and they said, well, we can't spend any more time with you and (laughing) I felt quite abandoned, I said, oh, I should write to them, and I did feel quite abandoned. But with my main midwife, that wasn't the case. She said, no, no, we'll be with you until the end, but unfortunately Well, for various reasons nobody could stay with me ... to see the thing through ... And ... I. I missed that ... Having somebody there, that I had a relationship with and could have talked me through it. Probably in a much more skillful way, yeh, but I mean my main midwife couldn't because she'd been up with me all night and she, you know, she just simply couldn't perform and I understood that It's difficult, you know, they have their system to work and they have other responsibilities and it's really difficult, to know ... what to do'

If, as the literature suggested, women can be adversely or beneficially affected by their experiences of birth, depending on how it fits with their hopes and expectations, women transferring to hospital are potentially at greater risk, given their expressed wish to avoid the hospitalised medicalisation of birth and the feeling of danger this might engender (see page 166). As the contrasting quotations below demonstrated, having a midwife accompany the woman into hospital appeared to allow the woman to continue to focus on herself, her baby and her labour and lessened the need for her to

focus on negotiations with new people. The midwife could contribute to maintaining a feeling of security despite potentially difficult changes in circumstances and environment, and the midwife's acknowledged disappointment could enable the woman to express hers, and yet feel positive about her experience:

N How do you feel about having the same midwife with you, did that make a difference?
Oh massively yeh, yeh, yeh totally. I mean I trusted them with it and they were very supportive and actually they were very disappointed that I never managed to deliver it and they were very disappointed for me which was, you know, I mean, it was just very touching. And they, yeh it was nice that they saw me through the whole thing and they remembered all the things which I'd said [...] Yes it was nice that they were the ones that stayed right up cos, as I say, they shaved me for the operation which was, it was good, they were there right to the very last possible moment. I think that made a lot of difference. I think if I had been sent in and handed over to complete strangers, cos they were also able to negotiate with the doctor then as well on my behalf which was good, cos they had seen what had happened so far, you know, because the hospital didn't actually have a birth plan or anything for me'

'but [midwife] was great because she didn't have to stay and I did say to her look, I said you know, I said, you could just go. I said, just hand me over to one of the midwives here I said. But she's like, no, I'm staying, I'm staying through it. So it was really good, at least I got my midwife, you know

N Do you think that made a difference

It did, definitely, definitely, especially with it being [midwife] and she knew my partner really well, and she knew exactly what we wanted, and she was really good about, even though I was in hospital, you know. I'll go away and I'll leave you and you know, you can get on with it and, she was really nice I was a wee bit worried about going in, but I didn't have to go through the rigmarole of signing in and you know, admissions and everything because it was [midwife] that was with me. So it was just a case of you know, she got us the best room, and she said right, I've got you the best room, in you go. I didn't see any other staff. I didn't see anybody, I mean, it was completely quiet. She said, right, you know, just get on with it, do what you want basically. So I think that helped as well, because I think it's the whole idea of all these strange nurses. The first thing they want to do is give you an internal, and because, [midwife] knew that I didn't want any of that, you know. I mean, the only time she gave me an internal was when she thought that I was, you know, he was just about coming and so I think that helped, you know. [...] So I think, I mean, if I'd had to go in and be signed over to the hospital staff, that would, I mean, I would have hated that I think. It would have been people I didn't know and as I say, I would have had to go through the whole routine of you know. [...] and then by the time I got taken up to the ward it was 2 in the morning and so everybody was sleeping and it was just a case of tiptoeing in and getting into bed and my partner wasn't getting to come up and [midwife] had said, look I'll go and speak to them because I had said, you know, no way. He's staying just now, you know. So she got that sorted out as well, and she took us up and then she, you know, and I said, oh, you should go home, I says, you're working tomorrow morning, you know. This was like 2 in the morning and she was still working, and so she went away home and she was back in at 8 in the morning to see me. She was so good honestly, because she only got a few hours sleep herself and then she was back working. So I think that all helped. I mean as much as I had to go into hospital and everything just the fact that I didn't have to go through the hospital routine and it was [midwife] that was with me you know²¹,

²¹This could break down if women distrusted their community midwives. The quotations above were in stark contrast to the one below, from a woman who transferred to hospital during her labour and felt that her community midwives were

As was evident in the previous chapter, engagement and trust were the key to understanding why women felt it was so necessary to get to know their midwives and brought to light the chasm between what many women felt they needed and what the service provided. The articulation of the difficulties women experienced by not being able to get to know a midwife, and the difference it made to those who did, opened out the different contextual meanings of support, defined through the different meanings of birth. It clarified some of the anomalies in the research on continuity. The battle over continuity symbolises a battle of philosophies and whether birth is defined as an essentially social transition to motherhood supported by midwives, or a medical event orchestrated by doctors. In the same way that obstetric safety could not approach women's meanings of safety, continuity of care could not approach their needs for relationship. In the previous chapter, I explained that in a social/midwifery view of birth, safety is embedded in relationships, through knowledge of each other, confidence, trust, and 'announcings'. In the following sections, I explore the detailed workings of these by looking first at communication.

Communication

'I'm always aware that these people are pushed for time'

I discussed the role of time and its mediation through ideology in relation to risk in the previous chapter on page 156. The deployment of time had other implications. For example, time was allocated for the physical checks that are central to medical/mechanical views of birth but not for engagement/emotional work based on relationships. Time and resources were deployed in ways that prevented the development of relationships, by not leaving time for conversation; the 'real talk' described by Belenky and colleagues (1986). Feminist perspectives on women's talk (when talk is connected to knowledge) in both the review and methodology sections, suggested that time is one of a number of prerequisites for 'real talk' or engagement to occur.

'like that time I offered one of them to have a look at my bedroom and stuff, and she just seemed to want to get on to her next visit just somehow a distance, to not really engage with you and really enter into your experience of what was going on. It's just kind of, right, blood pressure, urine and now, any problems? (laughing). You know, cos I didn't exactly have problems but just things to kind of think over and talk through a bit maybe time'

Thus from their perspectives, women observed that the community services were under consistent time pressure:

'I'm always aware that these people [midwives] are, you know, pushed for time and I don't want to blether and all that sort of thing [...] I feel I need to get on and out of their hair sort of thing'

'when you're waiting in a hospital waiting room, you know, you see everybody else waiting and I think you are very aware of the amount of time you're spending with that person and I do think you do try to sort of try to hurry along'

opponents rather than advocates. The difficulties the woman discussed in the community were intensified in a hospital situation:

'I felt manoeuvred in hospital there was the renegotiation about the pool, there was negotiation about taking the baby the away, and they seemed absolutely determined to do that, and I really had to put the labour to one side and concentrate on that for a long time [...]. One of the things they said was would you like to speak to our paediatrician. That was when they were trying to negotiate taking the baby away before she was born. And I said, no thank you and then she arrived [...]. I'd actually refused that and I was ignored yet again

The organisation of time, meant women had to be creative and uncharacteristically assertiveness to attempt to take time, when this might seem to take time from others, or put added pressure on their midwives. As can be seen from the above quotations, they were more likely to comply with constraints than challenge them²². And where women felt distant from midwives, because of lack of continuity, and because they felt that midwives had aligned themselves with dominant ideology, lack of time distanced them further:

'it [talking about birth] never seemed appropriate. They always flew in. You offered them a cup of tea to try and make a little chat. Tried to communicate but, you know, sometimes it was me as much as them. I just, you knowYeh, I wanted them out of the house just as quickly as they wanted to get out of the house'

Women identified lack of time as a barrier to communication, which prevented them from engaging with midwives and talking about their hopes and concerns about birth. The short time for questions and answers after the 'checks' was not conducive to 'real' talk, or gaining knowledge.

Information gathering: 'I didn't feel there was a dialogue'

While it was clear from the literature (page 75) that good communication is generally thought to be the basis for information giving and thus control, this is problematic (Comaroff 1977, Kirkham 1989, Stapleton et al 1998)²³. The tendency to conflate "good" communication with "good"

²²The following quotation exemplifies how the cascade of ideological assumptions and practices combined to distance women and midwives:

N How would you say your antenatal visits have been?

Short is the short answer I suppose ... sort of 10 minutes sometimes and talking with [a women in my antenatal class] you know, she managed to sort of spin it [antenatal visit] out for half an hour or 40 minutes. I was really impressed, you know. How did you manage that sort of thing. Again because I didn't feel there was any urgency on their part to really get to know you or It was strange, yeh. It's basically what the doctor would have done. It's really no different, you know. How are you doing? Oh you've got varicose veins you poor soullet's take your blood pressure and that was really it, you know So disappointing really I suppose. I expected them to say, and how are you? [said in a soft caring voice]. And I don't know. I suppose if they try and get to know you a wee bit and find out what, what you're about and what you would want. And in that respect I suppose, I expected them to think that the job would be easier because they would know you. But it's not been like that really. I thought it might be now, you know, when you're sort of seeing them weekly but not really It's been a bit longer perhaps but, you know, there's more to do or, you know, you don't have your little specimen bottle all ready and waiting, you know, you might have to do that, so, they're about longer but it's not developed a relationship particularly

N Do you feel you're given the opportunity to raise issues with them?

No I haven't asked anything at all in fact ... I've brought things up you know, like they talked about the ball because it's just sitting in the middle of the floor (laughing) it's difficult to ignore it and I said and I'm going to have a pool. It wasn't like they were saying and have you thought of a pool. I had to tell them and then they would say, oh well our policy is, you know, that you don't actually deliver in the water that sort of ... it's been that kind of exchange So yeh it's been like that really. Och it sounds terribly negative, you know. It hasn't been. I think it's just, it's, it's just not been. Do you know? Do you know the difference?

²³There is an additional assumption that communication can be standardized. This suppresses different communication styles. So those women and midwives who related in different ways were disadvantaged by the assumption that good communication occurs in any setting, within or outwith relationships:

'the midwife who I've seen most often, I think I found it most difficult to start speaking to her but having met her several times, I think she's probably just like me. I'm quite hard to speak to when you first meet me as well and I think over that time, I've definitely built up to being able to speak with her'

'the midwife that I saw this time was one of the ones that my friend had really not got on with at all, and when I heard her name, I just felt my (laughing) heart going boom, boom, boom, and I thought if she takes my (laughing) blood pressure now it's going to be sky high. But I got on with her okay actually. Her manner was a little bit strange, but I work with some people that are like that ... and I immediately recognised her type, as just being somebody that's actually quite (laughing) nervous. So I just started to talk to her normally, and, you know,

information within a paradigm that predetermines the nature of legitimate and illegitimate information, exerts control over women. It suppresses fundamental questions about different knowledges, and provides women with limited information rather than knowledge. That there was a gap between women's need for knowledge and information given by professionals was confirmed by the innumerable comments about lack of information which littered the women's accounts. On the one hand, there was a general consensus that information was 'not handed on a plate', and depended on the women seeking it out²⁴. On the other hand, information from professionals could seem formulaic and didactic, based on predetermined notions about women's needs to know. Some women's experiences of being 'bombarded with things you don't want and not getting the things you do want' were similar to those reported by Belenky and colleague's (1986); namely that concerns were often dismissed and that "experts" usually tried to assert dominance [...] either by assaulting them with information or by withholding information' (194):

'They [midwives] were very helpful, but one thing I would say about both of them, which does seem rather churlish, is that they seem to have been trained how to treat people and the sorts of problems people have and the sorts of anxieties people have. And when they're faced with you, which is 'a' person rather than 'the' person. You know, you're an individual, and you might ask questions in a different order, or you might ask questions you shouldn't really be asking until week 38 and that seemed to throw them and with the best will in the world they were trained to death and I didn't sometimes think that I was being heard. I think they had lots of answers, but some of them were to questions I hadn't posed and, do you know, I didn't feel there was a dialogue. I felt a little bit invisible [...] It was a bit smiley and a bit formulaic [...]. And what about caesareans, you know, how often does that happen? I had all these questions and they tended to say things like, you don't need to worry about things like that at the moment. And I was like, is that going to stop me wanting to know? I don't think so. So in the end I just switched off and thought, I'll go and get a book (laughs)'

The literature I referred to in Chapters 3-5 demonstrated how patriarchal beliefs and structures all but silenced women's (and midwives') knowledges. From women's point of view, talking together is a powerful means by which to resurface and expand their knowledge. The women in my study observed that when appropriated by a medical view of birth, communication has a sharply defined and limited meaning, in which relationships are unnecessary. It is the means by which to convey information, in the limited time available, to ensure "informed consent" rather than informed dissent (Goer 1999) without appearing to force or coerce. It's primary purpose is not to develop knowledge, but to increase conformity with medical ideology. The short question/answer sessions following the 'checks' were thus a gesture towards woman-centred care, which would not destabilise obstetric priorities. In the context of authoritative knowledge this is not so much a deliberate attempt to oppress women; rather an inevitability.

in the course of the conversation I actually realised, well, I thought she was (laughing) quite competent, and was going to listen to me and care about me and so, I got on fine (laughing) with her'

'there's one [midwife] that I thought I wasn't going to like, and then I found out she was a runner, and I run, so that was something to talk about, just you know, much easier, because it's sometimes just finding a hook in to mm so yeh, I've found them [midwives] okay'

²⁴Many women reported gaining information from community childbirth networks, antenatal classes run by childbirth educators, books and other women. The option of home birth was particularly singled out as invisible and even in the last interviews, there were a great many comments about the need to make this option more visible and 'real'. But in exemplifying the power/knowledge struggle between birth ideologies, home birth challenges the very core of medical ideology. The only example of co-existence in the Netherlands appeared to be not so much a choice for women, but a state organisational/resource solution regulated through increasingly rigorous, medical risk criteria.

Information which might lead to women making decisions which challenged midwives' policies was particularly difficult to obtain. For example, a number of women's babies were breech during part of their pregnancies. None of these women felt that this should automatically necessitate a hospital birth. They found however that they were unable to engage midwives in discussions about this. They were told that breech babies are born in hospital, and some felt the midwives were evasive:

'they [midwives] proclaimed the baby breech and then insisted the baby would turn and they wouldn't talk about what the implications were and they wouldn't say what ... what their procedures were or what hospital policy was if the baby stayed that way. They just kept on saying well, if you use this Alexander Technique the baby will probably turn. And I wanted to say, well that's okay, I could cope with that. And what if the baby doesn't turn. Let's talk about that so that I can be prepared and make an informed decision. I need to make an informed decision. I don't want to be caught out at the last minute and for them to say to me, oh well, it's hospital policy, you have to go in, that's it'

Women were well aware that midwives' practices were regulated by medical policies, so while getting to know midwives was important, it became equally important to get to know 'what their procedures were'.

Getting to know the system: 'I can't find out about their procedures'

These often seemed as elusive as other information that they attempted gain:

'most of the questions I had I wouldn't get a satisfactory answer to, so I stopped bothering asking them, and just found out myself really, although that does leave you with a lot of gaps. It means you're going in blind. I could find out a lot about the physiology of birth without asking a professional, but I can't find out about their procedures without asking them. And when they're not very forthcoming - I wouldn't say that they were deliberately vague. I don't know. Somehow it all stayed vague, just like my questions'.

It was apparent that, as I discussed earlier, the values and practices of dominant ideology are so culturally embedded that it is only in the light of different beliefs (for example, Davis-Floyd and Sargent 1997, DeVries et al 2001, Jordan 1993, Oakley and Houd 1990) that they become more visible. Thus it was only because NHS community care represented views of birth that were sufficiently different from those of many of the women, that it became a necessary focus for their attention. This divergence meant that a significant proportion of their energies had to be devoted to getting to know midwives as a way of getting to know the system; developing strategies to resist routine procedures; and finding out about alternative viewpoints. Ironically, when women were less able to get to know their midwives, it was more important (but more difficult) to get to know about their policies and practices. The onus was on the woman to identify and research these policies and practices so that they could form a view. But inevitably, some remained invisible and women were only able to say after birth that had they known about certain practices, such as carrying out a vaginal examination in order to decide when to call a second midwife, or using a hands on technique for assisting with the birth of the baby's head, they would not have agreed to them:

'it is difficult if you're having a home birth, because there's so many layers of medical expertise that you've got to get through. You've got to tell them, you know, that you don't want syntometrine or whatever. And you've got to know all these things that they're going to do just as a matter of routine. So, you have to be familiar with that routine and be able to ... Because if I would have guessed that she was going to hold the baby's head as it was coming out, I would have put that in my birth plan, to say, you know, no, I don't want that'

Communicating through birth plans?

I suggested (on page 75), birth plans were initially seen as a means to enable women to express their needs but became a mechanism for aligning their choices with localised policies and practices. Thus the birth plan represented a script for the unknown, as well as the complex negotiations between women's desires and knowledges, midwives' views, and medical policies. In other words the birth plan became the material representation of the struggle between the woman's attempts to assert her needs and the midwife's need to 'steer' her through the system.

In practice, women found that there was an expectation that the birth plan would be limited to relatively "safe" issues. Thus while women could state preferences to avoid isolated, routine practices "if possible", questioning the ideology in which these were located, in order to resist it was effectively muted²⁵. Their stated preferences were expected to be couched in a language of flexibility which gave professionals ultimate control. In other words the preparing of birth plans appeared to be a carefully managed activity that would allow women choices from the limited menu referred to by Rosemary Mander (1993, 1997).

How contested practices were dealt with provided a useful example of how women's decisions could be influenced and then formalised in birth plans, which were then not revisited. For example, where midwives favoured actively managing the birth of the placenta, women who expressed the desire to birth it themselves were often given information to support active management. The discussions below took place during the first, second and third interviews with one of the women in the study. In the first interview the woman clearly stated that she wanted to have a physiological third stage. She was given information about the dangers of haemorrhaging, and discouraged from this. She agreed to syntometrine and this was documented in her birth plan. However, in later pregnancy, she acquired further information, and decided to have a physiological third stage. The final irony was that she received syntometrine because this was still in her birth plan²⁶:

'I did consider not having the syntometrine injection, and they're not keen on that at all. I'm finding more opposition against that than having the home birth and my GP's not very keen on that either. So I said well we'll just see how it goes, but I mean if the birth ... if everything goes the way I'm hoping it's going and everything's natural then I'm just going to carry on. I don't see why I should get some intervention then, when everything's going so fine'

'N How have your discussions gone about the syntometrine?

Ah, I've given in to that I must admit, I have. I've given in. My GP wasn't happy about it, I mean, he's been great about everything else but the midwife told me last week that he got a fright with one of his ladies who started bleeding, so I don't know if that's got. That's probably got a lot to do with why my GP is so adamant about me having it and all the midwives. I've spoken to a few of them and because I've seen different midwives I've asked them all, just to get their, you know, just to find out sort of, you know, what their opinion is and they're all very for it - everybody. Yeh, they're not keen for me not to have it so I've sort of given in. I mean, I did want just to put the baby to the breast and hopefully, you know, the stimulation of the, you know, feeding would sort of bring it away, but, och, I'm not

²⁵They were expected to use it as a means to state intentions to avoid pharmaceutical pain relief, routine time limits, routine vaginal examinations, reclining positions, routine syntometrine for the third stage of labour and routine vitamin K for babies, "if possible".

²⁶One woman did not write a birth plan as she was concerned that it might be used to override her views during labour. The few women who had one to one care from a known and trusted midwife felt that they did not need a birth plan in the same way that they would otherwise have done, rather, it was a useful tool for promoting discussion in pregnancy.

going to be silly about it. I don't want to go through the home birth, you know, give birth, everything being fine and then have to go into hospital because I've got a retained placenta, I mean, I think that would just be being a bit silly. So I have given in to that, so I am going to be getting an injection (laughs) so'

'I was given syntometrine, but it was a mistake because I'd written on my birth plan that I was. I did say when I'd written the birth plan months ago, that I would be quite happy getting the syntometrine and it wasn't until I read some information [...] I decided not to have the syntometrine, and I never changed my birth plan, and of course with going into hospital and everything and I just forgot and I wasn't even aware that I'd been given the injection in my thigh. And then it wasn't until you know, once the baby was out and I was breastfeeding and I said, oh, was I given syntometrine, and she [midwife] said, I have. And she panicked. She says, listen it was on your birth plan. And I said, oh I know, but I changed my mind (laughs). I'd spoken to another midwife about it, because she had come up that day, because I'd had a home appointment that day and she'd said, oh well, it looks like you are in labour you know. She said, oh well, we'll maybe get a call tonight, and she said, just keep doing what you're doing, and if you want us to come back out, just phone or whatever. And I'd spoken to her about vitamin k and I'd told her that we'd just see what kind of state the baby was in and decide then whether to give it vitamin k or not. And I told her about the syntometrine. And then it was a few hours later and then it was the other midwife that I'd phoned and she said like, come right in. And of course I was so worried about the baby being okay and the fact that I was in hospital that the third stage just went out my head. I mean, you know, the third stage is easy, it's like let's get the baby out get the first and second stage over with first. So I was a wee bit upset and my midwife spoke to me about it in the morning again, and she said, you know, are you sure you're okay, and I said, aye, it doesn't matter now. I mean, (laughs) it's too late now'

Alternatively, if women continued to favour "off the menu" choices midwives would sometimes adopt a 'wait and see' approach²⁷. For women, the birth plan could be a way of attempting to assert views which they felt hesitant to raise face to face with midwives²⁸. Indeed, when women saw different midwives at each antenatal visit and there was little time, and when midwives were obliged to practice within certain constraints, it seemed difficult to discuss differences of opinion in any other way.

Setting the scene for 'real talk'

While lack of time prevented 'real talk', separating communication from relationships, muted women's ways of talking and relating in other ways. As I noted in my review, many feminists observed that 'real talk', occurs in informal rather than formal settings and has thus been attached to the private (supposedly inconsequential) world of women and devalued as 'gossip' or 'chat'. Yet, the women confirmed that this is the way 'small truths' are exchanged (Spacks in Belenky 1986: 116):

N Do you feel you can raise any concerns you have about you pregnancy, labour or birth with your midwives?

Yes, but I think I would pick and choose who I spoke to

N Would you?

²⁷This 'wait and see' approach is quite distinct from the 'wait and see' approach associated with the watchful expectancy some midwives describe. The former manipulates the woman, the latter attempts to support her. Going with the flow of the birth process is very different to going with the flow of medicalisation, at a time of heightened vulnerability.

²⁸As I suggest below, women went to great lengths to avoid conflict with midwives and it seems that midwives, too, shy away from conflict (Kirkham 1999).

Yes, if I walked in and found it was One or two of them, I would sit and think, na, I'll wait till next week [...]. But if it was maybe my named midwife or [the midwife present at my last birth] sitting there, I would chat away to them about it. You see, I think so much of it is, you come in, you sit down, they take your blood pressure, whatever. They do all the bits and pieces, but if they don't chat to you about inconsequential, how's you son, bla bla bla, you don't end up saying they don't learn so much you know, because you end up just .. you walk out of there and you think, oh I didn't, I forgot about, or or you don't feel comfortable and you think, och, I won't bother, or if they give the impression that they're well, you know, you're a bit late for your appointment and there's somebody else sitting there, then you think, och, it can wait [...] you know. [Midwife at last birth] will chat to you, my named midwife will chat to you, [...]... but it's the ones that you know, they don't. I don't think they get so much and you don't get so much, you know [...] But I suppose it's just getting to know somebody as well'

'I haven't really talked to her [midwife] at all she just says things like, plenty of movements them? And I go, yeh. And then sort of afterwards I think, I wonder what plenty of movements means, you know, like, what is plenty cos I don't know, and I've never really talked to her about anything. Whereas the other one [midwife], who I met just once, when she came round, we just found ourselves chatting. And she included my partner as well [...] she sort of asked us questions that encouraged us to talk ... cos often I can't think, I don't think of problems or worries. It's just like, here's my blood, and here's my (laughing) urine and all that, whereas she encouraged me to think about things slightly differently'

While communication in obstetrics is grounded in information, choices, control and rights discourses, communication for these women was based on connection, trust and the sharing of experiences (stories). Unlike the didactic, disengaged, reductionist and coercive nature of communication within obstetrics, these structured, purposeful narratives generate as much knowledge about the teller as about the subject matter. Thus, they hold within them possibilities for communication which can destabilise authoritative knowledge and create new epistemological spaces (Code 1998). Power relations can never be erased, but the telling of stories enable women and midwives to engage, negotiate their different subject positions and joint meanings of birth, and dialogue in ways that effect more expansive partnerships. So while women needed structures and settings in which stories could be told, these were not provided within the existing framework of care:

'N Have you talked to your midwives about your thoughts about birth?

No (laughs) is the short answer I'm, you know, I'm just sort of thinking, imagining that conversation. There's no way into that really. The times I've seen them, it's not been, you know, a natural progression of a conversation'

'there is so much procedure and so many stock tests to be gotten through. By the time you've done that there is no slack in the appointments procedure for any vague chatting, as they would think of it Which I think needs to change because I think that's more important than anything else.... I think it's very important to know what someone's fears are and what they're strengths are you know ... To me that's crucial and I could bet my bottom dollar that there was no question that would ever address that. Umand the framework even of my own questions at the time ... I couldn't ask questions like that because it would be so jarring It would be like me saying in the middle of the appointment How are you getting on with your husband, you know, what's he like and It would just be so personal. It would be like I was gushing all over them if I'd said anything like, I need to discuss how I feel about being naked in front of a complete stranger, or I need to discuss how I feel about making noises. It would seem embarrassing. I'm not embarrassed to

discuss these things but in the framework of the NHS system ... it would be very embarrassing to bring that up you know because all they're asking you is questions about your weight and your bowel movements and your pee and You know within that setting to try and bring up more emotional complex issues would feel quite wrong really ... you would feel like you crossed the boundary and I'm sure it would be quite embarrassing for a lot of the individuals ... if you did that. I don't know though. Maybe they would welcome it but I never felt like trying it really'

Communication confusion

Attempts to communicate were often filtered through dominant medical ideologies, which could lead to confusion as women attempted to decipher what the midwife was trying to say through her own negotiations between policies and the rhetoric of choice :

'one minute you're a child who's being told to shut up and not raise difficult issues and the next minute it's like, well, it's absolutely up to you. You're an adult, you decide what you want [...] but it's very unclear which attitude applies to which issue'²⁹

'she [the midwife] was at the very most a foot away from me. She was being very directive and saying that, you know, we should be going to hospital, bla, bla, bla. And then she said at the end of all that, of course we would be very happy to stay here and deliver you at home and in hindsight I thought well if you are worried then surely you wouldn't be saying that. Surely, (laughs) surely you should be saying something else. So althoughI think that, I felt that they'd tried to indicate that there was a sense of urgency, I felt that, that particular thing that they said meant that they weren't all that worried that's what struck me about saying that to me, you know, of course we'd be perfectly delighted to, so you know, what I nearly said. Did I nearly say, I don't know if I nearly said, but I nearly said in hindsight you know, ten hours later. By the way are you really worried about this baby, is this baby actually distressed'³⁰

A number of women articulated the midwives dilemma that I discussed earlier, of trying to reconcile restrictive policies with the expectation that she should support women. They commented on the difficulty of addressing this, and the underlying of uncertainty this created:

'I suppose even just thinking about their attitude towards breech birth and You know, when I've asked them about this and that it's oh well, oh well, sort of this is how it is. and I suppose it's that feeling of the midwives actually being very by the book and not sort of free to make their own minds up about things ... which I expected them to be a bit more like that. And they might be on the day. I mean, this is just to say how I feel at the moment. This is not saying that I find them all the same or that they are really you know, awful or anything (slight laugh). It's a bit of a feeling that they are very much like I don't know what the leeway is in their criteria for, you know, doing certain things ... Maybe I should ask them really I suppose. I haven't really been that communicative with them, so maybe it isn't fair just to have been upset about them and to say that they haven't been with me But I've found the relationship hasn't been able to develop for one reason or another ... and yeh, I suppose you do feel a bit maybe a bit more vulnerable. Especially if you've got a midwife who isn't that sure. So they're going to make decisions ... you know, like take you to the safety of the hospital. Although I must admit, most of

²⁹ As the quotation suggests, the idea of communication and decision-making is built on a long history of infantilising pregnant and birthing women (Adams 1994).

³⁰ This quotation from footnote 94 on page 190 demonstrated how the creation of safety and relationships could not be separated, and that disturbances reverberated between the two.

them did seem quite relaxed and they're in it because they want to be community midwives and they want to see home births, so I imagine they're going to be doing the best they can for you ... yeh, I'm sure ... I think I would ... be ... you know ... led by them. I'm sure if if I can stay at home they'll make sure I do ... but on the other hand, I just hear so many people planning home births and going in [to hospital] for what seem like very small reasons and I wonder you know, **how can you sort of get round that**' (my emphasis)

This conflict or 'splitting' (Debold et al 1996) that I discussed earlier could be unknowingly internalised by the midwife herself:

'she [senior midwife manager] talked about how I would be in control of the situation. It would be my choices that were being respected. But then she would slip into language that was much more geared towards power and control - at this point we'd send a woman into hospital. And I found in our whole conversation that she was slipping into this kind of language quite unselfconsciously. She did it several times. She was saying one thing and then undermining it. [...]. Her language seemed to indicate a set of attitudes at odds with the message she was trying to get across, which was one of me being in control of the situation'

The power of talk: Talking across boundaries

Of course, in the hands of resourceful women, boundaries could sometimes be permeated. This provided spaces for more meaningful communication, so that even within the existing framework, resistance occurred. When women and midwives made time, away from hospital premises, where they were freer to behave outside institutional norms as described by Ruth Wilkins (2000), possibilities for connecting, communicating and developing relationships emerged:

'they're [midwives] never rushing away, you know, I always feel, you know the way you can, when you go to a doctor's surgery. You can sense it, oh no, hurry up, get on with the next patient. Well they're all really nice, they come in, have a cup of tea, they sit. I mean the last one that was here stayed for about 2 and 1/2 hours, you know, and we talked about everything, the TENS machine, the labour, I mean, everything, so it's really relaxing and I think, you can ask more questions cos if you're in a clinic, you do feel like, you know, oh you know, they've got other appointments and you see all the women waiting in the queue, you know, in the waiting room. Whereas when you're here you're more relaxed, you can ask about things and there's things that ... I maybe wouldn't have asked about I think if I had been at the clinic'

One of my interviews demonstrated the process of moving from quick didactic information giving to more thoughtful dialogue. This occurred when a midwife arrived during an interview shortly after the woman had been discussing her difficulty in engaging midwives in meaningful conversation. We resumed the interview after the midwife's departure. One can hear the effort, determination and skills that the woman and her midwife needed to move beyond the pervasive communication channels, and why these have a limiting effect:

'it was interesting because because, I feel that the way it started, and perhaps the way she came into what was going on between us, and sort of like, don't let me interfere with what you're doing, and then me saying oh no, I'd love to meet you for sort of 10 to 15 minutes. So I ended up saying 10 to 15 minutes as though it was much longer than just saying hello and us carrying on. But in fact 10 to 15 minutes wouldn't have been very long either, to meet somebody. So it's amazing how quickly you can get into this sort of dance of I don't know a sort of superficial or ..

you know because what would have been the point of her coming and not interrupting what we were doing, you know, it and what could I have said in Well, I suppose 10 or 15 minutes is some time, but it's not very much really to get to know somebody. That would have been a bit pointless too and in practice I found, I did use a couple of the questions that we'd talked about and I think that did help, and I explained that I'd been having the interview with you, and it had raised certain questions, and that I thought this would be a good opportunity to put them to her, and the things I wanted to know, and also it could help us get to know each other a bit. And we talked about reasons for going into hospitals, and ways of supporting and I mean, yeh it's funny, because in many ways it wasn't, I kind of thought, well, yes, I kind of do know the answer to these questions. I know the answer as far as it goes, because there are so many questions around what'll happen. So things like, when I said, you know, what sort of support do you feel you could give. Or, you know, and I need to think about what I want, although I find that hard to answer, and she said, well, I'll try and give you whatever support you need (laughs) and she said, some women want tactile support, some women want to be spoken to, you know, some women need reassurance, other women want somebody to be quiet, and we try and respond to what's going on at the time. And I thought ... yes, you know, maybe you can't say, I want this, I want that, I mean, I didn't feel I could sort of say, I think I'd like you to massage my shoulders and will you be the one who holds the sponge and (laughs), because it's not as specific as that. And then I said, when it comes to positions, I said, you know I feel ... I can't quite see the role of the midwife in that, or you know, where you'll be, and she said, well, again, it's quite hard to know ... what position you might want to be in you know. But it felt as though, we were sort of talking about the possibilities, which was good And with the question of going into hospital, she sort of listed things that she felt would be indicators that we would need to discuss, and again that seemed quite straight forward really What I did find ... which echoed some of the things I've said earlier was that she was very fast (laughs) And it almost seems as though that's part of the It's quite common in my experience of midwives, sort of like ... to be quite fast and to be quite purposeful and business like. It almost feels and I'm aware, you know, I said that my favorite midwife stands out as different from that and there's one other midwife who also stands out as different from that they just seem to use less words and speak more slowly But it does seem as though it's (laughs) fairly common to sort of, so, and how are you feeling about it and how are you keeping (said quickly) and (laughs) very fast kind of. Maybe it's part of sort of like, we can deal with any eventuality (said officiously). And yet I could also see a listening side in her. And you know, when she said, so what are your questions about that, or when she'd run through something she said, how does that feel or, you know. So I could see that there was a sensitive side as well. But I found yes, it's almost like being a "do"er (laughs). I don't know whether that's quite a common trait or, you know, that midwives feel they need to come across in that way efficient, and

N How do you experience that fastness?

Um, how do I experience that fastness I think it makes me shut down, I think that's probably the point where I sort of, cos, if I were to think about the emotional or the spiritual .. parts of the birth or It almost feel as if they're too tender and too ... soft to be talked about in that fast way and so I think that, you know, that sort of thing does narrow down .. what we would talk about and which is a shame, and I don't really feel I can go around saying to all midwives (laughs) actually can you slow down a bit please'

Communicating knowledge: 'It was more of a discussion'

The profound difference between the meanings of communication depending on their ideological location was even more evident when women and midwives formed close relationships and the medical smoke screen through which they usually communicated was removed. The series of quotations below came from a women who moved her booking from a team of community midwives to one-to-one care from an independent midwife. They initially show a similar process to the one above, demonstrating the possibilities of knowledge acquisition, through asking questions in a different context, but then move beyond this, to different styles of communication resembling Lorraine Code's (1998) description of stories:

'because my midwife now knows me, the way in which I ask questions feels more intelligent to me and I think sometimes I'd felt like I was asking questions because there were 2 minutes allotted at the end of the session to ask a question. If you didn't have one, you felt like you'd be at the bottom of the class, you know. It's almost like you wanted to fill a gap because you're with this stranger. So, you'd go, um, er, and you'd ask some daft question which wasn't very meaningful. Whereas when I ask my midwife questions, I've found that I ask more questions but they're different ones. They're less specific and more general things. How can I explain that. I think the way the NHS system works is that the questions you'd be encouraged to ask would be measurement based. So, if I wanted to know, at such and such a month how big would the baby's head be, they would give you a rough idea in centimetres or something. It's those sorts of questions that ... that seem a bit empty. Whereas, when I discuss things with my midwife it would get to the level of like last night, it was, you know, at what point does the placenta detach, and how does your body work that cut off. How do you not bleed too much, and you know. Do you know what I mean? [...] Now I couldn't see myself asking those sorts of questions before. So I think I got to the stage where I was quite a sulky adolescent and just sort of said as little as possible and got out as soon as I (laughing) could. Whereas now I'm asking question that I really want the answers to instead of just filling a slot'

'I think in the beginning I would be nervous when she [independent midwife] was coming and I would think, I want good questions, you know. It's like I wanted to be a good pregnant woman and have intelligent and well thought out questions to prove I was capable. So it took me ages to stop doing that and just make a cup of tea you know and have a chat to her. And whatever came up came up and if it didn't come up it probably didn't need to. And not have to be scripted, because I was so used to the other system. Even though I knew I needed to get away from it, I was more used to it than not, so it actually took me a while to stop asking questions that I didn't even care about that much you know, that I just thought were the right thing that I should be doing at this stage. So it took me a while and I think she helped me to to just become more in touch with what I really needed to know or what I really needed to do in the time that we spent together - which wasn't always ask questions. It was sometimes to ask her questions about her life or just chat about something that had been in the news³¹. You know sometimes that was a better use of the time and we would just do the standard tests and then that would be it. We wouldn't cover any major ground. And I think that took me a while to swing into that very informal structure, but I began to realise that I was enjoying the times that I spent with her and that I was feeling more and more confident, even when I hadn't cleared up any specific issue'

³¹ Also embedded in this quotation is the ability to cross another boundary - that of professionalisation (if professional means being distant). I address some of these issues in a later section on professionalisation on page 229.

'I didn't feel like I could ask open questions and then by the time I transferred my care to [midwife] I didn't need to ask the same questions. She answered all my technical questions which was very helpful because I had a lot of very technical questions about procedure. But in terms of environment, I no longer needed to ask those questions because it was up to me to set the tone. So I didn't have to find out what it was going to be like on the day because I could decide you see. So my questions changed

N How would you say they changed?

I could just ask the technical questions that I needed to know about intervention that may be necessary, and counter effects of drugs and so on very specific sort of questions. And then wider ones about the environment and who would be welcome and autonomy and so on. We just we slowly discussed how we both felt about the birth environment, and as we concurred on that, I didn't need to sort of set the tone really. It just became sort of seamless. It just seemed to gel together. And also I certainly didn't have to impose any strict rules because it was my house and I knew that [midwife] would respect my feelings. So you know my previous worries ...I didn't need to clarify things like, who will be in and out and whatever because I knew it would be up to me who I wanted there So in that way [...] they were different questions really It was more of a discussion. We would have discussions about things that would come up. There would be a programme on TV about birth, so we'd discuss it a bit. So we found out how each other felt that way rather than having a question and answer sort of dialogue'

This level of communication resulted in the relationship being able to reach a point of resolution from which the woman could approach her birth calmly and confidently:

'there was a kind of silence in the relationship, a stillness which was very important. And we'd done all the talking in the build up. So the talking was done. I felt confident that she [midwife] knew where I was coming from and vice versa. It was like we'd done all our dress rehearsal - what if ... what if ... And on the day there was nothing left to say really. So it just felt very calm, and I think that was the most important thing'³²

When communication was reconnected to relationships the possibility of increasing safety through trust was articulated. This trust arose from the need to know and to be known and the discovery of shared values³³. When this was not the case, women often felt resistant to disclosure with midwives.

Women withholding: 'Hiding things'

When women and midwives engaged in a marginalised activity regulated by medical ideology, relationships could become sites of muted, but parallel discordance, withdrawal and withholding, rather than sites of co-operation based on mutual trust: midwives attempted to maintain their own and women's safety by 'steering' women in line with their policies and women attempted to maintain safety for themselves by distancing themselves from perceived threats to this. If women felt that midwives were practicing from a standpoint that was not in tune with their own, they often felt it was safer to withhold information in case it jeopardised their plans to have home births. Thus not only could 'announcements' be suppressed, but even basic information might be withheld:

'I had to tell everyone I was fine to get a home birth. It was almost like I couldn't risk telling anyone I was having any trouble [depression] ... in case that was a reason for me not to be able to have a home birth [...]. They'd say things like, how are you doing, but, I don't know, I never wanted to tell them'

³² This level of confidence and calmness before birth was exceptional, as my discussions in the previous chapter and on page 240, 'Trusting in retrospect', suggest.

³³ I raise trust in connection with communication here, but develop this issue in a later section on Trust on page 236.

'I just thought that every time I conveyed a fear, it was going to be another black mark against me being able to stay at home or something, you know. So I began to develop a habit of hiding things. I just answered her [midwife] questions in a very bland way³⁴'

I mean in general I sort of feel that the less you actually tell people that something is bothering you (laughing) the better it is, because you might get someone who jumps to the wrong conclusion'

Ultimately, if women felt unsafe, their attempts to converse were severely limited:

'so to be honest (laughing) with you, I think it's always easier to talk about things that have nothing to do with the pregnancy or the birth and talk to them about human things or your house or garden and whatever. But actually getting round to the issues of birth is sometimes not very comfortable to talk about'

Additionally, when women and midwives were unable to develop relationships, they experienced their care as impersonal. Many women observed that personalised care could not be divorced from relationships. Thus, I examine how professionalisation could be at odds with attempts to provide individualised care.

Connecting or disconnecting through professionalism

Disappearing personalities?

Many women hoped that in planning a home birth they would develop relationships with midwives, so that their care would be individualised, engaged and intimate, and that it would therefore be less impersonal than they had experienced, or imagined hospital care to be. As I discussed above, many found that the structure of care frustrated this hope. Despite women and midwives' best efforts to personalise an impersonal service and despite the benefits of some antenatal care being provided in women's homes, these could only partially ameliorate the deep-rooted influence of an ideology that undermined personalised care. As the literature demonstrated, while professionalisation, can foster engagement (Pairman 2000, Smythe 1998, van Olphen Fehr, 1999), this is unlikely when it is defined through male-based ideologies and institutions, which foster facelessness and disengagement.

It was clear from a cluster of observations made by the women that: lack of continuity and time; standardised care; general policies; and the mismatch between these policies and women's ideals, increased the experience of the service as 'professional', 'impersonal' and 'institutionalised':

'N What did you think the advantages were going to be of being at home as you gradually decided that that's... where you'd prefer to give birth?

Um well, I mean, obviously there'd be more privacy at home and I ... felt more special being at home as well because I was the only one giving birth there, whereas in the hospital you're just one of a crowd and (laughs) ... And I felt, yeh, that the care at home would be more personal and more concerned with me. That at home people would be ... more

³⁴And yet when the woman booked with a midwife who she felt was on her 'side', not only was she able to share her fears, but these were accepted and understood and posed no threat to her decision to have a home birth. This is the potential of empowering relationships in which women can grow:

'in the beginning I asked a lot of horror story questions And the way in which she [midwife] answered these made me know that she took my fears seriously and that she understood them. But still, after hearing all of that, she still had confidence in me'

willing to listen to my point of view and answer what I wanted than in the hospital. I didn't really feel I would be able to assert myself very well in the hospital in terms of getting what I wanted[...] I think I indicated that, you know I felt that at home you're more likely to be attended by people that you do know or that you know have greater respect for your your personality, your individuality because they're in your house ... But I didn't feel that in meeting the community midwives I was making much headway on that ground because .. here were different ones coming round .. all the time and there's no way of knowing when you meet any particular one that they're going to be the one that will be with you at the birth and they don't know that either. So, the lack of continuity of care I think is really a problem'

'it's [community service] institutionalised in as far as I've not got to know them [midwives] and that's the same with institutions, the nature of them really isn't it. You know, you can't get through so easily'

'I just feel like it's their job It does feel quite impersonal. It feels like it's their job I suppose I've got a certain amount of confidence in them because they've done it for quite a long time and they probably do know what they're doing [...] It's just the impersonal type of NHS feeling [...] Yeh, I wouldn't say there was any sort of common ground, you know. There was nothing bonding between me and my midwife'

'any of the ones [midwives] I've seen all look like they'd not be willing to make a huge amount of judgement on their own. They'd probably stick very much to the rule book. But that's just a feeling and I'm not saying I blame them for that'

Women described how midwives sometimes attempted to disappear behind routine policies and practices, uniforms, 'black bags', efficiency and officiousness, otherwise known as professionalism. This limited the potential for personal relationships and distanced midwives from women by imposing a detached way of being with women as they moved through an intimate, life-changing experience. Yet, paradoxically, detaching care from the individual providing it, exemplified by the notion of continuity of care, and the implicit uniformity presumed, could not erase personalities and personal qualities. Thus while women were informed that continuity of care meant that their care would be seamless, and their midwives interchangeable, diversity was experienced, but remained unacknowledged. It did not prevent women and midwives from experiencing affinity, lack of affinity, warmth towards or distance from each other³⁵:

'they're [midwives] definitely all very different people, and I suppose the system is such that you can't chose the one that you feel will help you without really disrupting the way they work and causing bad feelings. And ... I don't know if there is anyway round that, unless you hire an independent midwife who will attend you throughout'

'N How would you describe the relationships that you had with your midwives?
Really varied, depending on the individual and some I took no heed of at all (laughing) I'd say you know. They didn't love me either and then we kept a very formal

³⁵That two 'biographies' (Weiner et al 1997) were involved in dialogue with one another remained muted. Comments such as 'I just don't want anybody (laughing) that's bossier than me basically' demonstrated the complexity of relationships. These are not necessarily dependent on individual, fixed qualities but occur in dialogue. Thus the "fit" between women and midwives was as important as their individual qualities. The lack of continuity inherent in the services could have a curious effect on women when they particularly liked individual midwives. Some almost forced themselves to deny this affinity with certain individuals in order to protect themselves from the impersonal rota system, whereby they would not know until labour which midwife would attend them. Paradoxically, women thus distanced themselves from midwives they would otherwise have engaged with.

.... you know okay that's your decision, that's your right [to have a home birth] it's my job to have to provide that service but I don't want to, you know Others were much more you know, I do think home births are quite a good idea, but maybe not for the first. It's sort of quite a range And some were much more open and friendly people Some disclosed a lot more about their own experience as well ... which was nice And others didn't tell you anything so (laughing) So it really depended on the individual'

As Carolyn Weiner and colleagues (1997) showed, personal biographies contribute to how professionals do their work. Attempting to neutralise this is not only impossible, but undesirable. Women frequently sought the person behind the professional, but because of the rhetoric of professionalism found it difficult to find out about their midwives' experiences, knowledges, views about birth, family situations, or the contexts in which they practiced (Bewley 2000, see footnote 59). Yet, they still experienced their care through the qualities and personalities of the individual midwives.

Claiming professionalism/losing experiential knowledge?

As I discussed in Chapter 4, midwifery in Britain and elsewhere has struggled to maintain a space and identity. From this perspective, professionalisation was used as a means to compete with obstetrics. By adopting professionalism, midwifery hoped to increase its authority. Part of that authority lay in the claim to specialist "scientific" knowledge (Oakley 2000), which rejected other knowledges. It's claim to rationality and objectivity mutes personhood³⁶:

'the intuition side has been sort of overridden really, with technology a bit of a loss of information really'

Relying on "scientific" knowledge (evidence-based care) potentially undermines the midwife as an experienced person, with her own authoritative knowledge, and as Elizabeth Smythe (1998) discusses mutes the knowledge contained within the dialogue of relationships. As has been suggested, evidence-based care can be reduced to rigid policies and protocols: "midwifery by numbers". Just as the woman has been disconnected from her own knowledge of birth, and redefined as a vessel for her baby (Duden 1993), so the midwife can be disconnected from her knowledge, to become the transmitter of scientific evidence, (which despite its location in belief systems, is deemed to be correct) on which women are expected to make their own choices.

As I discussed in the previous chapter, women were well aware of the complexities of birth and the limitations of obstetrics. Women balanced different knowledges in different ways, but all recognised that their midwives were a potential source of knowledge. They wanted to engage with midwives who could draw on a range of knowledges, which included their own experiential and intuitive knowledges, rather than be met with rules and regulations based on "scientific" knowledge alone. They appreciated when midwives were able to help them weigh up evidence by complementing research from their own wealth of experience:

'you know, everything's so uncertain around vitamin k. I just asked, you know, what's your opinion and I felt I got a really good answer to that. Cos I mean, sometimes, you know, medical professionals (laughing) don't like to give opinions when, you know, things are uncertain and I felt I got a really good answer from her [midwife] [...] I was very impressed that she was happy to offer, you know, her opinion and her knowledge'

³⁶I discuss the emptiness of the rational subject in Chapter 10 on page 264

'she [midwife] didn't seem to think it was unprofessional to give an opinion. Her opinions were always given subtly and I never felt dictated to in any way, but she would if I pressed her. She would understand that I needed to know what she thought, you know Whereas I very much think that with the NHS midwives there's almost this text book kindness that says, you don't actually show your feelings and everybody gets the same treatment [...] when you might want to know what they thought. They didn't seem to think it was important that you wanted to say, can we just skip past the information, can I ask you person to person, you know, what do you think. I didn't feel that I could do that'

Being professional/relinquishing responsibility

In the previous chapter, I discussed how women often felt that responsibility for safety and risk was theirs alone. Ironically, when midwives were reluctant to personally engage, women felt that they (midwives) were relinquishing responsibility for any decision-making, and thus protecting themselves rather than supporting women:

'I did think they stuck very much to their rules very rigidly I mean they weren't very good at giving themselves away. I think that's the problem. They were always sort of like covering their backs almost and I think that's something I've felt maybe more recently than I did before. Do you know what I mean. Like she was, well unless you tell me to, you know, get lost But then, you know, I thought, well that's fair enough but ... you know, why can't you make a judgement, you know. Why can't you say, I think you're okay, you know. They could never do that. It had to be you that had to take the onus and fair enough ... to a certain extent that's okay, that's acceptable, you know. I should take the onus, but they could at least sort of encourage you a bit more'³⁷

In other words, they needed thinking, feeling people rather than neutral professionals. Indeed, women hoped that professionalism would embody the qualities raised in the caring literature (Halldorsdottir 1996, van Olphen Fehr 1999): knowledge, experience, honesty, empathy, respect, and an ability to 'be with'.

Competency without caring

But a medicalised view of birth, predicated on dualism, separates mind and body and focuses on managing the body efficiently. Efficiency and competency rather than caring attributes become the main measure of a good practitioner³⁸. Though women frequently emphasised the importance of the qualities and personalities of midwives, and the connections between relationships and the birth process, many concluded that they had too high expectations, and that they could only reasonably expect competency, as if safe care could be provided by competency alone:

³⁷ This sort of professionalisation, was bound up with symbolic external appearances - 'uniforms', 'very neat and spruce', 'black bags'. As one woman commented, it was designed 'to get that professional feel ... to inspire confidence ... whereas I suppose it doesn't really. It just inspires sort of rigid rules'. As Mary Cronk (2000) suggests, '[u]niforms are associated with military discipline, orders and hierarchy' (22) and as the above woman's quotation suggests, this conveys 'the midwife obeying hospital policies relayed then to the woman as orders' (Cronk 2000: 22).

³⁸ As I also alluded to in earlier sections, the capitalist definition of production fails to acknowledge nurturing or caring as a legitimate and necessary part of human (re)production. The designation of this as woman's work increased its invisibility and the apparent conflict between professionalism and caring. The essence of caring and the qualities it embraces were set adrift from detached, body/task-orientated professionalisation and relegated to mind/emotion/counselling (Belenky et al 1986). These are being reappropriated, by practitioners, but require skill and commitment (Siddiqui 1999) in the context of relationships. The detachment of care from competency parallels the separation of physical outcomes and experience, as if a midwife's technical proficiency could be the only measure of being a midwife and as if having a live baby could be the sum total of the experience of childbearing.

'I did hope at the beginning that it would have been a wee bit more ... I did hope I would have had a better relationship with them all. But not to worry, and they're all really nice. They've all been. I met one of them. I think she's a sister, I met her at the hospital. She's very bossy and you know, (laughing) she's very, very intimidating [...] I think my partner (laughing) might be a bit ... I think he was a bit sort of terrified as well. She was quite, I don't know whether being the sister, and sort of in charge, but she was a bit bossy

N What, what sorts of things

Just, oh I don't know, just very Well, I think... It was a hospital visit. She said come up to the hospital for one visit, she says and that way, you know, you get a look around. And I said well, fair enough I said, but I've worked in the maternity hospital so, you know, I do know what it's all about. And she says, well come up anyway, and I thought, right, okay. So my husband got the day off and we took our son up. So family visit up to the antenatal clinic, and she came in and, you know, she introduced herself and that was fine. And then my son sort of got a little bit shy and she was very abrupt with him, which just made him worse. [...] And he sort of hid behind my skirt the whole antenatal appointment, so I don't know. You know, I don't think he'll be very relaxed. And after we left, my partner had said, oh you know, (laughing), she's a bit of a monster basically. And I thought, oh dear. I think she's just very professional, I think. And I think just I don't know, some of them just can't sort of. They're not very good socially with you, I think, you know. She's obviously a very good midwife and very highly trained but just not able quite, to sort of speak to you, you know, on a sort of ordinary level. I think maybe, that's what it was'³⁹

Engaged professionalism: Going beyond 'just a job'

The exceptional midwives were those who, women felt, crossed the boundary from professional detachment to professional engagement. They showed enthusiasm for their work and an expectation that all would go well. They were able to allow policies and professional allegiances to recede as they moved closer to the woman and allowed her individual needs, circumstances and knowledge to be consequential as the following quotation exemplified:

'she's [midwife] different from the other midwives and she's quite kind of ... I don't know, doing her own thing or something. And I think in a way I maybe got more of a chance with her ...

