Learning to birth, mastering the social practice of birth: conceptualising birthing women as skilful and knowledgeable agents

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

In this thesis, I draw inspiration from Bourdieu's theory of practice to inform a conceptualisation of birthing women as skilful and knowledgeable agents. The study contributes to geographical knowledge about spaces of birth and about how these represent key sites of learning. Empirical data were collected in 2011/12 through in-depth semi-structured interviews with 26 women living in North-West England (involving 68 childbirth experiences). Two key themes emerged from the women's narratives: the prevalence of trouble (and how this is accepted as 'just the way things are') and routine (and non-medically indicated) diversions from an undisturbed physiological birth process. This thesis argues that rather than representing a space in which women might learn to protect the physiological process of birth, successive experiences of birth seem to represent a space in which many women learn to shut down that possibility. Rather, they prioritise defensive action to protect themselves against emotional and physical harm, with some women learning that a physiological approach to birth is unnecessary, abnormal and dangerous. Whilst there is evidence that some women learn to birth physiologically over their childbearing careers by drawing on their experiential knowledge, the main finding is that being skilful and knowledgeable as a birthing woman frequently works in the opposite direction. The study thus offers new understandings of birthing women as skilful and knowledgeable agents and explores the diversity of women's learning about birth by drawing a distinction between how women come to master the social practice of birth and how they learn to birth physiologically over their childbearing careers. For the wider academy, this study brings a renewed emphasis on the key role of childbearing women in the social practice of birth.

Contents

Chapter 1 Introduction

> '… the first time is all panic. The second half-panic, but at the third and fourth times something began to dawn on me ... if you can *marry* the movements, go with them, turn like a screw in the river and swim on, then the pain ... then I believe the pain ... becomes a flame which doesn't burn you' (Bagnold, 1938, p100-101)

Enid Bagnold's 1938 novel *The Squire* portrays a woman who increasingly learns to birth physiologically over her childbearing career. The novel focuses on the woman's perspective of her fifth experience of childbirth, with the action spanning the weeks surrounding the birth. Before this birth, the main character, the Squire, is presented as well-prepared, drawing on what she has learnt from previous birth experiences, especially about how to cope effectively with the pain of labour. The Squire is clear that labouring is hard work, requiring 'tremendous determination, and will, and self-belief' (ibid., p101). The Squire's account raises the question of how many birth experiences make for a solid learning base. From the Squire's perspective, the fifth birth is where her learning should come together. Asked by a friend if she had managed to cope with the pain during her fourth birth experience, the Squire admits that she did not:

> '… [b]ut I got moments ... It's clear to me now. I know what I've got to do, if only I can keep my head ...most of us don't get enough practice' (ibid., p101-102)

And the Squire does indeed manage to 'keep her head' during her fifth labour and birth experience, with Bagnold describing how:

> '… [h]er mind went down and lived in her body, ran out of her brain and lived in her flesh ... She was not in torture, she was in labour; she had been thus before and knew her way ...' (ibid., p145-146)

What I consider most surprising about Bagnold's fictional representation of a woman becoming increasingly skilled in the practice of birth over her childbearing career (and how this increased level of skill contributes to an improved birth experience), is not its *presence* in English literature but the near *absence* of such representations in social science scholarship about birth. It is *as if* the possibility of labouring and birthing women as real-life skilful and knowledgeable agents, whose knowledge and skill about birth is rooted in significant part in their personal experiences of childbirth, is just too fantastical to contemplate, a notion that is as good as irrelevant to serious scholarship about birth: an object neither to be sought, and certainly not to be found, in real-life experiences.

The treatment of Bagnold's fictional account, when analysed in the academy by English literature scholar Tess Cosslett, might be read as lending weight to this argument (Cosslett, 1994 and 1989). For what I read as the useful insights, and spur to research, offered by Bagnold into the possibilities of a woman's experiential learning about childbirth over her childbearing career, Cosslett presents quite differently. Cosslett seems uncomfortable with the hybrid presentation of birth which Bagnold offers, for example, in which the 'natural' physiology of birth necessarily intermingles with social practice, suggesting that Bagnold's account, through a sleight of hand, seeks to deny the social nature of the birth practice described (Cosslett, 1994, p24). And rather than leaving open the possibility that the notion of an increasingly skilful and knowledgeable birthing woman might be drawn from Bagnold's own nursing and childbearing experience (Bagnold, who drew extensively on personal experience across her writing career, had worked as a nurse and given birth to four children prior to the publication of this novel (Bagnold, 1969 and 1918)), Cosslett questions its provenance. She suggests instead that it represents a fictionalised adaptation of popular contemporary approaches to birth (in particular that of Grantly Dick-Read) albeit altered to depict women (in this case, the birthing woman and her midwife) managing the birth successfully, thus claiming 'natural childbirth as a women's unaided power and marginaliz[ing] or render[ing] invisible its male cultural origins' (Cosslett, 1989, p276).

Cosslett's reluctance to assign legitimacy to the concept of women as skilful agents in the matter of childbirth is underscored when, discussing Bagnold's own childbearing experiences, Cosslett prefers to assign Bagnold's apparent increased enjoyment of her second birth (compared to her first) to the advice of the doctor, Waller, rather than to Bagnold herself, noting that '[t]he change in her experience of childbirth may have been due to experience, but more likely was due to Waller' (ibid., p275).

It is not my purpose here to challenge Cosslett's analysis of either Bagnold's own childbearing experiences or Bagnold's fictional writing about childbirth (although it is not clear to me why Cosslett does not seem to entertain the possibility that Bagnold found some resonance between her own experiences and the fictional account of those of the Squire). I rather wish to draw attention to how neither Bagnold's depiction of this experiential learning nor Cosslett's interpretation have encouraged any further scholarly debate on this point, and that, more generally, this notion seems to have been of little or no interest to the academic community. In contrast, the main focus of this thesis is an inquiry into a conceptualisation of birthing women as skilful and knowledgeable agents. In examining how women learn to practice birth over their

childbearing careers, I aim to pay particular attention to the contribution of women's experiential knowledge: that is, what they learn from their personal experiences of birth.

In the remainder of this chapter, I explain how the focus of this enquiry has developed (including its disciplinary origins), introduce my own positionality with respect to the topic, explore some key assumptions inherent to this inquiry, and outline the structure of the thesis.

1.1 Research beginnings

This thesis focus developed in the context of reflecting on the conclusions of an earlier investigation (undertaken for a Masters qualification) about women's decisions about where they give birth, and in particular why so few women in contemporary Britain choose to give birth at home (Dagustun, 2009). From that investigation, based on qualitative interviews with women about their birth experiences, including an important narrative element, I concluded that what was really at issue in birthplace decisions was how women conceptualised birth, because women's conceptualisations of birth seemed to drive women's imaginaries of where it was possible for birth to take place. If, for example, a woman's conceptualisation of birth is based on an understanding of the process of birth as dangerous, of the birthing body as weak and likely to fail, and of the need for high-tech equipment, operating theatres and highly skilled surgeons to be on hand to ensure a safe birth, then an imaginary of home as a suitable place for birth starts to become unlikely. Thus the conceptualisations that women have of birth, and of physiological birth, significantly influence how a woman is able to imagine and practice birth.

Alongside this conclusion, I was struck by how many women's narratives seemed to represent the practice of birth as remarkably difficult emotional and physical experiences. (This was beyond any suffering associated with what is generally represented as the inevitable pain that accompanies the process of labouring and giving birth.) Not only this, but the women in my study represented these experiences as neither remarkable nor worthy of ongoing attention. For me, this finding resonated strongly with Naomi Wolf's notion of women's acceptance of 'ordinary bad birth' (Wolf, 2002). This disappointed me: for all the effort that has been made in the UK in terms of policy, professional and community efforts to improve women's birth experiences (and the Changing Childbirth report (Department of Health, 1993) is perhaps most notable in this policy context), many of the women I spoke to seemed to have experienced key elements of their birth negatively, and these experiences also seemed to work to

underpin women's low expectations for subsequent births. This represented an intriguing puzzle: if such well-meaning initiatives continually fail to deliver, what else might be necessary to effect substantive improvement? In reflecting on this, and drawing on my own experience, it seemed that one key question had been left unaddressed. That is, what more might individual women themselves do to improve their birth experiences? One issue that I did not fully appreciate at this point in my study was that such action, and the objectives of such action, might take different forms; on this point and others, the benefits of applying a Bourdieusian theoretical framework emerged during the course of the study.

Influenced by Ivan Illich's (1975) warnings of medical nemesis (the potential ill-effects of an over-dependency on medicalization) and perhaps an overly optimistic assessment of the desire of women to achieve for themselves a more physiological birth, I therefore embarked on a study which was based around the notion that an important part of the solution to this puzzle might be related to the role that women themselves played - or might be persuaded to play - in seeking to ensure for themselves a positive birth experience. I surmised that whilst women might be surprised to experience birth negatively first time round, in subsequent births they might be better prepared to avoid such experiences. I was therefore interested to investigate how some women seemed to be better able than others to put their agency to good effect in this regard.

1.2 Positioning the researcher

My particular interest in this topic is grounded substantively in my own personal experience and positionality, including but not limited to my own childbearing career. For me, geography represents a space in the academy where the politics of nature/society interactions, including how a physiological process such as birth can be practised within the social realm, can be taken seriously. I trace my interest in space and gender inequality, and feminist geography more generally, to a UCL geography undergraduate course, including my final year project investigating the division of domestic labour in an intentional community. I trace my interest in, and awareness of, the limitations of public policy to my career as a public policy advisor, at the national, multi-national and international level. I trace my interest in learning and knowledge management to my time spent studying for an MBA, where I investigated organisational learning in my sponsoring organisation for my dissertation. And finally, I trace my academic interest in birth to a particular reading (about the geographies of

dying at home) offered as part of an MA in Social Geography (Brown and Colton, 2001).

My childbearing career, spanning 20 years and including four childbirth experiences (the first of which took place whilst studying for my undergraduate degree and the last of which took place during the preparation of this thesis), has also been influential in how I have worked with this topic. I work from a personal position in which my birth experiences have become progressively more physiological over my birthing career. To illustrate this, I gave birth for the third and fourth time at home. I do not wish to suggest, however, that locating birth in the home is necessarily a hallmark of a non-medicalized approach to birth. Indeed, I would categorise none of my births as non-medicalized. But given my own childbirth experiences, I have a personal stake in the idea that, unavoidable contingencies excepted, women can learn to birth better physiologically over their childbearing careers. (This is not, of course, to say that they should.) Indeed, well before I came across Bagnold's work, I would joke that I would maybe 'get it' (that is, be able to birth physiologically) if I had seven children. Many women, of course, do 'get it', without having to give birth multiple times, and in any case few women in the UK now have as many as three, let alone four or more birth experiences. I will return in Chapter 9 to consider the relevance of this study in that context.

1.3 Identifying study aims and assumptions

Thus developed my line of enquiry, of how women come to learn to practice birth over the course of their childbearing career, paying particular attention to how different spaces of birth (including the space of the birthing body) might allow for the contribution of women's experiential knowledge in this context. The initial aims of my research were:

- to investigate how women conceptualize and experience personal childbirth knowledge, especially as it develops experientially over a childbearing career, including its creation, development, communication and utilisation;
- to investigate the status of such lay knowledge in the UK's contemporary hegemonic birthing culture, and in particular in the context of the 'normal birth' agenda;
- and, based on the above, to assess the potential contribution of lay knowledge to the broader UK childbirth knowledge management and improvement strategy, and to explore any implications.

In starting to engage with this enquiry, it became increasingly clear that I was making a number of assumptions, and I will introduce these briefly here.

First, I make the assumption that the practice of birth, as a widespread and ongoing practice which represents a significant site of harm or injustice, would benefit from continued feminist scholarship. Indicating its widespread nature, I would suggest that every one of us is, or has been, to some extent engaged in the practice of birth. This might be simply in relation to our own birth; to the birth or birth-giving of people close to us; if a woman, to the fact that we have given, or might one day give, birth; or to those concerned about justice and equality at different scales, to an interest and sense of concern about the circumstances in which both nearby and distant others are born or give birth.

Second, I make an assumption that the mode of birth - how babies are born - is worth investigating, on the basis that mode of birth matters. This is both controversial and something of a taboo. For some, it would seem that mode of birth is almost irrelevant: all that matters in the business of managing birth is that the pregnant woman is delivered of a live baby and that the mother and baby are healthy (or, at least, seen to be physically undamaged by the birthing process). For others, the practice of birth (how one is born and how one gives birth) is highly significant, with lifelong material consequences for mother and baby. I make the assumption that mode of birth might indeed matter, following in particular the work of Ina May Gaskin, Michel Odent and Kerstin Uvnäs-Moberg who have worked to raise awareness, inter alia, of the importance of the microbiome into which a baby is born, the key role of oxytocin during and beyond labour, and the concept of neocortical inhibition (Uvnäs-Moberg 2016; Odent, 2014, 2001 and 1986; Gaskin, 2002). I accept that knowledge is still developing on exactly how mode of birth might matter - that is in terms of the long-term impact on individuals and society of the modern shift towards medically managed birth located in increasingly specialized settings - and I appreciate that this assumption might be a trigger for some disagreement. Nevertheless, this thesis takes seriously the claim that protecting a physiological mode, or ecology (Davis-Floyd, 1992), of birth might be important.