N More of a chance?

Well, just because when she came she said that the head was still high and I said, well, where you're pushing, you're having to push much harder to feel where his head is than the other midwives did.. And she went, oh, right, right, right. Well since you think he's moving down, you know, when I come back we'll sort of see how things are going. So I don't know if any of the other midwives would have done that, because you don't know. But I just felt that she did really trust. She sort of seemed to say, well, you'll know, and I did know [...]. I feel that there is a possibility that with some of the other midwives they might have said, no we're not happy with this Whereas I felt that she ... she did sort of give me real autonomy on what was happening. But speaking to her today was really good because she said, oh, I just felt that the contractions were really strong and, you know, things seemed to be going well, so I was quite happy, you know, slightly concerned at that point, but, you know, things progressed well. [...] I don't know if other midwives would have been more sort of textbook in the way that they approached it. You know the comment that one of the other midwives made when she came to see me. She said, [midwife] does her own thing

³⁹ This quotation encouraged me to look carefully at the woman's accounts for the counterpoints between general themes and individual stories. This sort of quotation was not unusual and may also have reflected Asch's (in Hadikin and O'Driscoll 2000) findings that 'to gain a consistent overall impression people would try to avoid mixing positive and negative central traits. For example, people find it hard to imagine that a 'good nurse' could also be a 'cruel' person' (50).

and that made me think that perhaps that was a really really good thing that she did do her own thing, cos someone else might have been much more kind of, well, no, I think we've got to do this. I can see she's quite a sort of autonomous person, and she really cares about what's happening [...] She's just very straight forward which I really appreciated at the time, you know, cos I felt I could really trust what she was saying cos she didn't hide anything'

However, most women found that within the constraints of the NHS community midwifery services, despite their conceptualisation of birth as a personal, special experience, the usual professional boundary was unlikely to be crossed other than superficially or exceptionally:

'it's their job and I completely, I do totally understand why it is like that for them ... It's like this is my special day and for them it's, you know, the tenth or fifteenth of the week or something and it's very difficult for them to bring that newness with them It's almost like the informality becomes blasé or I don't know. There is a word for it. It's like this woman that I met in the hospital. It was sort of like, I'm so and so, you know, how many weeks are you now, and it was almost like, you know, she didn't, it wasn't that she was disinterested, but she wasn't ... and I mean, I suppose you **can't** be like that for everybody if you're doing so many of them. It's not, you know, a really special event for you anymore. Especially if you've been doing it for years with little respite. So, I don't imagine I would get that feeling of or get many of those qualities with someone like that. And through no fault of their own I think (laughs). It's a bit like if you go for an interview for something. It's your one interview, but the interviewer is, you know. You're tense and they're a bit jaded by then, and do you know. It's that division between you. And I don't know whether it can be crossed really, unless in very particular circumstances'

Women were aware of the midwives' dilemmas and the paradox of attempting to provide a personalised service through an impersonalised framework. They were also aware that midwives' themselves were often uncared for and therefore unlikely to be able care, when they seemed to be exhausted, stressed, and over-worked. In these circumstances, women observed that inappropriate superficial, or blanket reassurance could take the place of genuine caring:

'I did find them quite quick to say, oh it'll be fine, you know which doesn't work in dispelling (laughing) people's anxieties, you know at all It doesn't matter how motherly you try to be, you know, you're not my mother (laughs) And I didn't particularly want to be mothered (laughs slightly) [...] It wasn't what I wanted really [...] a kind of semi humorous, mothering type approach. I just didn't like that. I mean if people are scared, being humorous with them doesn't work, I don't think. And I really don't like that ... I find that very minimising of my fear [...] But it's like any helping profession isn't it. In order to really listen to somebody in ... a ..painful, emotional state, you've got to feel it a bit yourself haven't you, and I suppose they don't want to be (laughing) doing that 10 nights a week while they're on shift or whatever but I think that's the only way you're really effective'

Professional or friend, or professional friend?

Where women had one or two midwives throughout their care, the professional/personal divide was less visible and divisive. Midwives could be experienced as the 'professional friend' described by Sally Pairman (2000). One woman in the study who got to know her midwife well explained the value and the complexities of the professional friend: the dance between closeness (that enabled her

to feel engaged and comfortable), and distance (that prevented her midwife's issues from encroaching on her own), described by Sigridur Halldorsdottir (1996):

'I mean, I'm not saying we know each other inside out, but I know what her husband does, I've met her little girl and I've been to her house and you know, I think that makes a difference. I mean everybody would say, oh, that would be nice. Of course it would be nice. But in more ways than the sum of it, it makes quite a big difference really [...]. She's very tactful and very subtle, so there may be certain things that she had to adjust in terms of the way I feel and I've just not seen it. But I don't think so. I think broadly we suit each other really. Another thing that I've found important is that she's a warm person, but she's also quite a private person and I quite like that. She's not private in a way that, you know, some people can be private in a way that would make you feel awkward [...] because they're so closed or something. It's not that sort of thing. It's just that I know there's so far with her. She'd be warm and friendly, but her life's her life and she has a kind of demarcation and I like that [...] I feel much more comfortable than I would have imagined possible, but the funny thing is, you build up a relationship that is in some way ... it has a lot of trust, implicit trust in it. But at the same time you both know that it's built around a professional thing and it is. It is built up quite quickly. So (sighs) so that you know in a way, I'm asking her to behave like a very close friend in a way, on one level and she's isn't .. And I know that, and she knows that and that's okay, but do you see what I mean'

The professional friend may work within more flexible boundaries. So while many women felt their relationships with midwives came to an abrupt end 10 days after birth, she and women set their own boundaries on a more flexible, individual basis:

'I feel quite sad that the person who delivered my baby can't just come and see her, because I don't have any way of communicating with them. You know, had I had a private midwife, they probably would have not just done postnatal care, but would have popped round, to see how the baby is doing. And I just like to show her off I suppose. [...]. But I mean, I suppose they have work to do and they can't go round seeing every baby they've delivered, unless they have a personal interest. But I can't believe they don't all have a wee personal interest in the babies they've delivered'

Thus professionalisation could provide spaces or closures, which resulted in mutual support or shared powerlessness⁴⁰. While they attempt to find workable strategies to achieve small changes, as Ruth Wilkins (2000) suggested, without moving outside the accepted paradigm of professionalism, women and midwives cannot move far together. In the same way that lack of continuity prevents relationships, the construction of professionalisation imposes ways of relating that maintains obstetric hegemony and denies women and midwives ways of engaging that might develop transformatory knowledges.⁴¹

⁴⁰Disengaged professionalism and lack of continuity muted the potential support that could be gained from women. They reported being told by midwives about how short staffed they were, how exhausted they were, and how they were expected to work in their day clinics after attending births that occurred during the night, with no expectation of constructive support. As I suggested earlier, women have often led campaigns in support of midwives. The mutually supportive and beneficial aspects of on going relationships between women and midwives is evident in Juliana van Ophen Fehr's (1999) study, where one woman immediately supported her midwife when she was under threat for practising midwifery in a North American state where midwifery was illegal.

⁴¹Two contrasting quotations about water birth demonstrated how relating on a different basis, through mutual sharing, honesty, respect and openness opened up possibilities for both midwives' practices and their relationships with women. They also demonstrate how defensiveness, closedness and divisiveness is entailed in maintaining a detached professional persona, and it's inability to understand that one of the main sources of support available to midwives is from the very women it is in danger of alienating. Whereas the former opened up possibilities, the latter closed these down:

'I needed to have everything in place with everybody happy doing what they're doing and the water birth, they're happy to do the water birth as long as the baby's not born in the water. Now I would like my baby to be born in

There was a tendency in the literature to focus on individual caring qualities in ways that muted the necessity of relationships. But, as I mentioned on page 213, the women in the study observed qualities such as 'friendly', 'good hearted', 'lovely', but at the same time noted that midwives were 'strangers'. So while they demonstrated qualities of warmth and responsiveness, women were clear that trust occurs in relation to others, and takes time to develop.

Trust

The need to know

The level of trust felt by women was the most significant indicator about the relationships between them and their midwives. Yet, as I discussed on page 182, the institutions of high modernity, disconnected trust and relationship and invested it instead in bodies of (inaccessible) knowledge and skills, and groups of (unknown or little known) professionals, who are assumed to have the appropriate knowledge and skills (Giddens 1991). Blind trust or 'hoping for the best' was sometimes the only realistic option:

'I've just been trusting that everything will go okay and I won't need to worry about it, and, yeh, there's something that is unresolved in me or between me and them. I'm not sure what it is, but I guess it's probably between me and them. But we haven't really talked'⁴²

the water, but I won't do it if my midwife isn't confident about that, you know, doing it. I think that's fair enough, they have to say what their limitations are and I have to go with that ... [...] They've never done it before, this is the first time that any of the team have had experience of a pool, so I've given them a video, and they may change their mind, you see, cos on the video there are 2 births and they're both in water [...] I don't know whether it's textbook stuff, or whether it's, you know, whether there can be dangers, I have no idea, I don't know enough about it ... They don't either, but certainly, I mean, it looked very attractive to have it in water, I have to say, than to have to climb out ... But they may change their minds when they see the video (laughs) cos I don't think it needs any special skills I think you just have to be ... you know ... on the ball. I gave it to them to take away with them because, I don't know if you've ever seen the video. It gives the midwives point of view and I thought that might be ... interesting for them, you know, kind of like the hands off, it's not .. as, hands on, so I'm wondering what their reaction will be to that. But they're very game, I mean, they really are so I'm very grateful that they've come this far with me'

'well where exactly are you planning to deliver? Have you got a spare mattress or something? I looked at her and she [midwife] looked back at me and she suddenly realised she said, you're not planning to have this child under the water are you? And I said, well yes, what did you think I had the water pool for? And she said, well I thought you were just going to have the water pool just for pain relief. And I said, no I actually anticipate delivering in the water. Oh no, she said, absolutely no way, absolutely no way. This is just going too far, you're going too far with this. Absolutely no way. None of us in the team have experience of water birth delivery. Absolutely not, this is the most ridiculous thing I've ever heard. I mean we could probably accommodate you in the home birth but you would have to deliver on land. This is just .. absolutely not. And I said, well to be honest, it's my choice, and if I want to deliver in the pool then I will. Well none of us have any experience at all and actually I just don't think we're going to have the manpower to cover you at all And what happens if all of the girls go into labour and these poor girls, they've been you know booked since they were eight weeks and you may just .. you know deprive them of their choice. Absolutely no way. Oh this is just the most ridiculous thing I've ever heard. And I said, well I don't know what your concerns about water birth are but that's probably where I will end up delivering if that's what's suitable at the time and you know I've got a lovely book here you can read. And she sort of picked it up and said, no, no I don't think I'll take this away with me. And I said, well it's got a section at the back especially written for midwives, to give them some guidance. Oh well, do-it-yourself water birth midwifery now is it. And so she wasn't very impressed'

⁴²Hope and faith were responses to decreased agency in an immutable system. While women continued to feel strongly about their ideals and the importance of trusting midwives to support these, many resigned themselves to 'hoping' as the only realistic coping strategy: 'there's an element of just hoping', 'I'm fingers crossed that she's the one, you know'. While hope usually centres on the self as agent, in this case, perceiving themselves as powerless to affect their circumstances, hope was vested in (particular) others, (or in the healthcare system), where the agency of another, or the quasi-agency of the system, might have fulfilled their hope. Though, as the rota system of midwives was random, and in

The women's accounts confirmed that trust 'seems to be a major determinant in developing a relationship and lack of trust seems to be one of the major reasons for nurse-patient detachment' (Halldorsdottir 1996: 47). They searched for the level of trust found in other studies (Lemay 1997, van Olphen Fehr 1999). In these, uncertainty and fear did not feature as they did in my study.

As the previous chapter, and this chapter demonstrate, women needed to trust that midwives would support their meanings of birth, and would convey trust in the birth process and the individual woman's ability to birth her baby⁴³. As the women's quotations suggested however, they needed to know midwives to know whether or not they trusted them:

'N How far would you say you've developed a trusting relationship with your midwives?
It's really hard to say, because I just don't know them well enough
and some of them I've only met once for just a few minutes⁴⁴,

'N And what was it about (midwife) that you liked?

She's just very friendly and very reassuring and, great with, you know even the with the older ones [children], you know. She always remembers what you've had, and if she sees you up the street, she stops and talks to you and she's just more a friend than anything else eventually, you know, you just end up, you feel really close to her, you know. She's just good at winning you over and yeh

N Do you feel that's quite important?

Definitely, yeh, cos you trust that, you know, I really trust her and I trust her judgement you know, and, I know, you know, when I go into labour and she'll come and she'll check everything and if she says everything's okay I'll believe her you know, I'll trust her that it is okay. But yeh, it is important cos you know, if you had a midwife that you couldn't communicate with and you didn't feel comfortable with, the whole thing just wouldn't work I don't think, you know. I think it is really important to have a relationship with your

fact 'hope' was invested in chance. So while primary hope is usually motivating, this hope was a passive hope that women could not act on, other than 'having faith. It took the place of knowing that their needs would be respected and was a way of attempting to construct positive responses to uncertainty. I thank Jayne Wentworth for her paper on hope presented at the 'Gendering Ethics/The Ethics of Gender', International Conference, Leeds, June 2000 and for her further comments on this aspect of hope in a personal communication.

⁴³ Maggie Banks (2000) suggests that 'the most essential component of [the midwife's] kit often goes unnoticed. That tool - her most powerful - is her trust and knowingness in women's ability to give birth. From her first contact with the pregnant woman, this trust is usually the most needed and frequently utilised of her tools' (132). Women's comments and comparisons frequently confirmed this:

'Well [...] you see, that's why I like her [midwife] . I get the sense that she ... trusts. Yeh, you know, there's no reason for anything to go wrong. You know, you're 95% it should all go fine. And I feel she would be there saying, yeh, you know, you're going to be fine. Whereas I don't feel like [midwife] does know that. I think it's that that makes a midwife. Somebody who has a lot of trust in the thing of birth and is able to go with the rhythms and understand it and sort of link in with it and yeh I don't think that's her thing'.

But given the review and Chapter 8, it was clear that there is little fertile ground from which trust can grow. Fear predominates, there is little trust in women's bodies and births, and midwives are expected to 'steer' women.:

'Well ideally, it would be .. that someone does know what is risky, and so I'd feel really good that there's somebody there who I can trust, who'll reassure me ... if everything's fine but just taking a long time or whatever, and say, no, this is okay, don't be worried. And if there's something wrong, now hold on, we should be doing something now, and this is what's possible. And I'd trust them. The problem is that I don't'

⁴⁴As one woman commented:

'I think you ask a lot of questions of the NHS midwives, trying your best to make up for the fact that you don't have a relationship with them. So, in a way, some of my questions were trying to find out who is this person that I'm speaking to, what are they like, how does their mind work, how does their logic work and so you find you turn your questions to try and get through the skin of the person, you know [...] I would go in armed with all my specific questions and find I still came out feeling upset, you know, because I still didn't know that person and I still really didn't feel any more easy'

midwife. And it's important to see the same one all the way through I think, cos otherwise, you know, you wouldn't have had a chance to build up that relationship, you know. We're quite lucky that there really are only 2 midwives that you would see locally and then they're both on call for you going into labour. I think there are 3 but they sort of split themselves up between areas, so basically you see [midwife] most of the time you know, specially if you are having a home birth. She makes sure that she's got the continuity'⁴⁵

Trusting across ideologies: Adapting to limited trust

Given their divergent ideological views about birth, women often remained uncertain about whether or not their ideals and integrity would be respected and protected during the vulnerable period of birth itself. Some were unsure about whether or not they would be able to focus completely on the challenge of giving birth, or whether they would need to 'watch out' and be ready to negotiate or resist, and how possible this would be from a position of vulnerability:

'I don't want decisions to be made on my behalf, in the sense that I got this feeling about being given syntometrine or vitamin k or something like that. You know, I got this worrying feeling that even if I said beforehand that I didn't want it, that at a vulnerable moment they [midwives] might try to persuade me. And I've heard that this actually happened to some people. You know, that even though they'd said something beforehand, people have tried to manipulate them with clever arguments at vulnerable times. And I didn't want to have to deal with that. I wanted my opinions to be respected. And just the control. Yeh, somebody not trying to dissuade me from what I want to do'

Some women felt that there was such an irresolvable gap between ideologies with no mechanism for addressing this, that they distanced themselves from trusting midwives. Some women looked for trusting relationships in their own social networks and placed less emphasis on midwives:

'N How far would you say you developed a trusting relationship with your midwives?
A trusting relationshipum..... well .. no I don't think that really enters into it (laughs). That wouldn't be the way I would describe it No, I don't think I would put any trust, and I think that maybe I tried to do that when [daughter] was born, and that actually that is not the ... the right place to repose your trust (laughs) you know. I mean, you really have to trust in your knowledge of your body and yourself and the relationships, the lasting relationships that you have with you know, "non professional" (laughs) people'

'I'm going to have to rely on the fact that I'm in my own house and I've got my partner with me'

'I'm not putting too much emphasis on the midwife. I sort of see the midwife as somebody there to deal with emergencies and do the sort of paperwork'⁴⁶

⁴⁵This was an unusual quotation because it suggests the midwife 'leaping ahead' in a way that was not the case in other interviews with women being cared for by NHS midwives. There was usually a sense of the woman's commitment to home birth leading the way and the midwife following. It demonstrated yet again, the necessity to attend to detail and be wary of theoretical generalisations.

⁴⁶Yet there was a paradox here. Women planned home births in the hope of integrating different aspects of birth which they felt would be fragmented in hospital. But fragmented support at home could lead to conflict, where those present could represent the struggle between different birth ideologies. I discuss this in the following section on support on page 242.

As women assessed the balance between trust and mistrust, a typical view was that women could trust community midwives to provide a reasonable level of support for their home births:

‘on the whole, I think, yeh, I think they know that I definitely want to have a home birth and they’re not going to be flippant, you know. I don’t think they’d use the smallest excuse for transferring me and I think they’re all into talking and discussing it beforehand’

I come back to the two quotations on page 190. Where mutual distrust arose from differences in ideology and lack of relationships in which to negotiate this, both women and midwives approached birth with different anxieties:

‘I don’t trust her not to panic and send me off to hospital just because things are bit slow or something And if there was a good reason for me going into hospital I still wouldn’t trust that it was a good reason, because I wouldn’t know that she wasn’t just panicking or like (laughing slightly) plotting to get me away, you know [...]. And I don’t think they trust me at all [...] I think [midwife] is ... very frightened that I’ll stand there saying, I’m not going into hospital, and I’m staying here, you know, and just be really uncooperative and put her in a really difficult situation of not knowing what to do .. So, yeh, I don’t think she trusts me that way’

The heart of the matter seemed to be that in meeting an attenuated medical ideology, through their meetings with midwives, many women came to understand that their midwives could be competent and trustworthy in relation to the model that they were practicing in, but that they could not necessarily trust them if their values differed:

‘if the baby’s in danger, then of course do anything. But I suppose, it’s just that if I don’t know that I’m coming from the same value basis as somebody, then I don’t know if they’re going to be making decisions on the same basis as I would⁴⁷,’

Mutual trust based on shared views about birth in the context of a relationship, increased trust between women and midwives and reinforced their shared trust in the birth process and the woman’s abilities to give birth. Women approached birth with confidence derived from trust and sharing:

‘the difference of just knowing I’d have someone more in line with my thinking, I didn’t feel that I needed a birth plan any more. I don’t need these things any more. I don’t need all these things because I trust her opinion and that way I don’t have any fears. So I don’t have to swot up so much and, you know, be so defensive’

⁴⁷As I discussed in the previous chapter, and above, attempting to relate, communicate and trust across ideologies limited safety, increased risk, and restricted women’s abilities to remain autonomous and responsible in a number of ways. Carolyn McLeod and Susan Sherwin (2000) suggest that gaps in available knowledge are as constructed as knowledge itself and that oppressed groupings may thus have good reason to distrust information provided by care givers. In other words, even if women trust their own decision-making capabilities, knowing that they lack knowledge, they cannot trust the outcome. They suggest that health care providers are in the same situation and thus ‘have a responsibility not to take over decision-making from patients but to ensure that patients understand the limits of the knowledge the former can provide. Moreover, health-care workers should appreciate their collective responsibility to work toward filling in these important knowledge gaps’ (268).

Trusting in retrospect

Despite their fears and uncertainties about their midwives, many women found they did support them during birth and gave examples of them 'being with' women, staying with them on their journeys, and supporting their hopes. But this was often only in retrospect and partially dependent on the woman's commitment to home birth. The first quotation came from a woman who felt she had had to battle for her home birth and was convinced her midwives had little intention of supporting her home birth:

'I've had a fine experience, you know, my birth was wonderful. The midwives were super, especially my main midwife. She kept me going because, you know, obviously you don't know what the pain's going to be like and she could have had me in hospital like that (snaps fingers). She could have broken my waters a bit early, I couldn't have stood the pain and she could have said, well, really there's nothing much. She could, you know, just a bit of subtle. But she didn't. I was begging to go to hospital, yeh, but it was almost like a relief and I said to her afterwards, if you'd said to me, oh the ambulance is on the way I think I would have been a bit annoyed. But it was almost a relief to say, okay I give up, I give up, take me to hospital and she, I think, I said this earlier on, and she made some comment to me like, do you want me to call the hospital. I said something like I can't stand it, and she said do you want me to call the hospital and I just swore at her. That was earlier on and then later on, when I was like you know, how much longer, I can't stand another contraction, call the hospital and she'd say, fine, after, I examine you next I'll call the hospital and I'd say fine, and I thought I was saying it after every contraction, but I couldn't. My contractions were very fast, but if I could catch my breath what came out was, call the hospital, you know..... But I don't know what would have happened if an ambulance. I probably would have said ... get out of here. To me it was almost a relief, but somebody else might have just gone and picked up that phone and had me in and, you know. But she didn't and she knew I was coping because I think it was earlier on, like when she mentioned, shall I call the hospital, I got a bit upset. But after that it was just you know, breathing on that gas and air kind of thing. I mean there was no argument by them. I think if there had been, I think they could have ruined it'

'During the pregnancy, I didn't know [midwife] very well really. I met her like about 5 times. Well I met her more than anybody else and I found her very relaxed, and you know, more friendly than the others. I did find she was more friendly because she had more confidence in herself. At first I didn't, you know - it's more like when something big happens, like labour and birth, I suppose, that you really see what a person's true colours are like. I didn't know if what she was saying was maybe just to keep me happy until the birth. I didn't really know that. I didn't know if she was any more to be trusted than the others. And during the labour she was very good. So before, I couldn't really have told whether or not she would be. She was the friendliest, you know, and I suppose she was less strict than the others, because she did say that I didn't have to have an examination, an internal during labour, whereas all the others had said I would have to. So in that way she was a bit more lenient'

Trust and confidence

I discussed women's need to feel confident about birth in the previous chapter on page 148. When confidence developed in tandem with trust during the woman's pregnancy, the woman sustained her own confidence and trust through the midwife's:

'obviously it was my decision as to how much I could take but in the end it was all fine [...] But I mean basically, you know she [midwife] stayed as cool as a cucumber, which you know, if she hadn't, if she'd at any point suggested that I wasn't going to make it then that would have had a huge influence on me, you know, cos I would have said, oh great you agree, okay, I can't do it'

Many women had their own fears and anxieties, and any lack of trust and confidence on the part of the midwife influenced the woman's trust and confidence as in the following contrasting quotations:

'you're not a hundred percent sure that it's [home birth] the right thing to do and that it's going to be safe and everything will be okay. But you know getting such a positive attitude off the midwife is such a big help in keeping you to your decision'

'N What do you feel about the decision to go into hospital when you were in labour?
Em..... I think I maybe went in too early
..... but I think I didn't have if I'd had
..... an expert there, who'd been saying, you can do this, then that would have made the difference. But because they [midwives] were anxious, it completely, I mean, my husband says that it completely changed the way I was looking at the situation. Up til then I was coping and then suddenly I was like ... no I just want it taken out, I just want to go [...] They didn't put a lot of pressure on me, only that I knew they were anxious about it'

Very rarely, the woman and midwife developed a trusting relationship to the extent that the woman could let her midwife absorb any anxieties, and both could trust the midwife's judgement about the woman and baby's well-being enough for the midwife to contain any slight doubts she might have. (I return to the quotation in footnote 94 on page 190 to illustrate this):

'I knew that she would tell me if there was anything wrong and if she was ever really worried about the baby you know because it was a long labour. And you know, I did have meconium staining at one point and we carried on. Whereas definitely it seems to me that with the community midwives that's it, you're just into hospital. And she knew I didn't want that, so she said 'mm the heartbeats fine, I think we're ok', and I thought well we must be. I never thought that when I was in the bathroom that she would say to [partner], 'look another half an hour and that's it, we're going to have to go'. I never felt there was any subterfuge. I knew that she was respecting me and telling me the truth the whole time which I mean later she said to me there were a few times when she was a little worried but not much you know. So if you like it was good cos she made me confident ... She never lied to me but she was able to manipulate that a little bit in a positive way you know. I trusted her so much that I let her take the worry, one or two times when there was a wee bit of worry. She absorbed that without me knowing which is really good'

Trusting in the face of vulnerability?

To sum up this section on trust, the main issue to arise was that of trust in the face of vulnerability. Birth is a transitional process (rite of passage) in which women's identities are more fluid and therefore more vulnerable to cultural influences (Davis Floyd 1992), and their bodies, material sites of instability (Shildrick 1997). They are simultaneously powerful and vulnerable. In order to be powerful and manage their vulnerability, they needed to trust those with them to enable them to reorganise their identities in keeping with their values, rather than external values.

If vulnerability is seen as moving beyond the symbolic, women needed support and protection in a place where autonomy and dependency meet⁴⁸. Thus the potential to reorganise fragmented identities positively, depended a great deal on those helping her. In this scenario, lack of trust is dangerous as their identities were at risk of being changed or harmed in some way. Because the language of identities is not part of the language of birth, this might be expressed in terms of emotional hurts after birth:

‘in most of my life I'm in control of what's happening or whatever and that suits me. And once you're like that it's very difficult to then give control to other people, especially about something as important [as birth]. And I felt that after [child] I was quiteem I did have postnatal depression after [child]. I wasn't myself after I had her [...] Everybody has that to a certain degree, but I just felt if I was more in control of what was happening to me, thenI might have, with hindsight, I might have been a bit better, later on’

‘I don't have any anxiety about things going seriously wrong and having to be rushed to hospital and having to have a caesarean. It's like, well, I don't want that to happen, but if it does, I'm really glad that that's something that's available to me [...] I think what I would find really difficult to cope with afterwards would be if I had been taken into hospital, or kind of pressured to have a birth different from the sort that I wanted, on the basis that there might be something wrong, and then to find out that there hadn't been anything wrong. That's the kind of scenario that I really feel would be very difficult to handle. The kind of aftermath of that. Feeling very angry and cheated. Especially if I'd been kind of resisting and saying, no, no, I think it's okay’

Thus, the onus is very much on professionals to respect women's values and to be trustworthy in relation to these, rather than in relation to medicalisation, (I explore the ethical, emotional and material impacts of accepting or rejecting women's values in Chapter 10). In the following section, I bring together the above discussions on continuity, time, communication, caring and trust in terms of support and what this means for women and how they identify their needs for support.

Support

‘What I really need is support’

Broadly speaking, the women identified their needs for support in terms of trusting relationships with midwives who could help them move through pregnancy, birth and early motherhood, in a way that would honour their integrity and maintain well-being. that I discussed in Chapter 8.

However, given ideological distinctions (Davis Floyd 1992, Murphy-Lawless 1998a) and the embeddedness of concepts and terms in the belief systems in which they emerge or are appropriated (Treichler 1990), it was clear that “support” within a medicalised system would necessarily differ

⁴⁸ Analysis of birth literature by Alice Adams (1994) Tess Cosslett (1994), Kathryn Rabuzzi (1994) and work by French feminists, Luce Irigaray, Julia Kristeva and Helene Cixous, referred to by Adams, locate this rite of passage beyond the symbolic, to what Kristeva terms the semiotic. Paradoxically, it could be that imagining birth beyond language provides a concept for hearing women's accounts of birth. Despite the limitations of work by French feminists (see footnote 13 on page 263) and criticisms that it is essentialist, it creates a space in which it may be possible to reconceptualise the “otherness” of women through the fragmentation of her identity which is socially, culturally, physically, mentally, spiritually and sexually reconstituted through the complex transition to motherhood. Part of the definition of “otherness” arises from the medium (medicalisation), in which birth takes place being limited to the symbolic. The potential for harm eludes the medical model so that it cannot even recognise, let alone comprehend the concerns of women giving birth. Thus, as I discussed in the previous chapter, while death at birth is a devastating tragedy which transcends belief systems, it is not the only potential tragedy. Pitting safeties and tragedies against one another is endemic in hierarchical, dualistic thinking and anathema to women's experiences.

from that provided within a view of birth focused on individual women. As I discussed in Chapter 8, risk management forms the basis for obstetric support, and while women in the study were not necessarily familiar with all the theoretical assumptions embedded in obstetric care, they found that they could not always gain the positive support they needed from their midwives⁴⁹. While ‘steering’, surveillance, and monitoring may seem logical within a medical framework, women had different and/or additional needs for support which were not always easy to articulate. The separation of birth from its social context and the emphasis on physical health muted the support midwives were capable of. It remained largely beyond the concepts and language of both women and midwives.

‘when people stay at home, it’s almost as if they’re saying, well I don’t need any of these things. I’m going to do it on my own. But I’m trying to say, well, in fact I do need a lot. I need all of those things, but in a different way at home. Not the drugs, I don’t need the drugs and I don’t need surgical instruments I hope. But what I really need is support’

‘What they did was checks, lots and lots of checks’

Most women in the study first saw their midwives between weeks 10 and 20 of their pregnancies, continued to see midwives at monthly intervals until around 28 weeks, 2 weekly until the last month and then weekly. The women stated that these appointments varied in length but usually lasted 15-30 minutes (especially when they attended midwives’ clinics in hospital, where 15 minutes was apparently allocated for each woman⁵⁰). The women reported that the main purpose of these visits was to carry out physical health checks (checking the woman’s urine and blood pressure, palpating her abdomen and listening to her baby’s heartbeat) and that this took up most of the visit. Even when midwives asked how women were, this seemed to focus on physical health rather than emotional well-being. So although women appreciated the care they received from midwives and found it reassuring, many experienced it as limited and failing to meet their other needs⁵¹:

‘what they did was checks, lots and lots of checks which I didn’t need. I felt like I was able to gauge my own health, and that I didn’t need to be measured, weighed, checked so much and I needed something else and there wasn’t anything else. The medical check went under the guise of getting to know you, and you know, I just thought, actually this is all wrong, you know, just having my tummy measured and if that’s all that was going to happen, it was ignoring so much’

In the context of the perceived lack of any other midwifery support, some women found it more akin to surveillance than support:

‘I felt that what was clearer to me now is that they are just here to take a monitoring role. I mean, they just see themselves as monitors. They’re not really here to support’

⁴⁹ Many women located the lack of support they experienced in an inappropriate system of care rather than in individual midwives. As I mentioned elsewhere, many described midwives as having the best of intentions, well-meaning and kindly, but that they were locked into beliefs, policies and practices which could not provide the support women needed: ‘they don’t instill you with confidence and they don’t have faith to say that you can do it. But they said that to me beforehand. I mean, they admit that [...] and their intentions were very good’

⁵⁰The length of antenatal visits was frequently commented on. Time was restricted by organisational constraints, and the priorities of the service rather than the woman’s individual needs, as I discussed on page 217.

⁵¹Focusing on physical aspects of health ignores what is lost through separation and what can be gained from a more holistic (relational) approach to health care. A contextual engagement with midwives seemed to be at the heart of what women considered to be supportive - the need to be known and to know - for health care to be worthwhile. Without this holistic context, engaging with professionals could seem rather meaningless to some women:

‘when there’s a problem or whatever, I think, you know, is it really worth it, you know, to phone a health professional, because they won’t know the, background or the history of it’

'I mean, yeh, the point was that ... you know that the midwives stressed that their role would be just to check for abnormalities. That they would be on hand to ... so ... I, at one point during the conversation I sort of felt well, that it would be quite uncomfortable having them here in a way ... because they would be constantly looking for the moment that, you know rather than providing encouragement and support and oh, it looks like you're fine and it's going to be great and you know just keep persevering (laughs) [...] I mean it seems that the minute you ask for anything or that you indicate that there's a need that they will say right we can't fill that need for you here, you'll have to go to hospital ... or you know, we can't do anything about that'

However, the same woman who felt that the 'checks' were unnecessary, even undermining, redefined this when she transferred from a team of 8 midwives to one midwife. When the focus changed from physical health to well-being, so did her experience of her physical health being cared for:

'the difference [...] is because I have time to get to know [midwife]. So what normally happens is that she comes round, we have a cup of tea, we have a chat, [...] then by the time she's been there for 45 minutes or an hour, we do the check, so she will do all these things, but it seems relevant, it's like somebody you know who's caring for you, checking that you're okay, so it feels different because you're not straight in the door and on the scales, or straight in the door lying on your back with your top up, you've actually engaged as an adult with somebody first'⁵²

Going beyond the checks: 'I really wanted them to be with me'

As I suggested, midwives and women, found it difficult to create spaces, concepts and language in which to discuss support and move beyond the rhetoric of obstetric support. One of the difficulties was the location of support in dichotomous thinking, which renders some terms more visible than others. For example, as I discussed on page 57, normality is the less visible partner to medical ideology's abnormality. And the 'absent' body (see page 365) is only visible through symptoms indicative of illness, so the medical model only sees abnormality; normality remains invisible. Thus women and midwives attempted to articulate support for invisibility. This is not to say that midwives were not skilled in supporting women during labour, but because this remained unarticulated, they were not necessarily aware of their value. Women sometimes had to ask them to put aside their paperwork or stop chatting to each other so that they could put these into practice:

'there came a stage when I really wanted them [midwives] to be with me. I just remember looking really hard into her eyes and she absolutely meeting that stare, and taking it in and giving me strength just through the way she looked at me, which is exactly what I needed'

The emotional presence or absence of midwives was acutely felt by women, and while obstetric care disconnects emotional from physical care, for women, support meant reconnecting these.

Supporting normality

Just as the focus on risk that I described in the previous chapter conveyed an emphasis on medical ideology, the focus on physical health that excluded relationships, and their integral contribution to

⁵²In challenging the focus on physical checks from relative strangers, women challenged the objectifying of women, when care is 'auxiliary to that central point, which is, you know, do you feel alright'. While women need to be repositioned as knowing subjects. Adams (1994) suggested that: 'in the theory and practice of medicine, psychology and economics, mothers are often represented as nonentities, nonparticipants, environments, or functions (246).

safety emphasised the same ideology. The relentless screening for abnormality in the context of powerful demarcationary lines between midwives and doctors led to the same fear of being transferred to hospital and medical care unnecessarily, that I described in Chapter 8⁵³. Most of the women in my study wanted to avoid interventions (their definitions varied but tended to mean the avoidance of what Adams (1994) described as ‘the machine/physician [entering the woman] by way of needles and monitors’ (57)). The crux of the problem was the same as the one in the previous chapter: there were few authoritative midwifery skills to assist normal, but more difficult or unusual births:

‘I felt they [the midwives] did make a huge effort to do what we wanted so I appreciated that. It’s just that I guess I was then [immediately after birth] more appreciating what they had done, whereas now with more distance I’m a bit more aware of what they failed to do in some ways [...]. They don’t know really simple things, like they don’t seem to have explored all the possibilities. Like we used homeopathy and they were really impressed with how well my tear healed with, you know, just using hypericum [...]. So she’s learnt from what came along but you know it’s **there** it’s available for them to have learnt about. Like if I was a midwife I’d have explored homeopathy and herbalism and shiatsu. There’s so much wisdom that they could tap into that they don’t seem to be interested in - it seems bizarre’

N What, what do you feel about the home birth services, looking back on it would you say? Well, I'm glad they're there. I think they could be .. greatly improved and the systems around it could be more supportive of that choice, should you decide to take that choice, em and I suppose fewer of the kind of, you know the the loopholes. Well, you know, if you've to be induced you've to go in, and sort of fairly arbitrary things, you know’

N How, how would you envisage that could be otherwise do you think?

I suppose training .. midwives so that if a woman did feel that that, you know, they weren't going to have this child, anywhere else but at home, that they would feel happy enough to, to deal with you at home or ... I suppose that comes from experience. But it just feels like they're actually not getting the experience, cos they're not getting any strange⁵⁴ births at home, it's, it's, it's just the normal ones that get to do it, you know’

As I explained in this section and the section on trust, women articulated the need for support for vulnerability. But if they had no evidence during their pregnancies that their midwives would be able to provide this, they looked to alternative forms of support through their own social networks. I

⁵³Paralleling the women’s views on obstetric risk, monitoring pregnancy was experienced as surveillance because of its location in the normality/abnormality pairing. From the woman’s point of view, the ‘checks’ were to detect abnormality in order to position her pregnancy or birth on one side or other of the demarcation between normality and abnormality, where normality has been shrunk and abnormality expanded. Thus detection of abnormality meant being plunged into the heart of medical ideology, trading in their autonomy and agency, on trust (when many women felt distrust). As I suggested earlier, women frequently articulated a need for midwives to develop authoritative knowledges and skills not only to detect abnormality, but to be able to maintain normality. In van Ophen Fehr’s (1999) terms, being able to ‘leap ahead’ in watchful expectancy when all is well, in the context of being able to ‘leap in’ and draw on skills that would not always necessitate immediate transfer to the medical model of care. This is the ‘buffer’ between women and obstetricians that I mentioned on page 202. So rather than defining normality negatively as the absence of abnormality (a questionable project in itself), an emphasis on positively maintaining normality could return a certain level of autonomy and agency to both women and midwives; extend the boundaries of normality and midwives’ sphere of practice; and delay or avert the necessity for medical or technological help which the women wanted to avoid. This more complex system draws on other sources of knowledge about health and well-being. It might include ‘low technology’ interventions which work with the body and its processes (Murphy-Lawless 1998a) and which engage rather than distance woman and midwives from each other and from themselves.

⁵⁴This quotation should be seen in the context that none of the women wanted to put themselves or their babies in danger, but all viewed the definition of normality to be inappropriately restrictive. Thus ‘strange births’ fall into the category of normal, but not textbook births.

have developed this theme further here, to look at issues of support and advocacy and the potential for change through relationships.

Support and/or advocacy

As I suggested in the section on professionalisation, some women observed that midwives did not encourage them to draw on other support, or even expressed concerns about this:

‘it's surprising in a way that that's not more encouraged by the midwives who attend the birth, that say, well, you know, what people would you like to have and you know Do you have some girlfriends that would like to come along or that you would like to come along?’

‘they [midwives] asked me if there were any AIMS people coming and I said no, on the grounds that there was nobody that I was inviting that was to be there as an AIMS representative. I said that there were going to be birth supporters, friends [...]. They were very interested in [friend]. In fact they kept on saying, and they'll look after the children. There was one in particular, I can't remember which midwife it was, but she kept on saying, and they'll be looking after the children and I didn't confirm that or deny it⁵⁵,

The fraught but often muted discordance between women and midwives meant that women usually selected birth supporters who would support their views as well as provide emotional support. Advocacy was implicitly or explicitly implicated. This could be threatening if midwives felt less able to persuade women to conform with local policies and practices and thus less able to safeguard their own positions⁵⁶. Of course, some midwives were welcoming of women's chosen supporters, but only the women attended by independent midwives reported that the possibility of other supporters was actively explored and that their midwives initiated meetings with those who would be present, to discuss how they would work together to support the woman.

The observations women made about support, along with other views on muting (Doucet and Mauthner 1998) and support (Leap 2000), articulated an aspect of support that had remained muted and which moved beyond the existing framework in which the discussion had hitherto been set.

Challenging the limits of support: Support for motherhood

In the same way that I described that women initially responded to issues of safety through dominant ideology, using counter statistical evidence, and then redefined safety in terms of well-being, so their definitions of support moved beyond those set out for them, to include support for the transition to motherhood⁵⁷. Extending a metaphor already used in birth literature, the women's

⁵⁵AIMS is seen by some midwives as representing “radical” views, that are dangerous from their perspectives. The presence of an AIMS member can therefore be seen as threatening.

⁵⁶ Recent unsolicited feedback from a senior midwife about my support role at home births provided an example of the underlying fears that midwives might have about birth supporters. It also demonstrated a variation of the sort of horizontal violence between women (midwife advocate to woman advocate) to effect conformity (Hadikin and O'Driscoll 2000, Leap 1997, Stapleton et al 1998). The midwife attempted to define my role as disruptive, preventing midwives from practising as they wanted and construing a scenario both to me and to the local Health Board that should a “disaster” happen at a home birth it would be my fault, and hence not the midwife's or hers. While some women believed that the medical model could be dangerous for them, those espousing a medical model saw other beliefs about birth to be dangerous, even courting disaster.

⁵⁷While there were diverse views about motherhood and parenting, birth was about setting the scene for relationships. For some mothering was the predominant consideration, for others it was about integrating it with other aspects of their lives.

articulation of birth as a journey within another journey of motherhood/mothering⁵⁸ moved beyond medical meanings and its focus on birth.

From this perspective support was limited. It emphasised birth as an event and de-emphasised its social context. So while women appreciated their and their babies' physical health being monitored, and the limited opportunities to talk with midwives, the role of the professional midwife seemed too narrow and inflexible, providing only limited support over a short designated time period. As I suggested earlier, the lack of emphasis on social aspects of birth led many women to experience it as surveillance rather than support. So in addition to discussing how current services could be improved within the existing framework (by providing greater continuity; more time and flexibility antenatally; more home visits; more information and discussion; emphasising emotional well-being; prioritising women's needs and beliefs; and integrating community and hospital services), they also questioned the assumptions about birth on which care is based. They imagined that midwives' skills could include skills to facilitate birth and also skills to facilitate mothering⁵⁹. Some felt that part of their midwives' role could be to help them connect into the wider social network of mothers. But in a culture with designated pathways for becoming a mother, which simultaneously devalues it, the possibility of ongoing nurturing support remains muted, and those who might provide it remain excluded

Women were aware that both public and private networks around them were insensitive to birth as a transition to motherhood, rather than a transition to having a baby. For them birth was about forming relationships with babies, families and communities. But even within their own friendship networks the potential for birth as a connecting mechanism for communities of birthing women in need of support for mothering was suppressed.:

'I think it's a shame that, you know, that I'm not asked to come and attend other people's birth and that..... you know, that that's not more of a usual thing, that if you have female

⁵⁸This echoed with birth literature which focuses on past cultures and those outside the westernised world. Many of the birth practices described by Jacqueline Vincent Priya (1992) and Shelia Kitzinger (2000), for example focus as much on the early mothering period as on pregnancy and birth. We must, of course be cautious about interpreting other cultures, as the debates and disagreements about Margaret Mead's work and the subsequent work of other anthropologists in the same field demonstrate (Oakley 2000: 55). But the focus in some cultures on the time after birth contrasts sharply with practices in parts of the West, where postnatal care is not necessarily provided on a statutory basis (as in North America) or provided minimally (as in some of the Scandinavian countries), or focuses on babies' physical health (where it is provided by paediatric nurses). Postnatal care is still statutorily available to all women in Britain - though it is always under threat. Very few women now receive care postnatally from midwives for more than 10 days and qualitative research by midwife, Patricia Mary Hamilton, presented at the 4th International Home Birth Conference in Amsterdam in March 2000 suggests that women receive visits less frequently than they want or need. Similar to qualitative research on pregnancy and birth, her work shows that despite apparent choice being given to women, professionals remain in control of how and when it should be given and consciously or unconsciously 'steer' women towards certain choices rather than others. Although women in the study tended to find that their care postnatally was rather more relaxed than during pregnancy, and that they received a certain amount of reassurance, they still reported a focus on physical checks.

⁵⁹ It was perhaps because of this 'mothering' aspect of birth that some women felt that midwives should have had children themselves. There were different views on this. Some women felt it was more important that midwives could provide unconditional, empathetic support, and some felt that if unprocessed, a midwife's individual birth experience could cloud her view of women and birth (see Mander 1996). And yet, as I observed on page 185, some needed the presence of someone 'who knows'. This led me to speculate on Christine Bewley's (2000) work on childless midwives. It could be that in de-emphasising experiential knowledge and relationships, women focus on the issue of midwives having or not having children. Women had few ways of getting to know midwives or accessing midwives' experiential knowledge: asking how many home births they had attended and whether or not they had children represented ways of attempting to establish this. As Bewley suggested, the hierarchical nature of the woman/midwife relationship requires that women, but not midwives share personal details, so that there few opportunities for discussion about all that midwives have to offer, regardless of their motherhood status. In other words it may be that if relationships cannot be established, women attempt to ascertain some commonality with midwives. Having children is an obvious starting point. The boundaries between women with and without children and what they know or do not know is complex (Cosslett 1994). Interestingly, at least 2 of the women in the study had supported a friend or sister giving birth, before having their own children. In short, in the context of relationships, having or not having children may be less of an issue.

friends that that's part of your friendship, you know, support each other in labour, that, that way it's an ongoing thing.

Many women stated that their partners should be their main support during labour and birth, and that this promotes closeness and family bonding. At the same time, many acknowledged that birth and mothering take place within a community of women and over half the women in my study planned to have a female helper with them during birth:

'I think I remember saying with [baby's] birth, as well, that it's really a woman's thing, you know, that I really felt that I needed the presence of other women You know, particularly women who'd been through the process'

But the following quotation showed how the different kinds of support that those present were able to give needed to be cohesive to be supportive:

'I think she [midwife] was completely oblivious of what I really needed. You know, just the emotional support which although I got a lot, you know, from my friend and partner. But, I mean, they weren't midwives, you know. I was looking for somebody with the expert knowledge to tell me more things about what was happening, or how I was doing, or what I should be doing'

As the initial quotations about birth supporters suggested, most midwives were unwilling to encourage this, despite their limited individual roles in women's pregnancies ('you might see them that one time and then perhaps never again'), because of the threat it posed and the cultural focus on birth rather than birth in the context of mothering. And even if midwives were willing, the shifting patterns of communities, the distancing of midwifery from communities, the emphasis on the self-reliant nuclear family, and the suppression of 'unqualified' female helpers at birth, makes it difficult for midwives to begin to re-establish connections. However, Nicky Leap's (2000) exploration of community building during childbearing acknowledged birth as part of motherhood, the need for ongoing support and the limitations of midwifery (as currently defined). Thus her practice involved engaging with the woman's social network in order to help her gain support from her own community. The idea that those who support women during birth will form closer attachments to her and her baby on an ongoing basis was similar to views expressed by some of the women in my study. The midwife's role becomes one of fostering relationships between the woman and her community. This dissolves the potentially adversarial boundary, which some women were aware of between midwife and helpers at birth⁶⁰.

Revisiting relationality

Acknowledging difference

Women told me in a myriad of ways that relationships with midwives mattered a great deal. Their discussions often resonated with the relationship theories I discussed in Chapter 4. Relationships were seen as being able to provide the engagement, trust and nurturing needed for women to feel safe enough to move through birth to motherhood: 'what you want is a mother (laughs) probably, to be mothered when you're just becoming a mother yourself (laughs)⁶¹'. While home birth was an

⁶⁰In this scenario the adversarial context in which midwives practice is kept at a distance from the woman, so that she can focus on birth and mothering. This requires courage and strength on the part of midwives, as the quotation on page 241 demonstrated, when the woman described the midwife absorbing worries.

⁶¹This is in contrast to the quotation on page 234 where the use of the term 'mothering' implied a reduction of autonomy (Mander 2001: 82). Rosemary Mander points to interviews with midwives, which suggested that they saw their role of 'mothering' as one of increasing self-esteem and providing empowering role models. Like the quotation above:

attempt to define birth in their own unique ways, this needed to be in the context of supportive midwifery care. As I suggested, deciding in isolation, or against advice from professionals and others could be lonely, painful, confusing and disempowering. Relying on rights appeared not to address women's needs to be self-determining and empowered, because feeling empowered included sharing and receiving positive feedback. This demonstrated some of the potential disadvantages of relational ways of being (rooted in ethics of care) which seemed to leave less space for difference and conflict. And yet this "underside" to relationships was inevitable given conflicting ideologies about birth, and seemed very present in my analysis. But as I have noted, many women, like those described by Mary Belenky and colleagues (1986) found assertiveness problematic and conflict intolerable.