Third, I make the assumption that how birth plays out is not simply - or even usually - a matter of chance, but of actioned choices made by a team of skilled and knowledgeable agents, including the birthing woman, working within a set of power-imbued social and spatial structures.

Fourth, an assumption is made that women can be experiential knowers in regard to the practice of birth: not only that they might develop and hold knowledge about birth, but that they might develop such knowledge themselves, that some of this knowledge might be unique to them as individuals and that such knowledge might be developed, inter alia, in the context of their personal birthing experiences. Related to this, and the previous assumption, is that women are skilful and knowledgeable agents in the practice of birth: that they can and do utilise their own experiential and other knowledge to skilfully influence, alongside many other influences, how their birth experiences unfold.

Fifth, I make the assumption that a woman's childbearing career is a productive unit of analysis. Following Lewis and Weigert (2016), I use the term career not in terms of the paid labour sphere, but to refer to 'the passage of a person through a number of statuses which are meaningfully related to each other in a recognised sequence' (Lewis and Weigert, 2016, p89). Whilst this concept is frequently used in demographic scholarship, an analytical perspective based on such a sequence of a woman's birth experiences is seldom utilised in childbirth scholarship, although the concept of the childbearing career is sometimes central to the analysis of a particular topic (as I found in researching women's birthplace decisions; see also Coxon, Sandall and Fulop, 2013). The concept has been introduced in the context of women experiencing pregnancy loss or bereavement (Mander, 2006, p196) and also in explorations of women's experiences of being pregnant and having a major illness (Thomas, 2003). More generally, however, the concept is confined, in birth literature, to discussions about certain groups of women, for example where it is suggested that some young women undertake repeated childbearing as an alternative to the paid labour market (see, for example, Burt with Levy, 1987, p286) or in the context of the exotic other, where Jennifer Johnson-Hanks' ethnographic work offers an interesting perspective on the socially constructed nature of the childbearing career in Southern Cameroon (Institute of Medicine and National Research Council, 2005, p537). In this study, I claim that working with a conceptualisation of the childbearing career as relevant to all birthing women enables new insights and knowledge.

Sixth, and finally, I make the assumption that a UK-based study is worthwhile. Given limited research resources, this might not seem obvious, for example in the context of vastly worse birth-related maternal and infant mortality and morbidity elsewhere and notably in parts of the global South. By basing this research in the contemporary UK context, however, I intend to contribute to a discussion that problematizes the way in which countries such as the UK have historically exported, or 'efficiently evangelis[ed]'

(Thomson, 1986, p117), certain types of childbirth knowledge, practices and technology. As Thomson noted, following a World Health Organisation report that exposed key deficiencies in European birth practices (WHO, 1985), '[too] often Western medicine is held up as an ideal to aim for, this report demonstrates that in childbirth it is lacking.' (Thomson, 1986, p118). This study thus takes seriously the need to repair the ongoing damage done by such efficient evangelising (ibid., p117).

1.4 Structure of the thesis

Following a critical analysis of relevant geographical and other scholarship (Chapter 2), I introduce the key conceptual framework for this study, Bourdieu's theory of practice, suggesting that it provides a strong theoretical framework for this inquiry, in particular given the focus on women's learning over their childbearing career (Chapter 3). Continuing a discussion of methodological approach, I next outline the research design (Chapter 4). The following chapter situates the study in terms of its geographic, social and temporal location, offers a descriptive analysis of the sixty-eight birth experiences included in the study, and discusses the women's knowledge and expectations about birth, and about physiological birth, at the start of their childbearing careers (Chapter 5). In the next two chapters, I introduce the social space of birth encountered by the participants in this study: a space in which various types of trouble are encountered (Chapter 6) and a space in which routine diversions from the physiological birth process are taken for granted, that process being constituted as unnecessary, abnormal and dangerous (Chapter 7). In discussing these two key features of birth spaces, I illustrate how women's skill and knowledge are evident, and how their learning in these spaces positions them for further birth experiences. Working specifically with the notion of the childbearing career in the following chapter, I focus on how women variously seek to displace physiological birth or attempt to protect the physiological birth process over their childbearing careers (Chapter 8). I then conclude with an overview of the study's key findings, which work primarily to promote a conceptualisation of birthing women as skilful and knowledgeable agents and to offer a distinction between the mastery of the social practice of birth and learning to birth physiologically. I then offer some final reflections on the study and its findings, alongside a discussion of its implications for further research and practice (Chapter 9).

Chapter 2 Birthing women as skilful and knowledgeable agents: a literature review

> 'Birth is both a social and spatial process that is bound up with not only material but also discursive spaces. Geographers are well positioned to take on the task of thinking about birth ...' (Longhurst, 2009, p49).

In this chapter, I present a critical review and analysis of how existing scholarship works with the notion of the birthing woman as skilful and knowledgeable in the social practice of birth. I begin by focussing on the discipline of geography's engagement with the empirical issue of childbirth, and how human geographers have engaged with the notion of childbearing women as skilled and knowledgeable agents. In doing so, I suggest that geographers occupy an interesting space in the academy compared to social scientists from other disciplines, given the discipline's relative lack of engagement to date in mainstream social science debates about matters of power, agency and knowledge as they have affected the practice of birth. I also identify, however, how a strengthened disciplinary engagement seems to be long overdue. I then turn to social science scholarship more broadly, exploring why it might be the case that the possibility (and potential) of a role for childbearing women as skilled and knowledgeable agents in the practice of birth over their childbearing careers has been marginalised in that scholarship, despite its haunting presence in all of that work. In doing so, I examine the traces of this phenomenon that have found their way into the academic literature, in particular under the auspices of a growing tradition of qualitative scholarship emanating from schools of healthcare, within which midwifery and childbirth are now a significant focus. To conclude, I suggest that in consistently over-looking the notion of the childbearing career as a sustained and primary focus for analysis, existing scholarship has been unable to grasp the significance of women's agentic role in the production, as well as consumption, of social practices of birth (Dombroski, McKinnon and Healy, 2016).

2.1 Childbirth, spaces of childbirth and the geographical imagination

Childbirth is an established empirical focus in the discipline of Anglophone geography, with human geographers making contributions to academic scholarship about birth, and the social practice of birth, from a range of perspectives. The extent of geographical scholarship which is directly concerned with the practice of childbirth itself remains relatively small, however (in comparison, for example, to the bodies of work

offered by the social science disciplines of anthropology, sociology, psychology and women's studies). Whilst there is certainly a demonstrable interest from geographers in the reproductive body and its capabilities, materiality and interfaces with new technologies, much of this work is distinct from a focus on the practice of birth itself. Thus whilst there is a rich strand of geographical scholarship working empirically with the implications of the 'fleshy, material and messy bits' of the female body as a key site of biological reproductive practice, the practice of birth might 'still represent that which is too banal, too material, too feminised, too mysterious, too Other for geography' (Longhurst and Johnston, 2014, p274).

The disciplinary interest in the birthing body continues to develop, therefore, with geographers examining how the situated materiality of various aspects of the birthing body mesh with economic, technological and political contexts; this diverse and growing field includes research on geographies of lactation, lactating bodies and diverse practices of infant feeding (Boyer, 2016, 2014, 2012, 2011 and 2009; Holt, 2016; Longhurst, 2008 and 1997; Boswell-Penc and Boyer, 2007; Bailey, Pain and Aarvold, 2004; Pain, Bailey and Mowl, 2001) and on the human tissues which make up the female reproductive organs, including endometrial tissue, umbilical cord blood and placentas (Fannin, 2015, 2014, 2013, 2011). Geographers have also engaged in scholarship produced by the developing field of epigenetics, (which highlights the importance of environmental impacts on human bodies and human health, including during pregnancy, as a corrective to a previously intense scientific focus on genetic influence), taking a particular interest in its potential implications for the conceptualisation and autonomy of the pregnant woman (Guthman and Mansfield, 2013; Fannin, 2012; see also Hamond et al., 2013).

In this context, a contemporary focus on the practice of childbirth might seem rather mundane. Certainly, few geographers have demonstrated a sustained research focus into the empirical issue of the practice of childbirth itself, in contrast to the career-long interest demonstrated by scholars in other social science disciplines, for example Barbara Katz Rothman and Ann Oakley (US and UK sociologists) and Robbie Davis-Floyd and Sheila Kitzinger (US and UK anthropologists). Neither are geographers regular participants at inter-disciplinary conferences designed to bring together academics researching childbirth; nor are they, unlike scholars from other social science disciplines, represented on the 'natural birth lecture circuit' (Fannin, 2006, p79).

Nevertheless, there is an existing and developing body of geographical scholarship which relates to childbirth - how it is practiced and the spatial and social mechanisms

which support this practice - and in this section I seek to review this scholarship, drawing particular attention to how the treatment of birth as topic of inquiry within the discipline has shifted over time, thus tracing the evolution of the geographical imagination with respect to the material and discursive practice of birth, and noting the growing diversity of the discipline's engagement with childbirth. As part of this review, I examine how geographical scholarship has engaged with the wider social science scholarship on birth, and discuss how this has been achieved notably in the context of the discipline's focus on the places and spaces of birth, a contribution which has been well-received in the context of the growing spatial imagination in childbirth scholarship beyond the boundaries of the discipline.

Finally, I examine, with reference to recent studies from within the discipline, the potential of geographical scholarship to represent much more than a collection of studies which offer useful conceptual insights into the discursive and material implications of various places and kinds of spaces in which women birth, from which other disciplines might draw. In doing so, and situating the current inquiry in this context, I highlight how feminist geographers are also well-placed to make a contribution to academy-wide childbirth scholarship based on the discipline's foundational interest in how human beings manage their involvement in the ever-present intermingling of nature and culture, a relationship that is core to the practice and study of embodied knowledges of childbirth.

2.1.1 Early engagements: fertility as a key component of population geographies

Whilst the discipline of geography has had a longstanding interest in certain aspects of birth, and reproduction more generally, the discipline has only recently engaged with the embodied reality of birth in a substantive and critical way. The development of the discipline's engagement with the social practice of childbirth thus follows the development of the discipline more generally. From its early empiricist and then positivist approach (Johnston, 1986; Jackson and Smith, 1984), increasingly underpinned by quantitative methodologies, the early emphasis was on observable facts, such as the spatial patterning of various measures of human fertility, with the construction of local, regional, national and global demographic models as a key output in the context of the sub-discipline of population geography. This is illustrated in the two entries relevant to childbirth in Blackwell's 1986 edition of the *Dictionary of Human Geography* (Johnston, Gregory and Smith, 1986; see entries on population geography and fertility). Such scholarship seems to have been, for many geographers, the key point of disciplinary engagement with the practice of childbirth.

The discipline's potential interest in childbirth, however, has a far greater reach. The activities of being in labour and giving birth, and of supporting women to birth, are intensely physical embodied activities, which have to take place somewhere. Indeed, a consideration of different places and spaces in which labour and birth is practiced and supported has been fundamental to the changing dynamics of material childbirth practices, historically and geographically, as well as to ongoing academic and professional debate. Discussions about control over/choice of place of birth invoke important ongoing contestations, focussed on shifting understandings of power, knowledge and agency, and as such are frequently replayed in childbirth scholarship across the academy. This gives rise to an important disciplinary opportunity, as Robyn Longhurst has argued (see epigraph), with geographers well placed to contribute to increasingly sophisticated spatial analyses (Longhurst, 2009).

2.1.2 Childbirth as a site of injustice: national, local and networked perspectives

Before such a focus on the location of birth became established, however, the discipline's interest in spatial inequities encouraged an interest in childbirth. In the UK, the Women and Geography Study Group (of the Institute of British Geographers) (1984) made an early contribution to quite a new kind of geographical scholarship on childbirth in the 1980s, by putting the issue of equitable access to maternity services on the agenda for geographical study, focussing on class and race-based inequality. To meet similar objectives, geographers have played a continuing role in the mapping of maternity facilities and associated health outcomes (Kottwitz, 2014; Pilkington et al., 2012; Blondel et al., 2011; Grzybowski, Stoll and Kornelsen, 2011; Kornelsen et al., 2010).

Early feminist geographical scholarship on gender and the global South also included the practice of childbirth as a priority focus, drawing attention to spatial inequalities in maternal and infant mortality and morbidity, with Janet Momsen noting that '[w]omen's wellbeing in the Third World is closely associated with childbearing ...' (Momsen and Townsend, 1987, p38). This disciplinary focus on birth injustice in the global South continues, as evidenced by the predominance of this theme in Elizabeth Chacko's entry on Pregnancy and Childbirth in *The International Encyclopedia of Human Geography* (Chacko, 2009).