Assertiveness: 'I'm not really very pushy, I don't like to feel I make waves'

I have already suggested that women would only exceptionally exert their rights and were reluctant to make 'waves', have midwives attend them under duress, or cause more than minimum 'fuss' that might distance or alienate their midwives⁶²:

'the first time round I'd had a scan done, and I actually didn't want to have it done. But I didn't realise I had a choice about it, and to be very honest, I felt so relieved that my doctor had agreed for a home birth for (laughing) me, that I didn't want to push her. I thought, if I contest the scan, maybe she .. she won't be so supportive of me. So that was at the back of my mind. I better do this, to show that I'm willing to (laughing) cooperate and I didn't want to make waves'

'I probably wouldn't have changed [from a domino to home birth] if it had been a big administrative fuss, cos I'd already changed doctors, and used up my fusspot cards on the sexing issue [requesting an ultrasound scan]. So .. it was the fact that I had confidence in them not seeing this as a problem'

While I was very aware that all the women in the study had great inner strength, skills and emotional resources, it was apparent that very few women felt comfortable or even prepared to be openly assertive. The following quotation was an exception:

'this is my home so I am in more control. Even if I had a really stroppy wee woman [midwife], I would just say well go away, okay go away. This is your job and you're not doing it, so go away, you know (laughing)'

For most, being themselves and asserting their needs was extraordinarily difficult:

'I just felt what I always feel with medics which is, you know, just wanting them to leave it alone and stop worrying at it and not really being able to say so'

As Belenky and colleagues (1986) described, women often judged themselves negatively:

'I think I let myself down. I should have been more forthright [...] but it's difficult when you're relying on someone'

'I liked the fact that when I said to people, I'm going for a home birth, most people were surprised and there was a bit of me that was saying, well, you know, fuck you, of course,

⁶²In this way the midwife acts more specifically as a 'mother' to the woman in order to facilitate her ability to nurture her baby. This indirect intervention is summarised in terms of 'mothering the mother to mother her baby' (Mander 2001: 82).
⁶²I come back to this in my discussions about choice, rights and control in Chapter 10 on page 272.

that's what I'm going for and, and don't you be surprised, or don't you think ... anything about it, (laughing) it's perfectly normal So it was a kind of assertion of, of me as who I am and not having to make compromises. But you see (sighs) there's really two sides to that and and I'm quite cowardly with it. It's like there's a level at which I can't stand by what I want any longer, and it's all this assertiveness stuff. It's like, you know, I can feel quite strongly about what I want, and I can go for it to a certain extent and then there's a point at which it becomes too difficult for me And I think it's made me very aware, I think, possibly also talking to you over the weeks and months that we have done. It's like that's come up again and again. It's like, well I wanted that, but I didn't go for it cos I didn't, you know, couldn't, and I wasn't assertive enough, and this and that..... And that's really been pointed up .. and that's why I don't feel entirely good about the bit that says, oh well, I'm having a home birth..... It's because, yeh at one level it feels like I'm kind of showing off what an individual type of person I am, and yet actually I don't necessarily have the courage to stand by that if it gets really badly questioned (sighs)..... On the other hand, you know, if people had said well, you can't have a home birth I might well have fought a lot harder, so it's difficult to tell. I don't want to be too hard on myself for having you know difficulties and, and places where I've got ... barriers up, because I do want to do something about them but it is interesting to see, just, you know, where those contours have been over this time'

But it was also clear that while this was a difficult area, women felt that it may have been possible to address some of their difficulties in the context of relationships. They thought they may have felt less silenced and more able to find other ways of discussing ideological differences than 'having to be bluntly assertive'. But when there was so little time to talk to relative strangers this seemed to be the only (unsatisfactory) means available to them:

'if I'd had one midwife who I really respected and had built a relationship with over a lot of weeks or months then maybe I would have been able to talk to her about the kind of emotional difficulties that I had around You know, not being able to talk about the value level and things, could have been very different. It would have depended on what midwife I got obviously, but had it been somebody who I developed a rapport with, a lot of those difficulties could have been a lot less, just from knowing somebody and knowing where they're coming from and Even just having longer to work out how it is that I can say things that otherwise would feel difficult because that's another way round (laughing slightly) you know, having to be bluntly assertive, is actually working out, well, how do you say this in a way that can be heard You know, for me it can take quite a long time of negotiating around with somebody to find out, you know, what they can hear and what they respond well to and you know, what I wouldn't be able to say or whatever'

Finding resolutions: 'You can't knock six of them into shape'

Because of the potential accordance or discordance between women's views and midwives' practices, the meetings between them were necessarily sites for resolution, non-resolution or open conflict. As I described above, in terms of conflict resolution, most women and midwives were at a disadvantage for a number of reasons ⁶³: the midwife's overwhelming need to contain women within the limits of accepted local policies, usually managed by steering (Levy 1998, 1999b) and

⁶³I understand resolution to mean the process whereby, parties move from positions of disharmony to mutual satisfaction regarding the source of conflict. This might involve negotiation and compromise, but does not compromise a person's core values, integrity or autonomy.

diverting (Comaroff 1977) and their shared commitment to avoiding conflict (Belenky et al 1986, Kirkham 1999):

‘during my conversation with [midwifery manager] she persuaded me to talk to [midwife] before I made a final decision [about not wanting her to be involved]. And I said that that was okay but then she didn't arrive, so she wasn't available for talking’

A plethora of popular western literature suggests that cultural attitudes favour conflict resolution. This literature however suggests, not only that commitment and skills are prerequisites, but that resolution occurs between individuals. When conflicts were to do with ideology, some women felt that the sheer effort of trying to resolve this with a team of midwives who shared the same policies, but demonstrated individual variations was overwhelming, if not impossible:

‘even if you manage to ... reach an understanding with one of them, you know, you don't know if they're going to be there and it's quite exhausting in fact to have to make that effort 6 times over, you know, over the course of several months’

‘like I said to you before, all that time you spend with them and yet what do you do? You chat about the same things with each of them that comes you never really scratch the surface [...] I think it would have been better if you'd known who you were going to get and I know that's really difficult, but at least you could have said, right, well, that's who I'm going to get. Let me try and knock her (laughing) into some sort of shape (laughs) before the event. Whereas you can't try and knock 6 of them into shape by meeting them all once each or something’

And for some women there was a precarious balance between compliance and the risk of raising issues that could cause conflict, especially if they felt relatively powerless. As I suggested earlier, there was a tendency to withdraw rather than assert themselves:

‘I think what happens is that the ones I feel understand, I don't need to talk (laughing) to them because I feel confident, so there isn't actually anything to discuss. Their whole manner gives me confidence that it'll be alright. And the ones I don't feel confident with, I don't want to talk about it with anyway, cos I end up feeling upset’

The logistics of lack of time and continuity, combined with no apparent skills or structural mechanisms to assist or provide a safety net when conflict occurred, made it debatable whether or not addressing it was a desirable or achievable goal:

‘I don't know what you call the lady, the leader of the midwives, the supervisor of midwives and and she said she was there as a go between, between the midwives and, I can't remember what word she used, patient, client whatever. But she said that she was there to see that both sides got what they wanted, or were happy about what happened or whatever And I'm not sure that that was I didn't, well I certainly especially with all the negotiations and actually being ignored when I said I didn't want a consultant, and being ignored when I said I didn't want a particular midwife and so on ... That wasn't in my favour at all’

And while there appeared to be little in the way of support for conflict resolution, there was an expectation that women and midwives should resolve their differences, and little acceptance of genuine differences. The disregard for women and midwives having some autonomy over their relationships combined with a value judgment about conflict resolution and the need to maintain rota systems within limited resources pressurised both:

'one of the midwives [...] we really didn't get on with. I think I told you about her So everyone knew that we didn't get on with her and then this woman [senior midwife] phoned up and said, you know ... can I send her round to you, and you should all have a chat and try and get on sort of thing. No, she didn't put it like that, but she was saying look, part of her job is to make you feel at ease and everything and if she's failed to do that ... I think she needs to sort that out with you sort of thing. And I was pretty against it really. I thought, look, we just don't get on. It's not cos she's a bad midwife it's just cos we don't get on .. and I said that. But she sort of persuaded me that the adult thing to do was to meet her, so she came round and it actually was quite good [...]. But it was quite an odd situation cos it was like us reassuring her almost and we did sort of feel at the end of it that we'd talked through a lot of the problem [...] But at the same time I'm glad she wasn't on and we didn't have to deal with her [during labour]'

Playing safe?

In looking more closely at the emotional context in which women related to midwives, their unwillingness to assert themselves looked rather more complex. For example, as I have discussed, obstetric morality claims that "good" mothers are compliant and that compliancy ensures a healthy baby; the medico/legal alliance enforces this; the structure of professions fosters professional alliances; the potentially punitive attitudes towards challenging women have been documented; there is an (enforced) dependency on fragile relationships with midwives. Thus women's reluctance to cause conflict seem more of a pragmatic, self protective decision not to alienate midwives or draw punitive measures. They situated themselves as safely as possible in a blame/guilt culture, capable of ensuring compliance through enforced treatment. For many women avoiding conflict was a high priority. But the notion of caring and suffering the consequences (Belenky et al 1986, Gilligan 1985, Ruddick 1989), rather than asserting themselves and risking offending others seemed wanting at the very least. Deborah Debold and colleagues (1996) reinterpretation of relationality suggested that women internalise splits that enable them to hold conflicting internal positions in relation to cultures that deny their knowledges and experiences.

Revisiting relationality again

Listening to women questioning theory

The work that has been done on ethics of care and relationality by feminists such as Mary Belenky and colleagues (1986), Carol Gilligan (1985), Nel Noddings (1984) and Sara Ruddick (1989), and the criticisms by Nancy Goldberg and colleagues (1996), Linda Nicholson (1999) and Ann Oakley (2000) is undoubtedly crucial. But as the critics suggest, we need to avoid falling into the dualistic trap of believing caring to be either worthy of celebration, or a symptom of patriarchal power relations.

Women clearly articulated how relationship increased or decreased the potential for knowledge development, self-development and autonomy. For example, there seemed to be no doubt that the midwife/teacher analogy (Belenky et al 1986: 217, Stanton 1996) was an apt one and that women developed both their knowledge and identity in relation to others⁶⁴. But it seemed oppressive when women felt that they were unable to express themselves either verbally or behaviorally in order to follow their ideals when these were labeled "selfish"; or when their definition of relationship and nurturing towards their babies was compromised. In other words, relationality's potential was

⁶⁴As is evident from the quotations, the small number of women who knew and trusted their midwives told stories of a different quality. The knowledge, self discovery and reintegration that arose from deeper relationships was assured rather than tentative.

tempered by the women's awareness of its coerciveness⁶⁵. In providing examples of both its possibilities and closures, they challenged theoretical assumptions on both sides

As Nicholson (1999) suggested we need to maintain an openness that continues to create spaces for women not to be defined through theory. While it may be oppressive for women to **have** to behave relationally, society's structures need to incorporate women's ways of thinking and being, so that networks of relationships and dialogue may emerge⁶⁶ in maternity services and elsewhere.

Possibilities of relationships

From the women's accounts it seemed that relationships could potentially undermine the divisiveness and coerciveness of dominant medical ideology (where midwives are socialised into coercing women to accept the gap between potential experience and medical reality that they have internalised). While individual contributions to change from women, or midwives can be powerful, Code (2000) suggests that 'the force of the paradigms that govern medical knowledge is such that *individual* dissenting voices, whether of patients or physicians, have scant hope of claiming a hearing' (192). Transformatory power lies more certainly in the connection between the two groups of women. Reappropriating ways of relating, women and midwives (and researchers⁶⁷) can create knowledge and enable both to put their ideals into practice. Perhaps this is why continuity is threatening. It is in their dialogue that the kernels of transformatory knowledge, intuition and experience are located. It is their voices that cross the personal/political divide (Griffiths 1995) by revealing 'exactly what is "not supposed to exist" (Harding 1996: 446). As long as women and midwives are kept apart; as long as women internalise and mute the potential/reality gap; and as long as midwives internalise the current medical/midwifery boundary, the status quo, which disadvantages both groups of women remains intact.

At the praxis of connection and separation lies the balancing of closeness and distance I referred to on page 235, where the midwife has enough faith and trust in women to: share and dialogue from a more careful position; maintain enough distance for her to create her own knowledge and autonomy; and engage with her when she flounders. In other words, maintain a trusting respect as the quotation below suggests:

'I think women have a **tremendous** knowledge. I certainly find that it's just all there somehow. Yes, I knew that my baby was safe, I felt that she wasn't in danger when she was being born. Same with [son] same with [daughter] that they were perfectly safe and nothing would happen to them

N Do you feel there's a space for that sort of knowledge?

No, I feel that I had to make my own space for it, and I had to force that space in some ways I mean, part of me says that there shouldn't be a law that says that you must have a midwife with you and if there's anyone

⁶⁵Looking at these issues more broadly, there are important links with peace and violence debates, and debates which suggest that connectedness is the basis for community and self-development (Ruddick 1989, Starhawk 1990). But relationality can be oppressive if it becomes an expectation of women and not men, or if it demands self-sacrifice of women and defines those who step out of this mould as selfish. In relation to childbearing, we need to examine where connectedness oppresses and benefits women and oppresses and benefits families. For example, it is ironic to focus on women as nurturers, but provide the impersonal, institutionalised services women described. Additionally, in making a theory of caring gender specific we preclude men from being in nurturing relationships with children and yet many of the women in the study saw planning a home birth as a way of involving their partners more closely with their babies. In the setting of a nuclear family when women are expected to perform as workers and mothers, bonding between fathers and babies is perhaps all the more important.

⁶⁶Ironically this is being developed through computer technology, itself a site of male dominance.

⁶⁷My experience was similar to that described by Mary Belenky and colleagues (1986). As I engaged with, listened to and endeavoured to understand women, my knowledge, beliefs and identity were transformed.

else with you, they're subject to prosecution, because that means that by having women with knowledge or lay midwives or whatever, with a woman that puts that person in danger of prosecution, and I think that's **outrageous** Women know what they need and I find it ridiculous that the law puts itself in the way of that. They seem to have some kind of belief in the medical system, that it is appropriate. Birth is a natural normal everyday process and it doesn't need to be made right by the medical system There was nothing in **any** of my births that would have required me to be in hospital and and it feels like an invasion that What am I trying to say They were all there waiting for it to go wrong, and it wasn't going to go wrong ... and they saw it as their place to do that whereas that's my responsibility. It's my place to do that and I know when it's necessary Women love their babies . You know, we would never put our babies in danger. Well, you know I would never put my baby in danger and I don't know anyone who would ... The medical field is there when one needs it and one knows oneself when one needs it. [...] I think what women need is not to be patronised and ignored. I think we need information, unbiased information, not about how to do it, but about the possibilities. What movements make some labours easier, what things women find make labour progress better what to do when your baby's in a breech position, what to do when different things occur during a normal pregnancy and birth. Knowledge is what we need, you know, it's in women's hands, that's where it should be. That feels right because because we can work out for ourselves. We're not stupid, you know. I felt I was treated as if I was stupid in some way or not able to have a baby and you know, of course we're the ones who do it You know, it seems that we've come a long way, but not half far enough not half far enough In some ways it's in the dark ages because we're not trusted. We're not trusted to have our babies [...]. I think there is an enormous place for for women's knowledge, you know. I think the barriers have to be pushed in order to make that space'

It may even be possible to imagine scenarios in which subjectivity or the (becoming) self is perpetually constructed and reconstructed; where women's needs are less defined and able to arise in dialogue with midwives, and where midwives' practice may be defined other than through policies; where the "cultural gulf" between women's knowledge and that of dominant medical ideology is brought into relationship. In other words, forming relationships could be one way of shifting the focus from the 'immortality strategy' (managing risk to ensure a live woman and baby), to relationships to ensure the greatest likelihood of a safe transition through pregnancy, birth and the period after birth.

Can relationships transform?

Finally, to place this chapter in the wider theoretical and literary meanings of motherhood, feminisms have tended to take up what might initially appear to be diametrically opposite positions (Alice Adams (1994) provides a comprehensive discussion on this issue). Some, for example, have focused on equality through appropriation of reproductive technology, which would separate women from biological reproduction. Others have continued to search for utopian ideals, which incorporate birthing and motherhood as worthy. Adams suggests that both define themselves in relation to patriarchy and therefore remain within its grasps. There is thus pessimism about finding ways out of the motherhood/oppression pairing, as all potential exits have been, a priori constructed through patriarchy and thus inevitably, double back. The separation/connection duality remains intact.

To accept this would be to mute the women in my study. Through their words, I understood that birth could indeed create a space at the praxis of separation/connection. It symbolised a separation

that maintained connection. Women saw home birth as a way of decreasing the trauma of birth: making separation bearable and reconnection possible. Additionally, many of these women described their empowerment through birth and described personal change and growth which had increased their abilities to redefine themselves as more powerful agents of their own and their children's lives, as well as their strength to resist other aspects of dominant ideologies. As the women told me in many different ways, confidence and optimism is as contagious as fear and pessimism, and midwives were implicated in both.

This chapter has focused on the coerciveness of medicalisation through the particularities of individual relationships between women and midwives and the location of those relationships in debilitating structures of power. The following chapter looks at this coerciveness in more general terms. It considers the irony of an ethics that creates an adversarial milieu or battleground⁶⁸ in which women's attempts to move through pregnancy and birth, and midwives' attempts to journey with them are systematically hampered. In doing this, I hope to bring to light some of the other consequences of a medicalised belief system on these women's sense of integrity and identity.

⁶⁸Jan Webb first used the term battleground in response to my initial analyses of the material I had collected. I was shocked by the term at the time, and yet came to realise that this accurately described what many of the women articulated as they attempted to negotiate their needs within a system designed not to provide them, but to provide a set of predetermined beliefs and practices that some found invasive and inappropriate. The term was in fact used by one of the women in the quotation on page 300.

CHAPTER TEN - Ethics: Re-integrating ontology

Introduction

This chapter is about omissions, resistances and possibilities. In pursuing the ‘immortality strategy’ (Murphy-Lawless 1998a: 47), decades of obstetric discourse and research has focused on risk and death, to the extent that women’s qualitative experiences of birth have all but been forgotten about in the dominant rhetoric of birth.

The catalyst for this chapter was first and foremost what I initially heard as a muted subtext in the women’s interviews about the hegemonous medicalisation and technocratisation of childbearing¹. The women’s accounts spoke of unease about previous experiences and fears about potential future experiences of being coerced, manipulated or forced into agreeing to practices, or following advice that they believed to be inappropriate and/or harmful to them, their babies and families. Some women were afraid that a medicalised approach may extend into their homes and that they may thus lose “control” of what might happen to them and suffer the consequences, or that they may be transferred to hospital². Other women were afraid that ‘expert’ knowledge and the needs of the system might take precedence over their own knowledge and needs, thus appropriating their experiences and compromising their integrities. Yet others talked about having experienced, or fearing physical and emotional violation. In short, that they would be dominated by the rhetoric and practices of obstetrics, despite efforts to protect themselves, and despite their beliefs that medical ideology may not provide an ideology appropriate to their beliefs and needs.

And yet the women’s speech, facial expressions, bodily movements and depth of feeling portrayed through: animated conversations, silences, voices which could rise to a shout or drop to a whisper, laughter, sparkling eyes which could fill with tears, shudders, and long heartfelt or hardly audible sighs, spoke eloquently of agency and oppression and their ability to break through the hegemonic, symbolic order³. This is the pressing stuff of theory. It compelled me to attempt to theorise a balance of oppression and resistance at a deeper level than I might otherwise have done. This led to further theoretical debates about ontology, how subjectivity is constructed, how ethics is defined, how health care ethics in particular has come about, and the implications of these debates for childbearing women.

Because the catalyst for the chapter was women’s accounts of their encounters with medical ideology, I have started by providing an example of this from my interviews. In the accounts, the hegemony and coerciveness of a medical ideology and the effort to resist its practices were most visible in a hospital context where few of the mitigating aspects of home birth come into play. The woman and her body could become a manoeuvrable impediment to the emerging baby, to be restrained, controlled, manipulated and invaded according to normative practices in time and space.

¹The endemic and hidden violence inherent in obstetric practice was often not easy to hear because of women’s tendency to understate it by deflecting pain through laughter or moving swiftly past violating experiences. Though, for some women violating experiences were catalysts for thinking about home birth. These women spontaneously spoke about their experiences as violating, dehumanising or abusive, and often referred to these early in the first interview and in subsequent interviews, as they developed their own ideals against which to measure what had happened to them.

²The women’s fears of being transferred to hospital and the ubiquity of this fear no matter where I located the analytical starting point is suggestive of it being of metaphorical importance. As I noted in the previous chapters, fear of transfer to hospital was symbolic of the fear of medical ideology and the lack of trust that was often generated between women and NHS community midwives.

³As was clear in previous chapters, many women are socialised or coerced into accepting the dominant birth ideologies and practices of their culture. Not only did it require effort to resist these norms, but for many of the women in my study it generated emotional and physical pain (I discussed some of the costs in Chapter 8 and again in this chapter on page 323). Not only effort, but courage and faith were needed by many of the women in their search for autonomy and agency. This courage was matched by those midwives who trusted women and supported their beliefs and ideals, by moving outside the NHS system into independent practice, or by resisting the pervasive norms of medicalisation from within the NHS.

Her (tentative) resistance could be overpowered by the assumed certainty of dominant ideology (Belenky et al 1986, Fleming 1996, Smythe 1998). Thus institutional norms took precedence over the woman, the process of her labour and her baby in similar ways to those described by Robbie Davis Floyd (1992) and Brigitte Jordan (1997). These normative practices underpinned by current health care ethics allow the excerpt from one of my transcripts below, to remain an inevitability. It required a great deal of effort and resistance on the part of women to attempt to define their own meanings of birth and protect themselves and their babies from invasive practices⁴. The somewhat lengthy account best demonstrated the ways in which the playing out of medical ideology could and did override women's knowledge and resistance, and perpetuate behavior from professionals which in other circumstances would have been deemed intolerable. It raises many of the issues I have subsequently discussed in the rest of this chapter. The quotation begins with the woman in a general area of a maternity unit:

'I remember being against the wall and going oh no, cos I felt, push, (laughing) you know, I could feel it [baby] coming down inside me and she [midwife] was going oh, hang on, hang on, [...]. And she got a damn wheelchair, and she goes, sit on that. And I went, you must be joking. She said, no, sit down I remember sort of trying to get on this wheelchair, cos I could feel it between my legs, this big lump, if I sat down. So I was trying to hold myself up, on the arms of the wheelchair, and not push my (laughing) bum down and she **whisked** me off. I remember that. Ahh, I was whizzing about, and she's got me in this lift, and .. it was awful, because I remember, I was caught in the panic of her running, and I was going, oh my God, oh my God, you know, like, hang on, I'm going to fall off the chair. And we got in the lift and upstairs and it was just like, mad running about and ... [...] get the dress (laughing) off, get a gown on .. get on the bed (laughs), in comes somebody to examine me. And I'm going to her, there's no need to put your hands in me. I remember telling her, like, you know, you don't have to. Oh but I will, you know, but and right enough, she didn't get in very far. She went, oh yes, so there is, oh yes. Well I told you that didn't I, you know, believe you me, I can feel it (both laugh) and then at this point she said, she was going to put a drip in my arm, and I'm like the head is here. I am frantically, trying to get on all fours and they told me to get back because I was putting the baby in distress ... so I turned round again, and I was sort of sitting up, and she was going on about, she had to put the drip in my arm because I had signed the consent to say that I would allow them to put a line [...]. It was like something out of a carry on film. There I am trying to get away from her, you know, because I was trying to concentrate on this [having a baby], you know, and she's trying to get me to keep my arm still ... and she was (laughing) struggling with my arm. And eventually, you know ... she seems to have given up or finished, and you know, I wasn't really concerned [...] By this time I was more concerned about the midwife who was pushing the ... the skin, the stretching vaginal skin around the head of the baby, and it was **stinging** like hell, and I was saying to her **get off me** (laughs) **leave me alone**, and she was going like, oh no, no, no. You know, she has to do this, or something and I was going, just leave me alone, just leave me alone, and screaming and shouting andand it was all over before I knew it. She's going, look, and [partner's] going to me, it's there, it's there, it's head's there, you know, and I looked down, and he [baby] was looking up at me, you know ... all scrunched up .. And that was the other thing I didn't like, was like, she promptly then pulled the body out, and it stung like, you know. I remember, I was like, phew, I was in this relaxed, huh, you know, there he is, oh God, thank God. I felt safe and he's here, you know, cos his head's there, and I could see all this bit of him was out, you know, that .. phew that was it, you know, like the vital bits were there, he was breathing and crying, he was like looking at me, you know, and she pulled him out like this, and I was

⁴I used the term 'invasive' deliberately here. The practices described by some women were not only experienced by them as invasive, as the accounts demonstrate, but many involved manipulating, or entering women's bodies or bodily space against their express wishes.

saying, watch my clitoris, watch my clitoris (laughs), don't hurt it, I need that, you know, and .. I wish she'd waited. I remember thinking, I wish she'd waited, you know, for me, or, just for him to come with the next slither, you know. But this anxiety to get it out. And I remember thinking, don't give me that injection [syntometrine], you know, I'm not having that injection, and I wanted them to leave the cord, but I hadn't said it to them, and before I knew it, I was clamped and Well, the next thing I noticed, cos we were looking at the baby, somebody was in between my legs, and I looked up, and she's got a hold of the cord. And I said, let go of my cord (laughs). I said, **let go of my cord**, and she went, oh, I'm just helping, you know, I'm just seeing if it's loosened or something, you know. And I was going, don't pull the cord, (laughing) and she was going okay, okay, don't panic, you know, and and of course at this point we got really emotional [...] and they were all faffing around there. I remember thinking, just faff off, (laughing) you know, go away, and let me get on with this, you know. [...]. And then they've said could I get on all fours. Could I get up, kneel up because you know, some 15 minutes have gone by, and the placenta wasn't coming. And I said, oh, I've got ages yet, you know, just leave me. She said, oh no, you have to get up, there's only 20 minutes, and I'm saying oh, no, no, no, you're not going to touch that until at least an hour has gone past, you know So, I knelt [...]. So, yeh, the placenta came fine, and it was it was all okay ... and ... that was it. Well, we thought that was it, but ... I wasn't giving them (laughing) the baby back, ... cos he was quite happy. He was looking around and ... and I mean, I don't want you to go and bath him or anything, just leave him, you know Oh, they had to weigh him. They wanted to weigh him, and they wanted to do a glucose check. [...]. That was after they weighed him, because up until that point, I would say that everyone thought he was a perfect little baby. Yes he looked small, but I'm sure in comparison to me, lying on me, he didn't look that small, and it was like, they put him on the scales and attitudes changed. It was like, they wanted to whisk him away. They wanted the paediatricians. They wanted blood, and I was going like, no, no, no, hang on, hang on, you know. But it's, get the paediatrician and she's checked him over and ... he's fine, he's breathing he's mature, you know, he's full term, he's okay, he's just small, but he's been breathing, and he's looking about like this, you know. I'm going like, he's not in a bloody trance, he's not in a hypoglycaemic state, you know, you can tell. Look, you know, he's not ... Anyway, we're having this big, big row by now (laughs), cos I'm saying, well, I'm going home and I'll feed the baby, you know .. I'll stay awake all night, I don't care [...] My GP was going to come. He said he would come, cos I'd said to him that I wanted to discharge myself immediately and ... he said he would come to the house, to look at the baby for me .. so I couldn't see the problem myself. It was now, you know, he was born at ten to nine, and by now it was about eleven o'clock, and we're arguing and arguing, and arguing and nothing's happening, and I'm not feeding the baby, cos I'm going like, I can't feed the baby while you're rowing (laughing) with me, you know. I'm like, just go away please, you know, I have bottles, I have formula, I have a breast pump, I have boobs, I have milk. I'll spoon feed him, I will drip it in his mouth if necessary. I will get food into the baby, you know, don't worry, I'm not going to walk off and put him to sleep and leave him am I. You know like.. and so we left [the hospital]'

Through the struggles and achievements described by the women in my study, I continued to look at the oppressive consequences of the medicalisation of birth on women, the level of autonomy they perceived themselves to have, and their elaborations of how things might be different. Whereas their experiences were attenuated by midwives in the previous chapter, in this chapter the starkness of the ideological and ethical divergences between obstetrics' and women's concerns was more apparent.

Mapping out the territory

I attempt to address some of the material and ethical issues raised in the women's accounts by dividing this chapter into a number of sections. In Part 1, I provide a theoretical interlude, in which I collect up and elaborate on theoretical issues relating to the two main themes of the thesis; those of separation and connection, and domination and resistance. It became clearer that the apparently disparate strands contained within the patchwork of my review in Chapters 4 and 5 could be gathered together and taken further to create a more integrated weave, under the broad umbrella of ontology, and the main theme within this is ethics. I concluded that ontological questions were fundamental to theorising women's experiences of birth and that without looking at the central question of being, my theorising was unlikely to be liberatory. In other words, I needed to look at how both the foreground and background were constructed and woven together, in order to examine some of the seams.

In Part 2 of this chapter, I continue to unpack the rationalist, mechanistic project of modernity and dominant medical ideology in relation to childbearing by continuing to examine its terminologies. In the previous chapters, this resulted in identifying different readings of safety and relationships, where trust turned out to be a key feature. But as I explained, mutual trust between midwives and women was not a concern of medical ideology. In this section I attempt to unpack the concept of choice, and the embedded assumptions about rationalist subjectivity and hence equality and rights in dominant political theory and ethics debates. I similarly examine the concepts of control and power, to show that choice, control and power have become central to the rhetoric of medicine, in response to criticisms of paternalism. But as they stand, they cannot enable women's autonomy. In Tamsin Wilton's (1999) terms, they remain debates talking 'past each other' (49). By redefining some of the terms used, I attempt to breathe life into concepts that have been rendered almost lifeless through overuse and misuse.

In the third part of the chapter, I examine the issue of bodies further, to see how best to embody the subject in ways that liberate rather than oppress women. I attempt to embody my discussions in keeping with postmodern/feminist ideologies and with the women's accounts. Thus a central part of this chapter concerns: the bodies of pregnant and birthing women; the attempts to subjugate them through the constraints of medical ideology; and where women located their own embodied autonomy, agency and power, through an integration of freedom of thought and behaviour. This shed an entirely different light on the meaning of empowerment and how it might be facilitated or inhibited.

In Part 4, I look at the costs to women of challenging dominant ideologies and practices embedded in cultural norms, and the potential distancing between women, and the muting of individual experiences. Finally, I consider the possibilities of a more sensitive ethics, increasing resistance and accepting multiplicity.

In essence, in the light of the women's accounts, I discuss why health care ethics/obstetric ethics is essentially oppressive and why it cannot include the multiplicity of women and their material concerns. The discussion includes critiques of modernist's beliefs about the autonomous subject, which shape ethics and give rise to the focus on choice, rights and control for example. Much of this centres on the body as an exemplary or symbol of modernity's inability to free itself of 'exteriority' (Colebrook 1997) and the need to reconstruct its emptied out subject to include the material, sexed body as an integral aspect rather than an impediment to autonomy and ethics.

Before discussing the above in terms of the women's accounts, I provide a theoretical interlude. Feminist sociologists, Liz Stanley and Sue Wise (2000) have, rightly in my opinion, not wavered from their earlier contentions (1990, 1993) that theory and practice must remain inseparable and

engaged. They are critical of theoretical debates which take on lives of their own, and those theorists who promote this. In their characteristically forthright way, they suggest that if we want to avoid contributing to a reductionist, hierarchical, exclusionary, unifying, stultifying and “progressive” mainstreaming in the supposedly liberatory project of feminism, that practice **must** inform theory⁵. Indeed, my own understandings of theoretical debates only came to life in the light of the women’s accounts about their experiences. Thus taking their advice to heart, I allowed the women’s accounts to inform me about the shortcomings in my understanding and where I needed to carry out further theoretical explorations, as well as where theoretical debates proved to be enlightening and fitting. In doing this it became clear that my literature review had remained rather a patchwork in need of synthesis. The following theoretical interlude exemplifies the sort of dynamic movement that occurred between theory and women’s experience that I engaged in, to avoid fitting their experiences into the theoretical framework I had developed⁶. But at the same time, acknowledges the limitation of experience, as I discussed in the review on page 83. On this view, although childbirth has been sidelined in feminist literature, the woman’s ability during pregnancy to be two in one, becoming two at birth, and the concerns this generates offers a potential site for rethinking subjectivity, ethics and multiplicity.

Part 1 Theoretical interlude

Collecting up threads/following the yarn

As I suggested, the issues I addressed could be collected under a broad ontological heading. I began by following up the ontological issues that were more implicitly, than explicitly raised in the previous chapters. The ontological challenges I made were most evident in the literature review in relation to different readings of epistemology, subjectivity and embodiment. They were most evident in the Chapter 8 in women’s definitions of safety in relational, rather than absolute terms, and most evident in the Chapter 9 through the women’s annunciations of an ethics of care.

The four main areas I concluded needed further explanation were separatist ideology, the theories embedded in an ethics of care, political theory of the individual and its relationship to others, and the nature of embodiment. The main reasons for this were firstly, I wanted to provide a more theorised account of separation and connection. Secondly, I felt that my judicious use of an ethics of care and similar relational theories remained unresolved from both my point of view and the women’s. Ethics of care and similar theories are largely embedded in the psychological and psychoanalytical feminist traditions which I had supposedly rejected, in favour of providing a sociological account. But I had at the same time drawn on ethics of care as a way of explaining women’s ways of relating to midwives and others in both my review, and my analysis. These theories did not appear to me to be entirely satisfactory as a way of theorising women’s ways of being and relating. As I suggested in the previous chapter, they appeared to contain within them an oppressive turn, which prevented many women from asserting autonomy and agency and ensured a degree of compromise and compliance. Thirdly, in response to women’s discussions about some

⁵Their description of theory ‘stars’ (Stanley and Wise 2000: 267) and what they see as the suppressive tendency in feminists theoretical debates is reminiscent of George Orwell’s *Animal farm* (1946) and the progressively “progressive” moves towards a different but equally oppressive framework that had initially been the basis of the animal’s revolution. While I believe their criticisms of feminist theorists and those who interpret or debate this work (‘interpreters’) is overly harsh, I take their point, that if theory loses sight of practice, it can indeed take on a life of its own which does not necessarily reflect women’s concerns. They also point out that if theoretical discussions are unintelligible to most of us, they are of little value. I agree, but also sympathise with those engaged in complex but important theoretical debates which can be difficult to explain.

⁶This movement characterised much of my analysis, and as I remarked, I had misgivings about the format of a thesis in which review and analysis are essentially divided across time and space. However, as I also previously suggested, in the interests of clarity and time, I have in the main followed the usual format. I include the above as an example of how I moved between my review and women’s accounts, which often necessitated further reading/thought.

choices being unavailable in practice, and rights not necessarily enabling them to assert their needs, I needed a feminist perspective on political theory (particularly liberal readings of autonomy) based on difference rather than equality. And fourthly, because bodies were so deeply implicated in all the women's accounts, I needed a more nuanced theorising of embodiment, as part of my understanding of subjectivity and ethics: theorising that could not only take the body into account, but could theorise "becomingness" in relation to the body, the person, others, and the world.

So while debates about psychoanalytical feminism and its critiques, ethics, linguistics and agency in philosophy, sociology and psychology for example may have seemed far removed from childbirth in the literature review, it became crucial here, in the light of women's accounts. The ongoing, parallel debates in different disciplines, suggested that there might be merit in considering them together rather than in isolation. The fissures and overlaps between them provided spaces for imagining possibilities. And far from being theoretical indulgencies, these debates formed the often unspoken weft against which stories that shape our understandings of our world are woven: stories that form a powerful currency through which beliefs and practices circulate (Code 1998).

The linkages between postmodernist and feminist critiques of these apparently disparate fields of theorising the subject proved to be particularly enlightening. In bringing some of the theoretical threads of my review together and identifying the gaps, in a sense, this is a postscript to Chapters 4 and 5.

Domination/resistance: The potential/reality gap

In the previous chapters on planning home births, safety, and relationships between women and midwives, I explored some of the ways in which dominant discourses shaped women's decisions, views and experiences of child bearing and motherhood, and how they attempted to resist these, and define and remain close to their own meanings of safety and birth.

In continuing to elaborate the main themes of domination/resistance, and separation/connection, I attempt, to theorise these by moving closer to women's accounts and further away from dualistic thinking than I had in the previous chapter; and to unpack some of the ontological assumptions in medical ideology and terminology in the light of separatist or unitarist underpinnings, using women's views and those of theorists who have debated these issues.

In seeing the connections and parallel discourses between apparently unrelated fields, the consistently oppressive tendencies in different locations became more apparent. This in turn enabled me to understand just how resistant dominant beliefs, structures and practices are⁷. In short, I want to explore the discourses through which women are oppressed⁸, and where sites of

⁷The discourses that impact on this chapter are more complex, interdisciplinary and wide ranging than I could expect to understand or include here. I hope that in bringing some of these into the foreground and acknowledging the existence of others, I might succeed in at least opening up possibilities for further thought and research, and that I may bring to light some of the deeper structures affecting women's experiences and how carers care for them - thus giving some insight into the enormity and complexity of the task of theorising women's oppression and resistance and developing alternative practices.

⁸As Sandra Lee Bartky (1997) suggested, we need to know the basis of our suppression in all its different forms in order to have any hope of figuring ways out. An awareness of some of the underlying principles on which beliefs are based provides greater understanding about our own beliefs and practices - as women, researchers, midwives or others. Recalling Drucilla Cornell's (1995) words on page 84, it cannot tell us just how far we have internalised the norms of our times, but it can give us insight into how these might direct our thoughts and actions in relation to our selves and others - thus creating space for positive change and an ethics based on difference as well as similarities. In Starhawk's (1990) words, 'to change direction, or better still, to dismantle the machine [of domination] altogether, we must recognise that the system does not just act upon us - it shapes us and acts within us. Patriarchy has created us in its image. Once we see that image, however, it no longer possesses us unaware. We can reshape, create something new' (67). In other words, we need to understand how institutionalisation and medicalisation function as normalising practices.

resistance/transformation did, or could lie, without falling into the trap discussed by Nancy Fraser (1992: 191), of over or underemphasising women's victimisation or resistance or the one identified by Denise Riley (in Fraser 1992: 190), of over or under feminising women⁹.

In bringing together theoretical debates that have often remained separate, I intend to show that they are inextricably linked through dualistic thinking and that dominant ideology invades the structure of society in ways that create a formidable barrier to liberatory moves. Thus a sustained critical analysis is needed to provide some understanding about the networks of power across discourses, which maintain a changing but nevertheless patriarchal order.¹⁰

In doing this I hope to add to the compelling discussions about why we need to look critically at health care ethics and locate it in feminist, postmodern discourses to have any hope of theorising a feminist politics on childbearing. If we can continue to dislodge the oppressive definitions of femininity described by feminist social theorists influenced by phenomenology and postmodernism such as Sandra Lee Bartky (1992), Susan Bordo (1992) and Iris Marion Young (1990a, 1990b), we might begin to free embodied, childbearing subjects from some of the internalised restrictions that they described.¹¹ We might thus elaborate childbearing as a potential site for the disruption of oppressive practices and continue to initiate transformatory ones.

Meanings of autonomy: Struggling to resist

As I explored women's accounts from the perspective of resistance and took into account theories on power relations, I realised the need to understand more about the construction of the subject and how autonomy is defined and exerted by women. The three levels of power relations developed by Steven Lukes (1974), where: resistant thought can arise, but cannot easily be acted on; neither resistant thought nor action can arise; and in most oppressive networks of power the desires of those oppressed are shaped to the will of the oppressor, provided a useful starting point¹². Examples of these arose in childbirth and midwifery literature (see for example Levy 1998, 1999a) and elsewhere

⁹ Any critical analysis of this kind is both expansive and limited. It is expansive in that it includes the voices of many theorists and those of women who have most directly experienced the affects of domination. It is limited by my limitations and interpretations. It is theoretically limited by its own aspirations to instability and "becomingness". The view from everywhere is no less mythical or limited than the view from nowhere. Thus a realistic appraisal suggests that at best, this account may provide another story from which to imagine others. As a construction forged through engagement, it re-emphasises the importance of dialogue. Dialogue shows us how we internalise and resist repressive ideology in diverse ways and can thus collectively be more effective. In this sense, Irigaray is right about women, that (without positing a separatist ideal), we need to be among ourselves (Irigaray 1997: 256).

¹⁰ Talking in general terms about disciplinary practices (power), Bartky (1997) expanded on Foucault's claim that power is institutionally bound, to suggest that it can equally well be 'unbound', everywhere and nowhere, exerted by 'everyone and yet no one in particular' (142-143). Coupled with her observation on internalization - that is, when normative practices are incorporated into the structure of the self and become an integral part of a person's stable identity (145), the complexities of power increase many fold and suggest that those exerting power are as equally disciplined as those subjected to it. A balance between personal and collective responsibility is needed as neither women nor midwives may be aware of the particular constraints upon them. For example, practitioners often seemed to be unaware of the emotional and physical breaches of women's integrity that they exerted. One of the women in the study reported that when a midwife caused her pain by using her usual procedure of holding the baby's head as she birthed it, she shouted at her to stop, but the midwife continued. The woman commented: 'Well, I mean, you know, it's understandable from her point of view, cos she just doesn't know any better (laughs)'.

¹¹ I am aware of the dangers of over simplifying these issues and recognise the dangers of positing a natural body outwith the social order in some kind of essentialist location. I am also aware of the criticisms of French feminists (and some Anglo American feminists), by Anglo American feminists for their apparent valorisation of maternity as the only site of transformatory politics, subjectivity and ethics (see Meyers 1992 for example). I have discussed this further in footnote 13, and maternal ethics of care on page 266.

¹² The terms silencing, muting and erasing, which I had used interchangeably on occasion became clearer here. I attributed silencing to the suppression of autonomous thought and action; muting to mean that autonomous thought could arise but not easily be acted upon; and erasure to refer to dominant ideology's inability to see beyond its narrow limitations, thus erasing all that lies beyond its ken.

(Belenky et al 1996, Debold et al 1996). Michel Foucault's (1980) analysis of power provided a more fluid account of power relations, but how domination might be resisted by subjects remains unclear.

The searching questions posed by those who have examined the structure of language (for example, Jacques Lacan, Jacques Derrida, Julia Kristeva and Luce Irigaray), is whether or not resistant thought is possible and how far autonomous thought and action can exist. However, where to locate autonomy is problematic as I described in the review on experience, language and women's knowledge as well as in the analysis, where women struggled to assert themselves. As Claire Colebrook (1997) observed, wherever we locate ourselves in terms of modernity or postmodernity, we cannot talk of autonomy without acknowledging its inherent problems.

In theorising power and autonomy, I attempt to reconstruct the subject, (on the following page). The possibility of producing a textured account, which could acknowledge the unavoidable internalisation of the patriarchal symbolic order as well as potential ways out, then becomes imaginable¹³. More subtle accounts of agency suggest that while the culture is not 'wholly and seamlessly phallogocentric' (Fraser 1992: 17)¹⁴, it remains remarkably resistant to attempted breaches, as can be seen throughout this thesis.

Moving from separatism and connection to multiplicity

In the previous chapters, I identified and examined an underlying principle of separatism or unitarism or in Carol Gilligan's (Hamer 2000) words, 'disassociation', which lies at the heart of dominant, modernist ideology and practices across a wide spectrum of disciplines. I look at the impact of this on; different definitions of birth in different knowledge systems; the subsequent organisation and structure of maternity services; and relationships between women and midwives. I then describe women's alternative accounts in terms of connections.

The underlying separatist principle in dominant ideology and practice, and women's focus on connections still characterises my discussions. However, I focus on how separatism is infused into rationalist subjectivity, defining autonomy and agency and hence ethics, in certain ways. I consider some of the consequences of the bounded, disembodied (male) individual set in the narrow ethical code of Western modernity, on women's experiences and knowledges, and at their attempts to define their own experiences of pregnancy and birth. The essence of this discussion is my focus on women's multiple concerns (the qualitative experience of giving birth to a new family member who needs to be cared for) in relation to the unitary concern of obstetrics (the birth of a live baby).

¹³I discuss below that I felt my analysis would be incomplete without gaining more understanding about French feminisms and feminist psychology, its rootedness in linguistics and psychoanalysis and its focus on the matter of sexed bodies. In doing this and examining some of the critiques of their work by Anglo-American feminists (Fraser and Bartky 1992), it was clear that the main criticisms are that psychoanalysis is essentially oppressive and that by focusing on linguistics and the matter of bodies, their theses are essentialist and apolitical. From my perspective (as a half French subject), this seems to lack some cultural understanding that they are working within a language that is restrictively gender-packed and bound. In addition, French women's bodies have been, in my view, more strait-jacketed in terms of looks, behaviour and decorum than those of Anglo-American women. Luce Irigaray's concern with freeing the female body thus seems unsurprising, and in a rule bound/rule breaking society, Kristeva's focus on the symbolic and semiotic seems not out of place. In answer to the criticism of apoliticism, Irigaray points to multiplicity, which acknowledges both local and global aspects of feminisms. This concurs with urgings from feminists such as Fraser (1992) to encourage resistance at multiple sites and to look at both broad and specific oppressions of women. The focus of Anglo-American feminists is equally constructed by cultural concerns. What is of more interest is debate between the two, and how they may help us to destabilise debilitating certainties. The problem arises when they attempt to become certainties themselves - but as Stanley and Wise (2000) suggest, this may be more to do with the proliferation of 'interpreters' (266) than those who originally offered their ideas. In terms of essentialism, it is difficult to know what else we can do but experiment with different economies of the body, as it is negating the body that maintains modernist philosophy and domination.

¹⁴Though, as she herself says, while many of the contributors to her edited book 'oppose the view of culture as monolithically patriarchal [...] there is no unanimity on this issue' (Fraser 1992: 18)

It is the nature of the subject and the ways in which subjects are in relation to each other that largely define autonomy and ethics. Therefore, before theorising the separation/connection binary any further, I collect up some of the debates in my review on the nature of the subject and how it relates to multiplicity.

Locating the specificity of modernity's ethics: Dislodging the (empty) male subject

In this section I look again at how morality has been narrowly defined in health care ethics, through reductionist assumptions, which have defined the subject in certain ways. In the literature review I conclude that the isolated, self-created, bounded subject of modernity's rationalism has had a series of consequences on how health and illness has been defined, and how birth practices have arisen and developed. The construction of the rational subject, which shapes health care ethics, curtails women's abilities to claim subjectivity and thus constrains their abilities to change the narrow definition of morality, or fully exert their own autonomy and agency.

It was clear in the literature review that the same patriarchal discourses in which the definition of the rational subject had arisen were the same patriarchal discourses in which ethics and the construction of health and illness had arisen. In other words, in Foucauldian terms, rationality formed the 'episteme' (Armstrong 1987: 61) from which a particular knowledge of subjectivity developed - which itself formed the basis of ethics, health and illness, and subsequently, obstetrics¹⁵. This may seem obvious, and yet it is the intimate connection between the principles bound up in rationality, morality, health, illness and obstetrics that not only exclude women from subjectivity and ethics, but also prevents them and their embodied experiences from reshaping morality, health and birth from their point of view.

So not only does medical ideology exert control over its practitioners and therefore women, and not only is medical ideology itself controlled by wider beliefs and practices - often inaccessible and internalised - but ethics is deeply implicated in societal values and norms through a network of channels or disciplines. Appealed to as an independent adjudicator, it can usually only mirror these values and at best appeal to rights located in political theory. I thus look at criticisms of dominant political theory below, on page 270. The main point here, is that as Margrit Shildrick (1997) pointed out, rights, however liberatory do not confer moral agency (1997: 70).

It was clear from this that ethics reflects embedded assumptions, which arose from one of the organising principles of modernity - the privileging of rationality. Further, the general underlying separatist and mechanistic assumptions of modernity, translate into the mechanistic, rule bound ethics reflected in deontology, utilitarianism or other similar definitions (see for example, Seedhouse 1990). Ethics is then characterised by risk assessment and management (where the general concept of risk has been constructed in certain ways in obstetrics, as I suggested in the 'Risk' section on page 61)¹⁶.

¹⁵For example one of the consequences of modernity on the development of health discourse is the development of expert knowledge and professionalism. There was a series of moves implicated in the transformation of traditional healing to modern medicine, which I discussed on page 39. This resulted in the subject, previously at the centre of the healing process and arbiter of his/her condition, becoming the object of modern medicine. The subject's knowledge, even presence was of little consequence. In other words, the definition of subjectivity combined with dominant assumptions about knowledge and professionalism fused in medical ethics in a way that constructed the professional/client relationship or encounter as one between subject and object, an object that can be further fragmented into bodily bits and pieces.

¹⁶In the same way that obstetric policies and practices have been largely absorbed into midwifery, it has necessarily absorbed much of the ethics of medical ideology. But as we saw in the chapter on relationships, midwives have the potential to relate to pregnant and birthing women in different ways - but without theorising a clear alternative, they often oscillate uneasily between women's concerns and those of medical ideology. The frequently used term woman-centred does in fact provide a potential alternative to medical ethics - but without theorising what this could mean, it remains a

This in turn focuses away from the material subject of morality and towards identifying rights and wrongs which gave rise to theorising pathways for moral decision-making. Lawrence Kohlberg for example traced this among men and Carol Gilligan (1985) retraced this from a feminist point of view. As I discussed earlier, neither of these appeared to be satisfactory). The assumption is of similarity between subjects, which excludes difference, and thereby excludes women and others who lack these similarities (Diprose 1994: 12, Nicholson 1999: 28).

Because difference is erased, the heavily implicated power issues, which characterise the encounter between women and professionals are rendered invisible. Indeed, the oppressive subject/object relationship is so embedded that:

‘the dominant material, physical and psychological power of men over women is simply unacknowledged in the fiction that the transaction is between two equal moral agents’ (Shildrick 1997: 86)

I observed earlier that moral decision-making may be gender specific - or at least that a person’s location will affect moral decisions. Part of that location includes the person’s material body. The main point here is that the general principles of ethics are based on the white, male, western, privileged, rational, disembodied subject. I suggested that the epistemic field has been expanded, on page 80. The ethical field has been expanded by critical theorists in a similar way.

Fleshing out the terrain: Agency and the matter of subjectivity

It was clear from my review that health care ethics is disembodied and emptied of most other concerns - but that women’s bodies cannot be erased. Decisions about health necessarily involve bodies and a variety of other concerns (such as poverty for example), whether or not this is acknowledged.

We have seen how health and its practices have been equally narrowly defined, based as they are on the rational subject. Bodies are removed from subjectivity and feature as mechanistic bits of flesh (see page 91), rather than integral to personhood. Thus obstetric ethics inevitably erases the woman as an agent and/in a body and focuses on producing a live baby with the ideology, practices and tools at its disposal - arising from the same ‘cognitive space’ to use Armstrong’s (1987: 65) term that constructed morality and health in the first place.

Margrit Shildrick (1997) discussed the damaging effects of health care ethics on women (and others), and the need to include the body as a subject in health and illness. This would not only redefine ethics but would redefine what counts as health and illness. In other words, by taking bodies into account rather than disappearing them and constructing health to mean Drew Leder’s ‘absence of an absence’, women’s reproductive cycles and changing bodies could become part of a health discourse rather than one of pathology for example. Using a feminist reading of postmodernism and drawing on the work of Irigaray, she theorises women’s bodies and concerns in terms of difference, rather than uniformity.

The feminist/postmodernist views on ethics and embodied subjectivity I drew on in chapters 4 and 5, are succinctly captured by Colebrook’s (1997) definition of modernist’s autonomy, striving for equality and sameness through reductionism:

largely empty concept.

‘Autonomy - broadly defined as the ideal of self-legislation - characterizes an ethics of modernity in which the subject ideally acts independently of interests, bodily desire, others, prejudice or tradition’ (Colebrook 1997: 21)

It seemed clear from the critiques of the patriarchal discourses of modernity I discussed, that these discourses displayed enough internal consistency to have created a historically and culturally bound ethical code. A code, which cannot include women (or other subordinated peoples) as moral agents, let alone respond adequately to the multiplicity of our diverse concerns and ethical stances.¹⁷

Reviewing the territory: Ethics of care

Continuing the underlying theme of the previous chapter, just as engagement and lack of engagement characterised relationship issues, so engagement and lack of engagement characterise ethical issues. Closely connected to the move from separatism and connection to multiplicity, are the debates about relationality and ethics of care. These debates remain under the same ontological umbrella but pose different questions about subjectivity.

Thus far I have examined the nature of the subject and suggested that the subject needs to be expanded to include its body. In the next sections of this theoretical interlude, I have looked at how the subject is thought to develop and how the subject is in relation to itself, others and the world.

As I acknowledged above, I needed to explore the problems I encountered in the previous chapter pertaining to ethics of care. I realised that I was on the one hand rejecting a psychological approach to women and yet, on the other hand drawing on certain aspects of ethics of care, which come directly from feminist psychology (its recognition of care, love, nurturing for example) without having fully examined its gendered origins.

The question is whether or not ethics of care is a resistant theory or a theory, which provides a better alternative to that of modernity’s ethics but which is nonetheless a theory of compromise and selflessness¹⁸ which separates autonomy from agency. If this is the case, it offers limited potential.

As I suggested in the previous chapter, separation as ideology exists at every level of conceptual thought, and is the key to maintaining the status quo. Separation is one of the foundations for the oppression of women in Western philosophy, psychology and politics. It is the concept of separation that secures Western modernity’s (male) individual on which health care ethics rests. Leakiness in terms of relationality (connection), materiality (bodies of women) and the logos (words) (Shildrick 1997) threatens to unhinge patriarchal thought, and thus (possibly) domination. However, simply replacing separation by connection maintains this dualistic thinking. It cannot undo the domination/subordination binary. I thus discuss some of the critiques of connected relationality and ethics of care, which suggest that they are unable to move beyond gendered assumptions, and continue to oppress women through a different but nevertheless disabling currency of gendered autonomy and agency. And yet many feminists see relocating autonomy within relationships as crucial (see for example, Gregg 1994: 145 Mackenzie and Stoljar 2000) - as I do. The question is, how, and on what grounds would this be based. Could there be an elaboration of relationality that expands the definition of ethics?

¹⁷I use ‘code’ and ‘stance’ deliberately here, paralleling the earlier distinction I made between a medical ‘model’ and holistic ‘philosophies’, in order to capture the more closed nature of ‘code’ compared to ‘stance’ along the lines suggested by Drucilla Cornell (1995).

¹⁸Without theorising aspects of power, compromise and negotiation quickly fold in on manipulating women to agree to practices they disagree with but feel obliged to accept.

Ethics of care developed in the field of feminist psychology and psychoanalysis to provide a sensitive way of theorising women's beingness. Diana Meyers' (1992) consideration of reclaiming women's agency through psychoanalytic feminism offered a particularly sustained critique of why ethics of care and maternal ethics are additive and gendered and therefore fail as useful theories. Using the writings of Nancy Choderow, Jane Flax and Julia Kristeva as exemplars of feminist psychoanalytical developments, she identified the normative gender values embedded in these developments. She suggests that their accounts not only valorise motherhood, but rely on an inherent selflessness and conservatism of mothers, to the extent that becomingness and multiplicity fold in on 'sentimentalized motherhood' (Meyers 1992: 149-150). She concludes that while psychoanalytic feminism is so 'embedded in Freudian gender bifurcation', it cannot elaborate women's agency - but has provided an 'account of the tenacity of gender identity and the role of gender and women's subordination' (158).