An example of recent scholarship in this area is Jennifer O'Brien's ethnographic study of maternity care provision and take-up in a rural area of Uganda, an area of persistently poor maternal and newborn health outcomes (O'Brien, 2011). In this study,

and drawing on a Bourdieusian perspective, O'Brien comes to highlight in particular women's agency and skill in getting their health aims met. In doing so, O'Brien argues that 'individuals plot routes to achieve [their] health aims' (ibid., p69), thus challenging the assumption that patients are passive and ignorant individuals within healthcare transactions. O'Brien's focus on the agency and skills of birthing women does not extend to identifying how this might develop over a woman's childbearing career on the basis of women's personal experiences. Rather, O'Brien reports that she rarely saw any woman twice during her fieldwork, thus limiting the possibility that she might have identified this as a key issue. O'Brien's detailed analysis of how women and staff conceptualise the need for maternity care, and how they interact with the existing (formal and informal) healthcare services, allows her to offer an interpretation of the context within which formal maternity services operate, which she offers to local decision-makers in order to help them strengthen service improvement plans. O'Brien stands outside of the healthcare sector in offering this interpretation, and, based on her experience, O'Brien suggests that human geographers are well-placed to investigate healthcare services, 'much more so than healthcare workers themselves' (ibid., p77).

Academic interventions such as these might be usefully thought of as working from a perspective that foregrounds (and seeks to contribute to addressing), at various scales, inequality and injustice. Whilst such an engaged and justice-based agenda has been a productive perspective for much geographical scholarship, it seems to preclude an analysis, taken up more strongly elsewhere in the academy, that childbirth might constitute an activity in which injustice, by its nature almost entirely gender-specific, is widespread (that is, one which is not restricted to certain geographic, social and temporal locations). Geographers have also yet to present the case that injustices in diverse local childbirth practices might be frequently understood as reflecting the ongoing effects of global networks of childbirth knowledge. Such an understanding has key implications for diverse political and professional projects to improve maternity services and birth outcomes, in particular in recognising that efforts to improve childbirth outcomes for women, infants and families might usefully be considered not just as local to the intended sites of improvement but also in terms of their distantiated effects.

2.1.3 Developing a disciplinary interest in the diverse spaces of childbirth

Apart from the themes discussed in the two preceding sections, the relative sparsity of the masculinist discipline's engagement with the practice of childbirth remained evident until the 1990s. Since then, a growing number of mainly Anglophone geographers, based in the United States, Canada, New Zealand and Australia, have sought to take up the opportunity to engage with the empirical issue of where childbirth takes place.

The humanistic turn in geography in the 1970s, giving rise to a new sub-discipline of health geography, laid the groundwork for this qualitative focus around places of healthcare, offering the possibility for a new type of engagement with the practice of birth.

This engagement commenced most clearly with New Zealand-based scholarship which focussed on places and spaces for birth. Thus whilst anthropologist Sally Abel and health geographer Robin Kearns were able to suggest in 1991 that 'there has been no attempt to explore ... choices for place of birth from a geographical perspective' (Abel and Kearns, 1991, p825), this absence began to be rectified immediately. Health geography had much to offer, asserting the need to differentiate between 'spaces' and 'places', highlighting the socially constructed nature of place, complicating thinking that might seek to essentialise different kinds of spaces, and theorizing the different health properties of different places, drawing on the conceptual framework of therapeutic landscapes, encompassing the physical, social and symbolic (Gesler, 2009; Gesler and Kearns, 2002). As such, health geography offered a wealth of disciplinary experience that both complicated and elucidated. Health geographer Allison William's further development of the conceptual framework of therapeutic landscapes has been particularly useful to childbirth scholars, in the way in which she offers an extended definition of therapeutic landscapes as 'not only healing places, but those landscapes associated with the maintenance of health and well-being' (Williams, 1998, p1195). Health scholar Holly Powell Kennedy recognises this in her explicit reference to the useful contribution of theorists from the discipline of geography (Kennedy, 2009; see also Davis and Walker, 2010; Burges Watson et al., 2007; Carolan, Andrews and Hodnett, 2006). Different types of birth spaces have since been scrutinised by geographers, drawing on diverse theoretical frameworks and methodologies: these have included specific manifestations of hospital (Fannin, 2003), birth centre (Sharpe, 1999) and home (Longhurst, 2008; Kearns, 1993; Abel and Kearns, 1991), as well as local birth landscapes encompassing a mix of birth spaces (Hazen, 2017; Emple and Hazen, 2014; Pope, 2001).

Noting the prevalence of the risk/safety debate in scholarship about place of birth (which continues to this day), for example, Robin Kearns, working with anthropologist and midwife Sally Abel, sought to shift the attention of the academy towards a different kind of debate, one in which women's opinions about, and experiences of, place of birth were taken seriously. In the context of a national policy framework that was becoming more conducive to the option of home as a location for giving birth, Abel and Kearns studied the meaning of home as a place of birth for a group of New Zealand

women, suggesting that for some it represented an optimistic and vital space for childbirth (Kearns, 1993; Abel and Kearns, 1991).

Scott Sharpe continues this focus on the perspectives of birthing women, and on 'the body as a site for geographical analysis' (Sharpe, 1999, p93), with his research focused on birthing in the space of a birth centre; these are sites which are generally managed quite separately from the obstetric ward, by midwives rather than obstetricians, and are designed to provide a place of support for women giving birth with little medical intervention. Studying women's experiences in a new Australian hospital-based birth centre, Sharpe's phenomenological study examined how such spaces for birth produce contrasting experiences for different women. Thus whilst Sharpe found that the space of the birth centre can work for some women to challenge an existing hospital/home binary, creating a space in which birth can be practised differently, and in a way which may be more in line with the woman's wishes for a natural birth, Sharpe argues that this space does not always work in this way. Sharpe's data rather reveals how there is also an ever-present danger that the 'paternalism of obstetrics' remains (Sharpe, 1999, p96): rather than being erased in these new spaces, Sharpe demonstrates how it can mutate for some women into a new form of midwifery control over their birth (see also Walsh, 2006a and b).

Maria Fannin's (2003) structural analysis of 'hybrid' home-like birthing rooms within highly medicalized US hospitals represents a critical examination of these forms of birthing spaces, evoking Rothman's earlier analysis (Rothman, 1982). Fannin examines how such types of space draw on and work with a range of discursive formulations, including discourses of natural birth and domesticity, and on the binary of hospital/home. As such, Fannin's work provides a thoughtful and politically-aware contribution to debates about the potential impact of neo-liberalism to the practice of birth, about how these discourses operate in relation to space and place, and raises the key question of whether such home-like birthing room initiatives create a substantively different hospital-based space for birthing women, for example in which agency can be more effectively exercised, or simply work to serve the neoliberal ends of the competitive healthcare market (Fannin, 2003; see also Dornan, 2008). Fannin's interest in the 'neoliberal governance of pregnancy and birth' (Fannin, 2007, p171), and the new subjectivities it produces, has continued with projects spanning various scales, including an investigation of the idea and implications of a concept of global midwifery (Fannin, 2006) and a study of the twentieth century re-establishment of midwifery in Canada (with reference also to the tradition of midwifery in France and links between the two) (Fannin, 2007 and 2005). In this way, whilst Fannin's work is certainly

innovative in focus and approach, it offers little engagement with the notion of the birthing woman as a skilful and knowledgeable agent.