Thus ethics of care is still too narrow and gender-bound. It has predicated itself onto the development of a subject, which is itself subject to gendered accounts in psychological thinking¹⁹. The problem here, is that the relationality, or connectedness appealed to still relies on the "belatedness" rather than becomingness of the subject. So a relational ethics needs to look at its own assumptions about the development of the subject. The 'care' appealed to does not exemplify the openness of multiplicity. In terms of childbearing, it's tendency towards maternalism, nurturing (others) and selflessness elides with the baby-focused tendency in medical ideology. Thus I return to multiplicity.

Weaving strands: Moving closer to multiplicity

Bringing diverse theories to bear on birth, I was struck by Colebrook's (1997) critique of autonomy and ethics. Drawing on diverse theoretical strands herself, including Irigaray's notions on the matter of sexed bodies (21) she provides a crucial parallel between the theoretical unitariness and the material emptiness of dualistic thinking²⁰. This enabled me to theorise the separation metaphor more explicitly. Colebrook's reading of modernist's subjectivity as an emptied out category - 'a form of nothingness'²¹ (24), combined with Irigaray's (1985) view of women's bodies as a material site of multiple desire, offered a further challenge to the unitariness of the phallogocentric order and its various forms of boundedness and reductionism.

A number of issues flowed from the above. Firstly that dualistic thinking could be understood to fold in on itself, where the qualities of the designated substantive term are emptied out into the second, so-called subordinated term. These qualities are then discarded, leaving an empty shell. To call this dualistic is perhaps a misnomer and suggested that separation ideology is a myth, representing emptiness. This myth could obviously not account for the multiplicity, complexity and texturedness of the women's experiential accounts, or of their concerns²² - which, using Irigaray's

¹⁹I am not suggesting that we discard feminist psychological thinking - on the contrary, it has provided important theoretical tools for rethinking women's experiences. For example I drew on Kristeva's work on symbolic and semiotic language/experience to gain more understanding about the fragmentation and "otherness" of birth as a rite of passage which is far removed from medical understandings of birth (see footnote 48 on page 242).

²⁰The ideas from Claire Colebrook's (1997) paper that I have included here were in fact part of a wider critique of autonomy and ethics and problematised the notion of autonomy through the different but not unrelated discourses of modernity and postmodernity. In this well-argued paper, she theorises the limitations of attempting to provide a theoretical framework for autonomy from either the self-sufficient, pre-existing subject of modernity, or from the constructed subject of postmodernity. She also suggests that the supposed disjuncture between the arguments and therefore subjects of modernity and postmodernity are in fact not a disjuncture and that the threads of modernity's arguments are woven into postmodernity's discourses.

²¹This notion of emptiness or nothingness confirmed the idea that modernist ethics is unfeeling and insensitive. It also provided a contrast in which to further elucidate multiplicity.

²²It so vanishes the materiality of human existence that it cannot take its own concerns into account, let alone those of women and others - and hence does a disservice to the group of privileged men it supposedly applies to, as well as women

term were 'never one' (1997). The idea of emptied out categories provided me with the following parallel metaphor: that in medical ideology, birth has been emptied of its qualitative properties - yet women's accounts were packed with discussion about the qualitative aspects of birth. This was reminiscent of Patricia Kennedy's (1998) distinction (that I quoted on page 41) between the medical and holistic view of birth, which she described as the 'active uterus' compared to a 'complete physical and emotional being, part of a wider social circle' (10). In one of the woman's words:

'I mean, I wanted it [birth] to be as natural as possible. But as I say, with being induced, it was all sort of taken over and I had nothing to do with it'

Thus these ideas further illuminated the experiential aspects of women's accounts in which the unitary or reductionist outcome in medical ideology of a live baby could be challenged by women's focus on matter, process and quality (which would of course include a healthy baby²³). Using this metaphor of multiplicity, all aspects of the birth process could matter - though these could vary between women and may not have equal status among women. They need not be hierarchical and some concerns may be prioritised over others depending on what matters most at that time. For example, as I suggested in the Chapter 8, if a woman perceives her baby to be in danger, having a live healthy baby may indeed become the main focus and priority (but still may not erase all other concerns). To reiterate the main point of Chapter 8, all the women in my study embedded birth in their social lives and none of them saw having a live baby as the only meaningful outcome of birth:

'we've got a friend who's an anaesthetist and discussing it with her you know, her view is just so totally different from mine. I mean, she would have an epidural straight away and, you know, the whole works and her view is that a doctor, or an anaesthetist wants to have the safest birth, you know, and at the end of the day you've got a healthy baby, and a healthy mother, and note it's that way round too, and they're not equal. That's her approach to it. So, there's that sort of medical, you do it this way, and you whip it out if you have to etc, that sort of approach. But you know, it's not a separate part of your life. It's what forms - well, one of the things that forms you'

Thus not only could the chasm between the 'immortality strategy' of obstetrics and alternative readings of birth be made more visible, but the other sides of that chasm could be mapped out in more detail. As I engaged with the women's accounts and thought about mapping out the territory of their concerns, it became clearer that part of the difference between their accounts and obstetric ethics was indeed located in the definition of becomingness, and that assumptions about this necessarily influence how obstetrics treats women. I thus return to the literature, again.

Reductionist ethics and women's feelings bodies: Suffering the consequences/claiming autonomy

Embodied ethics and how we are in the world needed further examination. I needed to consider more fully the body as an unfolding event in time and space in the light of theoretical debates and the women's accounts. Indeed, women's responses in the study were grounded rather than abstract. There was always a connectedness with the body and the external world. But in terms of autonomy's assumption of mind over matter, i.e., that the mind possesses and governs the body and is therefore a possession of the person, (as it is in contract theories of the body and body politics that I discussed in Chapter 4, women spoke differently about their bodies. Using Natasha Mauthner and

and others in less privileged positions.

²³I make a purposeful distinction here between 'live' and 'healthy'. As I discussed in chapter 9 on page 172, women accepted the possibility of death at birth and some women did not necessarily see a 'live' baby as the best outcome in all cases.

Andrea Doucet's (1998) voice-centred relational methodology, when I listened carefully to the 'I', running through the interviews, women did not necessarily distinguish between themselves and their bodies. 'I' could refer to thoughts, feelings and bodies. Bodily functions, movements, temporality and spatiality were all foci rather than secondary in their discussions. Boundaries between mind and body were ambiguous. Women were in relation to their bodies rather than in possession of them and the mind/body interactions were dialogic rather than unidirectional. In other words, as Rosalyn Diprose (1994) observed, by subscribing to the disembodied subject and adhering to universal rules, biomedical ethics 'relies on an inappropriate model of the relation between the individual and her body and misconceives the nature of the relationship between the individual and others' (2).

Work by phenomenologist, Maurice Merleau-Ponty, has been developed by feminists such as Diprose (1994: 114), to suggest that embodiment is a dialogue. The assumption that 'the self remains the same through significant bodily changes' is no longer tenable. Rather, 'changes in the body effect changes in the structure and fabric of the self'. She contends that rather than labelling pregnant and birthing women as incapable of decision-making, we need to understand that 'such a significant change of body is a change of mind' (116-117)²⁴. This has enormous implications for midwives and doctors and how they respond to pregnant and birthing women. And yet, women's accounts suggested that embodied subjectivity may be more complex still during birth. That the woman may be both herself and not herself; present and not present:

'I worry a little about presuming you won't be *compos mentis* [...] and I mean, I was myself ... there were times when I was elsewhere [...] but that's another matter. I wasn't another person I had my sense of humour, I had my faculties and I had my own wishes. I was in a lot of state. But I wasn't in so much of a state that I did not know what I wanted. And I don't know how many people would feel confident that that would be the case. I felt confident in advance and that was the reality - that I was capable of making decisions. I know that because in the third stage I wasn't progressing and I didn't deliver the placenta for many hours and ... it was a wee bit of a worry. [Midwife] was a wee bit worried at one point that it might have adhered .. But I knew that I wasn't going to go into hospital. And at one point I thought, even if [midwife] says I think you should go, I'm not going. And I had a little word with myself because I could see that it was the first time that I actually saw that she looked a bit worried[...] It was almost an issue and at that point I was clear ... That was the only test I had if you like. [...]. That was the only one I had. Well I knew I might have to make quite a stand and I was capable of making that stand and that was after 30 hours in labour you know. So it worries me a bit that people think that they're going to become some sort of gibbering heap who won't be able to say no'

'I mean you cross a line. Something really ... major ... happens to you... your body ... you know physically and emotionally which will change your life for absolutely ever And it does, you know. I think it's an incredibly ... emotionally charged moment and time of your life [...]. I mean, I do really think that's something that's so big really and it's so incredibly strong at the moment, at the time you know I mean, I don't really support the idea that ... pregnant women are not really sort of fit to make decisions and that sort of thing because I think that's a whole load of rubbish I think they are perfectly fit because at that... They're actually probably more fit.. to make decisions because they are... you know they ... [...]. They are completely focused on... their task ... sort of thing ... you know. They are ... only mothers at that point and nothing else [...]. And I mean to sort of say they don't have the best interest for their children at heart is just like ... I think it's a huge insult to women ... an absolute insult to women huge... you know'

²⁴She criticises phenomenology for its tendency to interpret corporeal change negatively - as deviance from the normal. It contains no account of positive corporeal change, as in pregnancy for example (116-117).

If we expand the ethical field as suggested by Diprose, to mean how the self becomes, the nature of its relationship to itself, its body and others, and its 'habitation' (place and habits) - and if we take this even further to include Margrit Shildrick's (2000) daring suggestion that keeping our own vulnerability at bay maintains boundaries which prevent the other's becoming subjectivity and therefore agency, an entirely different ethics emerges. Put starkly, how we define subjectivity, and thus autonomy and ethics defines how we treat or respond to others - in this case pregnant and birthing women²⁵.

Knitting strands in: Political theory

Health care ethics has developed from ethics in liberal, Western political theory and therefore relies on the same sort of subject. Bringing together the criticisms of modernity's rational subject, and criticisms of liberal, western political theory shed interesting light on the notions of choice and control in obstetrics. The similarity and equality of subjects underpins western democracy. They are also assumed to be separate, discrete entities and can therefore be located within contract theories which construct particular relationships between individuals and between individuals and the state. Thus discourses about morality and ethics focus on freedom, equality, rights and justice, and the networks of power uncovered by social theorists remain invisible.

Those theorists who engaged with difference and marginalisation from a more overtly political stance²⁶ have examined notions of freedom, equality, justice, rights, citizenship and democracy in the light of what this suppresses (Reiger 2000, Young 1990c, 1997a). These debates parallel critical analyses of health care. They similarly find that if autonomy is based on subjects, which are emptied out of qualities other than the constructed rationalism of modernity, the notion of citizenship based on equality remains inadequate and forms a political barrier to autonomy and inclusion. In the light of criticisms of health care ethics, political theory and further theorising of the body, I was able to theorise the women's discussions of their different subjectivities and the inequalities they experienced in terms of difference and vulnerability. Their accounts held within them, not only an ethics based on material difference, but pointed to the changing nature of material difference during pregnancy, labour and new motherhood and spoke particularly eloquently of the unacknowledged vulnerability of birth. Equality suppresses any number of differences, including bodily differences, from disability to pregnancy. Its inability to locate even broad embodied differences, silences the multiplicity of embodied people. For example, the notion of consent remains unproblematic in health care ethics, but becomes immediately problematic if we look beyond equality and acknowledge power relations and bodily differences:

'I fear invasion more than I fear pain, so on balance it's better, you know not to have those things [interventions to hand at home] cos they have to be really sure if they're going to transfer you And I think it's very hard to bring that sort of thing up with a midwife, because they don't want to be seen like they're living in the bad old days and of course we won't do anything without your consent. Well, what sort of consent are you going to be giving at that point ... and that's not ever frankly discussed²⁷,

²⁵ I have used the words 'treat' and 'respond' here to make the distinction between the unidirectional 'doing to' which characterises medicine and the potential dialogic 'being with' of a different sort of attitude between subjects. The vulnerability of pregnancy, birth and motherhood, and how to respond to this was frequently referred to by the women in the study. I have thus developed ideas on vulnerability during the course of the chapter, and how it was obscured/muted by the notion of equality embedded in the rhetoric of choice and control, which undermined the entire thesis of this rhetoric

²⁶ Though as Luce Irigaray (in Fuss 1992: 105) comments, we could usefully expand our understanding of 'political' so as not to create discrete boundaries around different aspects of feminist thought which could otherwise usefully inform each other. She thus criticises those of her critics who accuse her of apoliticism.

²⁷ One woman described this as manipulative:

Women recognised the vulnerability of pregnancy and birth because of their changing nature and connection with their babies, and their different relationships to others, which were not necessarily matched by changing sensitivities of others. In other words their experiences were of vulnerability in a culture based on equality:

‘when you’re pregnant, you’re so vulnerable, it’s not just like the me you know normally, your emotions are running high, you feel so vulnerable and you don’t know. And when they start implying that in some way you’re going to be hurting your child, then I think that’s a dreadful, dreadful thing to say’

The meaning of equality vanishes when a body is giving birth in a system, which is insensitive to both the body/mind dialogue and the nature of the relationships between subjects. Hence the irresistibility of the medical model for women who had previously wanted natural births (Machin and Scamell 1997). The coercive aspects of medicalisation behave us to find ways of being with women that enable autonomy during a period of vulnerability and bodily changes. If we accept Diprose’s (1994) contention of becomingness, where bodily changes can change one’s mind so to speak, it becomes clear that disembodiment of the subject renders consent problematic. In this view, consent to medical ideology in fact rests on the vulnerability of the pregnant, labouring or postnatal woman and thus becomes coercive and expects compliancy²⁸.

By providing a critical analysis about where modernity’s patriarchal explanation of ontology is inadequate in relation to women’s accounts, I suggest alternative understandings in an attempt to take the question of ontology further. These debates about subjectivity and autonomy suggest that they cannot be pre-determined and arise from fluidity and becomingness. Nor do they develop in isolation - rather they are always, a priori in relationship to themselves, others and their habitats. This provides a very different concept of ontology. Instead of arising from individuality and separation *before* relationality, interrelatedness is the principle from which the subject forms and reforms itself. Thus I return to my literature review and Drucilla Cornell (1995) and Margrit Shildrick’s (1997) notions of ethics as a circumstantial process. Further, using Diprose’s expanded definition of ethics, it can no longer be separated from ontology into a rule-bound moral code, but becomes an integral part of each interaction. Ethics can no more be separated from interactions than can power.

Tying up loose ends

The theoretical debates I looked at tell us that a great deal of thought has been devoted to uncovering the nature of our existence and our relationship to ourselves, others and the world around us, but that any conclusions are tenuous²⁹. They tell us that any claims we make are made on shaky grounds. But it is as well to be aware of the terrain before commencing building work. This

I was manipulated in all sorts of ways, yes, of course I was. I was manipulated throughout the service they gave me, including the negotiations when we were talking about the pool. I think that’s a strong manipulation to negotiate something and then when I’m in labour, when I’m at my, you know, most vulnerable place, renegotiating. I think that’s disgraceful. I do feel strongly about it [...] You know, if you’re promised something, then they should come up with it and it’s that blip between what is negotiated and what happens that is ... that is certainly what made me feel unsafe unable to trust what was going on’

²⁸ The further irony here, is that women’s views about birth during pregnancy are expected to change during labour. But rather than meeting the needs of the changing body on its own terms, obstetrics ‘sees’ the changing body through its own ideology. Having constructed the body as weak and in need of management, it typically constrains it and focuses on reducing pain for example.

²⁹ As I previously noted, understanding the limitations of our work is crucial if we are to open, rather than close spaces for women’s experiences to shape theory and practice.

provides the opportunity to examine it, and pay more attention to the range of available designs and materials than we might otherwise have done. It encourages us to attempt to imagine and create others, when those available are inadequate.

The debates I engaged with also demonstrated the difficulty of finding any clear pathway to theorising resistance and liberation and suggested multiple avenues that are themselves continually reconstructed in response to the changing forces of patriarchy (see Bartky 1997 for example). These must therefore be encouraged at multiple sites - in practice and in theory.

We have seen some of the limitations of health care ethics and ethics in general when they are based on a subject which endlessly and unsuccessfully attempts to empty itself of subjectivity. Autonomy is twisted into a negation of (what) matter(s) - the concerns and bodies of women. Its limitations limit what it can see, hear, feel and understand. The consequences of these limitations cause erasures and abuses of women's experiences, especially through practices on and in the body.

Modern medical terms, like modern medical subjects have been emptied of substance to become somewhat sterile husks in an attempt to maintain certainty and thus dominance. It is the qualities that breathe life into these that have been removed. I thus attempted to evoke some of these qualities along with the uncertainties, ambiguities and messiness they entail.

My contention in the following section of this chapter is that the rhetoric and substance of choice, control and power are embedded in a health care ethics which is itself embedded in disembodied patriarchal discourses, which cannot by definition address women's experiences of birth. They also arise from a consumerist ethos, which reduces women to consumers, choice to a menu and control to making limited choices from that menu, rather than acknowledging them as moral subjects/agents, able to forge their own destinies.

Part 2 From choice to empowerment

Choice

Reconstructing choice: Choice as no choice

'how can you make a good choice out of five bad choices? And I just sort of thought ... now ... let's think ... where would I want to give birth here. And I thought nowhere ... not on this horrible plastic chair ... not on this horrible high plastic bed ... you know, none of those were sort of ... in any way inviting (laughs) for me to lie on or sit on or squat on and the bed was too high. You couldn't kneel on the floor, you know It was just, I thought, this is not a good place to have a baby, you know'

'If having an autonomous life is an ultimate value, then having a sufficient range of acceptable options is of intrinsic value, for it is constitutive of an autonomous life that it is lived in circumstances where acceptable alternatives are present' (Joseph Raz in Brison 2000: 285)

In this section, I continue to look at the appropriation of apparently woman-centred terminology by obstetrics and why these terms usually act as rhetorical/material barriers to transformation of, and resistance to dominant medical ideology. Their narrow definitions are locked into meanings which are in keeping with the project of obstetrics as a whole. They have been exchanged through medical currency in response to criticisms, but the central dilemma remains that obstetrics bends terminology to accommodate and reflect its own underlying, beliefs whereas women question those

underlying beliefs³⁰. In the previous chapter I discussed how terms such as continuity, communication, support and professionalism for example, exemplified reductionism in comparison to the meanings given to them by the women. As I described in the previous chapters, obstetrics oversees the location, structure and content of care provided to women, so that they and their midwives had minimal or illusory choice³¹. As I also mentioned, this discussion takes place in the context that basic choices about who will attend birth and whether or not to opt into maternity care are almost entirely missing. That it could be 'your choice to get her [midwife] in' sounded inconceivable in current circumstances. The imposed system of care left women far removed from fundamental choice and struggling to relate to how care was provided

'it's like trying to figure out the bus timetables (laughing) you know, you don't know who's going to be where and when'

As I suggested on the previous page obstetrics provides a limited, pre-determined menu of choices to certain women in certain circumstances (Kirkham and Stapleton 2001, Mander 1993, 1997). Women question how and why this menu has arisen and why their decision-making should be restricted to a pre-selected menu or 'shopping list' (Stapleton 1997). The moral irony of choice was that women were obliged to make choices. They were deemed responsible for making choices from those on offer, but irresponsible for challenging them³².

Clearly, it has been recognised that maternity services were lacking in choice and that the concept of choice for women is important. It has been focused on in policy documents (Department of Health 1993) and in medical, midwifery, and lay literature. But without questioning medical ideology, this usually involves urging practitioners to improve their knowledge of evidence-based information and communication skills³³. As I explained and as many quotations show, the information/choice pairing is problematic, and increasing evidence-based, "scientific" knowledge and communication skills cannot address inherent, but unacknowledged power struggles between different needs and beliefs. Without looking at issues of difference and power, medical ideology continues a project which it names "choice", but which in fact attempts to ensure that women make "correct" choices and provide the consent now needed by medicine to carry on business as usual. In other words, choice is a misnomer for compliance to the medical management of birth³⁴. Rhetorically severing information

³⁰Given the fact that home birth is reluctantly tolerated rather than encouraged, women's frequent comments about what they saw as lack of even basic information on which to base apparently straight forward choices in relation to place of birth and attendants, that I described in the previous chapters are not surprising. While home birth is supposedly a choice, it is restricted in a variety of ways and some women felt that their midwives would transfer them to hospital at the first opportunity:

'they [midwives] were speaking in one way but there was another agenda and the other agenda was to my mind, if I could be persuaded to go to hospital I would be. And I felt that we were talking about my life and what I was entitled to and what I could get and birth plans and etc etc. But there was something subtly discouraging in the whole line that was being taken that made me believe that there would have to be very very small - only very small problems before I would end up in hospital ... So I felt it was a wee bit dishonest really I didn't feel that there was the support there for actually being at home ... Not really ... Only if you had this sort of ultra normal birth whatever that is you know A lot of the problems that [midwife] said you would have to go into hospital for struck me as part of normal birth'

³¹ As I suggested in the previous chapter on relationships, women and midwives (as two distinct but overlapping groups of women) were subjected to both similar and different marginalisations and appropriations. There were also differences and similarities between individual women and midwives. So while power is ever present, it does not form a monolithic backdrop to women's experiences.

³²Midwives, Helen Stapleton (1997) and Nicky Leap (2000) suggest that the concept of choice may be inappropriate in a world of uncertainty and that focusing on uncertainty rather than choice could provide a more useful and integrated way of relating to questions of care during pregnancy and birth

³³There are tensions here, because although evidence-based care is located within the broad field of medical science and defines its own project, it has on occasion demonstrated the harmful effects of some obstetric practices. In addition, because of the increased fear of litigation, there is even greater emphasis on staying within the limitations of medical ideology, even if this means abandoning choice and imposing medical practices on women (Dimond 1993).

³⁴I make the distinction between ideology and practice here. I am not suggesting that all interactions between individual

and choice from knowledge and power, makes it a powerful mechanism for control. Women then have to reconnect and contextualise information and knowledge themselves:

'I have to know everything about it. It feels that, you know, I can't just have the normal knowledge of a normal person to have a baby. I've got to have all the knowledge of all the nurses and all the obstetricians and all the rest of it because they won't advise me according to what they know I want. They will advise me according to their own set of rules and what they want and that's not unbiased They didn't give me unbiased information, and allow me to make my own decision. They specifically veered me towards their own outcome'

'you've to know your stuff, which I think, that's not right. I shouldn't have to know my stuff. But I felt I had to read up so much because, they [midwives and doctors] could come across, you know, they could say something to me and I could say, oh really, oh dear, do I have that, oh gosh, my poor baby. Oh well yes, I'll have to go to hospital. So I felt I had to arm myself basically'

'one of the midwives that came round spoke to me about it [vitamin k]. But again, it was one of these things that was sort of dumped in my lap, as, this has got to be your choice. Though ... she only told me the good side. She told me about the importance of the injection, and then said, this has got to be your choice. And I didn't understand if it was so good, why it needed to be my choice. So it's been up to me to find the other side. I don't feel I've got a sort of unbiased view on it ... yet.... So again, I'm taking the advice of the medical people I have around me - which is the midwife ... who advises it'

As I suggested earlier, postmodernism has located the specificity of knowledge claims, suggesting that the subjectivities and interests of those implicated, produce specific knowledge which usually reinforces dominant ideology and thus maintains dominancy. Those providing information have similar interests and constraints. To claim that information is unbiased is to fall back on the notion of rationality, free of exteriority. If we accept, as I do, that subjects are constructed in relation to various influences including their place (habitat and habitual practices) in the lifeworld (Diprose 1994), then there can be no such thing as unbiased information or free choice. The vacuum assumed by the rhetoric of choice and consent is not a vacuum at all, but is filled with a complex interaction of interests. If we also accept, as I do, that there is no subject prior to relationship, then the other vacuum created by isolation and separation, according to the women's accounts in the previous chapter, is filled with muted dialogue. Obstetric choice assumes isolation, but in these women's accounts, knowledge developed in dialogue, which acknowledged different perspectives and was embedded in, rather than separate from relationships³⁵.

practitioners and women are coercive, or that "choice" is uniformly oppressive. Just as women and midwives struggled to engage and form relationships in an unsympathetic structure, midwives also attempted to provide women with the information they needed in order to make decisions. What I am suggesting however is that the concept of choice within medical ideology is essentially oppressive and maintains the status quo.

³⁵As I suggested in footnote 9 on page 85, dialogue also occurs within the self. Catriona Mackenzie (2000) takes this notion further. Choice in obstetric ideology implies that it is almost external to actors, whereas she suggests that self-definition is 'a process of negotiation among three related elements of the person: her point of view; her self-conception; and her values, ideals, commitments, and cares, in short, what matters to her' (133). She goes on to suggest that we are not simply a matter of choice, because of our complex personal/cultural biographies. 'Thus, we cannot simply choose to abandon our cares or give up what matters to us. Or rather, we cannot do so without forfeit or loss' (135). On this view choice is deeply implicated with personhood and autonomy. Her description of the self is akin to the becomingness I referred to: 'actively negotiating the relationships among one's point of view, one's self-conception, and one's values' (135). Equilibrium is then dependent on a reasonable level of integration for 'the kind of practical unity necessary to deliberate, make decisions and choices, and act' (135). This shows how the disruption to the self occurs when autonomy is threatened, and how choice is an integral part of autonomy. Thus as Shildrick (1997) and Smythe (1998) observed, medical encounters which undermine moral agency or discount what matters, threaten to undermine the self. The irony of

Applying the critical analyses of modernity's limited subject and morality, set in networks of knowledge and power, which are oblivious to difference (as discussed by Diprose 1994, Shildrick 1997 and Young 1990c, 1997a for example), we can see that choice has been affected by the epistemological fusion in health care of knowledge and professionalism on the one hand and equality on the other. This fusion has resulted in the belief that if women had the same unbiased "scientific" information, which professionals possess, they would make the choices advised. The problem becomes one of presenting information so that women "understand". Thus choice is predicated onto unacknowledged power structures that have created oppressive obstetric regimes and the systematic appropriation of women's bodies. This definition of choice erases autonomy, responsibility and moral agency.

Predicating choice onto a system, which is resistant to change has little effect on the hegemony of the obstetric model of childbirth. It can do little to address women's concerns, as it cannot identify them. Thus while Gregg (1995) for example, called for choice to become reality rather than illusory. I would suggest that we need to provide alternative readings of choice itself, if we are to move away from a definition that maintains oppression, and towards decision-making, which assumes women's moral agency³⁶. This is not to say that limited choice and rights cannot provide chinks from which to prize open spaces for women (see for example Krieger 2000) to redefine birth and exert agency - as the women in Gregg's (1995) study on antenatal choices and the women in my study demonstrated. But without context, choice remains as meaningless as the tick box mentality it has been reduced to.

Making other choices?

Jo Murphy-Lawless's (1998a), David Machin and Mandy Scamell (1997), and a great deal of other work, pointed to the coerciveness of medical ideology and the lack of choice this implies. This coerciveness, as I suggested in Chapter 8 is often located in the context of 'maternal responsibility', i.e. social expectations, censure and blame (Gregg 1995: 127). Choice is dependent on obstetric's definition of the baby's well-being, where its obstetrically defined needs takes precedence over the woman's choice. Further, Shelly Romalis's (1985) comment that women are unlikely to make choices that are not positively supported by practitioners (see page 73) suggests another side to the choice coin which coincides with Iris Marion Young's (1990c, 1997a) broad contention in political theory that inequalities between ideologies and individuals are such that some require more support than others. That is, that negative liberty (making a choice a legal right) needs to be replaced by positive liberty, where the choice is supported enough for it to become a reality (Gregg 1995: 10-11). The following contrasting quotations from 2 of the women in my study support these ideas:

'once you go into hospital (laughing) it's forget everything that you've learnt or put on your birth plan (laughs)

N Did you feel that?

(Sighing)I kept hoping that it wasn't the case, but it was very much the case, yeh .. And the other thing as well, was that eventually (laughing) you get so fed up, you know, that it's just like, oh do anything, (laughing) you know, to end this pain (laughs). And so it's (sighs) you are then asking for whatever it is that they're going to do, when if

the rhetoric of choice, which claims to increase autonomy, but in fact undermines it is clear.

³⁶As Carolyn McLeod and Susan Sherwin (2000) comment:

'Patients' autonomy is generally reduced to the exercise of "informed choice" in which the information provided is restricted to that deemed relevant by the health-care provider (and by the health-care system, which has determined what information is even available by pursuing certain sorts of research programs and ignoring others). Even in "ideal" cases in which patients have strong autonomy skills and full access to all the available information, it is important to recognize the influence that oppression may have on the information base and, thereby, on the meaningful options available to patients' (267).

they had been in tune with you from the beginning it might not have been (laughing) necessary to do what ... what ends up happening. [...]. If people would be much more involved with you mobilising you I suppose and trying to help you cope without diamorphine [...] then you know, it might not get to that (laughing) where you're just, get this over with (laughs). Cos that is how I felt at the end. It was, you know, just, okay, yes, let's just get this (laughing) over with, however it has to be done (laughs)

N So although it seemed as though it was coming from you?

You have no choice, you haven't really got any choice The choice that I made was (laughing) let's get this finished and over with or do what I had been doing (laughing) for the past 4 hours, for another couple of hours. So okay, let's get this over with Cos by that time it was really too late (laughs). Or I thought it was really too late I suppose (laughs)'

'I think that she [midwife] made me more and more confident to ... explore areas and actually just ... I think she made me feel that my approach was interesting, which you may think is an odd word to use. But it was important for me that I did what I wanted, and when I found that my midwife was really interested in the way that I thought, it made me feel more confident. Alright then, she doesn't think I'm wacky and she's not having to hold her tongue about things. [...] [Midwife] and I are very different. Even though she's very close to my ideas about pregnancy and childbirth, she's a lot straighter than I am in everyday life. She's much more of an ordinary family person than I am. So if you like it liberated me that she found some of my ideas amusing and fun. And because of the way we live and our whole set up we could do anything with it really [...] and I realised that she was enjoying that. And I think that helped me [...]. I just felt like she was saying, yeh whatever you do, it's fine by me and in a way ... of course it's my space and But it helped me to enjoy planning it knowing that she was enjoying some of the things that I had in my mind. I think that did help me to grow because ... I thought that she trusted my ideas and she found them interesting it made me follow through instead of just wishing. I got more and more confident about getting exactly what I wanted'

The contrast between these two quotations also concurred with what a number of other women described, that where ideology differs and medical norms take precedence (especially in a hospital setting) a narrow pathway through labour and birth is mapped out which gradually limits choices and renders the medicalised outcome more inevitable and apparently chosen by the woman herself (Machin and Scamell 1997). If on the other hand, the woman and her attendant share similar beliefs, choice is less of an issue. It becomes more a question of knowledge sharing, the weighing up of diverse concerns, to arrive at the best course of action or decision, through dialogue and consensus based on trust. So whereas choice in obstetrics is constrained by its own belief system (see footnote 36), women wanted access to information from a range of contrasting ideologies to increase their knowledge base from which to make decisions. A number of women commented that within a fragmented system of care based on generalities, making choices is an obligation, which can distract from the task of giving birth, (and as Smythe (1998: 13) suggests might even detract from safety):

'I suppose in some ways in the hospital I felt like at times you were having to listen to everything they were saying and thinking well, do I want that or, I mean I remember at one stage when I was pushing and they [midwives] said, oh I think maybe we better get the doctor in and I thought, oh I'm not having any doctors near me (laughs), you know, and I started pushing harder. And I think you know, it's almost like the threats of things in the hospital maybe make you do things'

Like the women in Gregg's (1995) study, these women's choices were made from 'a lifetime process of developing beliefs and attitudes' (125). But the definition of choice within medical

ideology erases the movement and depth that a lifetime process of becomingness suggests. It is this discrepancy between choice and process, movement and depth described by women that I turn to next, and which I rename decision-making as more reflective of their accounts about choice.

Embodying choice: Moving from choice to decision-making

Gregg (1995) suggested that:

‘we need to develop a more nuanced view of choice, one that recognises how historical and present patterns of oppression construct and constrain women’s choices, but also acknowledges women’s agency and capacity for self-determination’ (144)

As we have seen, obstetric choice is based on the disembodied subject, which assumes equality, fixedness and self-sufficiency. As I discussed above, theories of the changing body in dialogue with itself and others suggested that this is inadequate. Indeed, women in my study moved with their pregnancies, and with their growing knowledge and greater awareness of their bodies and babies. For example, some women decided to plan homebirths in later pregnancy and many moved to a position of desiring fewer interventions and routine practices than they had initially, but described a lack of flexibility, depth and movement in their care:

‘like I said to you before, all that time that you spend with them and yet, what do you do. You chat about the same things with each of them that comes you never really scratch the surface’

Paralleling the lack of movement I found when examining relationships, choice in medical ideology had no concept of process and movement. Rather, it held things in place. Women however, continually accumulated knowledge. Their decision-making was active, dynamic, procedural and dialogic rather than static. They needed to be in relationship with midwives who could move with them, discuss their views, knowledges and decisions, within a belief system that generally concurred with their own, so that specific decisions could be discussed but left open. Individual midwives and women attempted to move towards this, but were hindered by the rhetoric of choice that relied on isolated ‘episodes of care’ where constructed information could be provided at designated times during the woman’s pregnancy in simplistic, unidirectional, linear fashion. The woman was expected to make a choice ‘on the spot’, which would not be revisited, unless she specifically raised the issue again³⁷.

The definition of choice within a medicalised discourse reduces the desires and needs of women to simplistic choices and thus fails to acknowledge the experience of pregnancy and birth as a life-changing event. It fragments women’s considered ethical stances, which might, given favourable circumstances with supportive midwives, find greater integration as it unfolds through birth:

‘I find I still get great stuff out of it If I’m down about anything or I may have doubts about something I’m doing with [baby] you know. If I have a crisis of confidence, I think back to the birth and it’s a very good anchor for me in that way. You know it makes me believe in my ability to make good choices and things like that and I think it’s made a tremendous impact on how I can make decisions [...]. It just feels pivotal and kind of a pivotal part of my politics really It’s almost like it drew together lots of things that I Lots of sides that I had already and made them made it more cohesive as part of my life’

³⁷See the quotations about the woman’s views on syntometrine for the birth of the placenta for example on page 221.

Rights

Why rights are problematic

The rhetoric of choice is apparently supported in the background by a series of rights. As I observed earlier, women in the study were aware of the right to have a home birth and the right to refuse treatment or attendance by individual practitioners. Rights arise from the same rhetorical space as choice, predicated onto the subject of liberal, Western, political theory I discussed above and subscribing to a separatist ideology where decisions are made in isolation. Freedom, equality and justice are unproblematically assumed. Thus rights suffer from similar problems to those I encountered above in my section on choice. On a more superficial level, asserting rights (like making choices) was equally dependent on information, and then feeling assertive enough to enforce those rights. As we have already seen in the previous chapter, women found it difficult to obtain information which challenged their midwives' policies, and found it exceptionally difficult to assert themselves, even if this meant being attended by a midwife that, 'I had been dreading and not actually wanting to come'. In a rare example of open conflict in the quotation below, the high cost of appealing to rights and exerting autonomy was evident. It was clear that the energy and effort needed by the woman to maintain her position resulted in the potential undermining of that position and increased her sense of uncertainty and alienation. (I return to the issue of the cost of resistance to women in Part 4 on 321). The woman had been told by her midwives that she could not have a home birth and she therefore put her plans in writing to them:

'I showed them the letter and you could see her face cloud over.[...]. And she said to me, well, you know, I really don't think we can accommodate this. You've left it a bit too late and at the end of the day you know you've already been told that there are 2 other women booked for a home birth in [month] and that ... you know we couldn't possibly accommodate you [...] And then when I pressed the point and said, well you know I'm sorry you feel like that but I am going to have a home delivery she was very agitated and almost aggressive. [...]. Her body language and her immediate response - she squared up to me the moment she read the letter you know I'm the person in the uniform here, I'm the person with the experience, I'm the midwife and I'm telling you you're not having a home birth kind of attitude. And .. don't you dare ask me for one because I've already told you, you can't have one She made no effort to explore my reasons for a choice for home birth. She wasn't supportive in any way. She was adamant the decision was hers to take and left with, well I'll have to speak to the other team members and you know we'll get back to you with our decision. I was sort of left feeling well this isn't your decision to make it's mine [...] There was no smile, there was very definite eye contact, very square shoulders, very drawn up posture, very stiff you know that was quite frightening but
N How did you feel about that?

..... Quite angry. But at the same time because I knew it was my choice and my right to have a home confinement I thought, no. I'm not going to let you... dissuade me, you know I'm not going to let you put me off. I'm not asking to deliver in the middle of a field. At home is nothing unusual and I was quite adamant ... I sort of met her match to match I think for .. the more angry and adamant she got, the more adamant I got that this was my choice so ... I was quite ... But it's when you get home that you start to think, god what a big head to head I've had there and these are the women that are supposed to be coming and giving me care and if I alienate them I won't get the best care. Or perhaps I have made a bit of a silly choice you know perhapsyou know. The next day ... I actually returned home to the midwife I normally see knocking on the front door. So she came in and said that she had come to discuss the letter. She said [...] that she didn't think that this was an appropriate decision for me to make and that I'd left it a bit late and what

about the other girls that had booked for the home births. They couldn't possibly accommodate my wishes [...] I mean I don't think that you've read up about all the facts here ... you know I think that you're not making a sensible decision and you have left it terribly late, really I think you should just go ahead with your hospital booking. And I said, look at the end of the day I know it's my right to choose a home confinement and I understand I've left it late but this is what I want and this is what I'm happy with. And she said, well I don't think I can support you in this decision. In my opinion I think you're making the wrong choice. I don't think that home is the best place for you to have your first child. You don't know what it's going to be like. You don't know what complications you're going to have and goodness knows anything could go wrong and you know, you could end up putting yourself and your child in danger ... do you want your unborn child to die? And I was, of course I don't, but at the same time you know there's no reason why this unborn child should die, I'm not a high risk pregnancy, I've had a very low risk pregnancy. [...]. She did her very utmost to try and persuade me to change my booking back to [hospital]. Then when that didn't work she sort of covered the points of, you know home birth disasters and, you know, being a distance from the hospital and if you did have a haemorrhage well it would be at least 55 minutes before the flying team could reach you and you know you could have bled to death by then and what about your unborn child, I only carry oxygen in an ambu bag. [...] It left me feeling two against one and very isolated and very why did I have to fight? ... I would have been so much happier had she come in and said, okay we've got your letter, we're a wee bit concerned, we'll go over a few points... but at the end of the day if this is where you choose to deliver we'll give you all the support we possibly can and .. I would have felt so much happier. Whereas now I'm left with feelings of - what if something does go wrong, and am I going to get the told you so syndrome or you know, the, what do you expect you had a home confinement That's not a nice feeling cos you end up with self doubt - whether you are making the right decision or whether you are strong enough to actually go the whole way with it. So I'm just I'm glad in a way that I knew it was my right to have a home birth because if it had been anybody else who was unsure, I think they'd have been put off long before'

'The most important thing to me was to feel supported'

The adversarial, disconnected aspect of rights was clearly problematic to women. It was a far cry from the supportive relationships women described the need for, in the previous chapter where I described how reluctant they were to introduce conflict with the midwives that they were dependent on for care. In Gilligan's (Hamer 2000) terms, the dualistic, relatively simplistic notion of rights cannot begin to address the complexities of women's decision-making, which are connected rather than disconnected from their network of social relationships³⁸. Thus while some women found rights to be of limited benefit³⁹, most of the women did not respond well to the idea of appealing to rights. While they all knew that they had a right to a home birth - and this contributed to their confidence in planning it - most did not want to have to insist on that right:

'I found out that I had a legal right, but I didn't really want to invoke that (laughing)'

³⁸ In an interview with Mary Hamer (2000), Gilligan discussed the assumptions in separation ideology in relation to her work with women making decisions about continuing or discontinuing a pregnancy. 'Everybody has a separate life and a collection of rights they can exercise. I saw at that moment why women didn't fit into the existing paradigm in psychology which presumed a separate self and relationships as voluntary associations that you could make or not make.' (176). Her contention is that relationships are an 'entering premise' for many women and that 'any step that they took would reverberate through the whole network [of relationships]' (176).

³⁹ In the same way that the concept of choice (limited as it is in obstetrics) has offered some possibilities for women, rights have been useful in bringing issues to light and establishing some base lines, particularly in relation to violence against women for example. And given the normalising effects of society, women are more likely to plan a home birth if this is seen as a natural right than if it is illegal for example.

Nor did women want to be attended by midwives who they felt would attend them under duress.

‘The most important thing to me was to feel supported. From what I could gather a home birth wasn’t going to have much benefit if I wasn’t with people who I felt were supportive. And so up till quite recently - what 7 and a 1/2 months - I was still just trying to work out if I was going to feel supported enough by the midwives that were offering the service to actually want to go through it’

More difficult still was the right to refuse treatment. As Gilligan (Hamer 2000) suggests, imposing a system of rights on women who feel themselves to be embedded in a rhetoric of guilt and blame is not conducive to claiming rights. If they are, in addition, situated in relationship networks which demand they consider others before themselves, they are more likely to be pliable and even less able to assert their own knowledge and needs. As I suggested in Chapter 8, this is particularly acute in obstetrics, where risk becomes a powerful lever to prevent women asserting their right to refuse invasive treatments. The inadequacies and oppressive turns of both an ethics of care and modernity’s reductionist ethics are clear and leave women without support and blaming themselves:

‘it’s left me with a feeling that I didn’t handle the situation very well [...] feeling that I should have really handled the situation better. I should have been stronger you know. I should have sort of held out. I should not have given in ... I should have been strong and sort of said, no I don’t want to be induced you know. But the pressures I was under at the time I was sort of left with feeling, no you know why didn’t you just say no? Especially afterwards the midwife said you know, if you’d sort of made a fuss, they would have let you go back home..... And I just turned round and said, why didn’t I? You know. Why wasn’t I just strong Why didn’t I? You know I could have avoided all that. And I mean, I know why I didn’t [...] But I didn’t and it sort of I don’t know ... I just sort of feel I probably made the wrong decision although it’s understandable ... why I made it. But it was still not a good.... you know it wasn’t a good choice I made’

‘in hindsight, good old, you know, a wonderful thing, hindsight, I suppose Now, you have to get this straight in your head. I know that I made the decision I made at the time, for all the reasons that I had. And I know that they were good reasons at the time ... Looking back on it, you think, well, you know, it might have been better to fight for it a wee bit more. But then I know that the reason I didn’t at the time was for, you know ... reasons of safety, the baby, you know [...] I think the thing with my instinct was that, you know, he was alright, but he wasn’t terribly comfy, and you know, I really needed to do something about it But I wonder if I could have done something about it at home if I’d been given a bit more time, and felt that there wasn’t such a time issue around it. Which, in fact there wasn’t when it turned out, you know, it wasn’t like you have to get in there now, you know. There was a big time lapse in hospital so yeh [...] Cos I hadn’t really wanted to do that [have an oxytocin drip] and .. I suppose ... looking back on it I think, I should have just said, no, I’m not doing that, I’m just going to let it happen itself, cos it had started. It was just not quick enough [...] It’s a strange kind of situation because you realise what an arbitrary thing obstetrics is. It seems to create these situations of decision making that possibly don’t really need to be made. But at the same time, as the midwife said to me, she said it takes a very very strong person to say no I’m going to do it at home in the pool and I wasn’t prepared to make that decision, you know, and possibly put the baby’s life in danger’

Examining the concepts of choice and rights suggested that women often felt unable to follow through on their own ethical judgements. This was not only because of a competing, dominant,

medical ethical framework (which separates the woman from her baby by constructing a damaging dichotomy between the baby's physical well-being and the woman's experience in a coercion/vulnerability pairing), but also because of an equally oppressive rhetoric of selflessness. In other words, modernity's ethics and ethics of care could be seen as opposite sides of the same oppressive coin.

In the next section I focus on control. I attempt to examine the often assumed, "choice equals control" equation in the light of the women's discussions about what they meant by control and how in control they felt. Just as choice is limited by a range of factors, such as knowledge, beliefs, practices and resources, 'the prevailing coping-through-control ideologies are often limited by class, race and gender biases (Fine 1992: 62). And as I suggested on page 75, control takes place within the limitations of cultural definitions and language (see for example, Murphy-Lawless 1998a, Treichler 1990, Trevathan 1997).

As we have seen, it is also in the context of most women having little control over basic components of care during the childbearing period. In terms of autonomy and agency, this discussion is therefore a discussion about how women developed strategies and coping mechanisms in an environment designed to minimise their control and maximise its own (Murphy-Lawless 1998a, Fine 1992: 64).

Control

Meanings of control: On the surface

It was in looking at the women's meanings of control and the comparisons they made between experienced or imagined home and hospital birth that I was able to provide more nuanced debate about the perhaps too easily made assumption I referred to on page 76 that in their own homes, women are in control (Campbell 1994: 4, Green and Coupland et al 1998: 19, Martin 1987: 143, Murphy-Lawless 1998a: 245). A broad brush reading of women's experiences of hospital birth and their expectations of home birth confirmed that there was indeed an initial expectation among the women that they would feel more in control at home. There was also a broad consensus that meaningful control would be less likely in hospital (see Chapter 7), as the following quotations suggest:

'I think probably you've got more control cos it's your own home, you know. The midwife is coming into your home and they're a visitor whereas you're like a visitor in the hospital. So you maybe feel more pressurised to say yes to things that maybe you wouldn't have otherwise'

'I felt I wasn't in control of the situation at all. For instance even just walking into the hospital, they bring down a wheelchair and I said well you know I'd like to walk up the stairs and they said no, no, no, no, we can't take you up the stairs unless you're in a wheelchair. You **have** to be in the wheelchair to get up the stairs, you know. So you were out of control before you even got to the room that you're supposed to be at. Well all this freedom of movement and you can walk around - you couldn't even walk up the stair or into the lift. They wanted you in the wheelchair straight away and that was just the start as far as I was concerned'

And that the spatial, temporal and material arrangements of a hospital further reduced control:

'on thinking about it a bit more clearly, I realised that one of the other reasons [I felt disempowered] is that whatever you think that you can do, in terms of mobility, when you go into hospital, it just can't happen because the room's too small, you know. There's, lino

on the (laughing slightly) floor, so it's not very comfortable to get onto the floor, you know. The beds are hard (laughs), you know. There's machinery about and there's no way, that even if you wanted to that you could realistically walk up and down the corridors, because there'd be so many people there, and they'd be (laughing) wanting you back in the room. So even if everybody thinks, yes, it's a good idea to be mobile, then it's just not practical in hospital. And I didn't realise that until I got into the labour ward, you know. I'd been in labour for about 8 hours and I **really needed** to concentrate, and I just thought, I can't do it here (laughs). And at that point I actually got quite frightened as well, actually..... and wondered what was going to happen next, and didn't feel at all like I was going to be in (laughing) control'

There were even one or two examples of overt control. For example, a midwife did not want a woman to birth her baby in a birth pool:

'I moved back to the middle of the pool, and floated a bit and I came back to the side and a couple of contractions after that I was just moving from side to side and I felt somebody hold the top of my head and I felt that they were controlling where I was. And I said, who is holding the top of my head, and [midwife] said it was her and she let go. She was holding my ponytail, and I don't think she should have been doing that and I don't quite understand why she was, but it did feel like a form of control, I have to say'

As described by Robin Gregg (1995) and Jo Murphy-Lawless (1998a), these women described an ideology in the hospital setting that remained largely oblivious⁴⁰ to the control it exerted, and unaware of alternative ideologies. Women were often only able to draw on 'little strategies' to exert minor influence in a system which had erased their subjectivity and agency, prior to their engaging with it - hence from a position of subordination.

For one or two women, the difference in terms of control was relatively subtle and could be to do with the difference between a tendency in hospital for midwives to lead rather than follow:

'I mean I suppose .. like when I had [baby in hospital] ... they [midwives] were the ones that were telling me when to do things Although I didn't feel like they were taking over or anything. They were just you know giving advice and sort of saying, push now, or do this now or whatever [...] Whereas with this one although I was probably more aware of what my body was telling me to do rather than having somebody else say, come on now you need to push with your next contraction [...]. They [midwives] sat back and let things happen ... let me get on with things. They sort of helped [...] as they felt it was getting to the stage where I was needing help And I could hear things ... I could hear what they were saying [...] you know, I heard a little of the chit chat that was going on between them and ... But you know ... sort of, oh look you can see the head, and, there's the hair, and things like that so and I do remember hearing things but it didn't seem so important that I had to remember every single thing'

'N Looking back on things, how in control do you feel you were?

Em..... quite a lot in control really..... I mean at the birth itself, the labour itself I felt like it **was** just my body doing what it was doing and they were just there as stand-bys really ... It didn't feel like they were controlling **anything** then They really

⁴⁰ I use the term 'oblivious' with caution, as I do not intend to imply that medicine and its practitioners are completely oblivious to, or unaccountable for the control they exert. However, Bartky's (1997) extension of Foucault's work on power, suggested that normative values are so embedded in the foundations of the culture that those practicing are both aware and unaware of their existence. They are often integrated into the structures of normative institutions, so that the underlying principles are no longer visible or easily accessible.

just blended in really well, you know. They didn't seem like they were forcing anything upon me They were just chatting ... they were just chatting really nicely. They were just really helping it to be relaxed. But there was at no point any control that I can think of really because I was, yeh, I was eating when I felt like it. I was bathing when I felt like it. I was walking about ... and they were reminding me again to keep moving ... you know, stuff like that But they were just waiting for me really to hint or to ask for, or to suggest something yeh it was really good'

As I suggested above and in the previous chapters, there were many comments about the need for information, to be in control. But this was found to be lacking, particularly about obstetric practices:

'I just feel much more ... knowledgeable, even though I **thought** I'd read up quite a lot last time, I realise there's all these procedural things they do which you don't even know you've had. Like the syntometrine jag, and the vitamin K for the baby. I didn't even **know** that I'd had that last time, or that [baby] had had that ... And this time I'm aware of it and I'm saying no, unless it's really really necessary ... I just can't believe that that all happens completely outwith your control really .. unless you've read, or spoken to women before about it'

'I think my mum ... Although her and her friends all say, och the girls today, they know far too much. They swallow textbooks and it's absolutely ridiculous. And she says this to me. And I say, mum, there's only one way you're going to be in control and that's if you know something ... And I know,... you know, she thinks, yes'

And through the notion of "control", women also raised the issue raised in Chapters 8 and 9, that without the means to realise "choice", there are few options:

'N I just wondered what that means for you, what it means to be in control
Well, to have a choice first of all **and the means to do it** yeh, just being aware of all your options as well, so you know basically what's best for you' (my emphasis)

However, while the women agreed that exerting control in a hospital setting is problematic, their accounts also demonstrated that the coercive framework of the medical approach to birth crept into their homes in a variety of ways. Looking at their initial expectations and subsequent experiences during the series of interviews demonstrated complex anomalies, and experiences of control at home:

'it's made me feel a bit sad to think that somebody who is who is in a position to do a really you know, a really beautiful job, can be so officious and stick to the, you know, the professional, medicinal side of things, even though they're in somebody else's home She [midwife] did seem to put up a wall around her and come in as if I don't know

N As if?