Finally, preliminary outputs are beginning to emerge from Katharine McKinnon, Kelly Dombroski and Stephen Healy's investigations into the geopolitics of birth in contemporary New Zealand and Australia (Dombroski, McKinnon and Healy, 2016; McKinnon, 2016). In the first output, McKinnon (2016) explains how the project is intended to highlight the contested territory represented by both the birth space and the birthing body, and to examine the presence, and impact, of important human and non-human actors both within and beyond the birth space. Underpinned by the conceptual framework of actor-network theory, this work evokes analysis of procedures and artefacts in birth practices more generally, and in particular previous analysis of the use of the wheelchair in the obstetric setting (Davis-Floyd, 1992, p76-78). In the second output (Dombroski, McKinnon and Healy, 2016), and this time drawing on Annemarie Mol's theorisations of a logic of care (Mol, 2008), the team offer a contribution to the existing body of critical scholarship concerning the marketisation of maternity care, and the notion of choice in maternity care; these, it is argued (in the way that they work to position the birthing woman as consumer and decision-maker), detract from the recognition of the birthing woman as 'chief labourer', often work to disturb the physiological birth process, and threaten quality of care (Dombroski, McKinnon and Healy, 2016, p233).

As the authors intend, this work usefully opens up a discursive space to think about, from a community economies perspective, how maternity care is organised. At present, the team 'seek to imagine how existing diverse assemblages of childbirth can be 'tweaked' to enable better care' (Dombroski, McKinnon and Healy, 2016, p238). In the context of their recognition that existing (albeit 'polarised') scholarship 'allows recognition of disturbing and disempowering birth experiences as the consequence of unjust (and often abusive) treatment' (McKinnon, 2016, p5), however, this seems strangely lacking in aspiration, and perhaps suggests the dangers of drawing too exclusively on theories developed in very different contexts. An ambition to improve care for sufferers of type 1 diabetes by such 'tinkering' or 'doctoring' (Mol, 2008) is perhaps reasonable, but when Mol's theoretical framework is applied to birth it is crucial not to assume that birth is a similarly pathological process inevitably ending in an early death if untreated (De Vries, 2001) nor to overlook the harmful tinkering that women's birthing bodies have been, and continue to be, subjected to (Murphy-Lawless, 1998). That said, Mol's insistence on recognising the active participation of patients in their own care is particularly productive, and childbirth scholarship has similarly

challenged the possibility of good maternity care being delivered in the context of the market (Kirkham, 2017). Mol's invitation to think critically about the values to which individuals and groups of individuals aspire is also highly relevant, suggesting that discourses of market-based competition, individual choice and autonomy, for example, increasingly seem to colonise spaces in which the ideals of care, mutual respect, justice and solidarity might otherwise dominate. In these ways, Mol's theorisations are usefully mobilised in the context of childbirth and beyond.

Each of these geographical contributions to childbirth scholarship engage keenly with issues of the body, power and knowledge, and offer important insights into the nature of different spaces and places of birth and how these are constructed, not just physically but also discursively and politically. Academics from other disciplines have begun to draw on the work of geographers, and on the geographical imaginary, to develop this work, presenting it back to geographical and other audiences for continued debate. Working with spatial concepts as key to understanding the practice of childbirth, for example, Australian scholar Kathleen Fahy and colleagues offer a rich theoretical framework in which they introduce power-laden concepts such as the 'birth territory' and the role of the midwife as guardian of the birth territory (Fahy et al., 2008) to understand how maternity services might be improved. Holly Powell Kennedy has worked with a model of maternity care 'visualised as a geographical terrain to be navigated' (Kennedy, 2009, p419), as she explores further the position of the midwife, inter alia, as a key border worker.

2.1.4 Further disciplinary contributions (1): productions of physiological childbirth

The discipline of geography also offers an opportunity to investigate birth from the perspective of a nature/society lens. This is an emerging area of geographical scholarship, to which US-based human geographer, Becky Mansfield has made an important contribution, drawing on her existing (and continuing) research interest in nature-society relations. Whilst it is a well-established focus of geographical scholarship to investigate the inter-relationships and mutually constitutive roles of nature and society, Mansfield argues that geographers with a nature/society focus have hitherto demonstrated little interest in extending their insights to the study of human health (Mansfield 2008a, p1019).

Mansfield engages with the material practice of childbirth in two distinct ways. First, she undertakes a review of a set of pregnancy and birth-related non-fiction books, popular in the US at the time of her study, geared towards promoting 'natural birth', and

analyses the ideas they represent in terms of nature-society relations. As Mansfield argues, whilst the term 'natural birth' is often taken to imply that birth is simply a biological or physiological process, a close reading of natural childbirth texts reveals that proponents of natural childbirth generally accept that birth is also a highly social process (Mansfield 2008a and 2008b). Secondly, Mansfield offers a commentary piece in which she discusses her own personal childbirth experiences from a nature-society perspective.

Mansfield's analysis of non-fiction books can be viewed as a fairly straightforward interpretative account of the everyday research that is regularly performed by pregnant women (in this case, Mansfield herself), as they read books intended to inform them about physiological birth and as they seek to draw conclusions from their reading about how they might achieve it. A key strength of Mansfield's analysis is how she identifies the extent of work that might need to be performed by women and their supporters (including any health care workers, depending on the birthing context) to effectively prepare themselves for a physiological birth. One of Mansfield's key contributions from this analysis, therefore, is how this body of non-fiction literature presents a compelling argument that physiological birth, despite being 'natural', doesn't 'just happen'. In the context of an academic literature that can sometimes appear at a loss to explain and to provide solutions for (if it indeed recognises it as a relevant issue) why some women fail to achieve the physiological birth that they desire, Mansfield's account provides a useful contribution, raising key questions of the role of the birthing woman, her knowledge, skill and agency.

Mansfield's separate commentary piece works rather differently. Drawing on her two personal experiences of childbirth, Mansfield explores how she comes to construct and reconstruct her birth experience narratives, informed by her sensibility to a conceptualisation of the practice of birth in nature-society, rather than biological, terms. In this piece, Mansfield describes her pro-active engagement in the task of analysing natural birth literature during her second pregnancy - drawing on her academic identity, knowledge and skills to do so - as key to her ability to reflect upon and construct alternative understandings of what had happened during her first birth, in a way which positions her for a very different form of engagement as she approaches birth once again.