Well, as if, yeh, you are now under her control. That was the the feeling I got I should do as I was told (laughing). You will adhere to this. You may be at home, but you're not safe [...] I think I was going to say that I thought it [the home birth service] was a way of (laughing) controlling. Yeh, I think it's just almost like a form of controlling people and reminding people that, you know, it's dangerous to go alone and that it would be illegal to, you know, to have a birth without a midwife and, yeh, I don't think there's a great deal of choice about it is there? There's not there's not any variety. It is just a monitoring service, It doesn't allow you any opportunities to get to know a midwife, or trust a midwife. It's just about monitoring you and doing all the things they do in hospital but doing it in the community [...] I do feel that, your knowledge is totally

overridden [...] I do find it totally unbelievable, and I I don't think I appreciated that until I had a baby at home and realised that even you know, even although you're in your own home you still don't have great deal of control'

Meanings of control: Looking more deeply

Not all women experienced the same level of oppression. This largely depended on their position in relation to normative values and practices. The greater the level of discordance, the more the woman experienced medical ideology as controlling. As one or two of the quotations in Chapter 8, and the above quotation showed, this feeling was strong enough for a few women to feel that their homes became extensions of their local hospitals, through the presence of midwives, their practices and the tools of their trade:

'I felt like it [home] became an extension of the hospital with all the paraphernalia'⁴¹

For the women who distanced themselves most from dominant birth ideology, it was clear that the overt control exerted through the policies and practices of the medicalised approach to birth, was itself located within a broader coercive framework⁴². My findings confirm those that suggest that women who overtly attempt to exert agency are often met with hostility⁴³ (Green and Coupland et al 1998, Jones et al 1998, Scully 1994). As the quotation below suggest, while a degree of challenge was tolerated, those who were perceived to be a serious threat to the 'immortality strategy' of modern obstetrics found other barriers to their attempts to exert agency:

'I feel like I'm complying. That's what I'm doing. I feel that I feel I couldn't just go off and do it [give birth on my own] because because, I've been told in the past that I'll be committed to a mental hospital [...] So I have in the back of my head sort of, big brother [...] Yeh, I'm complying, you know, I'm doing what I have to do'

For some of these women, control was a necessity, to ensure that their beliefs and needs would not be overridden. Control in this sense was seen as the 'watching out' that I described in the previous chapter on page 238, and was thus a cause of anxiety and an interference to the process of birth. It took the place of trust:

⁴¹Passing comments that 'they [midwives] run round your house, raiding your things' and the strangeness of seeing 'all your everyday things being press-ganged into use', made by a woman who was full of praise for her midwives, suggested that whether or not it is experienced as invasive, there is some sense in which professionals claim the woman's home as their own terrain, rather than encourage her to claim it herself in the way described by Bernike Pasveer and Madeleine Akrich (2001: 233).

⁴²Women described being judged by normative values in a way that suggested that in making a decision to plan a home birth, their responsibility and ways of becoming mothers were open to question. They are open to scrutiny: morally, emotionally and physically, and were therefore under pressure to assume conventional personas in other ways. A number of women felt their homes were examined in this way:

'they were kind of looking at the house, you know. Trying to sort of perhaps gauge how fit or unfit it would be as a (sighs) delivery (laughs) stage or something, you know. But I felt a bit on my guard, because of that. I felt there were people sort of looking at your house, you know. Is it clean enough? Is it big enough? Or is it bright enough? And so you feel a bit sort of ... on your mark because of that. That, you know, they might decline to (laughing) attend you or they might say, well you have to go to hospital, because really you can't give birth in a place like this'

There was a tension between resistance and acceptance, when dominant ideologies relentlessly measures those on the outside from within, and may find them irresponsible, lacking or in need of punitive action to exact conformity. At a deeper level it pointed to the existence of coercion across a wide range of being and behavior, widening the gap/split between internal being and external presentation in those who resist.

⁴³I discussed this in Chapter 8, where I suggested that the usual meanings of responsibility and control, and the view that they are desirable and positive is redefined or suspended during pregnancy and birth.

N How far would you say you felt in control?

..... That's a hard one actually, because I felt completely in control of my personal safety and my baby's safety and I feel that I shouldn't have needed to (laughing slightly) be in complete control of my personal safety and my baby's safety. I feel that I should have been able to relax and for the labour to go on spontaneously ... Whereas, as it happened that couldn't be [...] I had to keep them [midwives] at a distance. They could do what they liked, but they had to take a distance from me. And I had to make absolutely sure that they knew that they **couldn't** take my baby away. That was not a possibility and that they would have to take me with the baby if the baby had to go anywhere So yes, I felt that I was in control of my personal and my baby's safety but only because I couldn't trust them'

The following quotation captured the complexities and inseparability of safety, control, trusting relationships and women's hopes and cautions in the context of: a coercive medical framework; the ambiguous role of midwives when it is mediated through obstetric ideology but tempered by the tentative relationships women and midwives formed; and not knowing whether or not it would be safe to give up control:

N I wonder if I could ask you what control means for you, what you might be in control of. You talked about it last time and I wondered if you could talk a little bit more about that? It's a confusing one, because I want I kind of want both ends .. of the (laughing slightly) spectrum. I want to be able to ... give up control completely and in terms of the process of what's happening, just be able to go with it. And I also want to have control complete control over the space and what's happening in it and .. the light and ... you know, who's doing what to me or who's doing what to the baby. And they don't feel very compatible, those two different states of kind of being - completely surrendering to a very powerful process and also kind of going, hang on a minute, I don't like what you're doing there, you know, go away or come closer or whatever. So (sighs) it feels like a funny balance, and I think that my partner will help to balance it more, because I think he will be able to take more of the .. active lead, asking people to do things or not do things, or whatever I suppose that that would be my you know, from the outside of the situation, from not having experienced it .. my ideal would be that I could completely let go and feel very protected by my partner and that he'd become a - form a second skin, which, you know, could cope much more with what was happening out there. I think originally I thought my mum might do that and that my partner might be much more in the experience with me. But I don't think that it would be as clean cut as that if there were two of them there It's that hope of being able to be very trusting in the event I think And I mean, the thing about being trusting is that it does tend to it is quite self-perpetuating. It does tend to mean that you can trust as well.... that being trusting is that you're open and relaxed and things can flow more easily So I think if we get on (laughing) the right line with it at the beginning or at some point, then it should actually go very smoothly. And if it goes very smoothly, then the midwives will be happy and then they won't be kind of looking at their watches, saying, oh well, we've got to call the ambulance in 10 minutes, or whatever And so I'll feel much happier about them being there, you know. So it could well feed into a virtuous circle of things ... being okay I suppose that's just what I hope. That's what I hope will happen, and also, it might not ... we'll just have to see'

Moving beyond control: Looking more expansively

Women described diverse needs for control in their lives. However, it was clear that just as choice had the potential for fluidity, women did not define control in absolute terms. Ideally control meant planning birth as far as possible and then responding mindfully to an unfolding situation in the context of broad philosophical agreement about birth. Thus for some women the emphasis was on being able to plan for their births, for others it meant obtaining detailed information about possibilities, for others it was to do with resisting outside influences. The common strand however was the emphasis on activity rather than passivity in meeting their pregnancies and births - making an active decision to have a home birth and following through on this⁴⁴:

‘it’s a different kind of state, head state I suppose that you get into when you go for a home birth. It all shifts. You become a lot more ... because you’re much more in control of how it’s going to be, you’re much more aware of everything else that’s going to be involved as well

N What sorts of things were you thinking of

Well just where you’re going to have the birth, which room you’re going to be in you know. Or how you want to be, or where everything’s going to be. Who’s going to be around - there are all these things. Although I haven’t made any final decisions about anything yet But in hospital all you do is go there and they seem to do everything for you. You don’t really **think** very much for yourself anymore⁴⁵

It was only after a few months of interviewing that one of the women in the study suddenly brought to my attention just how pervasive medical terminology is and how our discussions were limited through our acceptance of the limited concept of control that is provided for us by medical ideology⁴⁶. Her thoughtful response to my question about control enabled me to: understand more about this; listen more carefully and think more expansively about what women were saying in response to questions about control; and hear the irony of women attempting to relinquish control in the context of control being exerted over them:

‘N Right, right would you be able to say a bit more about control?

Um I I wonder, um I mean, control isn’t something that I would necessarily put lots of emphasis on. It’s not that I want to be able to necessarily dictate so much what goes on. Um ... more that I don’t want strong influence on me because I know that if I have that influence I bend to it, you know and in the long run, that’s no good for me. It’s much better if I’m doing what actually feels natural, I think. But also I suppose it comes down to knowing

⁴⁴ Drawing on the previous chapter and the analysis here, trust and control were very much embedded in relationships for women - but this did not mean substituting control for “blind trust”. Part of a mutually respectful partnership could include a healthy alertness and responsibility and thus agency. As one woman commented:

‘I want to be more in ... control of what is going on, because after all it’s our bodies, it’s our babies, and I now find it hard when my friend talks about things like - well I’m completely confident just to put myself in the hands of my nurse or my health visitor or whatever. I now think she’s completely wrong, you know ... And she was, oh fiddlesticks, you should be completely confident in your health visitor. And I said, well, I am confident in her but, there’s being confident and there’s still being able to double check what they’re going away to inject into your baby’

⁴⁵This quotation is suggestive of the political/consciousness raising potential of planning a home birth in a culture that generally sees it as risky and irresponsible. I discuss this on page 338.

⁴⁶ At the same time, because these terms have been appropriated by dominant medical ideology, there is a sense in which I/we are obliged to adapt to and speak in the useable, linguistic currency of the day.

Knowing what's going on. Knowing who's going to be there, you know. So that there's the midwife there, rather than ... I mean, the idea of sort of students, having a midwife popping in and out, and perhaps there'd be a doctor popping in and out feels very unbalancing to me. But the thought of having a midwife and my husband here, and also the fact that my husband will be able to, I think play a much greater part, and feel happy about playing a greater part is very important. [...] I suppose it's more ... dissipating control, you know. There's not so much of an issue of who is in control, when it's at home, because I don't intend to sort of .. it's not my wish to be pushy but more just that it's that there's no-one in control. That things can just flow and no-one feel that they're more or less part of things or so on if that makes any sense'

Challenging the controlling/controlled dichotomy

Culturally, control usually means control over, but as I discussed on page 76, Green, Coupland and colleagues (1998), and Jenny Kitzinger (1990) found as I did, that women wanted to avoid being controlled, without necessarily taking control or 'dictating' to others. The rhetoric of control within dominant ideology, even more than that of choice remains firmly embedded in adversarial relationships. Moving this type of control to women does not move beyond hegemonic dualism, or the subjectivity and morality it constructs. It does not depend on the sort of mutuality I discussed in the previous chapter, nor does it reflect the sort of multiplicity and relational autonomy I described in the theoretical interlude of this chapter. It merely shifts the grounds somewhat, in the perpetual struggle for control over childbearing. Indeed, it became clear that the narrow definition of control within medical ideology retains all the problems I described when examining safety, continuity and choice for example. Just as choice is a poor substitute for the trusting relationships, control is a poor substitute for empowering relationships and agency. So while women often responded to questions of control using the usual discourse available to them, I began to hear where they moved beyond this, to reconceptualise control in terms of relationships and moving through a rite of passage that I discussed in the previous chapter. I began to hear two distinct but related stories about internal/external control and moving from control to freedom. Thus one story was about increasing stability and reducing external distractions to a minimum, so that the woman could relinquish external concerns and remain focused and uninterrupted in her task of giving birth: 'it seemed to be all about removing obstacles'. The second story involved teasing out what control meant in relation to the birth process and whether or not it had any meaning when the women's concerns were to feel relaxed, free and uninhibited enough to give birth. I begin with the first story about familiarity and predictability⁴⁷.

Holding things steady

'N I just wondered if .. you would be able to say a bit more about what it means to be in control for you
.....Er ... to be in control. I think, I don't necessarily mean in control of myself, as much as in control of the situation That sounds like, a bit double Dutch [...]. Do you know what I mean? (laughs) Yeh, to be able to say, no, I don't want to do that, I'm not comfortable with that'

⁴⁷As Lemay (1997) found in her study, the woman's surroundings needed to be known and predictable. Thus many women made decisions to be relatively independent of midwives (and as I suggested earlier, depend only on partners or close others for their emotional and bodily needs during labour) because they were unsure about whether or not they could depend on them. The importance of continuity, and the discussion in the previous chapter about not knowing who would come when the woman called in labour became clearer still in the light of the need for stability and predictability.

As I have already suggested, women focused on setting up the most conducive circumstances for birth. As we have seen, this was the reason many gave for planning home births in the first place. The women's focus was on creating a safe, "free" space by stabilising outside influences and feeling able to be themselves. Even those women who discussed control at length in and across interviews focused on organising their environment and reducing the likelihood of unexpected occurrences. Their planning was to provide a level of certainty, in which to accept the uncertainty of the process of birth: to be free to work with their bodies in their own time and way and avoid a whole set of temporal, spatial and behavioral constraints. Thus territory became a major concern (though, as I observe in the footnote below, it is difficult to discern just how much this was in response to lack of trusting relationships⁴⁸). There was an acknowledgement that territory could make a difference in terms of spatial arrangements, which could free rather than constrain the body. Being at home could enable women to attend to their bodies in ways they could not easily import into a hospital as indicated by the following contrasting observations made by one of the woman:

⁴⁸Interestingly, one of the women moved house during late pregnancy. In response to my opening question asking her how she was getting along, she commented that as her surroundings were normally very important to her, she was surprised at how calm she felt. Feeling secure with her midwife was a significant factor:

'N [.....] Would you like to say how you've been getting on
I was wondering what had changed [...] But I would just say I think I've become much calmer, and I've enjoyed it. I've enjoyed the latter part of my pregnancy very much and I think the more I've got to know [midwife] the better it's been ... It's just more and more felt like the right thing, and now I can't envisage, you know, what women settle for because they don't know what they could get [.....] and I think the more you go on, the better you realise it is We're just so glad that it's worked out like that. Just perfect cos I mean, we had a bit of stress, with moving a couple of weeks ago, which is really way too late, you know. But because we felt so happy with [midwife] and there were so few variables that it didn't matter that one of them was rather major (laughing) somehow, you know. So I was quite happy [.....] it just didn't matter actually. But I would have thought I would have been really tearing my nails, you know, moving 3 weeks before her due date. But it didn't matter'

Indeed, if familiarity was one of the key components to holding things steady, then lack of continuity inevitably constituted a potential obstacle to the woman feeling secure enough to defocus on external matters and refocus on internal sensations. However positive women felt about their midwives and experiences, where there was no relationship, the woman invariably felt most relaxed on her own or in the presence of those she knew well:

'perhaps if the midwives had on occasion been able to just take themselves out ... perhaps that would have been a good idea, if there had been a bit more fluidity in the midwives going out and things just for focus and to be able to concentrate and to be able to talk very openly with my husband, you know. About what was going on, what I felt. Because there were things that I could say to him that he would know what I meant. I would be able to sort of share some of my real fears and anxieties, which I felt I perhaps couldn't share in front of the midwives because they might take them more seriously than they were actually meant, you know. Like the time when I said I'm going to die, you know. And they said, no you're not, no you're not. But I said, I know I'm not when I just wanted to be able to express some of this, you know. I didn't want anyone to do anything about it, but I sometimes wanted just to express things that that I felt perhaps a bit inhibited to do because I didn't want to .. worry ... the midwives because I was okay'

Without knowing each other well, it seemed difficult for women to express either their needs or for midwives to know when to withdraw and when to be present:

'In retrospect I was a little annoyed with what happened with the midwife. About the possibility of her going away and all that. It placed a burden of decision on me at a time when I felt, look, she should be here for me. But then this idea, oh no, you know, I shouldn't be a burden to her and all that. [...] The only time I didn't feel in control was when she said she might leave for a couple of hours. That part I felt uncertain about things'

The irony seemed to be that women in most need of support were those most removed from medical ideology but that in order to maintain their ideals, and retain a sense of autonomy, they felt they had to disengage emotionally from maternity services and midwives, by withdrawing, becoming businesslike (see page 299), or becoming more assertive, in order to create distance - a space in which to maintain their integrity. Either way they lost a sense of connection:

'I've had so many exchanges with different midwives and people I think that I just have to be blunt with them, or I just tell them straight out anyway. And it doesn't really bother me I suppose cos I feel stronger. I can do it, you know and I don't need them. That's how I feel. I don't really need them'

For some women, focusing on the environment increased confidence, but it is also possible that some women felt that in the absence of supportive relationships over which they had little control they had to focus on where they could have most influence, i.e., their home environments.

'and thenas things went on .. I was given diamorphine and the way that I remember it was, that it was suggested to me, to bring my blood pressure down because it would relax me ... And it probably did do that but it (laughing) completely spaced me out as well, and I had to lie down. And after that, I mean I was just completely out of it ... and hooked up to goodness knows what. Well since I got my notes I do know what I was (laughing) hooked up to, but I didn't know at the time ... you know - a fetal heart monitor, my blood pressure was taken every 15 minutes and I was getting .. syntocinon. I just knew that I couldn't move. I (laughing) couldn't get off the bed'

'you know, I know which bits of furniture that ... are the right height (laughing), the right shape, to be useful. I'm also looking forward to just the fact that there'll be ... soft stuff on the floor (laughs) .. and that I can maybe put something like a sleeping bag underneath the plastic sheeting and I can really use the floor. In hospital, I mean, on a lino you can be (laughing) uncomfortable to go on all fours or anything like that, or on your knees So ... I mean that's almost like the first thing that I think about when I think about (laughing) having the baby at home how I can manoeuvre myself comfortably'

So while women discussed 'controlling' the environment, this actually meant creating an environment that would be both familiar and which would enable them greater freedom. 'Losing control' was thus about being subjected to the constraints and distractions of an unknown environment in which they could lose control of their bodies' abilities to give birth:

'I need to work out in my head, you know, I know that that'll happen [losing control] (laughs), and when that happens, what will I do (laughs) so that I can have worked it out beforehand .. cos in hospital you don't really get a chance to do that. Well, you don't get any chance to do that at all (laughs) [...]. My mental plans are really based around which bits of furniture I think will be (laughing) useful and where I'm likely to feel most secure [...]. Now that I've actually booked a home birth and I'm really thinking about it, not having that and doing the opposite and going into hospital, I have to say, that would be horrible (laughs). And that's what I found very much last time - that you had no idea what you were going into. And .. I'm not the sort of (laughing) person who doesn't like to know what's going to happen next. I really like to have (laughing) planned and control of the situation, and it was horrible not to be able to do that So it's nice when you're at home that you can do that (laughs slightly) In a hospital birth there's absolutely no control over your environment actually. I mean, for people like myself who are totally used to (laughing) controlling their environment all the time, it's really scary and unnerving and that relates to both feeling disempowered. And also feeling like you're out of control, because your normal mode (laughing) is to control your environment, and you're not able to do that'

The current spatial layout of hospitals has bodies in mind only so far as institutionally managing those bodies. Labour suites were seen by many of the women to be constraining rather than enabling of labouring and birthing bodies. Women's accounts of spatial arrangements in hospital concurred with, but were rather more complex than Moira Gaten's observation, that the body is organised around culture rather than vice versa.. Their homes, however could be organised around the labouring, birthing and postnatal body to avoid the environmental disjuncture between home and hospital which could impact on their hopes and plans for birth ⁴⁹:

⁴⁹Interestingly, in contrast with Machin and Scamell's (1997) ethnographic research, I found that women saw separation during birth as an internal process and wanted to maintain the security and stability of their home environment as a way of providing continuity and connection during the fragmenting process of birth. And yet while Perakyla's observations suggested that 'spatial arrangements differentiate groups of people' in hospital (in Silverman 1993: 42), spatiality issues could be brought into the home by professionals crossing physical or emotional boundaries which are not usually overtly

'If you're in hospital and sometime in the past you've thought, this is what I'd really like to do. This is really how I'd like my labour managed, it just goes completely out of the (laughing) window once you're actually in hospital. And being told what to do by staff, because they think it's best. So it's only ... you know, after a couple of months when you've been home, that you think, oh,(sighing laugh) it was like it was a different world when you (laughing) said, or wrote down, I wanted to do that. It bears no relation to (laughing) what actually goes on. So, I see, and I don't know how this is going to work, but I see being at home as a way of joining up what you thought (laughing) when you were pregnant and what you wanted when you were pregnant, and what actually happens in the labour'

Controlling birth: 'That's like telling me when to poo'

As I suggested on page 47, an articulated rhetoric of natural birth began to develop in the 1950s in response to the sedation and control of women during birth. The various psychoprophylactic techniques that arose however, were clearly part of the same medical control discourse. The birthing body remained docile - under control, but the woman herself took on the job of external control, exerting her will to control her body and her responses to labour. More recently, the terminology of coaching, and asserting mind over body has been replaced by that of, 'going with the flow' and 'letting go'. But as Tess Cosslett (1994) suggested, and some of the women felt, there is often still a background sense of women being in control, coping with their labours in ways provided for them through an apparently new discourse:

'I mean, it does seem that is what is expected from the midwives point of view - or in this situation anyway ... Because they see you as staying at home, they basically assume that you're going to be in control (laughs). [...] That you'll be able to tell them what to do all the time'

As I suggested, the notion of control has been used in relation to both the woman and the birth process. The current natural birth discourse, based on a different interpretation of the physiology of birth, focuses on enabling the woman to follow her own instincts and respond to her body as she needs to. There was a general acceptance or experience among the women in my study that the process of birth itself should not, indeed could not be the subject of control. As Michel Odent commented, 'how can you manage an involuntary process' (Odent 1999: 31):

crossed. Returning to Bartky's (1997: 142) notion that the patriarchal 'gaze' is not only knowingly, but unknowingly represented through the eyes of others, enabled me to understand that the walls of the woman's home cannot provide a barrier to this 'gaze'. Nor can it necessarily prevent the woman from gazing at herself through others eyes - whether or not they represent dominant notions of women and birth. But the behavior and contact the midwife made could reinforce or dissipate the oppressiveness of this gaze, as the two contrasting quotations below demonstrate:

'I feel that I felt most at ease when they [midwives] weren't there at all. When it was all starting to build up I think they came first when my contractions started, and they brought the equipment then they went away and came back when it was more intense And when they came back it took a while for me really to do ... Well I felt I had to ... almost ask permission ... in a way... but I didn't really. I didn't ask permission, but I almost felt like I had to to go and wander off around the house but after a while I did relax with it completely and it was really good'

'the midwives sat, one on each sofa and watched me all the time and asked me questions and wanted me to lie down so they could listen in and ... were very intrusive, they didn't leave me in peace at all [...]. I was moving around. I was dancing. Well I was moving my hips with a contraction and that was fine. But I really felt that I couldn't do that in front of them you know. Most of the time I spent going out of the room, you know. I'd go into the bathroom for a contraction or I would just go out into the hallway. But I really didn't feel like labouring (laughing) in front of them you know [...] Yeh, I just felt uncomfortable in their presence basically'

'I've been reading the midwives textbook, and I think, that's not what they do (said slightly incredulously). What they say and what they do is like, you know ... Don't say push, push, (laughs). Well, (laughs) I think that's one of the first things ... No don't push, you know, and then push, and then don't push, and then push. And I'm going ... hang on, hang on. That's like you telling me when to poo. I mean, it's impossible isn't it (laughs). I'm constipated and you're trying to manage it, you know. Like it doesn't work'

Left to unfold in its own time and way, women believed that there was a certain sense in which they were not/could not be in control:

'I could even, I could sort of half see and hear what was going on, even though I was in terrible pain. But it's I don't know what woman feels absolutely, totally in control giving birth because it happens at its own pace'

'Maybe I couldn't have really controlled it, even if I had heard it [midwife's instructions in second stage] because you get so taken over don't you? You know. What you're thinking doesn't really count for much after a while does it? Because your body(sighs)'

The woman's discussion about the involuntary process of birth led to discussions about simultaneously 'letting go' and 'concentrating': holding on to let go. As I suggested in the previous chapter's discussion of the fragmentation of the self during a rite of passage, the patriarchal fear of losing control of the body reflects a fear of losing the ability to manage bodies. Women's accounts were positioned rather differently in relation to these discourses.

'Letting go': But not 'losing the plot'

Talking about passivity, Carol Macmillan (in Belenky et al 1986: 117) suggested that agency 'need not involve control over other events'. She used the illustration of women giving birth without pharmaceutical pain relief to illustrate the coexistence of forbearance, control and active agency. Nel Nodding's (1984) description of control as a letting go had parallels with the way women talked about control, when they applied it to the birth process and their own bodies:

'I let the object act upon me, seize me, direct my floating thoughts My decision to do this is mine, it requires an effort in preparation, but it also requires a letting go of my attempts to control. This sort of passivity ... is not a mindless, vegetable like passivity. It is a controlled state that abstains from controlling the situation' (163)

Many women saw 'losing control' as essential, if they were going to be able to give birth to their babies using their own abilities and efforts, or at least that it may be no bad thing providing the circumstances were in place to support this:

'this girl that I spoke to said she was really worried. She had a caesarean and she was quite happy in the end because she said she was really worried that she was going to lose control. And I said, well, I'd be more worried about not losing control, (laughing) cos it's like, you know, trying not to go to the toilet when you need to go, you know. You kind of better lose control otherwise you're going to be in trouble'

'like the control thing. I've got this idea that ... part of having a baby would be like the way that you the way that you .. open up to have an orgasm. Like if you sort of strain, then it doesn't happen. Whereas if .. if something melts inside then it does And I sort of

imagine that that kind of ... is similar to the softening that they talk about when you open up. I don't know'

'I mean maybe it's not a bad thing to, to lose control ...but you have to feel safe enough to be able to do that you know just(laughs) let it ride. AndI don't know if it's that. Maybe there are some women who can give birth and be in control themselves the whole time. But I thought it would always be very much a matter of - it would probably come to a point where that was it. I couldn't cope (laughing) anymore. I would just have to let go'

Women made distinctions between external and internal control. While control of external circumstances seemed crucial, they attributed a positive, potentially freeing aspect of 'letting go', in the context of labour taking its own course:

'N You mentioned a few times that you felt as though you were quite out of control towards the end of your labour

I mean, in the sense that I was taken by surprise by the labour, and that it all went so fast. And that, you know, the midwife didn't do as I asked (laughs). I suppose I was basically out of control at that point. But I mean, I don't think ... I can't picture myself being totally in control throughout the whole thing. I think there is a stage at which you really, let go, and let rip (laughs) as it were. And I felt better about that this time actually. Like it was more of a choice and and that you know, I was really wanting to do that to aid the birth process, as part of, you know, letting go. And .. I think I was very noisy (laughing). I really shouted a lot with this baby. It wasn't shouting so much - it felt almost more like singing [...] it was kind of exhilarating'

'It's almost like at some point I decided .. if I'm going to have this experience the way that I'm going to have to deal with it is to lose all those external control bits that I've put onto myself and just go with it. And once I'd decided that, I didn't care about the mess I was making, I didn't care about the noise I was making, it was a **really** freeing experience'

The fine line between 'letting go' and 'losing the plot'

Being taken over, letting go, surrendering to the process, going with the flow⁵⁰ were seen in a positive light by most women, but there seemed to be a fine line between this and 'losing the plot' or feeling taken over in a negative sense. The simultaneous losing control of the process, but remaining focused was both challenging and precarious⁵¹. The effort of concentrating, where the smallest distraction could defocus the woman, was almost palpable in the quotation below:

'I don't know control, it's a funny, it's a funny word..... I was kind of going **with** my labour.... and at times I was you know I was thinking of losing control I mean for me losing control would just be like either just losing the plot completely and not being aware of what's going on any more or ... letting myself go and you know I mean all the time I was breathing, I was focusing on breathing so much that I was actually wondering while I was breathing, how women had time to scream cos I was (laughing) doing such deep breaths in and then blowing out So I was really focusing on it so much, I was really wondering '**when** do they scream?'.... [...]. If I'd found

⁵⁰As I mentioned previously, when women talked about 'going with the flow', they usually meant focusing on their bodies and finding ways of coping with labour. When this was used by professional, it was often about the need for the woman to remain flexible and seemed more indicative of going with the flow of medical ideology.

⁵¹I discuss a further aspect of control in relation to empowerment on page 303, and the conflict of interests when women need to become uncontrollable and unmanageable in order to reconnect with their own power, but medical ideology needs them to remain docile.

time to scream I would have done it, but I didn't (both laughing), I just thought 'God, cos it's such a distraction if you scream ... you'd be lost ... you've lost the rhythm really of breathing ... as far as I could see'

The way some women talked about being in control in terms of focusing and steadying themselves, brought the term 'centering' to mind, but also invoked its precariousness and the risk posed by distractions:

'I think probably, the longer I can be on my own and come to terms with ... You see this is what I want to do. I panicked when I first got in labour with [first baby] and of course the more I panicked, the worse it got and the more I got myself into a state. Whereas this time I really want to have a clear head I really want to ... you know, relaxation techniques, breathing techniques you know. I really want to sort of get myself on a wavelength where ... I'm completely in control myself, you know. And I want to get on that before I have anybody [midwives] sort of coming in [...] Just getting myself worked up for this, and you know, getting ready for the birth. Especially with not wanting to take any drugs or anything. I really feel as if I want to get myself .. sort of steady before anybody comes in and, you know, starts ... listening to the baby's heartbeat and you know, doing all this carry on'

'Losing it'

The concentration exerted to 'let go' was in sharp contrast to 'losing the plot', where the woman described no longer working with her body, but described an involuntary rather than a voluntary letting go:

'I'd actually lost control I was in such terrible pain'

Thus, having a home birth and avoiding pain relief were not always interpreted as having coped well with birth. One or two women felt they should have done better:

I've always been very glad ... that I was here In my own space And I suppose glad that I dealt with it with a relatively small amount of pain relief, though I don't come away from it triumphant [...] in the long run I let go of my sense of direction and my sense of control [...] I'd sort of built up this picture of an ideal woman ... who cruised her way through labour, you know, and I felt very strongly that ... the next day that there were so many things I would have done a different way, that I would have done better. I felt I'd failed. Not **failed**, but just I should have done it better [...] and some of the books as well ... which ... led me to have expectations of myself which in the end I couldn't fulfill. And I think I blamed myself [...] I was expecting to be able to cope ... you know ... throughout the labour. Expecting myself to be able to get a grip on myself. I did have this quite high ideal really that I constantly wasn't living up to [...] the fact that I never managed to get myself on top of things and feel really good about it. It was always a struggle'

This might represent what Cosslett (1994) described as the natural birth rhetoric exerting its own gaze and exacting its own price on women who experienced birth as more painful than they had imagined or could cope with. It could also point to lack of support for individual women's circumstances and vulnerabilities that could only be addressed by trusting relationships⁵².

⁵²I was struck by the descriptions of 3 women about their labours. All had found them long, painful and challenging. While one woman found the experience empowering, another found it humbling, and another found it humiliating. I could not help but wonder, not about the skills of individual midwives, but about the influence of relationships and the opportunities afforded by engagement and trust. The woman who found the experience humbling, was attended by a

It was clear that the fear or confidence I discussed in the previous two chapters were highly implicated in coping or not coping with labour itself. Panic and fear were seen to be particularly threatening and associated with 'losing the plot'. I could also hear just how finely balanced the coping/not coping distinction felt to many women and how powerful and yet fragile the process of birth seemed to be. Although Michel Odent's (1998, 1999) interpretation of birth physiology and the need for minimal distraction has been largely accepted at a theoretical level, where medical ideology prevails, the women's accounts suggested that there was a lack of understanding about: the constructed nature of pain and its relief (Leap 1996); just how focused a woman needs to be; and the conflict between this need and the need for medicine to control and monitor labour. I have included a long quotation below, which demonstrates these components; the paucity of language with which to discuss this; and the strength women had to be able to resist 'losing it' to be able to stay in herself in difficult circumstances:

'N Did you feel in control would you say

I did unless I was (laughing) strapped onto the monitor and then it really changed me. I mean even [partner] said that, as soon as you were back on the bed and strapped to the monitor again, your pain seemed to be worse you know. But then it's probably all to do with what's in your head as well. I mean, I think my pains got worse because I thought my pains would get worse so they did seem to get worse, you know it was like So no I didn't feel very much in control then. But when I was doing all my different positions I was completely in control ... But [partner] said there was definitely a change in me once I was back on the bed. I suppose the worry as well, when you've got the monitor on. You can hear the baby's heart beat. I mean I know babies' heartbeats are really fast and you're sort of listening to it and you're thinking is that normal? [...]. I found that once the volume was down and I couldn't hear it, then I wasn't so aware of it and it was easier [...]. So no, I didn't feel very much in control then I must admit [...] but all the other times I was fine

N Would you be able to describe how it feels to be in control or not

Oh, I don't know I think when I did feel in control I wasn't even really aware that I was in hospital if you know what I mean. I mean I was very aware of ... of thinking positive, and I was very aware of every time I felt a pain. I was very aware of thinking, right this is bringing your baby closer and closer and it did make me feel much more in control. And I think because I didn't have all the staff running about as well. But I think I fairly much switched off when I felt in control, and I wasn't really aware of my surroundings and then I was I was in myself, you know. I mean, I was aware of what I was feeling, I was aware of my baby coming closer and closer, but I wasn't actually aware of anything around me, so God it's hard to explain, actually. You know what I mean?

N So when you felt out of control how did that feel

Well just the opposite really. I mean, when I did feel out of control, I was really aware of, oh God I'm in this hospital, I'm sitting on this hospital bed, I'm stuck to this hospital monitor, you know ... and even the smells, you even smell the hospital. Then you start losing it a wee bit, you know, and everything seems much more clinical But I was very aware of not wanting to feel like that. So if I did start feeling like that, I was trying to get myself out of it and thinking I remember at one stage when I was getting a bit stressed

midwife she knew and trusted who enabled her to find her own coping mechanisms. The midwife provided opportunities for her to talk about her experience, at length, on several occasions after the birth. The humbling experience turned into an empowering story (see Kirkham 1997). The woman who felt empowered was also attended by a midwife she trusted, and commented, 'I didn't feel humbled by my weakness in front of her'. The woman who felt humiliated by her perceived inability to cope as well as she hoped with labour was attended by midwives she found supportive and caring, but who she did not know. Sometime after the birth she became postnatally depressed. This is not to suggest a causal effect, but it caused me to ponder

out, and I was beginning to lose it, because I was panicking a wee bit - the pain was getting worse, and I was trying (laughing) to think of myself - I mean, I read this somewhere in a book - I was thinking myself just like a flower, and like opening a petal at a time and I was thinking of myself dilating you know, down below. So I think every time I felt like I was losing it, I was trying to bring myself back by thinking, you know. Right, you've got a contraction coming, it's going to be painful, but it's going to bring your baby a wee bit nearer to you, so so I was trying not to be out of control you know I was very aware of trying not to lose it because when I did lose it, suddenly if I lost it I really felt like that last contraction was just so painful, you panic, and when you panic and you're not in control it really is a hundred times worse so I really tried, and I think I did really well, I think basically I was much more in control than out of control sort of thing. But I was much more aware of being in a hospital'

Women both imagined and described the alienation from their own resources in a hospital setting where the locus of control moves from the woman to technology:

'it's this thing of as soon as they start doing interventions it seems to escalate. And so you get ... there are just more and more and more interventions. And as soon as they start monitoring the baby you can't move and so you get completely cut off from ... you know, as far as I can see, any of my own resources, if I'm having to lie on a table I would be so upset doing that. I'd be really miserable (deep sigh)'

'the bit at home I was in control of definitely..... and I felt much more relaxed [...] Even if it was painful, I do remember being in control of the pain..... Whereas being at hospital, I don't remember being in control of the pain. I remember feeling it had completely taken me over..... I couldn't stop it and I couldn't get my head round it and I couldn't go with it, you know And I think that happened quite gradually. But I do think a lot of the things... like... putting the belt on me trying to get me back onto the bed when I was walking around and.... all that sort of ... I mean it's all a bit of a blur, but that sort of gradually ebbed away at my ability to ... cope with it all'

Women's accounts suggested that being in what Ellen Hodnett (1989) described as a 'low load' environment (see pages 182 and 289), was crucial, and that even the slightest distraction or unfamiliarity could change the woman's focus. In the light of Diprose's (1994) theory that changing bodies change usual patterns of being and thinking, and Pasveer and Akrich's (2001) theory that environments change bodies, women's accounts suggested that their usual abilities to attend to their needs changes in subtle ways during labour in ways that interact with the environment:

'I think I'll feel in control in terms of finding it easier to be more assertive [...]. And just having all my own things around me. If I want to listen to a certain tape then I can. Whereas if I went to hospital I wouldn't know where to start unpacking a bag, you know'

'I couldn't just be you know yeh, I think I would have not been able to just be inside myself, so much. I think I would have been much more aware of the things that were going on around me and aware of my surroundings in a way that I didn't need to be here, cos I knew what was around me'

Being there but not there: 'I was there but not present'

As we have seen, for many women, 'losing the plot' meant being distracted. Most women described the need to be able to focus solely on giving birth. As women planned and formulated in their own minds what they might need, to give birth, it became clearer to them that pharmaceutical pain relief

could distract them and become an obstacle to tuning into their bodies, undermining their abilities to focus and work with their labours and those helping them⁵³:

‘If you can get through it (laughing) without pain relief so much the better really because, you know, once you start on pain relief, I think it also gives you less control over the labour. I mean, you don't know ... you can't feel so well where you are probably’

‘I think I would want to be in control of myself because ... I'm the only one that knows, that can feel what's going on, I'm the only that can look into my own body so hopefully, even if I can explain what I'm feeling or what I think maybe I should be doing then they can .. suggest, maybe you should change position, or maybe you should breathe like this. But hopefully I will be fully aware. That's why I don't want to take any drugs to make me disorientated or unsure’

Otherwise, typically, the woman disappears behind the usual management of birth, becoming the passive recipient of procedures: an object being done to rather than central to her own experience. Others could become more active and visible than the woman herself:

‘The first stage - there was not very much control at all, everything was happening to me and these people talking and talking at me and around me and I just couldn't cope with it at all. It just felt like I wasn't there. Once I had that gas and air it felt like I wasn't there, or I wasn't present. I was there but not present Once we got into the delivery room I felt much more in control cos I'd got my breathing back by then. I'd really got it. I mean, I'd been so worried about not getting my breathing right, and that was in my birth plan. Please help me with my breathing, and they did that too It's like I could feel the contraction coming and it's like, okay here we go, and even while they were happening it was like, I know what's happening. I know what's going on. I know how I'm dealing with it and I didn't lose it at all after that [...]. I was frightened then [during first stage]. All these things happening to me and not with me. But in second stage I felt I was really part of it. It was my experience. I felt I'd reclaimed it, and these other people were just helping me to have my experience - if that makes sense. Whereas the first half was like taken away’

Being at home clearly made a difference to women. But there were different views about how far a change of territory would or could facilitate or necessitate a change in ideology, and different views about whether or not (and if so, how far) it might affect woman and/or midwives⁵⁴. Being in one's own home was generally expected to have a positive effect on the likelihood of women being able to shape their own experiences. However, listening carefully to the women's accounts showed a diversity of opinion and experience that was not quite in keeping with this general expectation.

Summing up components of control

One or two women who had had distressing experiences of having little control when they gave birth in hospital, felt that being at home would enable them to assert control:

‘because this is my home, if you're ramming something on my face and I don't want it, then leave the room now, you know, this is my home. Okay, you legally have to be here, but I

⁵³This lent further challenge to the notion that women might be ‘experience hunting’ or seeking to have ‘nice experiences’ at the expense of safety. Their plans to give birth with as little intervention as possible was a deliberate strategy to move through labour and birth as safely and effectively as possible.

⁵⁴ Pasveer and Akrich (2001) suggests that this might be more complex than has been assumed to date, and that as ideology inscribes itself in the woman-in-the- body and midwifery practices, that this will impact on place of birth in ways we need to examine.

don't have to take any sort of action that I feel very uncomfortable with and so you know. I am in control of the situation The only time that that wouldn't happen here would be if there was something wrong with the baby, or if there was an emergency situation with the baby, in which case I would be quite happy to give them complete control I'm quite comfortable with that'

However, as I discussed in the previous chapter, these were the exceptions. Many women's accounts spoke of a complex interaction between their own territory and conflicting ideology and demonstrated a hesitancy about just how expectations of control would materialise:

'I like to do things my way ... mm I like being in my own space as well. And it's about control as well. I think if you're in your own home then ... people can't be telling you what to do. Well they could be telling you what to do, but not quite in the same way as they can in the hospital I felt'

But as I discussed in Chapter 8, those women whose ideologies and aspirations were furthest away from dominant ideology were least likely to experience their homes as protective of that ideology.

'You know, like I said before, just in terms of having who I wanted here. I could do that more freely cos it's my house And just having things as I wanted them But in terms of being assertive with the midwife, I don't think I was at all (laughing) really. I just felt really vulnerable physically'

Borrowing Smythe's term again, there was also a subtle sense in many of the women's accounts, which portrayed a 'semblance' of control, similar to the 'semblance of safety' that I described in Chapter 8. Dominant ideology maintained a hold in the background through community midwives, retaining the 'final say' (Romalis 1985), but imposed itself more carefully in the community. In other words, as I suggested earlier, the medical model was attenuated, and control was exerted less obviously and with rather more consideration and discussion than women experienced in hospital:

'every time ... there was something to be done, she did ask me if it was all right Or if there was anything I'd particularly want in a certain position, or You know, there was a lot of consideration when there was something she wanted to introduce..... whether it was an examination or what'

Summarising this discussion about control brought me back to the previous chapter. Unsurprisingly, given my framework, wherever the starting point to the analysis of the women's accounts, they inevitably lead to the same destinations - that of relationship. When theorised from the women's perspectives, continuity, choice, control and similar terms evaporated and were replaced by mutually trusting relationships. Given that this was not usually possible many women fell back on hope. In answer to questions about control, most women answered in terms of avoiding control: being with a midwife who would be present without doing, and follow without leading, unless she was needed to 'leap ahead':

'the midwife wasn't there till later cos I didn't call her till I felt I needed her ... so she wasn't around until later on ... And by that stage, I mean I'd been doing it myself and everything was going, you know okay and they were there sort of ... to assist which is really what a midwife is meant to be. You know just to help when you need a bit of help ... I mean when they came in I was busy doing things. They didn't really do anything if you know what I mean. They didn't sort of like say, oh we need to do this or we need to do that [...]. And I heard them, you know getting all the preparations ready and things for the baby actually

coming. But it was more like just having them there in case I needed them [...]. It was more the having somebody there and you just deal with things'

Turning to the issue of power extended what had arisen in my discussions about choice, rights and control. It extended my understanding of where and how women resisted meanings of birth that held little meaning for them and it extended my understanding of their imaginings about how birth could be for them.

Power

'Power over', 'power with', 'power-from-within'?

It is apparent that this thesis is about power. It is about the power of dominant ideology and its power to construct, maintain and enforce its own knowledge base and mute that of others. It is about women's resistances and knowledges, which destabilise dominant power and shape alternative discourse about power and knowledge. I used Steven Lukes (1994) and Michel Foucault's (1980) theories as a starting point for understanding how and where power is developed and exerted, and then at feminist developments of these notions in Chapter 5. I also borrow Starhawk's (1990) definitions of power over, with and within as a fitting framework to explore the notion of power further and to look at the divergence between the meaning of power in medical ideology and the contrasting definitions of power I located in the women's accounts.

'Power over'

The literature told me a great deal about 'power over': power which is 'linked to control and domination', internalised, ultimately 'backed by force' (Starhawk 1990: 9). This discourse ran through the review chapters - from the dominant forces of patriarchy in earliest times; the construction of a body politic in which public and private were constructed and women excluded from subjectivity and agency: 'like the hapless Jonah, she dwells in the belly of the artificial man [...] preserving its viability, its unity and integrity, without ever being seen to do so' Gatens 1997: 82); to the construction of power over the body and its location in health. It continued through the analysis through dominant definitions of safety, professionalism, disembodiment and control. 'Power over' provides the ideological concept from which the political and medical rhetoric of choice and control emerge.

In terms of Luke's (1974) definition of power over, there were many examples in the women's accounts (in previous chapters and above) of their desires bending to external power. However, unlike the women and their partners in some of the studies I referred to on page 75, these women were more aware of how their wills could be shaped by dominant ideology so that all parties apparently concurred:

'if I would have gone into hospital, they would have ended up inducing me, because they don't let you go on [in labour] like that for two days (laughs) [...] You know, I can see how that situation in hospital would have led to to disaster (laughs) because they simply don't have the patience and you don't either if you're there'

It is clear that women were aware that the services could not provide them with the holistic support they needed and that they were obliged to bend their ideals to accommodate this. They were well aware of how information and knowledge could enable or disable their autonomy and agency, and how difficult it was to break through the 'layers of medical expertise (see the quotation on page 220). They were aware of being coerced into complying with a style of care they found undesirable

but inevitable, for example, trying to meet all their midwives, despite their need to get to know one or two (see page 210).

Finally, I suggested that however midwives related individually to women, the coercive contract that women should privilege professional advice over their own and agree to this beforehand, firmly located the midwife/woman relationship as one of 'power over' rather than 'power with':

'they [midwives] would try and get me to assure them that if something was going wrong, that I would go into hospital, that I wouldn't be saying no, no, I have to be at home'

Women were not only aware of coercive power over, as can be seen in some of the previous quotations, they were also aware of invasive power over. There are numerous examples of territorial, spatial, temporal and ideological breaches of power. What seemed more hidden was the invasive aspects of power on the self/subject and how this affected women's abilities to 'be themselves' (Belenky et al 1986). In adapting to an apparently unchangeable system, many women withdrew in different ways. And although women made the best of this withdrawal, their habitual ways of being, their access to power and knowledge and their ability to be full agents during birth were curtailed. The possibilities of interdependency were often lost as relationships between women and midwives were mediated through the power of medical ideology. It inevitably entailed the woman relinquishing a part of herself and paradoxically, in exerting resistance to dominant ideology, she was often obliged to become a part of it herself: resistance often necessitated inappropriate separation from the self:

'we were too concerned to I don't know, sort of build up a relationship with the person who was going to be there at the birth and to sort of take them into our confidence or something. And I don't feel that anymore (laughing). I'm much more businesslike (laughing). My approach is just, let them get on with their side of it and I get on with my side'

While she described it as liberating, it was liberating in terms of giving up what was perceived to be a futile struggle, but this reduced other possibilities:

'they come and half an hour later they're gone - which, you know, seems fine in a way. There's no point in making more of it than it has to be, you know. If you can get through it as quickly as that (laughing) well, why not [...]. So they come along and maybe chat. And I just leave it to them to say what's next and you know, just a few routine things. It's, you know, do a urine sample and blood pressure and listen to the baby's heartbeat'

The milieu in which this change of relationship took place was essentially not one of empowerment or autonomy, but one of fear of domination⁵⁵:

'if you let these people into your confidence, then really you're putting yourself in a dangerous position. So it's just best not to embark on that. Not to make it too personal a thing'

Most women felt that they had no choice but to engage with NHS maternity services. If they experienced an ideal/reality gap, or if their ideologies and those of the service did not coincide, they

⁵⁵Much of the discussion in this section on 'power over' is mirrored in Valerie Levy's (1998) study on information giving from the midwife's perspective. At one level it supports the notion that power is held through withholding information that might challenge the midwife's policies and practices: 'Midwives limited information in order to protect themselves from getting into difficult situations' (111). At a deeper level it points to the layers of domination that are involved in maintaining medical ideology.

were obliged to oscillate between their ideals and reality (Debold et al 1996, Belenky et al 1986), living the tension, or suppressing their ideals. As I suggested in the previous chapter, this moved the woman's focus from herself and her pregnancy and birth, to that of negotiating a path through the services she met. Thus in terms of power, achievement could become focused on beating the system rather than on giving birth. I come back to the quotation from footnote 102 on page 196:

'all the way along I'd said if there's a problem I'd love to go into hospital and I think if there's an emergency I'll be very grateful for it, and I said that all along. But then it became a ... Then it felt like a battleground. And now I feel if I go into hospital I feel like they've won and I've lost but and it would be I told you so which isn't a very healthy thing either. I'm definitely going to feel that they're going to feel very smug if I do'

'Power with'

'Power with' held a very different meaning of power, to that of 'power over', which Starhawk (1990) describes in the following terms:

'the power of a strong individual in a group of equals, the power not to command, but to suggest and be listened to, to begin something and see it happen. The source of power with is the willingness of others to listen to our ideas. We would call that willingness respect, not for a role, but for each unique person.' (10)

Both women and midwives could be the subjects of the above quotation and from the women's perspective, it was clear that far from wishing to exert control over midwives, women needed strong midwives to inspire them. But they needed them to be strong in themselves, with no desire to exert power over them. As I described in the previous chapter, women were very aware of their midwives power and/or powerlessness, and its impact on their experiences. They recognised the connection between how confident or lacking in confidence midwives were, with the mutual support or shared powerlessness that could occur:

'I hadn't considered an independent midwife cos I didn't think I'd need one. I thought I had a positive attitude. I'd seen a successful home birth and I thought it doesn't matter I'll be able to give birth. I don't need, I'm not that bothered if I don't have any midwife. I was quite unconcerned until later on - until I actually met them one to one and met my GP. And when I actually felt that trickle down effect of loosing my confidence, I thought well hang on a minute you know. Maybe I do need someone more supportive'

In recognising their midwives' limitations, many women felt the need for midwives to be an empowered profession with empowered individuals:

'I would really like to see more power given back to the midwives in some ways, because I think that would make them a lot better at their jobs to be honest'

Examining different notions of power illuminated a puzzle from the women's accounts: that midwives seemed unaware of their own effects on women. Indeed, they often appeared to be unaware that they had any effect at all. It was as though they disappeared behind the policies and practices they carried out. Exacerbated by lack of continuity they seemed unable to acknowledge inequalities in their relationships with women, and unable to see, in Jean Robinson's (1999) words, 'the midwife effect', either the positive or negative effects women described:

I was really glad that [midwife] was there. Afterwards I was crying when I thought of what could have happened you know if we had had another midwife. I just kept saying thanks be

to god, thanks be to god all the way through cos I would have been in hospital you know. I would have been in hospital afterwards. [...] So I felt just so relieved that we had a midwife that respected me and [partner] and our relationship and just knew that we could do it ourselves kind of. I said thanks very much for everything. It could have been so different you know. And she said, you did it not me. This was nothing to do with me. She really was very modest and I mean I agree with her that we did do it like. But she was very, very helpful and she was a great support and it could have been very different, you know. She was very humble⁵⁶,

'I was asking her [midwife] how I'd know who was going to be coming and stuff. And she said, well, I live two doors down from you and I'm the only who's got a 4 wheel drive, cos it's due in the middle of [month] and stuff, so I'll probably pull the short straw. And I just (laughing) looked at her, and she said, oh I shouldn't have said that should I. And I was like, no way, you really shouldn't have said that (laughs). So, she's just obviously really nervous about it'

One of the problems in maintaining reductionist health care ethics is that rights, justice and equality cannot take the effects of one person on another into account. As I discussed in the Introduction above, Diprose (1994) identified, an underlying assumption within medicine and midwifery is that the subject is already constituted prior to any relationship and is therefore unaffected by others. It thus ignores both potential benefits and harm located within relationships. As I said on page 70, even when the woman/midwife relationship is based on partnership - the ideal of the New Zealand midwifery model (Fleming 1994, 1998, Guilliland and Pairman 1995, Pairman 2000), power relations make it easier for the practitioners desires to dominate and more difficult for the woman to resist.

And yet, from women's accounts it was a sense of 'power with' that could best facilitate 'power-from-within'. In the face of external and internalised oppression, most women needed the collectivity of their own and midwives' connected resistances. It is thus to the final power distinction, power-from-within that I turn.

'Power-from-within': Women's alternative discourse about empowerment

Starhawk (1990) describes 'power-from-within' as the positive sense of an able self, a self in connection with others and the environment - sustaining, creating, collectively opposing the control of 'power over' (10).

For the women in my study, planning a home birth involved all the qualities of power-from-within described above (though I am not suggesting that only home birth could embody these). It was about maintaining safety, safeguarding relationships, self-discovery, reclaiming self-esteem,

⁵⁶ There is a fine line between negating or exerting one's power. Nicky Leap (2000) suggests that parents should indeed feel that they have done it themselves - but this does not negate the sense of power-from-within midwives could allow themselves to feel when they have followed the woman: attentively watched, protected, facilitated, leapt ahead and leapt in as needed - and above all resisted inappropriate medical meanings of birth themselves and forged alternative meanings, in dialogue with individual women. In the quotation in the text, the woman referred to the midwife who had not only supported her decision to decline a vaginal examination, in the face of opposition from usual practices and her colleagues, she had also continued to support her during a long third stage:

'after [baby] was born, the placenta didn't come out for a few hours and she [midwife] had been in touch with people in the hospital about it and they had insisted that she bring me in. And she has said, she didn't think it was necessary, that I was healthy and everything was fine. So she did really put me first in that situation. And it could have been her reputation at stake, I suppose, if anything did go wrong. [...] I was lucky with the midwife I had that she did put me first I felt'

reclaiming the body, a rejection of violating experiences, reclaiming, furthering and protecting spirituality and sexuality, and reclaiming autonomy. All of these formed part of the women's alternative birth discourses about empowerment rather than power over. Instead of turning away from the currently overused, but misunderstood term of empowerment, I attempt to reconstruct its deeper meanings which move way beyond the sum total of choice and control, or even 'power over'. As 'power-from-within' suggests, its meaning is not only located in thought and feeling, but in behavior, actions and bodies.