In Mansfield's commentary piece, the benefit of decades of careful preparatory methodological work by feminist scholars is apparent, with their legacy of creating a discursive space in academic journals that embraces such autobiographical work. In presenting this work to the academy, Mansfield demonstrates the benefits of engaged

scholarship that draws on the positionality of the researcher as a key input. (In contrast, in the research article, Mansfield provides little overt indication of her positionality, although it is possible to detect an alignment on her part with a physiologically-based practice of childbirth, as confirmed in the accompanying commentary piece).

In discussing her own experiences as particular to an academic geographer with an established interest in nature-society relations, however, Mansfield seems to underplay that this reflective process, conducted through narratives that are continually made and remade, is not confined to academics. Rather, everyone is to some extent involved in such personal narrative work, and the outcome of this narrative construction and reconstruction process in the case of childbirth always works to embed and/or shift one's perspective on birth over a childbearing career, exactly as it does in Mansfield's case. Thus I would argue that Mansfield's reflection on her childbirth experience - and the difference that this makes to how she positions herself in relation to subsequent birth experiences - is commonplace.

Mansfield's work underlines the value, however, of seeking to better understand women's role in constructing the practice of childbirth. Mansfield's work also usefully emphasises that the practice of birth is a dynamic social process which is both produced from and works to produce a diversity of nature-society relations.

2.1.5 Further disciplinary contributions (2): productions of medicalized birth practice

In a further example of how human geographers offer a sophisticated analysis of the practice of birth, US geographers Jill Klimpel and Risa Whitson have offered thoughtful insights into highly interventionist birth practices found in urban Brazil, where many high-income women engage in a practice of birth (located in private hospitals) where c-section rates reach 80% (Klimpel and Whitson, 2016, p1211). Klimpel and Whitson identify a range of factors which explain these unusually high rates, including, for example, the use of sterilization as a form of contraception. In particular, however, Klimpel and Whitson highlight the key role of discourse in structuring local practice, and in particular the linked discourses of nationhood, modernity and development. Klimpel and Whitson thus explore how a 'modern' practice of birth (that is, the technology of a c-section) seems to be represented as conferring status and value on birthing women. In avoiding the pain and uncertainties of labour, for example, high-income city-based birthing women become modern Brazilians, 'more than' an 'animal, native or slave' (ibid., p1214). In this way, argue Klimpel and Whitson, differentiated birth practices in

Brazil '[function] to enact an explicitly racialized, classed expression of modernity' (ibid., p1214).

A key finding of Klimpel and Whitson's work is how some high-income birthing women, and their healthcare providers, have access to 'an imagined geography of development and modernity' (ibid., p1214) in the context of childbirth practice, in which well-off women in high-income countries are assumed to favour a highly interventionist birth practice (because these countries would have the knowledge and skills to deliver this kind of care and because these women can afford it); these imaginaries tend to over-estimate the take-up of highly interventionist birth practices in those places, however. There is also an accompanying imagined geography of non-modern practice, in which a low-tech non-interventionist approach to childbirth is, in contrast, assumed as an undesirable way to practice birth, and suitable only for women without the resources to command a 'modern birth' (such as rural women in their own country).

Klimpel and Whitson's conclusions are focussed on drawing attention to the work performed by these particular discourses of modernity and progress with respect to birth. They stop short, however, of engaging in another project represented within the discipline of human geography, which seeks to problematise the notion of a singular 'modernity': such plurality in what counts as modern, however, is evident in a wider-reading of scholarship about childbirth in Brazil. Thus in the private hospitals accessed by high-income women in the major cities of Brazil, Klimpel and Whitson may be right in representing a highly interventionist social practice of birth as holding a pivotal place in local discourses of modernity. It is also the case, however, that there are other models of birth in Brazil which similarly represent modernity to their stakeholders. The Brazilian version of the global initiative to 'humanize birth', for example, can be understood as representing a competing discourse of modernity to that identified in Klimpel and Whitson's study, one which seeks to reduce, rather than maintain or increase women's reliance on highly interventionist birth practices, since this is understood by some as a superior means of delivering progress and improving health outcomes for women and babies (Jones, 2009; Rattner et al., 2009).

2.1.6 Geographical scholarship on the practice of birth: a summary

As discussed in this section, the geographical scholarship in this empirical area is arguably rather sparse and intermittent, with few geographers engaging with the issue of childbirth in an ongoing way (whether as a research focus or call to scholar-activism). Nevertheless, it is also the case that the diversity and theoretical underpinning of geographical scholarship offers a useful contribution to the scholarship

of childbirth, and it would seem that the discipline of geography has much more to offer to the wider academy in this context. It may also be the case, as Dombroski and colleagues (2016) suggest, that the relative lack of disciplinary engagement in the mainstream social science debates about birth, and the medicalisation of birth (Abel and Kearns, 1991), positions geographers well to take up neglected avenues of enquiry. One key way in which the discipline might offer a supportive output is to retain a focus on where birth takes place - by continuing to investigate the spatial and placed aspects of the social practice of birth - and I am encouraged to know that scholars such as Kelly Dombroski, Stephen Healy, Helen Hazen, Katharine McKinnon and Risa Whitson have an intention to do that, with their planned (or continuing) scholarship based on empirical work in Australia, New Zealand and the US. It is notable, however, that the social practice of birth and the spaces in which it takes place in the UK has not yet been a focus of attention for geographers, and the UK-based findings discussed in this thesis thus offer an original contribution to international geographical childbirth scholarship.

A review of existing geographical scholarship also points to the opportunity for geographers, based on an interest in the physical-human interface that is core to the discipline, to further explore the nature/society relations implicit in different practices of birth, not simply to 'line-up' (Dombroski, McKinnon and Healy, 2016) but to contribute productively to ongoing debates about how birth is conceptualised and practiced. O'Brien and Klimpel and Whitson's work underscores the diversity in global birthing practices, as well as the vast inequalities of outcome that persist for women and babies. Klimpel and Whitson's work highlights the inter-connection between different birth practices across the globe, whether based on past knowledge transfers or current imaginaries. Working at the scale of the body, Mansfield's work demonstrates that geographers have yet to fully engage in empirical research which seeks to offer - beyond the autobiographical - an interpretation of how birthing women come to understand and accommodate, during their experience of birth, the entwined elements of the social and the biological. Mansfield's work thus encourages further investigation into how this might work over time, as women's experience of birth produce new understandings and perspectives (then accessible in the context of subsequent births). This thesis builds on this existing scholarship, focussed on an analysis of women's dynamic conceptualisations of childbirth, through a career-long process of narrative construction and reconstruction, based on their own childbirth experiences.

Whilst the case for extending geographical scholarship in this way seems to make sense from the perspective of the geographical literature, I will next examine the extent

to which scholarship beyond the discipline of human geography has already contributed to this focus.