Facilitating 'power-from-within'

Looking at power-from-within joined strands from the women's accounts with a number of theoretical perspectives, which converged on the term "relaxed". The word 'relaxed' was one of the most frequently used words in all the women's accounts. In attempting to understand the significance of this and why it is unrecognised or trivialised in medical ideology, it became clear that it can only be understood when autonomy recognises bodies, the mind/body dialogue, the power vested in practices on and in bodies, and the everyday capturing of women's bodies. While disembodied ethics systematically disables women, their conversations focused on enabling themselves/their bodies to give birth. They described their power as resting in freedom: to create circumstances which would decrease both the everyday capturing of their bodies and the constraints of medical practices and which might release the potential for their bodies to be/feel freer and more powerful. Women understood that while there was no simplistic connection between physical and mental techniques which apparently free the body to be able to give birth, there were nonetheless deeper meanings of freeing the mind/body which could increase the likelihood of being able to give birth⁵⁷.

Their description of power did not include power over midwives, unless they felt threatened by their practices. Indeed many women talked about the importance of their midwives feeling relaxed, free of constraints and at ease with them - able to be themselves. As we saw in the previous chapter, the women understood that this does not usually happen automatically, or outwith the context of relationships:

'lack of continuity of care I think is really a problem and I think if you're going to provide a service for women to give birth at home that, that is something that is going to be really important. Also for the midwives, because to be fair you know to give them a chance to get to know women a bit and to feel comfortable in her home, (laughs) you know, those things take time (laughs). I wouldn't expect anybody just to feel comfortable in my home right away'

Returning to the previous chapter, I explained that women found it difficult to discuss how midwives might support them in labour because midwifery support for labouring women is not part of the medicalised discourse about birth. Discussions about how a midwife might support a woman

⁵⁷ Bartky's (1997) detailed analysis of women's bodies, using Foucault's notion of constrained bodies provided one of the flashes of understanding I had during my analysis. Her observations about how constrained women's bodies are in terms of looks, comportment and movement provided the key to why women needed to be relaxed approaching and moving through labour. If the body is already constrained, then to meet a physical challenge, which relies on the body opening, requires the body to be more at ease than usual. As I observed on page 148 in footnote 81, I had puzzled for many months about the deeper meanings of women's focus on relaxation, feeling uninhibited, avoiding constraints and being able to 'open'. It was clear that this ability to be relaxed was felt to be precarious and that women needed to create the kind of environment that would most set them at ease - hence the concerted focus on a variety of potential obstacles to this. Taking into account Diprose's (1994) mind/body interaction also explained the footnote on page 180, in terms of emotional relaxation and the inseparability of emotional/bodily relaxation. In other words, the peace of mind women searched for, also freed their bodies.

to find her own powerfulness were entirely missing. The women knew that this kind of conversation would have to be set in the belief that women are indeed powerful (though this is not often witnessed or experienced during birth) and that they can find their own power through being free and supported enough to find their own coping mechanisms.

As Starhawk's (1990) definition of 'power with' suggests, unleashing this power was about removing obstacles and opening possibilities rather than directing. This depended on midwives who felt powerful themselves. Without having some experience of feeling powerful (though not necessarily through birth, as this would valorise birth as the only site for reclaiming power, when there are many), and without having let go of the fear embedded in medical ideology, midwives could not assist women in finding their power and letting go. Too often midwives were trapped by medical policies and practices in which they could only support women to beat the system, rather than offer empowered support for them to give birth in their own time and way. This 'semblance' of resistance to medical ideology was in the context of a deeply disempowering system, which overrode both women and midwives' knowledges and experiences:

'even though [she was] not supportive particularly of home birth, [she was] supportive of me and did say things like, oh we can do this, you know ... And ... even though I think she was wrong to expect me to push that time she was constantly saying you know, I really want you to be able to do this, and, you can do it and you know, let's get this baby out before the doctor comes back ... And you know it was just like she was on my side, and that was good'

As I noted on page 266, there is an underlying fear of women's power, especially during birth, as the literature about the monstrosity of women demonstrated (Adams 1994, Braidotti 1997). Birthing practices are designed to control women and foster dependency rather than unleash their forces and those of their bodies.⁵⁸ And yet the sense of empowerment and its ongoing effects, in the accounts of those women who felt it was overwhelming:

'because I know that I truly was in control and powerful enough, strong enough - just as an animal really - to cope with that [giving birth] ... I find that I can cope with other things because I always think, well it can't be bigger than being in labour'

'at that stage I cried because it really was all over, you know, and the relief was enormous. And the happy feeling you know. I really couldn't get over how happy I felt, you know. We just felt so empowered. It was brilliant really. We'd done it ourselves, you know. We really felt there was mostly just the two of us'

'I still have the confidence of that whole period you know ... I think well ... I was so right in the way I planned that. But it stays with me that I have the ability to plan big things, big important things other than the normal and pull it off. I pulled it off brilliantly really. And I

⁵⁸ One of the most unsettling experiences I had was of being invited to a woman's birth where she was attended by a very experienced, spiritual and positive midwife. I noticed that as she helped the woman to breathe through contractions, a dependency was set up. The midwife became increasingly directive as her second stage became longer. I observed that during her long labour the woman never found her own coping mechanisms and never became powerful in the way I have witnessed other women becoming powerful. I fully understood that because of the local policies and practices, the midwife was prioritising the woman's desire to remain at home and thus becoming increasingly directive in an attempt not to stretch the usual policies too far. Over many years of attending births, mainly, but not exclusively at home, I have noticed that women move into the power of birth at different stages and in different ways, and although it is difficult to explain what this is, it is clear to witness. Put simply, the woman becomes an active agent, in a way that she cannot easily be controlled or manipulated - so it is not surprising that practices are designed to avoid this happening, if obstetrics relies on maintaining control of women.

think that will stay with me for the rest of my life Definitely a great sense of triumph really It's incredible'

Hearing women's responses to control in terms of freedom for the power of birth to be released in them brought the issue of embodiment to the fore again. In the following section, I thus explore how and where power was exerted over women's bodies in both constraining and violating ways. And how theoretical debates about the body interacted with their accounts to construct a more expansive view of the birthing body, beyond medical definitions of choice, control and power.

The matter of bodies

Power over/powerful bodies: Reconstructing the unfeeling, unknowing body

Looking more closely at the oppression and resistance of bodies: their pains and pleasures, the women's accounts constantly challenged the dualistic ideology which privileges reason and produces a smokescreen behind which bodies are regulated. The following discussion is thus set in a number of diverse theories, which have examined how dominant meanings inscribe themselves in bodies in different ways. The debates about embodiment demonstrate how problematic it is to theorise the body (as I discussed above), but also that to exclude it maintains the dominance of patriarchal modernity and limits how we talk about women's experiences.

As I suggested in the review, modernist assumptions have resulted in the body being disassociated from the animate self and at the same time appropriated by both the modern subject and the state through contractarian arrangements (Diprose 1994, Pateman 1989, Young 1990b, 1997a) On the one hand it has been rendered partially invisible: an unfeeling, fragmented mass rather than a connected part of the self. On the other hand, as Lois McNay (1992) noted, nowhere is power so dramatically played out as in and on the (invisible) body.

It is perhaps not surprising that as particularly aberrant bodies, women's bodies have been the objects of stringent regulatory ethical codes and practices. Where 'absence' (Leder 1990) should reside, their constant cycles of 'leakiness' (Shildrick 1997) force themselves into awareness, making them objects of both horror and fascination (Braidotti 1997). Their ability to be more than one is particularly disconcerting and threatening to the traditional order of unitariness and separation.⁵⁹ As I suggested earlier, it marks them out as matter out of time (Adam 1992) and place (Douglas 1966).

Drawing together different theoretical strands, it is possible to see the particular ways in which bodies are regulated and thus where seeds of resistance may lie. Foucault (1977) suggested that with the move from sovereign power to disciplinary power, the modern individual subject was constructed to be disciplined and disciplining. In other words, it is both subject to, and reflects, the gaze of normative practices - policing itself through its habitual way of being. As Diprose (1994) suggests, the body not only creates these habitual ways of being, it also constructs itself through

⁵⁹Iris Marion Young's (1990b) account of fluid boundaries in pregnancy and other accounts of similar fluidity (Adams 1994, Marshall 1996, Rabuzzi 1994, Shildrick 1997) highlights the modernist need for a sharp delineation between self and other and brought to mind the current western practices during the birth of the placenta. Anxiety seems particularly high at moments of separation. Franca Pizzini (1992) described mounting tension and activity the closer to birth women appeared to be (see page 60). There is often an anxiety about the third stage of labour, which is suggestive of underlying cultural fears beyond the immediate situation. The placenta and cord form the material substances, which blur the boundary between women and babies. While third stage practices are apparently based on (factual) anatomy, physiology and safety arguments, if one of the underlying reasons is to separate woman and child as quickly as possible and so return to the "natural" order of the bounded self, then it is possible that this has become rationalised in scientific research and that it "sees" physiology and risk in ways that support this ideology. Murphy-Lawless' provided an alternative explanation of the anatomy and physiology of the third stage which acknowledges the complex interaction between connection and separation, at the European Midwifery Congress for Out-of-Hospital Births in Aachen, Germany, Sept/Oct 2000.

these habits. The added influence of gender inequalities intensifies the everyday experience of this for women, restricting their very movements (Bartky 1997, Young 1990b). And yet in locating the body in restrictive movement and dialogue with the self, it is possible to see that providing different spaces and dialogues could turn oppression into resistance - the embodied **productive** aspect of power (see for example, Bartky 1997, Diprose 1994, Griffiths 1995, McNay 1992).

In looking at the consequences of obstetrics imposing its own ethical code and practices on women's bodies, and examining some of the silences, mutings and erasures in terms of the above theoretical debates, I was able to explore women's pains and pleasures, their abuses and desires in the wider arena of sexual politics. Thus, in the first part of the next section, I look at how bodies are possessed through separation ideology, giving rise to contractarian arrangements. As possessions, bodies can be appropriated, processed, constrained and violated in ways that seem normal and acceptable. As possessions, they remain silent. It is only in dialogue, specificity and multiplicity that they can become the 'noisy resistance' I heard in the women's accounts. I turn to the appropriation of the maternal body and its contents first of all.

The body's belongingness

The disconnection of the body from the mind underpinning contract theory, together with the obstetric moral project meant that the woman's body could become a metaphorically and materially free floating entity - a third party located between obstetrics and her fetus/baby:

'suddenly I'm there with my boobs out, and I've got one woman [midwife] squeezing this nipple, and another woman [midwife] trying to get the baby on here. And they're all playing with my nipples like it's some sort of third party, and I'm sitting there going, my **God**, what's happening'

'I asked about stitches and I asked if they did them in the subcuticular way or if they ... Because I realised that it made a difference to swelling and so on and I wanted to know .. even though I felt quite clear in my mind that I didn't want to be stitched. I thought I don't want to be faced with it happening and then not be able to say, what are you going to do? And when I asked these sorts of questions, I didn't think you know, that they thought that was appropriate for me to ask. It would be like asking a mechanic how he was fixing my car'

The added complication of obstetric ethics having constructed two separate bounded individuals from the women/baby entity⁶⁰ is that having separated the two, attention has been focused on the

⁶⁰I unwittingly introduced this very dichotomy by the way I phrased a question to one of the women and asked her about her baby's experience before she had talked about it herself:

'N Right, right, yeh do you think there might be any advantages for the baby being born at home, is that something that you've thought about at all or not?

Um I suppose I just assume that because I'm feeling more comfortable that it would be better for the child You know, the picture in my head of childbirth is not one of trauma and you know ghastliness for this new born child so Maybe I'm just (laughing) being naive of course. But I mean, as I read about it, yes, oh yes, definitely I think it is safer for all the different reasons that there are. But, it's funny that actually, I haven't really thought about it that way you know, what's better for the baby. It's terribleI feel guilty now, (laughing) because it's been very sort of me oriented or us oriented

I was troubled by my breach of the woman's integrity and in the following interview raised this again:

N Last time we were talking I have a feeling that I might have introduced a certain division between you and your baby which was different to how you saw it. I wondered

I remember you asking that question and feeling really guilty (laughs) that I hadn't thought about this baby, like that ...

N I wondered if perhaps that that was more, you know, to do with my assumptions and

baby (see page 41). The possession of women's bodies and the woman/baby separation becomes further entangled with ethics of caring on the one hand and obstetrics' divorcing of babies' outcomes and women's experiences on the other. Both urge women to be selfless. Thus subordination is valorised but attempting to reclaim the bodily experience of giving birth is constructed as selfish. On all counts a spectre of so-called selfishness embeds itself in women's psyches in a blame/guilt setting. Thus the relationship between the woman and her baby is used to construe responsibility negatively, as a form of coercion, rather than positively in terms of connection and empowerment:

'I don't know, maybe, I mean, maybe it's just me personally, but I've never worried about my babies when I've been in labour - maybe it's just a selfish thing'

'the line that they tend to use seems to be..... you know, like no matter what your wishes are concerning the birth and where you'd feel more comfortable, surely you should consider the baby. And how would you feel if something happened to the baby. So I feel like, if something did go wrong and something happened to the baby ... I would have a heap of guilt, mainly from what they've said. Because they've put it on me, that I'm making an irresponsible choice that they're going along with. And if anything happens, it's my fault'⁶¹

Separating the woman/baby entity, destabilises relationship. The baby is constructed as "product" (Duden 1993, Davis-Floyd 1992: 57) and becomes as open to appropriation as women, as can be seen from the enforced caesarean debate I referred to in footnote 70 on page 174, and other struggles for possession (Young 1997b). This can be seen in the apparently innocuous normative practices referred to in the women's accounts. There were frequent comments about babies being taken from or not given to parents at birth, being weighed, measured, cleaned and dressed sooner than the parents wished, or against their wishes altogether. This seemed to be embedded in the assumption that "experts" must "deliver" babies and symbolically intervene between the parental/baby relationship, to assert ownership. For example, when one couple expressed their wish for the baby's father to catch the baby, their midwife assumed this to be illegal:

'I had said to [midwife] the day before that I really wanted [partner] to be able to catch the baby you know. And she said she'd have to ring [her supervisor] about it but she really thought it was illegal. That we weren't allowed to do it. That was the impression that she had - that, you know - that they [midwives] had to deliver the baby. That was her understanding that, you know, legally she wasn't allowed'

I thus attempt to explore further how and why the woman has become disjointed from herself and her baby, how women experienced this in practice and their views about how reclaiming/rejoining processes could occur.

I suppose ... yeh I was thinking of myself as myself and the baby I suppose. I hadn't really considered it as being divided I don't know possibly because you ... I remember clearly you asked me that and it has been more on my mind as not just, you know, it's not just me that's giving birth but that it's being born too (laughs) so I have divided them (laughs). Interesting .. so I can't remember what you asked me now

N Well I just wondered if I had introduced that for you and whether you actually saw it differently and that it was to do with me rather than to do with you?

I think I must just have thought of it as yeh, well just an entity rather than separated

N: Yeh I'm sorry afterwards that I'd introduced that actually

It's alright I'll forgive you'

The potentially invasive nature of research, even from a supposedly ethical stance is clear.

⁶¹The selfishness, blame and guilt, which I discussed in Chapter 8 relies heavily on the separation of women and babies and the appropriation of women's bodies. Part of the context for this discussion is the disassociation of life and death in obstetrics and women's acceptance of the cycle of birth and death which make up the meaning of life, that I also discussed in Chapter 8 in Part 3 on page 172.

Managing bodies: 'You're on a car assembly line getting a little bit done at a time'

Different sections in my review suggested that birth practices have developed within a shifting milieu of discourses, which include the distrust of nature's disorderly ways, the belief that so-called science could bring it under men's control and the development of materialism's industrialisation and factory-like fragmentation. Within this framework, the body is viewed as mechanistic, unfeeling and unknowing matter. Women and babies experiences are not only of no consequence, they cannot be understood to be potential sites of consequence. The focus inevitably turned to efficiently managing and processing bodies:

'I mean, we just had loads of waiting. It was like, oh come through and then (laughs) you'd get through and they'd go, I'm just weighing you and doing your height. Go back through and wait, and then you're waiting for another half hour, and then it's your name again. Oh (laughing), I'm just doing your blood pressure. Go back through. You're in and out like you're on a car assembly line getting a little bit done at a time'

Comparisons with previous experiences of this type of care, with care from community midwives in a midwife clinic or at home were common. Many women felt that despite the problems I discussed in the previous chapter, their antenatal care was so superior to the care that they had received previously, that whether or not they actually had their babies at home, it had been worth planning a home birth for the antenatal care alone:

'the other thing about the antenatal, that I really, really didn't like and was very glad that I'm not having to do it this time, is to almost be seen in (laughing) groups. At your 12 weeks appointment in hospital people are taken in 4s, and so you might have to give a urine sample in 4s, and get weighed in 4s and it's just (laughing) you know, like a sheep pen, and it was **horrible**. It was really dehumanising actually and I didn't enjoy that at all, and I really wanted to avoid that. Even if I end up having the baby in hospital, it'll have been worth ... doing this to (laughing) have the antenatal care that I'm getting (laughs)'

Obstetric management is a mechanistic approach, which reduces the awesome complexities of bodies to mechanics. The temporal and spatial arrangements of hospitals reflect their management and vice versa. Buildings are 'concrete manifestations of a culture's deepest assumptions, structures, and power relations' (Starhawk 1990: 95) and Foucault (1977) suggested that our institutions reflect the ideological and structural properties of jail. The Panopticon is thus the central metaphor for modern institutions and manifests a culture steeped in domination and punishment (Starhawk 1990). It is therefore no surprise that temporal and spatial arrangements both reflect and enforce the notion of mechanical, docile bodies and that women felt that no matter how assertive or resistant one is, the power held within the institution swept aside her needs and changed how people usually relate to each other. As women remarked: 'it's like going to jail or something'. The experience is one of constraint⁶².

The overtly dehumanising processing of bodies in an institutionalised setting was attenuated in the home. But the inevitable appropriation and depersonalisation that occurs in a system of domination where the body is assumed to be mechanistic, could still be experienced through surveillance in the community: the 'checking and monitoring'. Thus home birth services were often experienced as less mechanistic than hospital services, but part of its inflexible structure nonetheless:

'in many ways in the procedure I was struggling Prior to engaging [independent midwife] I was struggling to find a place for me in the whole set up I felt almost like I

⁶²Research in this area suggests that research subjects quickly take on punitive roles assigned to them (Milgram 1963).

was ... an encumbrance They had this reel in motion, and I would get in the way of that every now and again.

N How would you get in the way of it?

Just by being too assertive or asking them lots of questions or not doing things in the right order or my concerns weren't fitting into the plan and And also you don't seem to be allowed to participate in the system in any sort of piecemeal fashion. You go for it or you don't [...] and it's a bit like you have to get all the tests done, all the weighing and the protein test which you can easily do at home. I thought, you know it's very easy. You don't need anyone to do them. You don't need to wait for 2 hours. So if you like I felt like by not wanting to take the whole package I had to take the whole package if I wanted anything at all and I found that very frustrating'

In the following sections on the body, it became clear that the disembodied discourse of health and ethics provides little access to how bodies can be abused or empowered. The implications for women and practitioners are profound.

Violating bodies

Over half of the 30 women described incidences during a previous birth or during the birth they had during the study, in hospital or at home, that they found distressing and violating. Others described practices that they did not necessarily deem to be overtly violating, but which were nonetheless carried out against their previous stated wishes, or in the face of resistance at the time. And some of the most negative narratives in women's accounts focused on invasive bodily practices.

Erasing the body from subjectivity leaves it open to invasion through institutionalised touch (the material manifestation of internalised expert knowledge) and less able to resist or develop its own alternative knowledges. Lacking in theoretical sensitivity, health care ethics leads to potentially painful and violating practices on/in the body. (Because of their potential for violation, vaginal examinations in particular, became a symbolic focus for institutionalised touch which women resisted.) However, the more normative the practices, the more invisible and irresistible they were to practitioners. This was perhaps exacerbated by lack of relationships. Recalling Roslyn Diprose's (1994) theory of bodily changes changing the mind, midwives who were unaware about women's views before labour were even less likely to know how they might respond in labour.

While there is a growing body of literature on women's experiences of abuse, birth has not usually been discussed in these terms. When it has, this has usually been from a structural perspective, focusing on the generalities of appropriation and abuse. That actual violation occurs on individual women has been less researched and documented. It can be seen anecdotally, in birth accounts, but where it has been looked at more systematically (Kitzinger 1992) there are marked similarities between women's narratives of abuse and those of traumatic birth experiences.

Foucault's observed that we must look for the material signs at the apparently innocuous end points of dominant power - the placing of the stethoscope on the chest, the seemingly innocent question that invites disclosure (see Armstrong 1987: 70). Thus inevitably, the women's accounts led back to the issue of 'checking and monitoring' that I discussed in the previous chapter. The different 'end points' which subjected women's bodies to different forms of violation during labour, were located in those practices which were routinely imported into the home: listening to the baby's heartbeat at regular intervals with a sonicaid or pinard, assessing the dilation of the woman's cervix by carrying out vaginal examinations, measuring blood pressure, holding or applying pressure to the baby's head during its birth, managing the third stage of labour and so on.

Checking and monitoring: Reassurance for who?

The unease women expressed about the 'checking and monitoring' of pregnancy could intensify during birth, when potential control over, and breaches of the body became more apparent through the practices of listening to the baby's heartbeat and internally examining women. I thus explore women's accounts about their views and experiences of these practices.

As on every other topic, women positioned themselves diversely on the issue of midwives checking their baby's heart rate and examining them during labour. While some women found monitoring their labours at home to be reassuring and not overly invasive, many women questioned the necessity for some of the routine practices during labour and birth⁶³. Their views depended initially on how they positioned themselves in relation to different birth ideologies. Subsequently, these depended more on how they experienced their feeling, knowing bodies, in addition to their views on birth. The practice of monitoring babies and women during birth forms the bedrock of obstetric safety and is an integral part of midwifery care. But while research has considered different methods of monitoring babies' heartbeats (see Goddard 2001) and the accuracy of vaginal assessments (Crowther et al 2000, Robson 1992), no research has been done to ascertain whether or not these practices are in themselves beneficial. With notable exceptions (Bergstrom et al 1992, McKay and Barrows 1991, Warren 1999), few have considered how women feel about these practices, or avoiding these. They are so culturally embedded in both hospital and community midwifery practice, that with few exceptions (Central Sheffield University Hospitals 1998) they remain unquestioned. Yet some of the women in the study challenged the necessity for these, and voiced some of their potentially harmful effects, and all the women maintained a desire for few or no vaginal examinations during birth.

Because they were so focused during birth, some women felt that they knew their babies were well, and they knew that their labours were progressing as they should, and could see no reason to interfere with the delicate balance between remaining in tune with their labours, and coping with contractions. A number of women felt that monitoring their labours and their progress would not only interfere with the process itself, but could also cause doubt in their own minds and bodies and affect their own confidence, ability and instincts:

'it requires a certain amount of quiet round about you, and trust and respect really, and when that isn't given it's easy to doubt yourself or not to be able to hear what's actually going on [in your body]',⁶⁴

⁶³ The black boxed assumption that birth must be attended by designated professionals, was cracked open by a circulating story of a woman who chose to give birth to her baby at home with her partner and friends. (It is only in the context of home birth that this issue can be raised at all). The story questioned the professional role and the need for surveillance:

'there was one girl who's had a birth without any professional supervision as far as I know. And well, I mean, it just sort of opened my eyes that, you know (laughing) you can do it on your own and how much of a help is it really, you know, to have a midwife'

Raising these questions raised a series of further questions. For example, some women questioned how far interventions are helpful or mechanisms for control. Their questioning included the practices that could be transferred to the home. They began to reconceptualise these practices in terms of interventions. For example, if drugs for the first stage of labour are interventions and best avoided, does syntometrine constitute an intervention and can it be avoided?. Similarly, if injections are seen as painful and invasive, does an injection of vitamin k reflect the gentle, intervention free birth some women wanted for their babies? If routine continuous monitoring of the baby's heartbeat during labour and birth can be avoided, how frequently should it be monitored intermittently? Does it need to be monitored at all, if the woman feels all was well? In other words some women raised the question that if birth and their knowledge could be trusted so far - could it be trusted further? It was this sort of knowledge that was particularly difficult to develop within a medicalised framework, where these questions could not easily be asked or answered.

⁶⁴ I return to the issue of knowing bodies below on page 314.

'I was assured that they would only do them [vaginal examinations] out of necessity, but I still don't understand why they're necessary. I can't clearly see that myself. And the same with the blood pressure, somehow I have the feeling that they can't observe women and feel that things are alright and that she's alright without having to use physical monitors all the time. That is what I find slows me down, interferes with me and made me feel that I had to be checked. And then I was looking for reassurance after every time I was checked, to make sure I was actually alright, when in actual fact, I didn't ever think it was necessary or helpful. And I would say that again, but I don't feel like I'd get very far with my point of view It comes back to confidence again. I think that they are the trained individuals and I am not, and yet I feel they could use their powers of observation better, just to watch a woman and see. Is she coping, is she not? Does she look distressed? Does she look happy? Is she managing? Or even physically, just watching a contraction, rather than actually having to monitor it, somehow, just to experience the woman, I suppose, a whole experience rather than breaking it down all the time by measuring and calculating and feeling that you're controlling something you're not controlling, that in actual fact it's something that moves completely on its own. And it's actually only hindered, I think, by the interference' ⁶⁵

'if she'd examined me, I could really picture myself just getting closed up, thinking of someone touching me inside'

'the idea of, you know, interfering with birth and, you know, like manually, actually to me that idea of being I never thought of that, of someone actually coming in you know, with their hands [to birth the baby's head]'

'to be very honest when I decided to actually get the pool I think there was a feeling of liberation about it that actually it would give me physical distance from the people around me during the time of birth. And it was actually a feeling that I could run away from the midwives to go into the pool ... which was Yeh, for the first time I thought I could do something positive to take a bit of personal power in the whole situation and that that would give me confidence, you know. I could actually remove myself physically and have something to get into which they weren't going to follow me into [...] But then the next visit, one said to me very proudly that they had a sonicaid that worked under water and my heart sunk, and I thought, oh, they're going to chase me in the pool and then they said they would want to measure my blood pressure and the temperature of the pool, and all these sorts of things and I thought, well, here comes the control issue again'

'the first thing they wanted to do was an internal, and they were quite insistent about that and that was horrible, it was quite horrible I was in quite strong labour by then, and it was just interfering, there didn't seem to be any need for it'

'looking back now I suppose it's [monitoring the baby's heartbeat] something else that is a bit unnecessary you know - that's just a tiny bit of intervention that needn't really happen. I don't think I felt that there was anything wrong with the baby during labour, and I mean, I don't think I would have been worried about the baby if the sonic had never been invented. I don't think I would have been worried about how the baby was because it felt that

⁶⁵ The woman provides an interesting comment on 'observation' given that medical practice is based on privileging sight over other senses. Visual technologies of the body and the medical gaze "see" in certain ways and are directed at bits of the body, or part of the reproductive cycle. In the quotation above, the woman talked about using their powers of observation holistically. When women talked about their midwives experiential knowledge, this was part of what they meant - her observation of women and labour as a whole from which to make holistic assessments.

everything was going fine. I mean it's nothing in comparison to what could have happened you know. In comparison to maybe an epidural or something like that. But it is still kind of an intervention and something that I wouldn't really see as being very necessary'

N Would you be able to say anything more about how you feel it's unnecessary and how you feel it's an intervention?

Yeh well it's a bit kind of, I suppose it's not that they're meaning to like you're ... The midwife came in and I had to kneel down and they tried the pinard first. It's just the whole idea of having this little box and my front being attached. Like it was a bit, stop we have to kind of control something that kind of a way. So I didn't really feel upset or anything at the time having to have the baby's heart beat checked but it did I suppose remove me from how I was feeling a little bit and started me thinking, you know, how is the baby? And then I was relieved that the baby was fine. But if they hadn't started at all. If they hadn't asked me to allow them to check the heart beat then maybe I wouldn't have worried at all about it. So I don't know if it's really completely necessary. If they had found out that the baby wasn't okay maybe it might have been very effective then in saving the baby's life or something. But I really can't imagine how you would not know if the baby wasn't okay yourself, you know. I mean I just felt things were progressing fine and there was no need and it happened every 15 or 20 minutes. That was the only reason that the midwife came into the room really, to check the baby's heart beat. So I suppose another reason I would have for it being unnecessary was you know that we could have been left alone if it wasn't for that and you know that gave me a strength. All it was, was myself and [partner] that were there and that little bit of control that they had was a small bit irritating. Like I said, when I did hear the heart beat was fine it was a relief. But again I wouldn't have had to feel relieved if I didn't think that they were worried it mightn't have been okay. So I don't think I'd have a sonicaid again'

These views question the very core of medical and even midwifery practice. And yet, even during the course of this study, there have been developments in midwifery in Britain on the issue of internal vaginal examinations during labour. A unit in Sheffield brought in guidelines suggesting that they should only be carried out during labour if the midwife and/or woman think it necessary (Central Sheffield University Hospitals 1998). Is it possible to listen to women's views on monitoring baby's heart rates and respond to their apparently diverse needs? Drawing on Chapters 8 and 9, it seems that this could only conceivably be considered in the context of relationships.

Inflicting bodily pain

The (internal) experience of the pain of labour and birth was seen by many women as different from the (external) production of pain through examinations and other procedures. Different forms of pain were identified as helping, or not helping the birth process. The pain of contractions was often seen as positive pain - pain 'as it should be' and so could be integrated as part of the experience of birth. The most distressing experiences were when women felt practices were inflicting pain - breaching their bodies and their trust. Given the lack of relationships, inflicting pain during a single incident could become a significant marker for how trusting, how respected, and how in control women felt. The network of meaning between trust, advocacy, security, vulnerability responsibility, control and power fuse in the following two contrasting quotations:

'it was like when [midwife] came in, it was straight away into a VE, you know. Like I just want to give you a VE, okay? [...] I felt, oh God, this is happening straight away. There was a bit of control being pressed on me. I felt, the power's being taken, kind of thinking, this was it, and they were going to start taking control. But I was really relieved and my trust was perfectly intact when [main midwife] said, no, we've already discussed it and she's not going to have one. That kind of came at the very beginning when they arrived and it really

mattered then to know that I could trust her with something like that. I felt I could trust her further, you know, because she was taking my side above her colleague's really'

'it would have been useful to have talked about it... from their point of view. Like for example, saying, you know, we might well examine you to see how far you've dilated before we phone the second midwife. I mean, I'd never heard of that being an idea till it happened. And then I might have been able to think that through, cos I couldn't at the time. I just thought, oh, right, that's what we have to do. Whereas, you know, afterwards you think, well, did we need to do that? (laughs slightly) [...] And also like when she said, right, I'm just going to keep my hand in you whilst you have a contraction Well, you know, what can you say about that when it's actually going on But, again I didn't know what that was for [...] It seemed a bit unnecessary but I did find it a horrible part of it and painful, and not really part of the process of getting her [baby] out necessarily You know, the pain of the contractions you can sort of think ... Well, like, it was really useful [friend] saying, now that's another one gone, you know Whereas an examination's different isn't it? It's just an intervention [...] And I do think having had that internal examination, I don't think I really trusted the midwife after that, because that had been so sore ... and I just didn't feel I'd been prepared for that. It was like, she got me on the bed and said, I'm going to do this and then she got her hands in and then she said that she was going to do something else cos she hadn't said before, I'm going to keep it in while you have a contraction and that was a different kettle of fish [...] I think part of me feeling, in a way tense with that placenta not coming out was, I just kept thinking she was just going to pull the cord and and I think I hadn't realised but I think I didn't trust her because of that internal'

As some of the quotations suggest, inflicting pain was not limited to obstetric practice alone. The women found that their midwives hands could work with or across their bodies. Whether touch is experienced as supportive and skilled, or as institutionalised violence depended partially on whether the woman felt that she, rather than normative practices was the midwife's focus, and on how trusting their relationship was. It is difficult to disentangle just how far lack of relationships might or might not impact on feelings of pain and violation and how far this was to do with the invasiveness of the practices per se, or the context in which they were carried out, as Green, Coupland and colleagues (1998: 205) suggested. However, where routine practices were least used, women often compared this positively to previous experiences or imagined experiences:

'I mean when I was having [first baby] the midwife was coming in every ... I don't know how often it was, and checking the baby's heartbeat. Just putting leads on a cable and seeing the baby's heartbeat ... I mean this time, you know, I laboured all the way through and I think they came and listened to it once and then he was delivered shortly after. So you know, you think well ... if everything is okay and the baby seems okay and it's kicking fine in between the contractions, you know obviously the less intervention there is the better it is'

'I was just talking to [friend] recently about how she was examined and she had felt fine all along until she was examined and the midwife left her hand in while the contraction was going on and that she found that very very painful. So you know it just reinforced for me how glad I was that I didn't have any. I remember thinking at the time that, you know, putting anything in would have been wrong. It just felt wrong. Everything was meant to be kind of coming out and it would have kind of stalled things I think. I do still think that alright. I don't think it's necessary really for me anyway. Maybe if there was a problem you know that they might have had to. But no I don't think it's necessary'

Women frequently felt that in retrospect, they should have declined to go along with painful procedures for which they could see little reason:

‘looking back on it I think, I should have just said, no, I’m not doing that [having a drip], I’m just going to let it [labour] happen itself, cos it had started. It was just not quick enough, and the reason that they put the drip in was, that they weren’t sure the baby, you know, they didn’t know what condition he was in. And I can understand that. But then, as I say, in hindsight, you think, oh I should have just, you know. Because that was what I was frightened of, because I knew how painful it was. I mean, in effect that did affect the way that I delivered so, I’m not sure why [a drip was inserted]. Yet, I’m wondering whether maybe the midwife said to me, well I think we better put this in because she was getting snash from the consultant. I mean, to be fair, I didn’t know the woman, so I had no relationship with this woman. So I couldn’t tell whether she was reacting to some outside force that was saying, you know, really, get that woman on a drip .. now (laughs slightly). Just tell her anything (laughs) you know’

Thus while the body is silenced in obstetric ethics, this does not silence women’s experiences of their bodies as sensitive, feeling, knowing bodies. But this seemed secondary⁶⁶ to monitoring the birth process and birthing the baby appropriately - according to local policies and practices. As we have seen, obstetrics is located within the powerful, everyday coercions of bodies through the everyday spatial arrangements, temporal frameworks and the normalising ‘gaze’, which exact conformity over the natural rhythms of pregnant and birthing women’s bodies - inducing a variety of invasive and painful practices on and in their bodies.

Finally, I come back to Murphy Lawless’ (1998a) observation from page 38, that, ‘representational’ (96) violence derived from normative practices masks actual violence, superimposed on the view of women as weak (103). In a curious sleight of hand, the ritual abuse of women and their bodies, is reinterpreted as necessary, inevitable, heroic, even kind.

Summing up resistance: Silencing or quietening potentially powerful bodies

There were many examples of women’s fears or experiences of the gap between thought and action because of the coerciveness of dominant ideology and the fragility of women’s ideology. In other words, not only was there an ethical code located in maternity care that was at odds with women’s sense of their own morality, decision-making processes, and behavior, but the dominant ethical code seemed to rather easily take precedence over their own ethical stances.

Medicalisation was experienced to be most intensely coercive during labour. The theoretical notions of vulnerability and inequality that I referred to at the beginning of the chapter were particularly visible during birth. I have suggested that while women want natural births, there is on the one hand little theoretical or practical support and on the other potential hostility (Green and Coupland et al 1998, Jones et al 1998, Scully 1994). The dialogue between feminist theory and women’s experiences, suggests that women cannot maintain an intellectual ideal while also experiencing the vulnerability of a challenging rite of passage. The balance of power between dominant medical ideology, and the fragility of alternatives and women’s subordination through lack of self-confidence in their own knowledge and assertiveness made resistance problematic. This is where my interpretations and those of Machin and Scamell’s (1997) about the process through which

⁶⁶I say secondary here, because although medical ideology theoretically casts bodies as unfeeling and unknowing, obstetric has been forced to acknowledge some of the challenges from alternative theories. But the soft chairs, low lighting disappear at the hint of a problem. Thus, the uneasy compromise I mentioned on page 182 is easily dismantled. If doubt exists, medical definitions take over and the body disappears again.

women move from holistic ideologies to accepting medical ideology, differ. My understanding from the women's accounts was that trusting relationships were so crucial, and being able to set up the best circumstances beforehand so necessary precisely because many knew or suspected that they would not be able to attend to these matters while simultaneously negotiating their own internal experience of fragmentation and reintegration. And yet, in the face of coercive medical ideology, women have to do this, or give up on what matters to them. The popular idea that women do not care about what happens "at the time" is a misinterpretation of this process of having to prioritise and defocus in some areas in order to focus on others, while they are enveloped in the enormity of giving birth to their babies⁶⁷. This provoked feminists and others to criticise the natural birth discourse as setting women up to fail. I suggest that we need to look at how the system fails women, and hides its own oppressive project behind individual failure, rather than discount natural birth as a potentially liberatory site.

Medical theorising about women's bodies rendered them at best weak and docile and at worst invisible. Without the critical analyses I discussed, women's embodied experiences of being violated may have remained more hidden. The potential for women experiencing their bodies as desiring, creative and powerful may have remained equally hidden. Conversations about the sensual and powerful nature of birth did not necessarily arise easily or spontaneously. However an awareness of this potential from the limited literature in this area (see for example, Adams 1994, Chester 1997, Fehr 1999, Gaskin 1990, Kitzinger 2000, Irigaray 1985, Lorde 1997, Rabuzzi 1994) enabled me to remain alert to the possibility that women may raise aspects of sensuality - or may respond to openings to discuss this, and that their accounts would inevitably contain this whether or not I was aware of it. Thus, how transformation through birth occurred became as much a focus as how transformation was prevented. Part of the context for this is the power/knowledge dyad and where knowledge can be legitimately located. While the previous section was embedded in resistance, this next section was one of reclaiming - particularly that of embodied knowledge. In the same way that patriarchal forces made resistance problematic, reclamation was equally difficult.

Part 3 Power/knowledge

Knowing bodies

In my review in Chapter 4 on page 78, I posed questions about who can know what. Over the course of the chapter, I discussed how dominant ideology constructs and legitimates what counts as knowledge, how it forms the basis of oppression and oppressive practices, and how knowledge is unaware of its own materiality. I also explored embodiment and subjectivity. In the introduction to this chapter, I examined the issue of subjectivity and the mind/body in terms of becomingness and dialogue. In this section, I have brought these explorations together to examine the question of a more integrated knowing.

As I suggested earlier, knowledge about childbearing has been largely replaced by information. The emphasis is on information giving, and women are made very aware of the need to gain information. Davis-Floyd (1992) observed that in her study:

'Most of [the] women seem to equate knowledge with *information* - to place their trust in intellectual knowledge, and not in intuition, emotional, or bodily knowledge - and to equate only this sort of knowledge with power and control' (31)

⁶⁷Given the differences between women's ideologies and their midwives' practices, most of the women prioritised what mattered most to them and directed their energies to this. Other needs had to be dropped.

I found however that women drew on different forms of knowledge and that alternative forms of knowing were at the heart of freeing up their bodies and challenging powerful assumptions about childbearing bodies and mothering⁶⁸. Their views commented on the ontological questions I discussed in the theoretical interlude at the beginning of this chapter. But while they moved between intellectual and other forms of knowledge, as I explained in Chapter 7 “scientific” research is the currency of power and control. Thus in order to enter discussions with professionals, most felt obliged to inform themselves about medical knowledge. Despite their experiential, intuitive and bodily knowledge, they used medical knowledge as the main overt currency for discussion and decision-making. Other knowledges entered into their decision-making processes, but were less often shared with professionals, as legitimate talk. Embodied knowledge tended to develop in parallel, but its possibilities were hindered by lack of acknowledgement and support and thus often remained subordinated - lying beneath dominant knowledge⁶⁹. The oppression of other knowledges formed a barrier to women developing their own knowledge of empowerment. The problem was not necessarily medical knowledge per se, or that women did not find it useful. It was rather its legitimisation as the only form of knowledge and the subsequent tendency to have to focus on it in order to resist (see the quotations on page 274: ‘you’ve got to know your stuff’ and ‘I can’t just have the normal knowledge of a normal person to have a baby’)

In the way described by other commentators (for example, Duden 1993⁷⁰, Gregg 1995, Jordan 1997), women observed the subordination of their knowledges, yet felt that it was legitimate and should be recognised:

‘well I think that the woman that's in labour herself is the best source of information about whether things are going okay or not. She knows best like if her body is working right more than anybody else. And yeh, it didn't feel like anything was going wrong during labour even though some things are happening. Most of it was very unknown to me, but I still knew that it was nature taking over, that things were fine. And I definitely feel I have a good knowledge of my pregnant body kind of, and me as a pregnant woman’

But a number of them commented that their knowledge was unwelcome, belittled or silenced in the face of “expert” knowledge:

‘it really, really annoyed me when you go to your GP and you’re pregnant and he says, what’s the date of your last menstrual cycle. And I just think, well, I actually know the day I conceived. Would you like to know that? No, no, no, the date of your last period. And

⁶⁸ While women are expected to take responsibility and know how to care for their children after birth (Cronk 2000), dominant meanings of birth assume that women cannot know about their babies’ well-being before or during birth. As some of the quotations show, women, however, often felt in tune with their babies before birth, and home birth was often seen as a way of retaining this connection and providing a gentler transition. But, in the way described by Belenky and colleagues (1986), they were often reluctant or hesitant to make claims about this. So while women’s knowledge is systematically undermined during pregnancy and birth, they are expected to “know” when this supports patriarchal nurturing ideologies, i.e., to know when a baby is hungry, or needs to be changed for example. What women can and cannot know, in relation to dominant ideology has led to confusion among both women and professionals:

‘my experiences have always been that they know best. And I just think it's a great contradiction that paediatricians and health visitors and people like that - they're always told that the mother's instinct is great, you know, in making any sort of diagnosis or considering any complaint. That mother's instinct is something that you should always go with, you know. So why, when you go into [hospital], why do they think that you don't ... you know. They can't seem to think it starts before. When it comes down to it, really mothers don't know. That's how they put it across to you, you know. And as I say, I find that it's all very contradictory’

⁶⁹ As I discussed on page 79, and noted elsewhere (see page 194), a number of feminist researchers have observed that women “know” differently in different settings (Belenky et al 1986, Jordan 1977).

⁷⁰ Barbara Duden (1993) asked ‘whether medical technologies, particularly prenatal diagnostic techniques, have usurped women’s own bodily sensations as indicators of the baby’s reality (66). She gives the example of ‘quickening’, (now all but lost from our vocabulary, which only the woman had access to, and was used as an indicator of the baby’s gestation), being replaced by ultrasound.

actually my GP had the nerve to say, how do you know you conceived on that day? And I just thought that is so incredibly patronising, you know. I know that is the day I conceived, you know, it's just so disregarding'

As I observed on page 186, in the light of alienation, not all women have the same level of knowledge about themselves and their bodies, nor is it always more accurate than other knowledges. But it is systematically muted. In Kirsi Viisainen's (2000b) study with parents who had planned home births, one woman described professionals as having 'such authority that I get the feeling I can't know anything myself' (806). Some women experienced this as humiliating:

'about a month before my second child was due to be born I had a whole night of contractions and I told them [midwives] about that and on the next visit I found her [midwife] terribly patronising. She made me feel so foolish. She brought a student with her and she was pointing at what the scan result was and what the date had said it was. And I mean, I felt quite humiliated the way she said that I couldn't be right. [...] I mean the fact that I was up all night and was having contractions five minutes apart didn't seem to - although they frittered away. I was concerned that they would restart and that maybe we'd been a month out, but because they had this result from the scan, she was able to treat me in that way'⁷¹

Whether they are located in psychology, political theory or some other field, feminist theorists have come to similar conclusions about the alienation of women from themselves, their knowledges and their bodies (Belenky et al 1986, Brodkey and Fine 1992, Debold et al 1996, Fine and MacPherson 1992, Hamer 2000, Starhawk 1990, Young 1990b)⁷². It is the severing of insider knowledge and the definition of women's desires as passive (that I noted on page 94), that makes the violence of obstetrics possible and the acts of violence in the previous section likely⁷³. Obstetrics depends on a culture in which women find it difficult to identify and resist abuse because of its context and their subordination.

Women and midwives negotiate the same oppressive cultural norms and are subject to the same violating experiences (Rouf 1999, Thomas 1994). Few midwives have acknowledged or attempted to redevelop their own histories and futures based on midwifery knowledges, or looked at their personal or professional experience of violation (Tilley 2000). Their alienation from their intuitions and bodily needs (Kirkham 1999) unwittingly continues a long tradition of silencing and oppresses those women who seek to reclaim their power. So women not only withdrew from relationships because they could not support their meanings of birth, they also withdrew in order to protect their bodies. The lack of a relational, embodied ethics alienated women and midwives from themselves, their bodies, each other, and ultimately, their worlds⁷⁴. (This is particularly true of sexuality for example, as I discussed on page 94).

⁷¹The woman and the midwife may have arrived at the same conclusion by pooling their knowledge in a way that would not have humiliated the woman. It could have encouraged her to continue to develop her own knowledge, in order to develop a dialogue between different knowledges within the context of sharing relationships, rather than dualistic closure.

⁷²Glimpses of embodied knowledge appear in some forms of therapy based on work by Wilhelm Reich (1972), Frederick Perls and colleagues (1972), David Boadella (1976), Stanley Keleman (1985) and others. But these often replicate the gender oppression I have described and draw on patriarchal terms of war, such as bodily 'armour', or privilege the therapist as knower as in the case of somatic resonance.

⁷³As Franca Pizzini (1992) suggested, even when women recognise the violence being done to them on doubtful grounds, they may not be able to reject the normative interpretations of birth.

⁷⁴This links back to the point I made about the 'midwife effect' (Robinson 1999) and the apparent lack of awareness that they have positive and negative influences on women and birth. From women's accounts it seemed that all bodies present during birth contributed to their experiences. By its very matter, it is a presence - no body can have no effect (double entendre intended).

As Murphy-Lawless (1998a) pointed out, one of the ways in which obstetrics exerts and maintains its knowledge and thus power over women, individually and collectively is through the separation of birth from women's private lives. Some women were aware that lack of intimate knowledge before becoming pregnant themselves renders them more dependent on professional definitions of birth and less able to forge their own alternative meanings:

'I suppose it helps to have a sort of general idea of what to expect. I mean, you know, to have been to a birth (laughing) before I think that would really help women having their first babies, more than anything else, would be to actually attend a birth at home'

Conversely, experience of hospital birth could raise awareness about how women's experiences could be shaped by fragmented, institutionalised and medicalised approaches:

'what I found there [in hospital] was that although it was a private room, people just came in and out and in and out the whole time and didn't introduce themselves and you didn't know what this person was coming in for. And you didn't know if it was an anaesthetist or an obstetrician. And then the shifts changed and you've got a whole new set of people. And ... you know here's my friend just lying there naked (laughing slightly) sort of thing, you know. And it's just like she hardly existed and she's quite assertive and was trying and I think did really well under the circumstances but it was kind of down to her, I think, you know

N Down to her?

To keep asking things and checking things and asking for information so she could make an informed choice. And [...] so like when they started saying, look you're not dilating, I think you should have an epidural, [...] it was quite difficult for her voice to be heard saying, can we just wait another hour, you know

N What did you make of that experience?

She had this heart monitor belt on the whole time which she said was really uncomfortable. And then she had to have an epidural, which meant she had to sort of lie down [...]. And then at the end of it all, she wasn't even able to walk, you know, cos the epidural was still affecting her legs and so she had to stay in over night. So I took her up to the ward and it was night shift staff on, who weren't welcoming or sympathetic at all, and just kind of came over and told her the rules and then went away and left her. So I think the whole thing was pretty horrible for her'

In attempting to erase the body and its ability to feel, childbirth is not only sanitised of the everyday oppressive practices carried out on women's bodies, it also all but erases power, desire, sensuality and spirituality as potential experiences of childbearing. However hesitantly, women rejected the notion of their bodies as mechanical, unfeeling, unknowing or separate. Piecing together where women talked about their positive, as well as their negative bodily experiences in the accounts gave insights into the potential for more expansive, embodied meanings of birth.

The potential of bodies

In the earlier section on control, the women's focus was very much on freeing the body from control, reducing obstacles and setting up circumstances conducive to it being able to give birth, knowing that this is a challenge:

'I just imagine I'd find it harder to loosen up, or lose control. Like I guess, I don't know anything about it. But I sort of guess that part of it is about ... you have to lose control don't you, to give birth. Cos if you try and control it, it won't come out ... and I don't seem to

find it ... very easy losing control anyway. But I can't imagine it being conducive in a hospital place'

Despite the attempts to silence women's knowledge about their bodies, babies and birth, and despite attempts to render it irrelevant, meaningless, or an obstacle to obstetric conformity, their embodied knowledge found gaps and spaces. So while birth has been defined through obstetrics as pain, the women's accounts frequently defined it through both pain and pleasure.

Reclaiming desire

One of the positive aspects of embodiment is that of desire. As I suggested on pages 94 and 314, some commentators discuss birth in terms of its sensuality, (or eroticism, as described by Kathryn Allen Rabuzzi 1994). But when the woman's experience is secondary to selfless nurturing, any articulation of desire is seen as challenging. Given the patriarchal definitions of sexuality and the violence it systematically enforces through defining women as objects of sexuality, it is not surprising that many of the women in my study focused on harm minimisation rather than on positive aspects of the experience of birth. However, once I began to hear the 'barely audible' (Fine and Gordon 1992: 45), I was able to link the different parts of the analysis through the concepts of multiplicity and integrity that I referred to above.

Sensuality: Sexuality and spirituality

Sexuality and spirituality are not overtly part of medical terminology. Alicia E Adams' (1994) analysis of 'A Night in June' provides a graphic, if shocking description of the need for medicine to distance itself from women's feeling bodies. The doctor in this narrative, attending an apparently prolonged birth, tries to extract the baby by reaching up into the woman's womb:

'The maneuver requires personal and prolonged contact among all four, and William's account reveals the circuitous mental maneuvers he undergoes in trying to incorporate their intimate physical conjunction into his private philosophical world [...] but his description conveys a sense of sexual violence as well. With his hand pushed up inside the passive, compliant Angelina, her sister-in-law pulling against him with all her strength, the doctor savours his position between them, the contest between his force and their resistance. But then, as though suddenly aware of the suspect nature of his enjoyment, he distances himself further by viewing from the perspective of the past: "This woman in her present condition would have seemed repulsive to me ten years ago." Now, if she is no longer repulsive, it is because he has learned not to identify her as human. His narrative transforms Angelina into a cow, bestial and mindless, locus of a purely maternal pleasure. Having thus disarmed her of identity, humanity and sexuality, he finds himself free to be "comforted and soothed" by her touch' (Adams 1994: 40-41).

Starhawk (1990) comments that the erasure of spirituality and the erotic through the suppression of ritual, magic and mystery are the bedrock of patriarchal oppression and that the 'control of sexuality by others is a primary way in which our sense of worth is undermined, and is the cornerstone of the structure of domination' (25).

For many women in this study, pregnancy and birth held spiritual and sensual qualities and for many was clearly part of their woman-ness and sexuality⁷⁵. The meanings of birth they met in terms of medicalisation, lack of privacy and presence of strangers were all identified as possible threats to

⁷⁵Where women felt 'asexual', this was usually in terms of dominant definitions of sexuality. That is, that they did not want to have sex with their partners and/or felt unattractive.

their well-being and ongoing connectedness with the meaning of their lives as sensual and spiritual and the possibility of reconnecting pregnancy, birth and motherhood with broader meanings of sexuality:

‘as a pregnant woman your sexuality is huge, and profound, but it's quite fragile. And I don't find my sexuality is very robust. So I'm not sexy in a kind of red lipstick, leather trousers sort of way, which you can be sassy about and quite do you know. So I can feel very sexy, but if somebody makes me feel insecure, I'm crushed, you know. And I think I would say that a hospital experience would end up making me feel really bad about my sexuality. And the way they focused on how you can help yourself is so mechanical. I mean, I'll do pelvic floor exercises, but the way in which it's talked about, it's like these awful sex education things in school, you know. It's just ugly, it's worse than that. I think it's negative, and I think it's awkward. I think it's not broached - the issue of sexuality. It's so obvious. It's obvious you've had sex if you're having a baby. You're going to be naked, you've got big (laughing slightly) breasts, and a big belly and [...] and everybody pretends that it's not to do with sex, and .. I think that ends up making it a bit dirty, you know. I think every bit of spirituality just gets left by the by, if you were in hospital. It certainly would for me. How can I have space to have these feelings. But the issue of sexuality would go the other way. It would probably make you feel less so. [...] In a medical environment [...] you're much more of a slab of meat and I think, certainly for me, sexuality during pregnancy - I don't want to feel like a slab of meat, you know. Because you are big and you are different and you're not sexy in a way that a skinny available woman is sexy. It's a different thing and as soon as you're .. laid out on a couch, that's enough to switch it and you become a sow (laughing) you know, in that moment. And if you're at home with candlelight and privacy you can be big and beautiful. But put you under a strip light and you're not, and it's that fast. And I think it's a great shame. I think that's one of the reasons so many pregnant women experience their pregnancies as a state of obesity. Because they feel measured and weighed and you know, and they feel that that's the main focus. And no wonder they don't feel very acceptable’

‘my God, the (laughing loudly) idea of trying to have any sort of spiritual experience in a hospital ward, or even in a labour suite with a bunch of doctors and nurses who I don't know, and not in my own space (sighs out). You know, I just can't think of anything more off putting to my kind of sense of what's essential and what's important in life than a hospital really’

The diversity in the quotations below shows the diversity and multiplicity of embodied places of desire and sensuality, suggested by Irigaray's (1985) metaphor of ‘this sex which is not one’:

‘I do remember what a sexualising experience it was and how animal and sexy it was to give birth. And I felt It's really hard for me to imagine because I don't feel like that at all now. But I felt so sexy when she was just born and I still remember I was really sore but somehow I still felt really quite animal and that was very powerful. That was very very helpful to give birth. It's nice to remember it and to think, ah yes I remember that. But yeh it was very powerful and that was a big surprise, I wasn't expecting it to be a very helpful feeling to get through the the sorer bits or the more difficult contractions To feel quite animal get into the smells and everything I found it was really really helpful’

‘I'd say it is a spiritual experience. I thought it would be and, you know, I think having it at home made it more of a spiritual experience because it wasn't being sort of clashed by a sort of sterile, clinical environment. It's difficult to have a spiritual experience in that’

'I felt more the spiritual side at the beginning and then when [partner] got up after my waters broke and was massaging my back for me and there was - it was like, I remember we said afterwards, it was like we fell in love all over again kind of. It wasn't the sexual aspect of it so much as just a real closeness kind of developed as labour went on for me. I felt that there was a great deal of strength coming from him and it wasn't like I was sapping or anything. I wasn't taking his strength, but we were kind of rejuvenating each other I think. And it was just very relaxing and kind of passionate you know. And I remember just looking at him sometimes and really seeing him in a way I had never seen him before. Kind of knowing that we were making, you know this amazing thing happen. So it was lovely to be able to have those feelings and to be able to express them, you know. I mean, I did find great relief actually in kissing his neck for some reason, actual pain relief you know. And when I was leaning over, he was sitting on the bed I think and I was kneeling on the ground in front of him with my arms round his neck and just looking into his eyes and being able to kiss him. I think it must have been between contractions or something, cos I probably would have bitten into his neck during a contraction. So yeh, that felt really really good. And again because we were here [at home], we were able to express that, and you know, I didn't feel under pressure to do anything that we didn't feel like doing you know. So yeh, it was very fulfilling the whole thing, in a spiritual way and in a kind of a physical way'

'I don't know, I mean, I found the whole pregnancy, I found it really quite I mean, this will maybe sound strange because I spoke to my sister about it and she said, you're weird. But it is. It is quite sexual. I mean, it got to the stage ... as much as I was in severe pain and giving birth to a baby it was it was. Oh God, like how do you explain it. I mean it wasn't like having an orgasm. But, you know what I mean, there was something that. There's, I mean there's definitely truth in that. There's definitely something about it and ... I mean I suppose it's all the blood and everything that's down there as well. I mean, you know, I said that to her, I said, you know, it was really quite a sort of sexual experience, and she's like, you are so weird. How can pushing a baby out be, you know. How could you look upon that as sexual. But I don't know, just ... maybe not even sexual, maybe more sensual would be a better word [...]. I said to [partner] as well. I said it wasn't like having an orgasm (laughing slightly) but I mean, it's hard to explain an orgasm as well. So you know, it's like how do you explain it. And he said, oh, what do you mean. Well it just felt so oh you know and I found it even hard just with him. I said, it just felt so sort of .. And he said, what? And I said, well (laughing) I said sort of sexual like. And he's like, well, I don't understand. How do you mean sexual like? [...]. You see, I think a lot to do with it is when you're actually pushing your baby out and you know that this is it. You've been through the first stage. You know, that another few pushes and you're going to have your baby. So I mean, that must set off all different kinds of emotions in you. You know what I mean. So I think that must obviously have something to do with it .. and you just feel this ... sort of God, I mean, I felt like a sort of overpowering energy trying to think of the best way to explain it. I mean, suddenly suddenly I had all this energy and I just felt great and you know, I was really quite. Oh, I don't know, I mean, I suppose I was really quite turned on would be the word to use. You know, I just felt, you know this is ... I mean it was agony. I mean it was absolute (laughing) agony, but that's what made me think it was sexual because it really, you know there's something there that is like when you're having great sex sort of thing, you know, when you feel this sort of great sort of emotion sort of overwhelming you, and you do feel quite turned on and that. Well it was similar, a sort of similar feeling and then you, you know, you suddenly just feel this sort of woosh, and you know, out the baby comes and it's just like ... I don't know, I mean, you just (laughing) you just glow suddenly, you know [...] I don't know but (sighs) it's hard to explain yeh. But it does happen. I mean, you don't even feel it when the head's out, it's just ... Well with me, I

feel it when, you know, the shoulders come out and the baby sort of wooshes out with all the water and everything and it's like, you know I mean, I just suddenly thought, you know, I'm a mummy, I've got two boys and I'm a mummy of two boys now, I mean it just made me feel so so emotional and you know I was so proud of myself as well, you know. It was just like, a great big smile (laughing) on my face. It was like I did it, you know. And, I don't know, I mean, all these emotions just suddenly sweep over you.'

'I was talking to my friend before and we were just sort of recalling ... remembering, you know [baby] whooshing out ... And we were sort of both revelling in how wonderful it is when you're placenta comes out because it's all soft and not painful. But it's actually ... quite a sort of naughty feeling of I don't know sort of a quite a sort of .. I don't know (laughs) sort of basic feeling of relief because it's all squishy and soft and comes out and I don't know. It's sort of a ... feeling of satisfaction. But you know, it is a really nice feeling because also it is sort of the last one and you push something out, but it's not going to hurt and it's all lovely and ... warm and and you've got this sort of mucky sort of ... bloody sort of wet baby on your tummy, you know. I think it's just a wonderful experience'

'there was this moment when we caught each others eyes and I went to him like, wow. And he's [partner] like what, and I went, plop. You know, like that was it [the placenta] out. I felt it like, like um a first kiss with your favorite boyfriend, you know. That sort of mmm, in your belly feeling. That's how it was for me. It was like, ping, big electric thing like that, and then I just felt it slide out, you know. It was like, wow, yeh, you know, like ... sort of er perfect, and it felt lovely, (laughing) I remember it was like, that felt really good on the cervix that was (laughing) you know'

An even more taboo area is that of sensuality and death. As we have seen, death at birth is untenable in obstetrics. And yet, in the context of an acceptance that death cannot be disconnected from the cycle of life and birth, some women articulated this connection with their babies whether or not they lived. As I discussed in Chapter 8, in the Part 3, a number of women articulated a profound unease about the medicalised response to death at or around birth. Some spontaneously mentioned a birth story from Nicky Wesson's book (1990: 184) where a baby with congenital abnormalities was born at home, and subsequently died at home after being cuddled by the parents for 3 days.

In the next section, I revisit relationship in terms of responsibility, and look again at how women are diversely positioned in terms of their ethical responsibilities in relation to themselves and others. Their accounts were often hemmed in by the theoretical perspectives of both medical ethics and an ethics of care - but also spoke of a relational ethics based on mutuality rather than the adversarial woman/baby separation locked into medical ideology.

Part 4 Reclaiming the self from self/ishness

Ethical responsibility: reclaiming autonomy

The patriarchal need for certainty underpins general ethics, and patriarchal subjects (Starhawk 1990). Uncertainty thus invades women's, children's and other subordinated people's identities. The focus on risk in obstetrics reflects this fear of uncertainty. The coerciveness of this fear (Murphy-Lawless 1998) and the powerful maternal responsibility/irresponsibility binary made it difficult for women to develop their own meanings of responsibility and autonomy in relation to childbearing.

For many women, connected nurturing was at the heart of moral decision-making. Their perspectives were indeed captured by Jo Murphy-Lawless' (1998a) definition, of the problem, that I

referred to on page 46: that women's criteria for success are to do with the 'ongoing experience of being a mother', while obstetrics is carrying out the 'immortality strategy' (47-48), that I have mentioned on numerous occasions. I return to the following quotation from page 161:

'my responsibility is to form a relationship. I don't know, it's almost like that the birth is a rite of passage in a way, and by the end of it you've been through it together and you're in relationship to the baby, you know. It's sort of, the baby is what comes at the end of the process of giving birth, and ... I think the more connected I am with the birth, the more connected I am with the baby. And maybe my responsibility is to be open to having that connection with the baby'

But the women challenged both medical ethics and ethics of care by defining nurturing to include qualitative aspects of birth for themselves as well as their babies. In other words, nurturing need not be selfless. And responsibility need not exclude autonomy (as I discuss in Chapter 11). Nurturing their babies, themselves, and relationships were not seen as mutually exclusive⁷⁶. For a number of women, the nurturing connection with their babies required them to be nurtured, free of control and free to become empowered. But when the emphasis was on separation ideology, their potential to maintain and nurture the woman/baby entity was confined to the private arena. The connection between woman and baby had to be forged outwith the ritual separations of the public arena, which they saw as part and parcel of institutionalised life:

'these rituals that, you know, help you cope with that [separation]. You know, christening a child or something, or when they go to school (laughs). These are all separation rituals I suppose (laughs). And yeh, on the other hand, you do have the bonding as well. But the bonding is an individual thing it seems, whereas separation is a social thing, you know. (laughs) I mean, if you want to bond with your infant, then it's probably your own responsibility and you've got to work at it yourself'

This became clearer through the experience of one of the women who planned a home birth but had a technological birth in hospital. Her previous dubiety about the benefits of home birth and feeling that it could be a selfish need on her part were thrown into sharp relief following a hospital birth. As the two quotations before and after her baby's birth suggested, rejoining responsibility to autonomy is problematic for women in patriarchal culture:

'I suppose you could argue that..... having a sort of easier birth.....calmer atmosphere all that sort of thing would be better for the baby [...] I mean I'm not going to go around and say all children born by caesarean have missed out on something [...] So I think in a way it is probably quite a selfish thing..... for the mother....I don't know .. I don't know really..... well..... I don't know [...]. So I think yeah there's a lot of selfishness in it.... and then on the other hand why shouldn't it be because..... I mean I have to go through this and it's pretty unpleasant.... so why shouldn't I make this as pleasant for me as possible.... within reason'

'I mean it [birth] was just taken totally away from you... but it was in every sense. I was always really sort of a bit wary about the whole sort of thing about empowerment, and.... you know, the whole thing. But I mean it's just so true [...] I just sort of lost every... you know, will to fight and confidence in my own body. Everything. It was just gone [...]. I

⁷⁶Ironically, a medical redefinition of connection between woman and baby is used to coerce women into complying with its focus on the baby and defocus on the woman. This is about sacrifice - a particular definition of nurturing which excludes the self. Women being selfless is part of the morality encoded in obstetrics to support its project. Just as surely as moral values were etched into and onto women's bodies through obstetrics and gynaecology previously (Scully 1994), so medical definitions attempt to, in the present.

mean I do feel you know, I do feel incredibly robbed after the experience of childbirth I find that really quite difficult to cope with (crying) ... The whole sort of physical I know it's all sort of messy and ... painful and things but do you know I feel ... that I haven't really deserved this baby. You know he's just come and (crying) I feel like a bit of a fraud you know [...]. I feel I haven't given birth you know. I didn't have any of that messy sort of contact with my baby at all you know it was nothing you know nothing of sort of blood, sweat and tears at all. And I mean if you know, if you had asked me before, I would have said 'hmmm' you know 'I could do without that' you know in terms of pain and everything and now I just feel that it's almost like having adopted a child. You know I've gained a child by sort of deception or by fraud ... because I didn't ... have it ... do you see what I mean So I feel a bit guilty about that because maybe I sort of feel - I keep quiet - because he sort of looks quite different from my other children and I sort of feel 'oh God' and he's got a really different name as well and I sort of feel 'oh God' I'm already sort of ... I know I'm a bit paranoid. I'm sort of already sort of making this distinction⁷⁷,

This took my discussion in the summary in chapter 9, about separation and connection a little further. It added detail to women's accounts of pregnancy, birth and early motherhood as the place where separation and connection coexist. Instead of being in discrete opposition, both co-exist in an ideology of multiplicity: both are fluid and responsive rather than fixed or immutable. But, as I described in Chapter 8, there were costs to women when resisting dominant ideology and attempting to exert their own meanings. As I found and as Bartky (1997) observed, liberatory politics bring both gains and losses to women. Otherwise, as she pointedly asked, why isn't every woman a feminist? (143). I look again at this issue, below.

The cost of autonomy: "Otherness"?

Like Kirsi Viisainen, I found resistance often took place within the pull of normative values and behavior. The following two quotations from our respective studies are remarkably similar suggested:

'it is easier to do what everybody else does, people do not want to step out from line, especially not Finns. They want to be like everybody else so that no one can say that they are different' (Viisainen, forthcoming)

'I was just trying to be good and do everything as it was meant to be done. You know, according to the system. That's why I went to all these [parentcraft] classes in hospital (laughs). Just trying to be a good parent, you know. Following all the rules'

Returning to the diversities and commonalities among feminist theories that I discussed in Chapter 3, the common strand was the collective attempts to focus on women's experiences and to find ways of representing women as other than "other". However, as we saw in Chapter 7, planning a home birth was firmly located in the margins of dominant society, and despite resistance to being labelled as 'radical', 'different', or 'making a fuss', the definition of "other", was frequently attached to women. Norms forced most women to position themselves in relation to them and their talk was often hemmed in by the hospital/home polarisation:

'what gets me is I'm not very radical, I'm not radical at all. I just didn't want drugs, I didn't want monitoring. I just wanted to give birth'

⁷⁷Again, it appeared that whatever women did they were trapped by paralysing feelings of guilt and selfishness.

'you know, it was like they thought that it was just me being rebellious you know. It [home birth] was considered a rebel thing to do you know because normal people tow the line and do what everyone else does you know. Why do you have to make a fuss'

'at first I didn't see myself as you know, unusual'

Yet stereotypical views of women who plan home births seemed to be held, even by the midwives who attended them.

'my partner had again said, is there anything you think we should get for the labour kind of thing, and she just said, oh well, we do like a cup of tea, and if you could get some chocolate biscuits in, we like that because we find that a lot of our home birth ladies are nuts and berries sorts of ladies and we do like a chocolate biscuit. They sometimes don't have them in, sort of thing. My partner lives on chocolate biscuits, but, you know, it's just being put into that kind of, oh you must be weird'⁷⁸

Given the marginalisation of home birth, women may indeed be more likely to share similar views and lifestyles, and midwives should be encouraged to express their needs for sustenance when attending women during labour. But when stereotypes prevailed, they could erase the individual women and her concerns, increase her otherness and decrease her sense of self worth and confidence.

As I discussed above, many of the women in the study articulated a growing political awareness. But this awareness could increase their sense of "otherness", and alienation from other women in their social networks. Ironically, it was often the women who expressed the most relational ways of being who could feel most isolated from their midwives and other women. The marginalisation of home birth imposed value-laden identities of "otherness":

'I don't know I guess I'm just young and rebellious still'.

Or could be used as a silencing mechanism to erase women's interpretations of their experiences:

'I did feel initially that maybe making a complaint about the service would somehow just make me a complainer - oh she's complained before, we expect that one to complain. And that would somehow take from the fact that I complained about [midwife] and the damage that she actually did ... They did far less damage this time, perhaps because they felt that I might complain. They didn't touch my baby. They didn't go **near** her. And I have to be grateful for that I suppose'

Women who experienced otherness, because of planning home births, could experience marginalisation beyond birth. Paradoxically, they sometimes redefined themselves or reinforced a conception of themselves as marginalised because of choosing a marginalised activity:

'you've had your baby at home and (laughing) everybody else has had theirs in hospital, Because they have an experience, they talk about it, and yours is just different and you're

⁷⁸ Although the woman interpreted the response from her midwives as one of stereotyping women who plan home births, as Mavis Kirkham (2000, personal communication) pointed out, this quotation could equally well be interpreted from the midwives' stance, of having their bodily needs ignored. Either way, it suggested fragility and the potential for stereotyping when relationships between women and midwives are missing. Interestingly, many of the women spontaneously talked about their midwives' needs and their concern to cater for them. One or two women had 'midwives' biscuits' or a 'midwives' tin'.

the odd one out. But ... you know, I tend to be that sort of person I think. I tend to do things differently or be the odd one out'

The experience of "otherness" could be doubly silencing and distancing in relation to other women in the community. Opting out of the space designated for women, designated them "other" of "other". Standpoint theories (see page 29) can accentuates the collective "otherness" of those outside, dominant ideology and thus obscures their individual similarities and differences (see page 94). Thus women with particular experiences and insights could be, on the one hand labelled "other", but on the other hand go unnoticed:

'I'm sure that they see it as something of an oddity (laughs), you know, me having had (baby) at home But I don't think they really think about it very much (laughs) I think you know, for them there's this paradigm. So it's almost as if I'd had [baby] in hospital as far as they're concerned, because they never noticed that I had her at home (laughs) you know'

Thus, as I suggested earlier, far from developing closer bonds within a community of birthing women, increasing support and reducing isolation, home birth could be divisive, as women are separated through dominant ideologies. For example, a number of women felt unable to draw on their experiences to challenge medical meanings of birth. They felt obliged to hide their own sense of empowerment and achievement, because of the common experience of disempowerment:

'I found that I haven't been able to share my experience that much, because my experience is so positive that anything I say seems like a judgement. And it's like so many women have just got bad experiences or it's such a loaded issue for them in certain ways because they didn't make the decisions they wished they'd made. And there was me. I made all the decisions that I hoped to make and ... I came out with a result you know So that's the only thing that slightly colours it really is that But when I think back on the birth itself, for me it's great. I wished I could share it a bit more'

'I can't tell people the details of my experience because it does seem to say I ... you know. Or people say, oh of course she had a really easy labour. And I think, no I didn't, I just managed it. I had a very hard labour but I did manage it and I did manage it well and I was happy. But ... you see you can never compare like the gripes, because the assumption is always, if you stayed at home it must have been really easy And I suppose I would sometimes like a bit of credit for taking control and for doing something difficult. It's not that important because I had a great experience and that's the main thing. You see the way which I couldn't share it, is that, if I said, oh actually I did have a few problems. I did have a difficult first stage. I did have a long labour. I was tired, but on the whole it was still very good. You know, I can't say that without almost implying that they could have been a bit butch-er you know and coped without pain relief or whatever'

'I don't really identify with them [women who have had hospital births]. I kind of switch off because it's Yeh, I don't want to impose the home birth thing really,(laughs) stressing how different (laughing) my experience has been'

Women experienced their enforced "otherness", muting and distance from midwives, family and friends as painful and undermining. Although they understood that this was to do with structural problems, the oppression they felt could be frustrating and divisive:

'women just have this weakness imposed on them. They accept it and I find that I've become angry about that instead of as broadly sympathetic as you would think I might be.

And I'm not sure how I feel about that. I don't even feel very proud of it because you know it isn't very generous of me. But I just think they're colluding And they need to take action you know ... It is possible. We have had women's movement in this country for many years now you know. When are they going to just say: Right. That's enough now, you know. And I just think yes it's time for people to just take action and not just be sorry and sad afterwards sad as that is. I understand when people are vulnerable and end up in hospital ... decision after decision and before they know it In those circumstances I can feel sympathy because they let it get to that point It amazes me that, you know, since I've been pregnant I have not had one story of a woman who's had a reasonable birth experience and I must have heard about 15 [...]. And I think that's very sad. But then I also think if everybody feels like this how come it's still going on What are all these women playing at. Why don't they do something. So it's a funny one, cos, as I say how can you be angry with a woman who's had a horrible birth experience you know I think that's what happens ... your heart goes out to them in one way. But then in another how can you say to that woman, well I hope for the next time you're going to kick that GP's arse and say you're not putting me in there again mate, it was crap, you know. But they don't, they just go, huh ... Put it to bed, get on with their lives'

And yet, how can women speak out in dangerous territory? As I suggested in Chapter 9 on page 252, we also need to 'play safe': protect ourselves. Both the women and I often felt a need to be careful about sharing our views with others. I have often protected myself by remaining silent, talking tentatively, or attempting to package my views in the language of others. As has been suggested (Belenky et al 1986, Debold et al 1996), we cease to be ourselves in a myriad of ways, and frequently work under cover (Hutchinson 1990, Levy 1998), imposing constraints on ourselves and attempting to do 'good by stealth', to use midwife, Mary Cronk's phrase. The cost is high whether we speak out or not.

Putting the self on the line

The gains of protecting the self and the self's integrity may be worthwhile, but the loss of integrity may be devastating. The uncertainty resting on the uncertainty of each individual birth is ever present, and as we have seen, while the home offers certain protection, if the woman transfers to hospital, the threat to integrity is of a different order. While the potential existed for women to resist medical definitions of birth, protect themselves from potential abuse, create their own support network and develop a stronger sense of agency, power, and confidence in their abilities to make appropriate decisions, there was the potential for the experience to be traumatic and undermining. This can be seen from many of the quotations in this chapter (particularly where women transferred to hospital and were unable to maintain a holistic approach). Women were often pulled between their own convictions and those of dominant ideology, displaying self doubt, guilt, fear and anxiety. They were not overly fearful or anxious about giving birth, or even necessarily about medical or technical help, if they are their babies needed this. It was rather the impossibility of a medicalised approach being able to meet their holistic beliefs, hopes and ideals that concerned them.

Women were keenly aware that medical ideology was at odds with their own beliefs, that it is coercive. They understood that many of their difficulties stemmed from this. Nonetheless, when they were unable to forge their own meanings of birth, they often explained this in terms of their own perceived failings. There was often an element of self reproach and blame - that they: had not informed themselves well enough; were not able to communicate adequately; were not assertive enough; or had let themselves down in some way, as the quotations on pages 250 and 280 show. Indeed the personalisation of structural problems, which characterises medicine feeds this view (Doucet and Mauthner 1998):

‘maybe I hadn’t really managed to communicate with them (said quietly). You know, I’m not such a great communicator’

The cost of putting one’s self esteem on the line is high, and raises ethical issues of its own. It may detract from a sense of worth and positive self-identity needed to become a mother and care for a child. And even when successful, the cultural negativity about home birth, and the difficulty in achieving ideals meant that some of the positivity about having a home birth was the triumph of staying at home and avoiding hospital/medicalised birth. Looking at women’s descriptions of the empowering nature of resistance through birth, the politicising effect it could have, and the cost of autonomy, there was a fine balance between the potential empowerment of achievement and the potentially painful consequences of greater awareness.

Much of the discussion in this chapter could be construed as my attempt to recuperate the disappearing woman from: the adversarial woman/baby dichotomy which prioritises the baby’s health⁷⁹; technology’s gaze and knowledge, which erase her sensations and knowledge (Duden 1993, Jordan 1997)⁸⁰; the simultaneous disappearance and management of the body in obstetrics⁸¹ (Murphy-Lawless 1998a); and the growing concern with fetal and paternal rights (Duden 1993, Shildrick 1997). In the final section below, I attempt to integrate some of the ‘loose ends’ in the above discussions, by focusing on ethics, resistance and multiplicity.

Part 5 Collecting up threads and tying loose ends again

The possibility of integrated ethics

If obstetrics does not rethink its ethical code (Cornell 1995, Shildrick 1997) based on embodied, vulnerable difference and becomingness, it cannot change its practice of treating women inhumanely. At present, obstetric ethics is derived from rigid, rule-bound views of morality based on a disembodied abstract, male subject, where bodies remain unfeeling, and unknowing about their own concerns and well-being (Shildrick 1997). By imposing its normative values, obstetrics has: incorporated and fuelled the view of women as “other”; decreased her ability to self-define; all but erased her body, her feelings and her knowledges; and, by fending off other interpretations/knowledges of birth, continues to inhibit her possibilities and potentials. The abuse of childbearing women stems not from abusive individuals (though this can be the case), but more surely from dominant structures which induce collective indifference in which abuse is carried out on women by individuals day in and day out under the auspices of what is right, necessary and ethical⁸².

⁷⁹Medical ethics ultimately upholds the baby’s needs if a dispute arises (Gregg 1994: 80). Though this has been challenged (see Hewson 1994, for example), it has not changed the nature of the adversarial relationship. As Davis-Floyd (1992) pointed out, ‘the most desirable end product of the birth process is the new social member, the baby; the new mother is a secondary by-product’ (57).

⁸⁰For example, photography reflecting the male gaze disembodies the content of the woman’s womb from her womb and the rest of her body (Duden 1993).

⁸¹The literature I reviewed suggested that health care ethics is disembodied. Women’s accounts showed me how it was disembodied in very particular ways and that it is in fact disembodied theoretically, but not quite disembodied in practice. The temporal and spatial arrangements in hospitals and the policies and practices of medical ideology are focused specifically on managing bodies - but the person is removed from the body (Kirkham 2001, personal communication) and bodies are reconfigured as mechanical matter/brute flesh. The curious fracture between theory and practice (where the woman is both disembodied and bodily managed) has contributed to the invisibility of bodies. In fact one of the main criticisms in lay literature about the medicalisation is its lack of attention to the emotional well-being of women. In this way, a mind/body split is maintained out of awareness. What has not happened is a widespread conscious acknowledgement of the mind/body connection and the need to develop ethics and practices that are sensitive/connected to this.

⁸²Genevieve Lloyd (2000) suggests that the becomingness of the individual is formed through temporal as well as spatial dimensions of the self: ‘In this relation to time, the limits of selves are less stable than in their spatial dealings with the

While being at home made a difference, NHS, out of hospital birth did not affect medical ethics' core values. It disrupted the more complete control and power exerted in hospital and enabled women and midwives to begin to develop alternative ways of being together, but it was still constrained by medical ideology. The patriarchal 'gaze' penetrated the home, and it offered only a buffer to the 'coercive contract'. Attempts to rhetorically mesh medical ideology with women's concerns resulted in what I termed an 'attenuated medical model' (on pages 199, 233 and 297). Locked as it is, in a series of patriarchal assumptions which have constructed subjectivity and ethics, medical ideology cannot easily turn itself inside out and prioritise women's concerns rather than its own (Murphy-Lawless 1998a).

As I have explained, neither medical ethics, nor an ethics of care enable individual women's concerns to be central. An ethics that is sensitive to their concerns, would have to develop definitions of autonomy that acknowledge, incorporate and work with specifically located, embodied, changing subjects. In doing this, we may find that our definitions of Heidegger's 'exteriority' (Colebrook 1997) would expand, and that our definitions of ethics and autonomy could change in response to changing understandings of 'exteriority' and vice versa.

Further, the relational autonomy I hesitantly raised in the theoretical interlude at the beginning of this chapter now appeared to bring together the key themes in this and the previous chapters. A relational autonomy, provides the potential for relationship to be acknowledged as a dialogue, between the continually emerging, specific embodied subject, and between different subjects (Colebrook 1997, Diprose 1994). The acceptance that identity is always in relation to the other and that meaningful relationships with others enables greater self-knowing changes the ontological assumptions underlying medical ethics and could prevent the disconnected forms of caring prevalent in medicine and midwifery (see Chapter 11).

From my analysis in chapters 8, 9 and 10, it is also clear that for women to exert autonomy by integrating thought and action, we need on the one hand a less coercive framework, and on the other hand, practitioners who are able to be fully with/present (connected) and yet maintain a mindful distance (separation). As I discussed in the previous chapter, at present, midwives are equally coerced into a frame of reference, which divides them from the women they are charged with supporting. For example, by uncovering the layers of medicalisation, and exposing the question - if birth could be trusted so far why could it (and women) not be trusted further - women asked why practices such as VEs and monitoring the baby's heartbeat could not be legitimately rejected. Given the ethical framework and policies in which midwives practice it is difficult to see how this sort of challenge could be resolved in a supportive/relational context⁸³. In the current (un)ethical climate,

world' (122). Medical ethics constructs the body in spatial terms, thus memory plays no part in defining practice, despite the evidence that birth has temporal influences on women. Taking this further, Catriona Mackenzie's (2000) discussion of the role of memory and imagination on the ability to reflect and effect transformation suggests that: 'The activity of remembering an event in my life by representing it to myself not only preserves my knowledge of the event but also rekindles the emotions associated with that event, leaving me to some extent in a similar condition as the one I was in when I experienced the event' (130). While this may be self-evident to women, it plays little part in decision-making in obstetrics.

⁸³There are numerous possibilities here. We may find that monitoring the baby's heartbeat during labour increases or decreases the likelihood of avoiding problems or is resisted by women for a variety of reasons. A more complex cost and benefit analysis based on the concerns of the individual woman may emerge, and whatever a woman decides she would be supported by midwives in a protective rather than blaming environment. The point is that if we cannot ask questions and initiate dialogue, the coerciveness of obstetric ethics continues to circulate and to hide a web of power relations that undermine women's and midwives' autonomy. As Mavis Kirkham (2001, personal communication) noted, midwives may be coerced into carrying out invasive practices whether or not they are logical or desirable, through fear. For example, there may not be a logical reason for a responsible, attentive practitioner to continue to listen to the baby's heartbeat during the second stage of labour, after the point at which the woman can birth her baby more quickly than interventions can be carried out.

the midwife's need to avoid risk to herself, is pitted against the woman's integrity. In other words, not monitoring the baby's heartbeat could expose her to stressful enquiries, threats of negligence, in which her license and livelihood could be at risk. However, this entails the equally problematic enforcing of practices on women's bodies against their unspoken or spoken resistance, or creating obstacles to women calling midwives if their integrity and agency depend on resisting normative practices. Thus women continue to be harmed or excluded.⁸⁴

The question is how to move from the oppressive generalities of obstetric ethics, to the particularities of an ethical attitude. How can exteriority be acknowledged and expanded in practice. In fact, by resisting, women continually forged new meanings, which spoke of a multiplicity and becomingness and which challenged ontological unitariness. Their resistance and resourcefulness hinged on telling their own stories, voicing their pains, desires and imaginings, which enabled them to reconnect with them/selves, and develop their autonomy (see for example, Cosslett 1994, Kirkham 1997).

The possibility of increasing resistance

Returning to the theme of voice and Lorraine Code's (1998) interpretation of stories, the circulation of the 2 challenging stories I mentioned on page 321 and in footnote 63, contributed to resistance. By voicing taboos, throwing basic assumptions into relief, and uncovering layers of medical dominancy, these powerful stories clarified in moments, what might otherwise fill a book. They challenged deeply held beliefs about the need for the medicalisation of the life world⁸⁵.

Women's voices and stories influenced others. For example in Chapter 7 it was clear that women were able to create support from an initially unsupportive milieu by initiating dialogue that enabled others in their social networks to reconceptualise their own meanings of birth, in the way described by Nancy Fraser (1992b: 180) and thereby increase resistance to dominant ideology. And as we have witnessed, women's stories are not so easily erased and the discrepancies between dominant definitions and lived experiences open up spaces for alternative narratives about birth. But this sort of undercurrent of resistance is fragile. For it to be more resistant, ontological, epistemological and ethical assumptions need to be changed in systematic, sustainable and lasting ways.

Change at any level is of course not insignificant and has multiple dimensions (see for example, Reiger 2000). There is no necessary break between resistance and oppression. However, feminist social and political theory (Bartky 1997, Fraser 1992, Young 1990c, 1997a) suggests that (loose) collectivities may produce more widespread and sustainable change. While the value of relationships between women and midwives has been obscured within dominant birth practices, it is these relationships that offer one of the greatest potentials for change. And while birth has been largely excluded from sexual politics, reintegrating it would enable us to identifying the erasures and abuses of obstetric ethics, and develop ethics of our own, more easily.

⁸⁴As I discussed in Chapter 8, women felt obliged to provide a 'safety net' for their babies. So some women felt they had to decide between two unpalatable choices – the risk of the uncertainty of birth or the risk to their own and their family's long-term well-being. Thus, some reluctantly called midwives as late in labour as possible, and a small number regretted doing so and said they would prefer not to on a subsequent occasion.

⁸⁵Not surprisingly, stories could also be used to suppress and encourage compliance, as one of the women observed:
'I have had some negative reactions from various kinds of people and it's usually increased risks. It's, oh dear, wouldn't want a home birth, you know, they're a bit dangerous aren't they. That kind of response And they often recount tales as well. Oh yes I know someone who the cord was wrapped around the baby's neck and they did a caesarean just in time, and if it had been 3 minutes later the baby would have died which They're actually quite powerful little stories if you're thinking of having a home birth And those are just recounted quite spontaneously in the swimming pool or ...'

Looking more broadly still, a further site for resistance is in *transformatory politics*' refusal to accept its own subjugation and marginalisation (hooks 1990). For example, the onus is often on so-called subjugated groups and individuals to produce convincing evidence with which to challenge dominant views. In terms of birth practices, Romalis (1985) points out; 'it is clear that there is an unequal burden of proof on any approach that diverges from conventional medicine' (198-199). There is less onus on dominant ideology to justify or probe its own central tenets or ethics. We need to move beyond this dichotomy so that assumptions are more visible and critical analysis is built into any process of knowledge formation⁸⁶. While this is beginning to happen, it tends to be tokenistic (Edwards 1996, 1996/7). As Gayatri Spivak (in Diprose 1994) and Elizabeth Stanko (1994) suggest, if we are unable to shift the burden of proof, we risk focusing only on women. In other words, focusing on the subjugated may leave dominant ideologies untouched⁸⁷. As Spivak continues, postmodern feminism is as much to do with refusing definitions, as it is to do with creating them (28).

As I have already mentioned on page 323, disrupting the status quo can be as frightening for subordinated groups (in this case usually women and midwives) as it is for those who dominate (usually doctors). The apparent stability, familiar practices and privileges, even for those in subordinate positions make it a painful and complex process of refiguration for both dominant and dominated. Both are dominated by an oppressive system (Bartky 1997, Starhawk 1990). The balance between overburdening ourselves and acknowledging our power to resist is precarious. We saw in this chapter and the previous two that given the marginalisation of home birth, the energy and persistence needed to sustain alternative meanings of birth, and autonomy was great and had costs attached.⁸⁸ Indeed the costs were high whether a woman resisted or complied. As I have suggested, the key to resistance and transforming ethics lies in the acknowledgement and expression of multiple diversities.

The possibility of valuing diversity and multiplicity

As can be seen from the quotations, though there were broad similarities between different women's accounts, they embodied diversity. While one woman talked about the 'earthiness' of birth, another remarked: 'am I not mother earth? Well, no, I'm not mother earth'. While some women wanted antenatal screening and were prepared to terminate their pregnancies, others did not and would not have terminated a pregnancy. While some wanted to avoid pain relief, others wanted pethidine available in case they needed it. There were different views about water labour, water birth, entonox, TENS machines, syntometrine and vitamin k, to mention but some of the issues on which opinions differed. In a sense this brings us back to where I began - with "choice". It is now clearer why choice, as part of a broader value system is so carefully monitored in medical ideology. If we accept multiplicity, women's concerns and an ethical attitude within a framework of diversity, choice is more problematic. We need to have some way of making ethical judgements and

⁸⁶One of the difficulties when using the logic of a medicalised belief system to challenge it and support a different belief system is that the economy is still one of flawed rationalism and any research is always created and measured against what is already dominant. Any challenge is therefore limited, and this sort of argument has a tendency to 'stretch' rather than change dominant beliefs. Women's concerns are still often omitted and we can end up falling back on rather sterile arguments. For example, using statistics to argue the safety of home birth, does not address substantive issues of safety.

⁸⁷Pam Alldred (1998) suggests that by accepting the poststructuralist claim that we cannot easily step outside the existing language system, feminists influenced by poststructuralism 'emphasize the recognition of resistance to powerful discourses'. This potentially increases the 'otherness' of marginalised groups (154)

⁸⁸As I noted in the literature review, we know, for example that some women would like home births, but have their babies in hospital. As long as home birth is marginalised it is inaccessible to the vast majority of women and to claim, that women do not want home births is to ignore the socialisation of women and the effort it requires to resist this (as I have already suggested, forces of dominant ideologies are formidable). To mark it out as elitist (Sbisa 1996: 366) is ironic, as it can only be elitist unless it is made more accessible ideologically and practically.

organising maternity services which arise from women's desires during childbearing. I discuss this in more detail in the next and final chapter.

But to conclude this chapter, the women's resistances to medical ethics and their ethical stances expressed through their hopes, imaginations and ideals, suggested dismantling the binary terms of resistance/ domination and replacing it with becomingness, and that of separation/ connection with multiplicity. The subsequent expansion of ontology and therefore ethics could include the diversities of women's beingness, as well as their diverse concerns.

CHAPTER ELEVEN - Bringing the journey to a (temporary) close

Weaving ends in

This thesis began with the intention of providing an in-depth exploration of a group of 30 women's experiences of planning home births in Scotland. This was to provide a prospective analysis of their experiences and to answer the original question, at a systems level, about why women planning home births often experience difficulties. Thus, at a broader level, it was designed to contribute to sociological debates about culture. This changed the focus from analysing the women's experiences in isolation, to examining the impact of sociological constructions on those experiences. Thus Chapters 7, 8, 9 and 10 expanded on the critical analysis of the influential discourses of patriarchy in Chapters 3, 4 and 5.

The predominant thread running through this work, is the reflection at a micro level, of the oppressive nature of macro patriarchal constructions of the lifeworld, and the attempts by marginalised groups (in this case, women planning home births) to forge their own meanings and actions, from the constraints they faced¹. So, the thesis was as much about power and knowledge as it was about birth.

My main theoretical and methodological tools have been the use of listening and dialogue. They formed a powerful counter to the silences, erasures and mutings that feminisms describe, and I encountered². I attempted to create dialogue between the distinct, but not discrete areas of theory, methodology, and experience; between disciplines, particularly between feminisms and postmodernism; between and within the women's accounts; and between me, theory and the women's accounts³. I thus forged dialogues between patriarchal concepts and structures of separation and those of feminist connections (and the fragmentation of birth); and ensuing dialogues between dominance and resistance; uniformity and multiplicity; and modernity's ethics and ethics of care. I discussed expanding subjectivity (particularly in Chapters 5 and 10), and developed ideas about ways of being and relating, from which different constructions of autonomy might emerge: with a view to increasing resistance to harmful dominant ideologies and practices; developing alternative views and practices; reducing women's marginalisation; and creating a more inclusive philosophy/ethics of becomingness.

¹As Carolyn McLeod and Susan Sherwin (2000) discuss, oppression impacts on social groups. But because 'traditional autonomy frameworks' focus on individuals, this aspect remains hidden (259). 'We must therefore evaluate society and not just the individual when determining the degree to which an individual is able to act autonomously (260).

²For example, in discussing the possibilities about home birth, and the comparisons between home and hospital birth, women identified possible meanings of birth that remain largely invisible and unexplored. But, as I observed in the literature review, birth practices cannot be separated from cultural beliefs and experiences, thus we need to spend more time listening mindfully to women's experiences: carefully analysing these in the context of current belief systems and birth practices. Yet, observing and analysing the status quo may only provide a critical analysis of norms embedded in birth, while telling us relatively little about possibilities of how birth practices could reflect women's needs. Thus we could usefully develop, and dialogue between alternatives, and critiques of 'what is', while listening to the imaginations of women and midwives. This methodology could thus be used to research women's experiences of birth in other circumstances and settings.

³There are parallels here, with Maria Lugones border dwellers. As Diana Meyers suggests: 'Although familiar with and drawn to both sides of the boundary line, border dwellers are not completely welcome and comfortable in either territory. Despite the awkwardness of this position, Lugones recommends inhabiting frontiers. In her view, border dwellers occupy an epistemically favourable vantage point, for the virtues and the defects of each community are easier to spot from the borders' (Meyers 2000: 155). This reflects my attempts to think more dynamically, by drawing on hitherto discrete concepts, disciplines and methods, using for example Rosi Braidotti's (1997) 'nomadic' (60) and Margrit Shildrick's (1997) 'bricoleur' (5) approaches that I mentioned earlier. These have been instrumental in dislodging mind-sets that lock us into man-made constructs, and move beyond the constraints of dichotomous thinking. They have opened a series of spaces in which the diversity of women's experiences can be made more visible. This in turn has been useful in attempting to move birth discourses beyond the natural-essentialism/medical-technology polarities.

Relationality has been one of the connecting threads between Chapters 8, 9 and 10 and it is no coincidence that the chapter on relationships is located between those on safety and ethics. Relationship potentially bridges the two: it is through relationship and multiplicity that reconstructed safety and ethics could be developed. By assimilating the benefits of postmodern diversity with feminist ethics and observations of connection, I hope this work contributes to a feminist reading of postmodernism, and suggests how appealing to it need not eschew value. Thus, in concluding this work, I focus on the issue of value in maternity care, and how debates about relationality can provide greater insight into what decision-making means, and why those engaging with pregnant and birthing women impact on women's experiences⁴. In other words, while I could elaborate on any number of themes raised by the women's accounts, I want to leave the reader with a more profound sense of how and why women, babies, birth, and midwives matter, and how and why their mattering can best be heard and responded to in relation to each other.

How value may be woven into postmodernism.

As I discussed earlier, the partial acceptance of diversity by current libertarianism accepts diversity on its own terms. It suggests that women need more, accurate and unbiased information and the right to choose the kind of birth they want, within its own framework. In practice, available evidence remains inaccessible to many women (Kirkham and Stapleton 2001, Mander 2001: 73). And in theory, even if it were disseminated widely, the development of knowledge is socially constructed; it is intimately connected with societal norms⁵, thus never without value; and women's knowledge and decision-making are more complex and relational than libertarianism can account for (Mackenzie and Stoljar 2000⁶). As I suggested, we need to move beyond the modern subject with its libertarian equality, rights and choices, to reflect further on how postmodernist diversity and multiplicity could be merged with community, value and ethics. To do this, I consider on what basis a less oppressive value system could be constructed. I then suggest that this means re-integrating the arbitrary division between safety, relationships and ethics, so that women's childbearing decisions can be seen as both a demonstration and development of an ethical stance. In other words, one of the substantive issues to arise from my analysis is that value or choice and ethics have been divorced, and that midwives are expected to, but prevented from bridging the gap (Clarke 1995, Kirkham 1999).

There is a network of possible values we could appeal to. If we were to limit ourselves to research findings, as I noted earlier, that which compares outcomes of birth in different settings shows that women and babies attended by skilled midwives in out of hospital settings receive fewer interventions and sustain less injuries⁷. Jo Green, Vanessa Coupland and colleagues (1998) contributed another pointer: that whatever women's views on technological or natural birth prior to birth, satisfaction rates were higher among those women who had fewest interventions (173-175). Research with women demonstrates some of the most positive accounts come from women who had home births, and/or one or two trusted midwives throughout the childbearing period (McCourt and

⁴In other words, this builds on Elizabeth Smythe's (1998) work on "mattering". It confirms, not only that birth matters, and that women's concerns matter, but also suggests how they come to matter and how midwives can honour that mattering.

⁵A recent collaborative publication (DeVries et al 2001) on birth in 9 countries lends further weight to Brigitte Jordan's (1993) and other work in this area (Davis-Floyd and Sargent 1997).

⁶This edited collection of essays on relational autonomy forms an important addition to work in this field. It provides a diverse enough range of views about what feminist constructions of autonomy need to take into consideration to avoid closure. But it provides enough consistency to lend weight to the view that autonomy cannot be other than relational. It clarifies how oppression can have severely limiting influences on autonomy ability, without precluding it. It thus provides a more theorised discussion about choice and decision-making and contributes to a more nuanced debate about the intersections and practices of oppression and resistance.

⁷Despite the wide use of interventions in British obstetric units (Down et al 2000) the dominant mindset means that these results have been tentatively used to suggest that women should not be prevented from having out of hospital births, rather than used to encourage this.

Page 1997, Noble 2001, O'Connor 1992, Lemay 1997, Ogden et al 1997a, 1997c, van Olphen Fehr 1999, Sandall and Davies et al 2001). I also observed the general movement of women in my study, away from medicalised practices. Research corroborates this: where midwives provide more holistic support, and where place of birth is more flexible, more women plan to give birth at home later in pregnancy or during labour (Smethurst 1997). I could add that from the women's accounts, discovering the power of birth provided benefits beyond their expectations. But, as I have discussed, none of the above necessarily leads us out of the polarities feminists have criticised (Annandale 1996, Cosslett 1994, Diprose 1994).⁸

The issue may not be, which practices are natural or medical, which are valid in feminist ideology or should be excluded because of their link to patriarchal ideology, but what kind of values and beliefs a woman has, what kind of a cyborg a woman can be without it breaching her integrity⁹. In other words the decision is less about natural versus technological, but prioritising different, even competing needs, in order to give birth in ways that are most likely to fulfill her values and least likely to 'betray' them:

'I didn't want anything injected while the baby was in me, and gas and air seemed the safest option. Um ... epidurals it's tempting. A cousin of mine, had what she called a mobile epidural and ... she could still push, feeling she had the urge to push but felt no pain at all. I thought, oh gosh, that's the way to go isn't it really. I mean why do I put myself through this? But

N And how did you answer that question?

How did I answer? I don't know. I mean actually my husband said, you know, you should, you might consider it. I said, but then it means going into hospital, and he said, well if you're so sort of ... if you're really apprehensive about the pain, maybe that's the way to do it. But I want the baby at home so much that I'll forgo anything which means I'll be hooked up to something. When you are hooked up, I mean even with a so-called mobile epidural, I can't imagine that you can sort of wander around too much the whole point is that you're anaesthetised from the waist down. You can't walk around if you're (laughing) anaesthetised. You can't stand up. So, I mean, it would just in a sense betray everything that I was hoping for and wanted. I mean, mainly, probably to give birth squatting, which is the easiest - not on my back or my side or whatever. But you just can't have an epidural I think with pethidine you also have to be monitored if I'm not mistaken. Maybe not, but you're basically confined to a bed as well with pethidine. I mean that ruled out pethidine as well, I mean, apart from the effects of pethidine. So gas and air, little tank, little mouth piece, basically wandering around. But, by the way, I would only take that when things got rough, because I'm going to use the TENS machine for as long as I can take it'

Understanding value through ethics

Examining women's qualitative accounts of birth in various settings with well-known or little known attendants, in the context of feminist theory assisted me to gain some insight into what generates and prevents a sense of autonomy/empowerment. Through their articulations of the power of listening rather than controlling, trusting rather than checking, the women's quotations confirmed that valuing and developing self-knowledge (Meyer 2000), self-definition (Meyers 2000, Mackenzie 2000), self-trust (McLeod and Sherwin 2000), self-esteem (Benson 2000, Mackenzie 2000) and self-reflection (Stoljar 2000) contribute to autonomy. Practices which reduce these have far reaching

⁸As Rosalyn Diprose (1994) contends, attributing medicalisation and technology to patriarchy effectively removes women's autonomy and replaces patriarchy with an equally oppressive matriarchy. Replacing one set of values with another risks imposing oppressive counter-cultural norms. In Lorraine Code's (2000) words this 'reduces "plurality" to variations on the Same' (198).

⁹I use Davis-Floyd's (Davis-Floyd and Dumit 1997) more open definition of the term cyborg here.

implications for women and are detrimental to them personally as well as to their contributions and places in society. On this reading, value is less about imposing what is “best” and more about providing opportunities which enhance women’s autonomy potential as they face the awesome responsibility of making decisions about the quality of life and potential harm in the face of uncertainty, during pregnancy, birth, and as mothers. Thus making decisions is an ethical stance. This explains why choice matters so much and why the way in which practitioners engage with women having babies matters. All too often (as Chapter 9 demonstrates), women and midwives are obliged to refine their balancing skills (rather than develop their autonomy skills), so that women can walk a parallel tightrope to the one walked by midwives (Levy 1998, 1999b). Both women and midwives need to abandon the restrictions of a tightrope, and expand their range of skills, including autonomy skills¹⁰.

It is clear from the women’s accounts in this study, that one of their commonalities was the desire to be autonomous, by putting their ethical stances into practice. This was often hindered in a myriad of ways by the oppressive patriarchal structures and meanings in operation. It is infinitely more difficult for those women who have been deprived of opportunities to develop their beliefs and values, who have felt unable to articulate them, and who have received little support to put them into practice (Mackenzie and Stoljar 2000).

So focusing on the range of actual choices, rather than the construction of those choices, is the same as focusing on choice as a consumer issue, rather than an ethical stance. From this perspective, women need support to find their own ethical stances from which they can make responsible decisions. So while knowledge forms a part of this process, it also involves helping women to develop their autonomy capacities. Thus the way to appeal to value without imposing oppressive counter-cultural norms is for midwives to interact with women at an ethical level - helping them and helping themselves to develop ethical stances in which decisions can be made and remade - where the focus is as much on relating as on the choices that are made.

Re-sewing the seams between value and ethics: The midwife seamstress

What emerged clearly from Chapters 8, 9 and 10, was that women held different meanings of childbearing, which at best, only partially coincided with obstetric meanings. While their integrity depended on being able to fulfill their own meanings to the best of their abilities, this depends on (autonomous) midwives being able to support them¹¹. As the women explained, without that support they were less able to make the decisions they wanted to, and less able to assume responsibility for themselves and their families¹². As I suggested in Chapter 10, this had many negative repercussions.

¹⁰But as Mavis Kirkham and Helen Stapleton show, the process of professionalisation can lead to the very skills needed to become autonomous being lost in training and/or practise (Kirkham 1999, Kirkham and Stapleton 2001)

¹¹There are many aspects to autonomy, as I have already noted. However, one of the repeated explanations women gave for midwives’ lack of autonomy, was the lack of a range of skills to support normal birth; the lack of low-tech midwifery skills to keep birth normal, and the lack of alternative practices for complications. As was clear in Chapters 8 and 9 without these skills, midwives are obliged to rely on medical policies or “rules”.

¹² Decisions are made in relationship with the self, with others and with the wider community. As theorists suggest (Mackenzie and Stoljar 2000), women need to be listened to, have their decisions respected (McLeod and Sherwin 2000: 262), and feel trusted, in order to make decisions for themselves: ‘Without a sense of her own worthiness as an agent and of the worthiness of her capacities, her desires, and her beliefs, an agent will not be able to conceive of herself as capable of effective action’ (Mackenzie 2000: 133). But this requires a degree of unity within the self (Mackenzie 2000: 135), which can easily be undermined by others. Questioning women’s decisions causes internal confusion if the women’s sense of morality is at odds with the morality designated to women in that situation, and can alienate her from her own self-reasoning (Benson 2000: 76). Likewise, ‘being assertive or confident to express your own opinions and feelings has a lot to do with trusting your own judgement about their accuracy and relevance in discussion with others’ (McLeod and Sherwin 2000: 273). So, as Susan Brison (2000) suggests, if we accept relationality, dialogic exchanges are influential: ‘If we are “second persons” - not just in the sense of having been formed by others in childhood, but also in that we continue to be shaped and sustained by others - then other’s speech to and about us and ours to and about them are crucially important in the development and endurance of our autonomous selves’ (287). So if we are distrusted and prevented from

In other words, while home birth with NHS community midwives enabled women to raise questions about, and reduce the level of seemingly necessary medical practices, and thus attenuate the impact of medical ideology, community services frustrated the development of greater autonomy for women.

Engagement, commitment, and passion sound loud and clear in both feminist methodology and my analysis. As one woman commented, 'I'm not looking for somebody [a midwife] to be a weary wally in the corner, you know'. Women needed midwives to engage with, and support their ethical stances, and provide opportunities to develop these. But midwives were unable to do this within the framework of medicalised and fragmented care, which fails to recognise women's moral agency, and does not locate childbearing in the social world. If they are not autonomous enough they cannot protect the woman's autonomy. In other words, what I suggested elsewhere (Edwards 2000: 80), that disempowered midwives disempower women, could be translated to suggest that for women to practice autonomy, they must be attended by autonomous midwives.

There are examples of midwife seamstresses: influencing the support women receive from family and friends for their decisions; bringing women together to support each other; increasing knowledge and confidence about birth in the community; diffusing professional barriers and working with women to dismantle structures and practices which work against relationships and therefore birth. I discussed the cost of resistance for women in Chapters 8 and 10. The cost for midwives is equally high. And the achievements, particularly of midwives working within the NHS, were seen as being against the odds¹³. In other words, women and midwives need similar ideological changes within society.

In order to engage with women in ways that could contribute to childbearing being a positive force in their lives (a contribution maternity care purports to make), midwifery as a discipline requires a different level of consciousness¹⁴. Self-awareness underpins feminist practice: 'to lack self-awareness is to lack autonomy' (Meyers 2000: 157). Without self-awareness, there is little possibility of helping women to develop theirs. Midwives need to be exposed to critical analyses of society in order to understand how they are co-opted by dominant ideology and socialised into practices, which reduce rather than enhance their autonomy and that of women. They need to understand how choice is located in a framework of ethical decision-making. Thus they need to experience environments and situations which expand their awarenesses and abilities to develop their own autonomy capacities¹⁵.

acting on our ethical stances, the effects reach down into the very fibres of our beings. And even though self-worth is complex, and (fortunately) women are resilient, Brison remarks that 'one assailant can undo a lifetime of self-esteem' (In Mackenzie 2000: 141), as birth accounts sometimes demonstrate.

¹³Birth at home and supportive midwives can have resistant and transformatory capacities - but these occur almost by chance, rather than by design. Midwives, like women, oppose medical hegemony, but their ability to resist is usually limited (unless they are practicing independently). As I discussed earlier, this has been exacerbated by the alienation of midwives from women by the professionalisation of midwifery. In examining autonomy and defining choice through ethical stances, it could be argued that the current definition of professionalisation not only prevents midwives from working autonomously, but also prevents them from practicing ethically.

¹⁴This is not to suggest that midwives should or could wave a magic wand over women's lives which are adversely affected by intersections of poverty, abuse and other oppressions:

'Health care by itself cannot, of course, correct all the evils of oppression. It cannot even cure all of the health-related effects of oppression. If health-care providers are to respond effectively to the problems, however, they must understand the impact of oppression on relational autonomy and make what efforts they can to increase the autonomy of their patients and clients' (McLeod and Sherwin 2000: 276).

As I suggested above, this includes listening to and trusting women. Self-trust develops from being in situations where it can be used. It can develop when others encourage and trust us (275).

¹⁵The negative impact of oppressive culture on midwives is clearly demonstrated by a number of researchers (Kirkham 1999, Kirkham and Stapleton 2001, Stapleton et al 1998) and commentators (Mander 2001). Yet, midwives who experienced empowering supervision, reported that it 'served to facilitate a change in their practice in the direction of becoming more confident and assertive' (Mander 2001: 147).

Midwifery practices and innovations based on more autonomous practice continually emerge, but often falter when they meet the strong oppositional forces of medicalisation and gender-blind cultural norms, which fail to support midwives as women. Potentially radical solutions and liberatory moves are often reconstructed into medically “safer” compromises: creating small ‘normal’ or ‘midwifery’ units within ever larger obstetric units. But freestanding birth centres, for example, are becoming more of a possibility (Anderson 2000, Rosser and Anderson 2000). As I suggested earlier, the future of midwifery and its innovations depends on how they mesh with political agendas and how women, birth and midwifery come to be defined. Thus, by its very nature, midwifery is a political animal, often too sleepy an animal for its own good (see for example Declercq 1994). Major changes in health service provision have frequently worked against midwives (Mander 2001: 165-166) and current trends in service provision are moving further away from providing women and midwives with settings in which to develop autonomy¹⁶. Larger obstetric units, even with attached midwifery units do not lead to autonomy, or reduce medical hegemony.

In a sense this brings me back to my theoretical starting points and how this influenced my interpretation of the mutual interaction between birth and sociological debates.

Coming full circle: Bringing birth back into feminist practice and theory

Even a cursory glance at the literature shows that birth and sociological literature remains relatively segregated. And yet it is by bringing birth and critical sociological analyses into dialogue that we can understand better how birth can be a site for liberation and transformation. We can also better understand (and thus be better equipped to respond to), how and why oppression occurs. As I have already suggested, there are parallels between desire and abuse in birth and other areas of women’s lives, but there are many other ways in which birth could be seen as integral to feminisms. In making the connection between what matters to women, and autonomy, Diana Meyers (2000) suggests how the expression of autonomy is what matters. In also asserting, with others (for example, Griffiths 1995, Mackenzie and Stoljar 2000), that autonomy cannot be separated from selfhood, birth practices are brought to the very heart of feminist theorising. It is only by looking at these wider issues, and reintegrating birth into sociological debates that we could begin to move away from the socially constructed home/hospital, and natural/technological polarities and develop our imaginations at a systems level, about how women and midwives could be themselves and be together¹⁷.

From this perspective birth is a valuable site of resistance, because it can provide: possibilities for autonomy; questioning rather than acceptance; heightened political awareness rather than compliance; agency rather than passivity; power rather than suppression; and loose collectivities rather than isolated individuals. The politicising effects of home birth was particularly evident in the

¹⁶It would be useful to focus more deeply on how ideology and environment interact, how transferable across geographical locations practices may be, whether or not differences between home and hospital birth are inevitable and how far physical distance from medical norms have an inevitable, or likely impact.

¹⁷ As part of this analysis, I looked at home birth as a potential site for: continued oppression and different forms of resistance; women’s expressions of internalised and autonomous practice; the comparison and continuum of home and hospital birth; and the realisation of ideals. I thus reiterate that place of birth is an important issue in its own right, but also that place of birth need not be synonymous with one model of care rather than another. Nor can it be assumed that home birth is synonymous with woman-centred care. Analysis needs to focus inclusively on place of birth and beliefs if we are to move beyond: reductionist dualistic thinking; stereotyping women (and midwives); cosmetic changes in hospital; and assumptions that only home birth can be paradigmatically different. While it is inevitable that ‘the alternative is dependent for its articulation on the hegemonic model against which it must be justified’ (Viisainen, forthcoming), the women’s accounts demonstrated that alternative readings of birth, can be less captured and defined by dominant ideology, in the same way that feminist discourses have forged spaces for women to occupy.

final interviews, 6 to 8 months after women gave birth. They still felt strongly committed to promoting home birth as a real option for other women and were aware that it is muted through lack of information within current maternity care, and that the medical approach to birth systematically disempowers women:

‘That’s the one thing that really angers me as well is that information isn’t there. Alright it is there, but it’s not being distributed as widely as information about hospital births and all the technical side of everything. When you fall pregnant, it seems like you just have to go and do your own research, and you know it’s like you’ve to struggle really, to get what you want. If you want a home birth it’s like you’re going against the norm. And it just really makes me cross that it’s expected for one to go to hospital’

‘afterwards I couldn’t get over how emotional I felt about other women’s experiences. You know, how much I felt, God I wish everyone could know that they can do it - know that it’s the powers in them, rather than outside. [...] And along with tears of joy, you kind of, you have this conflicting feeling of, it can be like this for everybody and why isn’t it you know? I hate the idea that the power isn’t seen to be the woman’s but it’s just like you’re a patient and the baby has to be taken out of you rather than your body can like work wonders you know [...] I really feel that doctors don’t see that at all that they really have no respect for the power the woman has, you know, even female doctors. I mean it’s just like not taken into account’¹⁸

From their developing perspectives, some women observed that the social structures and beliefs around birth are mirrored in other parts of life through other institutions and taken-for-granted practices - but that other ideologies exist. As Davis-Floyd (1992: 293) found in her study, having home births could destabilize other norms, even when these have been firmly held:

‘it’s like once you start you can’t stop. You know, you have to keep questioning and it’s not always easy. It kind of creates conflict. In my family and [partner’s] family, you know there’s a lot of trust put in doctors and I’ve always had that trust as well really. And it’s difficult for [partner] and I to try and go against that now you know. I suppose we had the strength of the home delivery behind us. That gives us confidence. But it’s still difficult you know you had to go out and seek out the information. You’re not going to be told by the people that are supposed to know about health care’

Just as feminists have argued that bringing passion into politics challenges oppression, home birth could be a catalyst for enhancing the life force and counteracting passivity.:

‘it’s not just the sexual/physical thing which obviously 6 months down the line you’ve kind of forgotten about unless you happen to be thinking about it that day. But generally you’re not thinking about that But the political effect has continued and I think it’s made me just feel more on-the-ball. I think there’s something kind of washed out and passive about people when they’ve had this really managed, probably awful experience that they want to put in a cupboard [...] These things just chip away at them, and they become a bit pallid ... And I think ... it’s kept it ... a vibrant issue ... Is that clear, do you know what I mean?’

¹⁸Note the striking similarity between this quotation and that of a Finnish, home birth woman: ‘We have such powers inside if only we knew how to use them, so that we would dare to go against the direction given by society and do what we feel is right’ (Viisainen, forthcoming)

In conclusion

To conclude, many areas of women's health have been appropriated by medicine and located in the dominant health/illness paradigm. Birth could be appropriately reconceptualised and relocated in the lifeworld, supported by obstetric expertise, rather than obstetrics being enabled to continue along an unrelated path of its own¹⁹. On this view, midwifery offers the possibility of holistic, social care from a dedicated practitioner with in-depth knowledge and experience. There is a great deal of merit in the idea of fostering and enabling this role rather than limiting or fragmenting it further by introducing subsidiary roles which might further undermine it and bolster medicalisation (Mander 2001: 168-9). The bottom line was that women located risk in the medical model of birth whereas medicine located risk in the social approach - but the research supported the women's views on this. The role of midwifery in women's lives to achieve this social meaning is powerfully exemplified by the quotation below, from a woman who had had a distressing experience of birth and booked with midwives she got to know and trust over the course of her pregnancy. Through only a few words, she brings together the substantive themes in this thesis - that birth is powerful and vulnerable, that it is a fragmenting rite of passage that needs to be carefully supported, that it effects the woman's sense of self and being in the world, and that the midwife is one of the main bridges between vulnerability and empowerment, through her ability to "be with":

'My daughter's birth was a true healing for me; both my body and my spirit were healed and put back together again. With the help of my midwives, I discovered the strength to reclaim my body and my baby' (Noble 2001: 113).

And as one of the women in this study thoughtfully commented, when talking about her decision to engage an independent midwife

'I think ... I think it was the only decision that would have been right for me and we're very lucky that we could afford to do it And I think at the time, when I did it I thought it was a luxury and that the community midwives would be okay as well, but that this would be better..... But now I don't think that at all [...] because I realised what I needed was not a home birth but a need for a midwife I probably needed that more than I needed a home birth ... In fact, I mean I don't know if it's even worth making that distinction because you wouldn't be offered one without the other. It would be very odd. But getting to know [midwife] and having her there and having the same care afterwards with the same person that you'd got to know was the main thing that I needed'

¹⁹We might also then be able to consider ecological feminist debates (Code 2000: 197-203) and the potential benefits of sustainability and self-sufficiency - both personally and collectively. While ecology can be a constraining influence if gender is attached to nature and nurturing, it can provide possible routes for engaged, responsible, transformatory action.

Postscript: Further research

This study focused broadly on women's experiences of planning home births. Any one of the main themes could be taken up for further research, with women planning home or hospital births. However, one of the most obvious next stages from the analysis would be to carry out similar research, using a similar methodology, with women and midwife pairs, to compare and contrast their accounts from their different perspectives. This might contribute to a debate about how women and midwives could relate together in ways that are mutually beneficial. Given that the accounts of the women who engaged independent midwives were of a different quality to those of the other women, this might include women and independent midwife pairs as well as women and community midwife pairs. This could take into consideration, midwifery practices in New Zealand, the Netherlands, and some of the North American midwifery practices.

The lack of alternative midwifery skills was one of the main barriers to safety, and protecting women from invasive and potentially harmful obstetric practices. We are thus ethically bound to more fully explore the limitations of medical responses to complications in birth, and the possibilities of midwifery/social responses to similar circumstances. Given that alternative approaches are potentially less interventionist and offer greater potential for autonomy, this particularly warrants further exploration.

Finally, a number of the women's partners were present and wanted to contribute, or spontaneously contributed during some of the interviews. It was beyond the scope of this particular study to include them, but as many of the women observed, there has been little interest in the fathers' experiences¹, and yet it is they who are increasingly expected to provide support during pregnancy and labour (Mander 2000: 62) and expected to then provide ongoing support as fathers:

'and for the fathers, I think they have a really hard time. Like [partner's] had almost no support Like at least people are always talking to the woman and various thing happen but my friend's partner said the same, you know. Even once it had happened, it's like nothing was there. Nobody was there supporting him, and encouraging him, and he was meant to be there to support and encourage my friend. But he can't do it if he's getting nothing. So I think that's really hard'

¹A forthcoming study (Mander) on the father's experiences and views will be a welcome addition in this field.

Dear

Your midwife has kindly agreed to give you this letter at my request and on my behalf, so that you can consider its contents in your own time and with no obligation.

I have been running antenatal groups for pregnant women in [city] for the last 10 years and I am currently a part-time researcher at [city] University.

Over the next 2 and ½ years, I am planning to carry out a study about women's experiences of home birth. The purpose of this would be to document the views and experiences of women planning home births in [area], to provide a useful account for women in the future, and to provide information for health professionals and those involved in planning maternity services, to help them provide a home birth service that takes women's views into account.

I plan to carry out this research by following women through their pregnancies, births and the time after birth. I would like to do this by talking to these women 2 or 3 times during their pregnancies, once soon after giving birth and again 4 to 6 months after the birth. Each interview would take place in the woman's own home or a place of her choosing, at a time convenient for her and would last about one hour - though this could be longer if the woman is willing. I would also like to tape record these conversations if the woman agrees.

Any discussions between myself and women will be entirely confidential, and names and details about each woman will be changed, to prevent her from being identifiable.

Your care from your midwife and/or doctor will not be affected in any way, whether or not you decide to take part in this study.

Thank you for taking the time to read this letter. If you are interested in the proposed study, but feel unsure about whether or not you want to take part in it, you can contact your midwife, or me for further information on [telephone number].

If you would like to take part in the study, please fill in the attached consent form and send it to me in the SAE provided. On receiving your form, I will phone you as soon as possible to arrange a suitable time to meet.

Yours sincerely

¹ I have anonymised Appendices 1, 2 and 3 in order to protect the women in the study

Appendix 2

INFORMATION SHEET

[Health board], in line with national Government policy, is proposing to extend its home birth service, so that healthy women experiencing normal pregnancies who choose to give birth at home will be supported to do this.

At present less than 1% of Scottish women have planned home births. Surveys suggest that more women would like the option of home birth and in particular, two surveys carried out in [Scotland] in 1987 and 1992 suggested that 6% and 7% respectively, of the women questioned considered this option.

Most of the studies on home birth have looked at the physical outcomes for mothers and babies. Few have attempted to find out about women's experiences and opinions, and of those even fewer have looked at Scottish women's experiences. This study aims to provide an in depth report on how women in Scotland experience planning and having a baby at home (or transferring into hospital). It is planned to include 10 or more women in the study to provide a sufficient range of different experiences.

If home birth is to become the realistic option put forward by [health board], women, health care professionals, managers and policy makers need to know more about this issue.

This research may not be of particular benefit to those taking part - though participants may find it beneficial to have the opportunity to air their views and reflect upon their experiences. The study is expected to be of more benefit to women planning home births in the future and to those planning the service and caring for these women.

The research will include a 1 hour interview in early pregnancy, 1 or 2 interviews in later pregnancy, each lasting approximately an hour, a 1 hour interview in the week following birth and a final 1 hour interview 4 to 6 months after the birth. All interviews will be carried out by the principal researcher, at the woman's convenience.

A woman is under no obligation to take part in the study. Her care will not be affected in any way, whether or not she agrees to take part.

A woman can withdraw easily at any time during the research process and her care will not be affected in any way.

A woman can contact her own team of midwives, or the midwife manager in her locality to discuss the study and its implications at any time.

All data will remain confidential and the researcher will protect the identity of women taking part in the study, by changing names and details where appropriate.

The woman's GP will be notified about her involvement in the study, unless she requests that this information is withheld.

Women will be asked whether or not they wish to see or have copies of any written material

Appendix 3

CONSENT FORM

Title of Proposed Research: **WOMEN'S EXPERIENCE OF HOME BIRTH**

Details of Investigator: **NADINE EDWARDS**
[ADDRESS AND TELEPHONE NUMBER]

Further Information is Available From: **YOUR MIDWIFE OR COMMUNITY
MIDWIFERY MANAGER**

I have read the enclosed information sheet, letter and consent form and:

- * I agree to participate in the study.
- * I consent/do not consent (please delete) to my GP being informed about my involvement in the study.
- * I understand that I am under no obligation to take part in the study and this will not affect my care.
- * I understand that I have the right to withdraw from the study at anytime and that this will not affect my care.
- * I understand that I cannot expect to derive personal benefit from the study.

NAME:

ADDRESS:

TELEPHONE:

I am expecting my baby in: (month) (year)

This is my 1st, 2nd, 3rd, 4th, 5th (please delete) baby

.....

TO BE COMPLETED AFTER DISCUSSION AT THE FIRST INTERVIEW

SIGNATURE OF PARTICIPANT:

SIGNATURE OF INVESTIGATOR:

DATE:

Appendix 4

Woman 1

Woman 1 was expecting her second baby. At the end of her first pregnancy she booked with an independent midwife because of growing concerns that her community midwives wanted her to be induced and give birth in hospital. Her baby was born at home with an independent midwife, her partner, mother and friend. During this pregnancy she booked with a team of 7 community midwives at a relatively late stage in her pregnancy, due to apprehension following her previous experience with them. She gave birth at home attended by 2 community midwives, her partner and same friend and used a birth pool, all as planned. She had planned for her mother to be present again, but she gave birth before her mother arrived. Her first child slept during her labour and awoke shortly after the baby's birth

Woman 2

Woman 2 was expecting her third baby. She inquired about a home birth when pregnant with her first child, but was told by her GP that this was not possible. She therefore had her first baby in hospital and found this a very positive experience. Her second baby was born at home with community midwives. She subsequently made a formal complaint about one of the midwives who attended her. Because of this experience she considered not booking with community midwives during her third pregnancy and giving birth with her family and friends. She booked with a team of 7 community midwives during the seventh month of her pregnancy. During the late first stage of her labour she was advised to transfer to hospital, due to meconium staining (though she remains unconvinced that it was meconium, as there was no further appearance or mention of it) and had a water birth in hospital, despite opposition. Her partner, children and friend were with her throughout, though there was resistance to her children and friend accompanying her (it was important to this woman that birth should be part of family life). Her community midwives continued to attend her in hospital

Woman 3

Woman 3 was expecting her second baby. She had her first baby in hospital. Her labour was augmented in hospital, she felt compelled to agree to pharmaceutical pain relief, and felt restricted and unable to move around and give birth in the way she wanted to. Although she had a "normal" vaginal birth, did not want to repeat her experience of feeling she had little control, in hospital. She planned to have a home birth before becoming pregnant a second time. She booked with a team of 7 community midwives and transferred to hospital during labour due to thick meconium staining early in labour. Her preferred community midwife and partner attended her throughout. She had planned to have her first child and her sister present - but was unaware that special arrangements had to be made beforehand to enable her child to accompany her to hospital. Although she felt the birth went as well as it could under the circumstances, she was disappointed her child was not present, as birth was very much a family event for her.

Woman 4

Woman 4 was expecting her third baby. Her 2 previous babies were born in 2 different hospitals some years ago. She gave birth vaginally but felt she had no control in hospital and decided before her current pregnancy to plan a home birth. She had inquired about home births during her first 2 pregnancies, but was told by her GP that this was not possible. She booked with a team of 7 community midwives and gave birth at home as planned attended by 2 midwives and her partner. Her children were visiting relatives during her labour and birth. The issue of control was important

to this woman, who felt that being out of control was harmful for her and had contributed to postnatal depression after a previous birth.

Woman 5

Woman 5 was expecting her second baby. Her first child was born in hospital. She felt that the birth went very well and initially booked for a second hospital birth. During her pregnancy however, she and her family visited a friend the day this woman had had her baby at home. Having witnessed the family at home immediately after birth and the flow of family life after birth, she decided to book for a home birth at around 20 weeks of her pregnancy. She booked with a team of 8 community midwives and had her baby at home as planned attended by 2 midwives and her partner. Her first child was present during much of the labour, but in bed, asleep when she gave birth.

Woman 6

Woman 6 was expecting her third baby. Her first baby was born in hospital, following an induction. She and her partner found the experience of medicalisation and 'interference' very distressing and resolved not to repeat the experience. She had her second baby at home and was delighted with this experience and booked to have her third baby at home as soon as she knew she was pregnant. All her care was provided by one community midwife who had also provided her care during her second pregnancy, birth and postnatal period and her antenatal and postnatal care during her first pregnancy. The support and encouragement of her midwife were crucial for this woman. She had her baby at home as planned, with her midwife, a second midwife and her partner. Her children were looked after by relatives nearby.

Woman 7

Woman 7 was expecting her second baby. Her first baby was born in hospital. She had considered a home birth during her first pregnancy, but was dissuaded by her GP. She felt the birth was a reasonably good experience, but had wanted to feel freer to move around and follow her own instincts. She had been attached to a fetal heart monitor on a bed and felt restricted. She wanted birth to be more of a celebration than it had felt in hospital. As soon as she became pregnant again, she booked with a team of 7 community midwives and gave birth at home as planned attended by 2 community midwives and her partner. Her first child was looked after by relatives. She had planned to have a friend to provide additional support, but her labour and birth were quick and the friend was not called.

Woman 8

Woman 8 was expecting her second baby. Her first baby was born at home. She initially considered a domino birth, but was told that this was not available for women expecting their first babies. She decided to plan a home birth and was then offered a domino birth. By this time she felt that a home birth was really what she wanted - though felt she had to 'fight' to have her baby at home. She planned to have her second baby at home from the start and booked with the same team of 6 community midwives. This woman wanted birth to be an ordinary life event, without fuss or interference. She gave birth at home as planned, attended by 2 midwives, her partner and mother. Her first child was in the house, but not present at the birth.

Woman 9

Woman 9 was expecting her third baby. Her first 2 children were born at home. She planned to have her first baby in hospital, but found her antenatal care disjointed to the extent that she felt out of control and decided to have a home birth towards the end of her pregnancy. Having had a positive home birth experience, she felt that planning home births during subsequent pregnancies was a foregone conclusion and booked with the same team of 6 community midwives. There was some disagreement about the baby's due date - the woman thought that her baby was due later than a scan date suggested, but she was persuaded to have an induction of labour. Her baby was born by emergency caesarean section because of a shoulder presentation following amniotomy. Although she was booked with the same midwives who had provided her care during her first two pregnancies and labours, she was transferred to hospital care when it was thought she was 42 weeks pregnant. She was attended by a hospital midwife who she happened to have met during her pregnancy - when the midwife was seconded into the community - and her partner, and a variety of hospital staff.

Woman 10

Woman 10 was expecting her first baby. She assumed she would have her baby in hospital until early in her pregnancy when a close friend also became pregnant and booked a home birth and asked her if she was planning to do the same. She began to read more about birth and home birth and was particularly moved by Nicky Wesson's book 'Home Birth'. She then mentioned home birth at a hospital appointment and arrangements were made for her to discuss this option with community midwives. She decided to plan a home birth and booked with a team of 6 community midwives. She gave birth at home as planned and was attended by 2 community midwives, her partner and friend. She felt she was unable to get to know her midwives and was disappointed that they did not seem to share her views or enthusiasm about home birth.

Woman 11

Woman 11 was expecting her first baby. She planned to have her baby at home when she became pregnant. She hired a birth pool, but was unable to use it as she transferred to hospital at the start of her labour when her waters broke and were meconium stained. She booked with a team of 6 midwives - but was attended by hospital midwives during labour and birth. She had planned to have a friend as well as her partner with her, but labour and birth were so quick, her friend was not present. Like woman 8, this woman wanted to give birth normally, with as little interference as possible, and saw home birth as offering the best place to give birth most efficiently with minimum fuss.

Woman 12

Woman 12 was expecting her third baby. Her first baby was born in hospital. She felt the birth went well, but found her postnatal stay in hospital distressing, because her baby was subjected to, in her opinion, too many blood tests due to jaundice and because she found the stay neither comfortable nor relaxing. To avoid the postnatal stay, she planned a domino birth with her second baby and then changed to a home birth booking later in her pregnancy as a domino turned out to be unavailable. She was very pleased with this arrangement and planned to have her third baby. She booked with a team of 7 community midwives and gave birth at home as planned, attended by 2 midwives and her partner. Her two older children were asleep, in bed when she gave birth.

Woman 13

Woman 13 was expecting her first baby. A neighbour had had her second baby at home and she felt she would prefer to give birth at home, in her own way. She initially booked with her local hospital, as she thought her request would be rejected and that she would have to 'fight' to have a first baby at home, and therefore wanted time to arm herself with statistics and information. She booked for a home birth with a team of 6 community midwives later in pregnancy, when she felt well enough informed to argue her case. She gave birth at home as planned, attended by two midwives and her partner. She considered having a friend present, but her partner was not keen on this. This woman felt that she would need the privacy and familiarity of her own home in order to be able to give birth.

Woman 14

Woman 14 was expecting her first baby. She and her mother and grandmother were all born at home, and she assumed that she would give birth at home. Her partner also had experience of home birth. She made enquiries about home birth through her GP before becoming pregnant, but found that her GP was very negative about this. When she became pregnant, she immediately contacted her local community midwives. This seemed to take some time to arrange, but she booked with a team of 6 community midwives. She hired and used a birth pool and gave birth at home, attended by 2 midwives, her partner and mother as planned. Like other women, this woman wanted to avoid interventions, and felt that she would be unable to give birth in hospital.

Woman 15

Woman 15 was expecting her second baby. She had planned to have her first baby at home, but transferred to hospital following a long labour. Her baby was born by forceps. She felt unhappy about and undermined by the experience - and not convinced that she could not have given birth at home with more support. Her feeling was that midwifery care is over medicalised, and not geared to supporting women to have normal births without interference. She planned to have her second baby at home and booked with a different team of 6 community midwives as she had moved following the birth of her first child. Her second baby was born at home in a birth pool as planned and she was attended by 2 midwives and her partner. Her mother was also present.

Woman 16

Woman 16 was expecting her first baby. She had planned to have a hospital birth because she had been led to believe she had no other option. During her pregnancy she moved to an area where a team of committed community midwives were providing a more accessible domino and home birth service. She booked with a team of three community midwives for a domino birth and three weeks before her baby was due booked for a home birth at the suggestion of her midwife, in response to her views about birth and fear of over-medicalisation in hospital. Following a long labour at home, using a birth pool, she transferred to hospital, was given pain relief, then later syntocinon and an epidural and her baby was born with the help of forceps. Her midwife stayed with her in hospital for a short time, and she was then attended by hospital staff. Her partner supported her throughout. She would have liked the additional support of a doula, but was unable to find one in time for the birth.

Woman 17

Woman 17 was expecting her second baby. She had her first baby in hospital and found the experience to be very traumatic. She was induced and given pethidine due to high blood pressure, and subsequently had an epidural and her baby was born by forceps. She and her partner decided to have their second baby at home before conceiving, following lengthy and detailed discussions. She

thought she may have to have a domino birth because of the previous complications and was prepared to go along with what her midwives suggested. She booked with a team of 6 community midwives and found them positive about her plans for a home birth. She described feeling encouraged by a 'mini home birth culture', as a number of her close friends had had their babies at home. She hired and used a birth pool and gave birth at home as planned attended by a community midwife and her partner. Her child was asleep in bed. (The policy was, and still is for women to be attended by 2 midwives at birth. The second midwife is usually called in late labour and in this case arrived after the baby's birth.)

Woman 18

Woman 18 was expecting her fifth baby. She had her first two children by caesarean operation, as both were breech babies. She found her first caesarean operation was more traumatic than she had been led to believe and searched out more information during her second pregnancy. She was reluctant to have the second caesarean and when her third baby was also breech, decided to have a vaginal birth, if possible. Despite opposition, she gave birth vaginally as planned. Her fourth baby was cephalic and also born vaginally. The woman described having to 'fight', during her labours in hospital and had 'had enough'. To avoid this, she decided to have her baby at home. She booked with a team of 6 community midwives but had little confidence in them and intimated to her midwives that she might not call them during her labour. She gave birth at home as planned and called her midwives shortly before giving birth. She was supported throughout by her partner. Her other children were in bed asleep during her labour and birth.

Woman 19

Woman 19 was expecting her second baby and had planned a domino birth. Although she had hoped for a natural birth, she had what she described as a 'technological' first labour and birth. She decided to change her booking from a domino to a home birth shortly before the baby's birth and remained with the same team of 6 community midwives. Having felt undermined by her first experiences, her confidence in her ability to give birth increased during her pregnancy. She was encouraged partly by women in her antenatal group who had had positive experiences of home birth and partly by her midwives when she tentatively raised the possibility of a home birth. She was also put off going into hospital for the birth following a visit there in late pregnancy. She gave birth at home, attended by a midwife, her partner, and friend. Her young child was looked after by relatives. (Like woman 17, her baby arrived quickly, before the second midwife).

Woman 20

Woman 20 was expecting her second baby. She booked with the same team of 6 community midwives she had booked with for her first domino birth. She described this as a positive, straight forward, but long labour and birth. Feeling more confident after having given birth before, she planned a home birth from the outset. She hired and used a birth pool and gave birth at home attended by 2 midwives and her partner. Her mother and first child were also present. She felt that the system of care, which included lack of continuity and time, prevented her from getting to know the midwives and she was therefore less able to discuss the more emotional aspects of birth.

Woman 21

Woman 21 was expecting her first baby. She felt very strongly about staying at home to give birth, and felt extremely reluctant to go into hospital, or accept any intervention, and thought that she would be unlikely to consent to a caesarean section and had explored the legal implications of this. She considered booking an independent midwife, but was unable to for financial reasons. The

Community Midwifery Manager agreed to provide a team of 3 midwives, to provide continuity, though this did not work in practice. She arranged to have a birth advocate, and her partner and friend to support her during her labour. She considered not calling the community midwives, but called them during her second stage. She planned and had a waterbirth.

Woman 22

Woman 22 was expecting her first baby. She found her first visit from a community midwife unsatisfactory, for a number of reasons. She felt very strongly that she wanted to get to know the midwife who would attend her during labour, and that this would be impossible within the services provided. She saw birth as an intimate experience, in need of sensitive support by trusted others. She also felt that her views and the views of the community midwives were too far apart and that they were likely to advise transfer into hospital during labour, when she would be at her most vulnerable. She subsequently booked with an independent midwife, who provided all her care. She hired and used a birth pool and gave birth at home as planned with her midwife and partner.

Woman 23

Woman 23 was expecting her first baby. She had planned to have her baby at home from the time she became pregnant, and had previously attended her sister's home birth, as a birth supporter. She booked with a team of 5 community midwives, but encountered opposition from GPs, and an obstetrician, as well as lack of support from her midwives. She felt (and the midwives acknowledged) that they lacked experience and confidence. She thus felt that she could not trust them not to transfer her unnecessarily into hospital during labour. Towards the end of her pregnancy she booked with an independent midwife. The independent midwife provided all her subsequent care and she gave birth at home as planned, attended by 2 independent midwives, her partner, her sister and sister's partner.

Woman 24

Woman 24 was expecting her first baby. She planned to have her baby at home from early pregnancy, having been very moved by a book she had read about birth some years previously. She booked with a team of 5 community midwives and encountered some discouragement from them. They encouraged her to have a hospital birth for a first baby. She resisted pressure to do this and gave birth at home as planned attended by 2 community midwives, her partner and friend. Like a number of women having their first babies at home, she found support through home birth networks and antenatal classes outside the NHS to be invaluable, in helping her to resist the pressure to have her baby in hospital.

Woman 25

Woman 25 was expecting her first baby. She had been impressed by Sheila Kitzinger's writings about natural birth and planned a home birth from the beginning of her pregnancy. She booked with a team of 6 community midwives and found them more positive about home birth than she expected. Her pregnancy was straightforward, but in the last weeks of her pregnancy, her baby was still moving between breech, transverse and cephalic positions and plans for a home or hospital birth changed from day to day. Some of her midwives encouraged her to plan a domino birth, but she finally gave birth at home attended by 2 midwives and her partner.

Woman 26

Woman 26 was expecting her first baby. She initially inquired about a domino birth and was told this was not possible, due to lack of resources. She then searched out information about the safety and risk of home births and subsequently planned a home birth. She felt unsupported by her team of 5 community midwives and at seven months of pregnancy considered a hospital birth, as she did not want to feel that her midwives were attending her unwillingly. Shortly before her baby was due, she was offered a domino birth, but continued with her plans for a home birth. She was then told her haemoglobin was too low, and agreed to go into hospital if it did not increase. After 2 weeks it was considered high enough, and she went into labour shortly after this. She transferred to hospital after twelve hours of labour due to 'failure to progress' and following pain relief, augmentation and an epidural had an emergency caesarean section. Her community midwife remained with her until she went into theatre and her partner supported her throughout.

Woman 27

Woman 27 was expecting her first baby. She had booked for a hospital birth, and changed to a home birth booking in late pregnancy, as she became more confident about giving birth and more concerned about the fear orientation of obstetrics and what she felt to be the over medicalisation of birth in hospital. She also had a spiritual orientation that she felt would be better supported at home. She booked with a team of 6 community midwives and gave birth at home as planned, attended by 2 midwives, her partner and mother-in-law. She described her journey through pregnancy, birth and the postnatal period as a struggle, which her midwives seemed unaware of, and therefore unable to support her with.

Woman 28

Woman 28 was expecting her first baby. She had not considered not having her baby at home, as she felt it was the best place to give birth. She booked with a team of 5 community midwives, but because of her geographical locality saw one midwife at most antenatal visits. She felt (and her midwives acknowledged) that her main midwife, and 3 of the other 4 midwives on her team were inexperienced, lacking in confidence and not supportive. She was thus afraid that they would suggest transferring to hospital unnecessary. She felt that this was never resolved, and as a result felt that the situation between her and her midwives became somewhat uneasy and polarised. She also encountered opposition from her GP and obstetrician. She gave birth at home as planned, attended by 2 midwives, her partner and friend. She relied almost exclusively on her partner and friend for support.

Woman 29

Woman 29 was expecting her second baby. She had planned to have her first baby at home while living abroad, but went into labour during a trip away from home, in a remote area. She therefore decided to give birth in a small local hospital. During her second pregnancy, she booked with a team of 6 community midwives. They initially suggested a domino birth and she found that their views and her views on birth were not as compatible as she had hoped, and found the service more medicalised and depersonalised than she expected. She considered booking with an independent midwife but remained with the community midwives. She gave birth at home as planned, attended by a midwife, a student midwife (although she had previously stated she did not wish to have a student present), her partner and friend. Her older child was looked after by a friend.

Woman 30

Woman 30 was expecting her second baby. She had her first baby in hospital and described it as a normal, straight forward birth following induction of labour. She stated that she was reasonably happy with the experience - though also described her induction as invasive and painful. She thought a home birth would be better in terms of continuity for herself and her family and that booking with a team of 6 community midwives would be preferable to receiving hospital care. She planned to use a birth pool, but transferred to hospital for an induction of labour due to reduced liquor and a query about the baby's well-being at term. Her baby was born in good health, but she felt that her labour and birth could have been approached more gently and more in keeping with her concerns. She was attended by hospital staff and her partner. She felt that the community and hospital services were disjointed, and that the community services need to be extended and improved for home birth to be a viable option for women.

Appendix 5

The second semi-structured interviews usually included variations on the following questions:

can you tell me how you've been getting on with your plans for your home birth
how are you getting on with your midwives
how far would you say you are developing a relationship with them
are you getting to know each other as well as you had wanted to
how are your antenatal visits
are they in hospital, in a clinic or in your home - do you have any preferences
what sorts of things happen
what do you talk about
have your midwives talked to you about their service
have you discussed reasons that might necessitate transferring to hospital
do you have the opportunity to raise issues with your midwives
can you talk to your midwives about your thoughts and concerns
how far have you developed a trusting relationship with them would you say
how comfortable do you feel with your midwives
what sorts of things are you looking for in a midwife
have you written a birth plan
what sorts of things does it cover
do you have thoughts on pethidine, entonox, TENS, birth pools, vaginal examinations, monitoring
the baby's heartbeat, syntocinon, vitamin K, student midwives
how do you feel about control
what does control mean for you
how do you feel about privacy
what sort of support might you want
are you preparing for your birth in any way
where do you think your other children might be
do you ever think about how and where you may labour and give birth
have you thought about when you may call your midwives
how personalised would you say your care is
how do you feel about your own knowledge about your body, your baby and birth
does birth have any spiritual, sexual, emotional or other aspects to it for you
do you think there may be any disadvantages to home birth for you
what arrangements have been made for checking the baby after birth

Many of these questions prompted further questions, or a woman might answer a number of questions together. If there had been an area of particular interest or concern during the previous conversation, I also asked about that. For example, if a woman had been troubled by her mother disagreeing with her plan to give birth at home, I would ask her how she was getting on with her mother in relation to this. If a woman was experiencing difficulty in obtaining information, I asked her how she was getting on with that now. During all but the first interviews, when asking about further thoughts, I frequently quoted women's previous comments. If themes arose that I had not thought of raising during the course of the previous interviews, drawing on grounded theory (Glaser and Strauss 1967), I would include it in further interviews with other women. For example one woman talked about how she would often think about her forthcoming labour, and imagine how she might use and place her furniture and how she might use the space around her. I then asked other women if they ever found themselves thinking about, or imagining how and where they may labour and birth. This made me think about temporality, spatiality and territory.

The third interviews usually included the following sorts of questions

can you tell me about your experience in your own words
how did it meet or not meet your expectations
would you change anything
how did your plans work out in practice
who was with you - had you met the midwives
how did you experience those with you
how comfortable did you feel both emotionally and physically with them
how did you feel about vaginal examinations and monitoring of the baby's heartbeat
how did you feel about control
how relaxed and free did you feel
what happened with your other children
how did you find the time immediately after your baby was born
what happened about the paediatric check
how did you find your postnatal care
has planning and having a home birth had any effect on you do you think
what do you think about the home birth service now

7 women transferred to hospital immediately prior to, or during labour. I asked them the following questions:

can you tell me about your experience in your own words
how did you feel about the decision to transfer to hospital
how did you find the decision-making process
how do you feel about the decision now
could your move to hospital have been made easier do you think
how far were you able to maintain your hopes and plans in hospital
did your community midwives or hospital staff provide your care
how in control did you feel
how do you feel about the home birth service now

I also included more specific questions in all the interviews, as each woman raised particular issues or had specific hopes, expectations and concerns. For example, if a woman had hoped her birth would be a celebration, 'a lively colourful experience', I asked her how she felt about that. If pain had been a concern, I asked her how she felt about the issue now. If a woman had been worried that she would not be able to maintain her spirituality in hospital, but transferred to hospital, I asked her how she now felt about that.

The fourth and last interviews usually included variations on the following questions as well as more specific questions:

can you tell me how you look back on your experience of planning and having a home birth (or transferring to hospital)
how would you now say it met or didn't meet your expectations
how do you feel about home birth now
do you have any further thoughts on the home birth service
how do you look back on the care you received
do you have further thoughts on continuity
how in control did you feel
has your experience had any ongoing effects would you say
how would you now describe your relationships with your midwives
do you talk to other women about home birth
how do you find that
what do you think or feel about your own knowledge about birth - was it sought and valued

how does it fit in, or not fit in with the midwives' knowledge

how does home birth fit or not fit with the kind of person you are, your outlook and lifestyle

If at any time during the study, the woman had had a particular interest or concern, I would raise the issue during the final interview for possible further comment. If a woman had talked a great deal about her views on the attributes, qualities and skills she thought midwives should have, I would raise this, and ask her if she had further thoughts. If information and choice had seemed a particular concern, I would ask her about this again

Appendix 6

Examples of 2 NUD*IST coding tree structures

Coding (at its most complex)

1. influences

- hospital
 - towards
 - against
- home
 - towards
 - against
 - death of baby
- away from formal services
- background influences

2. context of home and hospital birth

- norms
 - following norms
 - rejecting norms
- women as other
 - birth as other or abnormal
 - illness and hospital link
 - class and age issues
 - midwives as other
 - distancing women from each other

3. hospital as norm

- otherness of alternatives to hospital
 - home birth as other
- rejection of medicalisation
- acceptance of norms
 - midwives need to know that women will accept norms
- bringing hospital home
- uncertainty of home birth
- medicalised birth as norm
 - conflict between what women want and policies

4. conflicting models of health care

- difficulty of moving from medical model

5. institutionalised care

- distancing women
 - humiliation
 - imposing
 - getting to know midwives
 - personalities
 - distancing women from their bodies
 - difficult women
 - distancing women from midwives
- different agendas
 - women's agendas
 - information giving
 - support for women's agenda
 - medical agenda
- unequal investments in woman/midwife relationship

who should attend birth
power
 negotiating with institutions
 not understanding institutions
processing women
power and control issues
 overstepping boundaries
disconnections
getting around institutionalised care
 women and midwives
 outside support
routine rather than individualised

6. stories

conflict
 control and responsibility
 conflicting agendas
 support
 transitions
 silent resistance
 knowledges in conflict
 unease

pain
midwives
partner trauma
postmodern story
control
ironies of trust

7. knowledges

complementary knowledges
reflecting knowledges
women's growing knowledge
 experiential knowledge
passing on knowledge
competing knowledges
 marginalising women
 definitions of risk
 other definitions of birth
 feeling safe
 conflicting knowledge re women's feelings and professional judgment
 women being uncertain about their knowledge
appropriate knowledge
women's logic
lack of, or having knowledge of the system
women knowing
medical knowledge
 having to know
 women's scepticism

8. connections

with midwives
with life and community
with home and territory
within family
with body and self

- 9. embodiment**
- 10. uncertainty in childbirth**
 - uncertainty around home birth
- 11. safety and risk**
- 12. information gathering**
- 13. de-institutionalising care**
 - territory
 - time
 - environment
 - control over environment
 - continuity
 - control
 - feeling less inhibited
 - support
- 14. language**
 - language around hospital experiences
 - opposites
- 15. relationships**
 - lack of trust
 - trusting women
 - midwives qualities
 - finding out about each other through stories
 - not happening
 - imposed endings
- 16. questioning demarcation**
 - accepting demarcation
- 17. responses to home birth**
 - mothers
 - others
 - partners
 - midwives
 - GPs
- 18. resisting stereotypes**
- 19. practical issues**
 - antenatal care
 - paediatric check
- 20. alternatives or ideals**
- 21. fear of transfer**
- 22. support and lack of support**
- 23. radicalising effect of home birth**
- 24. expectations of home birth**
 - measuring expectations against hospital birth
 - relativity of control etc
 - not meeting expectations
 - initial expectations
- 25. birth plans**
- 26. how different understandings of birth fit together or not**
- 27. transferring to hospital**
 - decision to transfer
 - the transition from community to hospital based care
 - retaining control
 - importance of midwife support
 - looking back

28. views on home birth service
29. breech birth
30. fear, betrayal, abuse
31. alienation
32. feeling invaded
33. debriefing
34. research process
35. continuity
36. outside dominant ideology
37. role of midwife
38. sexuality
39. control
40. moving in labour
41. continuities/discontinuities
42. first contacts
43. professionalisation versus experience
44. confidence
45. comparisons
46. postnatal
47. normal fears
48. individual woman's stories
49. stretching the system
50. responsibility
51. talking to other women
52. feeling bad about oneself
53. women as powerful
54. looking back

Overall developing structure

POWER

norms

demarcation

stereotypes

KNOWLEDGES

philosophies/models of birth

safety and risk

ACCEPTANCE AND RESISTANCE

STORIES AS VOICE AND AGENCY

Coding (following refinement of substantive themes)

Context

Influences

Responses

First contacts

Norms

Medicalised/Institutionalised/Routine Care

Meeting or experiencing it

Continuity

Support

Control

Crossing boundaries/identity issues
Knowledge acquisition
Trust
Bodies
Making the best of it
Moving beyond - exceptions
Limitations
Demarcation
Birth Plans
Silencing
Fear of transfer

Women as Agents Defining Birth - Priorities

Different understandings
Safety and risk
Need for support
Family
Being in control
Knowledge - information
Ambivalence
Importance of territory
Continuity of relationships
Continuity in the process
Feeling relaxed
Trust
Midwives qualities/personalities
Power/sexuality/spirituality
Confidence
Resisting stereotypes

Role of midwives

Comparisons

Experiences of transfer

Views on home birth services

Reflections

Radicalising effect of home birth

Research process

Appendix 7

Women's experience of the research process

I did not initially intend to include women's views about the research process itself. As I instigated and carried out the interviews, I thought it could be difficult for women to tell me about how they experienced the process, openly and honestly. It seemed likely that I would receive positive rather than negative comments, which may lead to false assumptions. I acknowledge that this might be the case but include the following, as so many women commented spontaneously.

I have already noted on page 110, that women felt that it provided them with an opportunity to express known and unknown views and thoughts. I also inadvertently introduced a boundary between one woman and her baby that made her uncomfortable (see footnote 60 on page 305). Other quotations suggested that the process necessarily had some impact, that this could be experienced as positive, but that there could also be ambivalence:

'I always think before you come, what on earth can she have to ask me that we haven't covered already? Even the first time you'd come ... what can she possibly ask me about? You know, you have a baby You know the first couple of times you [came], like before I'd had the baby, it really made me analyse it a lot more myself. Yeh. Than just that I was having this home birth, and I would phone [midwife] at the right time, and that would be it. And I had to sort of think about why I was doing it. And you know you really made me think a lot more'

N Was that good or bad or indifferent?

It wasn't bad It maybe made me appreciate it a bit more you know and think .. You know, made me think about how I felt about it rather than just sailing through and not thinking and it being the experience is gone, and I hadn't thought about it It didn't change the experience but it probably did make me be more aware of it'

'Thank you, thank you for involving me It's been really, it's been really - I think I've done some debriefing in these sessions in a way. I'm sure I have and I'm sure that's been healing in itself

N Mm ... mm that's good

Not that I meant that to happen, but I think it's just talking about something, helps you to put it to rest if you like'

'it was incredibly helpful ... and so lucky ... (laughs) to have been taking part in this study ... So ... that was just brilliant That was, you know, really lovely timing. You know, I got a lot out of it'

A number of the women who had upsetting experiences commented that because the interviews were relatively unstructured and they felt free to tell me their stories (see Kirkham 1997), that it had been a healing process for them. One woman observed that something similar should form part of antenatal care. She commented on this several times and when she was pregnant on a subsequent occasion told me that she missed the opportunity to talk about and reflect on her pregnancy and birth.

Appendix 8

Parallels between the birth process and the research process

As my thesis progressed, the parallels between research and birth, and the similarities and differences between my experience of the research process and the women's experiences of their pregnancies and births became increasingly noticeable. Like Maxine Birch's (1998) description of researching alternative therapy groups, I too found that the 'mirror image [...] emerge[d] between the substantive issues and the research process' (171).

Just as the women read, I read. And just as they found, I too found that information was 'not being handed on a plate', and that alternative sources of knowledge needed to be searched out. While they sought out home birth research, home birth support groups and midwives who shared their views, I sought out feminist texts and researchers, midwives, and others who held alternative views. As I described in Chapter 9, midwives were the people most depended on for support by the woman. I relied on my supervisors. Unlike many of the women, I was trusted to grow my "baby" in the way I thought best, with the support of their knowledge, experience and encouragement. Unlike many of the women, I benefited from continuity, one-to-one care and easy access to my "midwives". Their belief in me, in the face of uncertainty increased my confidence and enabled me to successfully move through the research process. The quality of the support, not only from midwives/supervisors, but from family and friends largely determined the outcome and quality of the experience. This aspect of nurturance is as unacknowledged in relation to women's work, as it is in relation to motherhood, as I described in chapter 9.

There were parallels between the various stages of birth and research: the gathering and processing of information before birth and writing in the hope that all would be well on the day; the need for information and theory and yet the need to relinquish it - "throwing out" the books to focus on birth and "throwing out" theory to focus on the data; the simultaneous relational and solitary nature of giving birth and writing. At the same time, both the women and I were aware of the pull towards fragmentation in medicine and traditional research, and the need for connectedness, interdependency and unity. I/they needed both knowledge of the parts and a sense of the whole.

I found similar power/knowledge issues in medical birth ideologies and dominant research ideology: the muting of both women and feminist research; and the attempt to impose sameness on diversity. In other words, academia can be as socialising as medicine, and as the women attempted to hold on to their concerns, find their own languages and develop their autonomy, I attempted to break through the limitations of academia, to honour their stories (see Bannerji et al 1992). So, while the women attempted to imagine beyond the normalising influences of institutionalised medicine, I attempted to imagine beyond the normalising institution of academia.

Just as the women moved through a rite of passage, I felt I also moved through my own rite of passage, experiencing the fragmentation, the need to reintegrate and form a new sense of self. As I wrote and gave birth to the thesis, I needed stability, familiarity and above all, no distractions or obstacles, and understood more deeply, the women's need for all but birth to be certain, predictable and trustworthy.

The erasures I found in medicine were paralleled by those in research. The docile bodies I referred to in Chapter 10 applied as much to mine as I subjected it to the disciplinary practices of academia as it did to pregnant and birthing bodies. So, I experienced a similar pain and pleasure: negotiating and challenging birth/research issues - defined through the same male/rational constructions; experiencing the pleasure of creating my own meanings; and developing my own autonomy through resistance. Like the women, I found the emotional costs were high. I was changed in ways I could

not have imagined possible, as I was prompted to examine any and all assumptions I held¹. This undermined any sense of certainty or confidence I might have had, but at the same time increased my sense of purpose and autonomy. Both the women and I shared an ethical stance which rendered us responsible, powerful and vulnerable.

¹Indeed, research is an exercise in self awareness where both the researcher and the researched engage in raising each other's awareness and consciousness (Ely et al 1991: 225). So as the women examined their motives and reasons for planning and having home births, I too re-examined my own experiences of planning home births. I became more aware of just how oppressed I had felt, while planning my own home births from 1976-1980. Given the positive accounts of some of the women, and the increase in knowledge about the physiology of birth, I experienced a new sadness about how controlled my own experiences had been. Although I avoided most interventions, responding positively to the rhythms and needs of the birthing body was not part of the discourse about birth I had access to, nor did I have any consciously developed or articulated concept of birth as part of my ongoing spiritual or sexual/sensual journey. And yet, I am still able to appreciate that it was a powerful act of resistance in other ways.

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