2.2 Power, agency, knowledge: but where is the birthing woman?

The broader social science literature offers a far greater and sustained focus on childbirth, much of it with a key emphasis on critical issues of power, agency and knowledge. A growing body of healthcare scholarship extends this focus. In this section, I first examine social science scholarship beyond the discipline of geography, looking in particular at the context in which the role of the childbearing woman, her agency, knowledge and competency has been variously conceptualised. To the extent that childbearing women are conceptualised as having the potential to know about birth, I next review the scholarship on how women's learning about birth has been conceptualised to date, and how this literature understands 'the birthroom' as a space of learning. Finally, I turn to the growing work of health scholars, examining their contributions to the literature about relational models of care, to discuss how women's embodied knowledge is conceptualised in that context.

2.2.1 Understandings of birth and the role of the birthing woman

Whilst the wider social science literature offers a substantive body of work focussed on the issue of childbirth, this empirical focus is sometimes understood as marginalised, with British sociologist Ann Oakley, for example, describing a 'neglectful tradition' whereby '[m]ainstream sociology has traditionally paid very little attention to childbirth' (Oakley, 2016, p689). The UK-based healthcare scholar Denis Walsh makes a similar point, with his suggestion that there is a 'dearth of recent research and theorising around the act of parturition itself' (Walsh, 2010, p486). Nevertheless, and across a wide range of disciplines (including anthropology, women's studies, sociology, history, epidemiology and psychology), a tradition of social science research has developed, primarily since the 1970s, in which diverse practices of childbirth (across time and space) have been studied. This is a body of research that has been keenly influenced by a deep-seated interest in the way in which power struggles, based on positions of divergent values and knowledge claims, are enacted to gain and maintain control of childbirth.

At the core of these power struggles, the dominance of certain constructed discourses are implicated as key to the emergence and persistence of such control. As such, the story of the development of current childbirth practices is chiefly a feminist story about

a gendered struggle, which takes place against a backdrop of a society in which enlightenment thinking becomes dominant, with the consequential devaluation of non-rational knowledge and all things 'natural', leading to an increasing desire to tame and control the body, including through the professionalization and medicalization of childbirth (Davis-Floyd, 1992; Rothman, 1982).

Illustrating this process, research has focussed on how power in matters of childbirth has shifted from the community to the institution (Campbell and Macfarlane, 1990): from the birthing women and her lay attendants, into the hands of increasingly specialized midwifes who are then usurped by 'male midwives', finally ceding their power to the traditionally male medical - or obstetric - dominance found within the hospital environment (Ehrenreich and English, 2010; Murphy-Lawless, 1998; Connor Versluysen, 1981; Arms, 1975). One of the key emphases of childbirth scholarship beyond the discipline of geography has thus traditionally been, and continues to be, the different (and often competing) knowledge claims of various childbirth professionals, modelled and theorised in terms of competing paradigms (Darra, 2016; Davis-Floyd, 1992; Rothman, 1982). This focus continues, with ongoing analyses of struggles between obstetric and midwifery knowledge (Newnham, 2014; McIntyre, Francis and Chapman, 2012), and now a newly emerging set of analyses about the respective role and knowledge claims of midwives and 'less qualified childbirth workers', for example, traditional birth attendants (Moland, 2002), maternity care assistants (Hutchinson et al, 2014) and doulas (Henley, 2016; Horstman, Anderson and Kuehl, 2016; He, 2013). That is not to say, however, that a focus on the collective role of the childbearing woman, or lay community, has been omitted from this account (for examples of interesting analyses of social activism and childbirth see Rothman, 2016; Rabeharisoa, Moreira and Akrich, 2013; Reiger, 2000 and 1999b; Tyler, 2002).

There is also a developing body of work devoted to investigating issues of equality and human rights in birth, including access to maternity services and inequalities in childbirth outcomes (Miltenberg et al., 2016; Erdman, 2015). But as Figert suggests regarding the medicalization literature more generally, the top-down nature of much of the scholarship has tended to marginalise the issue of knowledge, power, authority and expertise on the part of the individual patient or, in this case, the childbearing woman (Figert, 2011; see also Nall, 2012 and Brubaker and Dillaway, 2009). An acknowledgement of the importance of a woman's own experiential childbirth knowledge in this context is thus muted, despite calls to better recognise the embodied and 'subjugated knowledge of women' (Newnham, 2014, p264). Indeed the limited attention paid to this source of learning seems to be triggered by concerns about how

such learning is either unhelpful, wrong or inappropriate, especially where it leads to women making choices for subsequent births that challenge the preferences of the maternity care system. Necessarily adopting the temporal frame of the childbearing career without necessarily conceptualising it as such, further research seeks to explore the link between women's separate birth experiences for the purposes of improving the therapeutic offer for subsequent births, for example where women come to birth after a traumatic birth experience (Thomson and Downe, 2010), a previous c-section (Catling-Paull et al, 2011) or a hospital birth (Catling-Paull, Dahlen and Homer, 2011).

Where scholars have previously taken up the idea that women develop knowledge about birth as a result of their birthing experiences, these research efforts have tended to remain isolated. UK scholar Judy Purkis, for example, focused on how and what women learn from their childbirth experiences, investigating the way in which women talk about their positioning with respect to 'experts' and how activities of UK midwives in the late 1990s acted to 'enhance or circumscribe' opportunities for women's learning about childbirth (her findings suggest mainly the latter) (Purkis, 2003). This study had as its central focus the potential importance of the role of women's knowledge to the 'improving birth' agenda. But as Purkis argues, the implications of such research findings are difficult to deal with, given that the challenges inherent in any attempts to shift the current positioning of women's knowledge would be immense, involving 'a complex and exhaustive cultural change ... it may be possible and it may not be' (ibid., p117). (Purkis' work on this issue had zero citations according to Web of Science as of April 2017.)

Another such study is Tanya Tanner's doctoral work (Tanner, 2012 and Tanner and Lowe, 2012), which takes as its primary focus the notion of how individual women might be more or less skilled at giving birth physiologically. Tanner's work is situated in the context of a steeply rising number of US labours that end in c-section, despite no identifiable pathology at the commencement of labour.

Underpinning Tanner's line of enquiry is Nancy Lowe's research (Lowe, 2007), which had identified how some women seemed to be more vulnerable than others to an outcome of a c-section in certain situations. Whilst Lowe's major recommendation is to reconsider antenatal education strategies, Tanner's approach seeks to understand whether this variation might be associated with any identifiable non-physiological differences between the women. Tanner's research thus works specifically with the notion that some women might be more able than others to 'birth well', in the sense of successfully accomplishing a physiological birth, and that an understanding of such

competency would be highly useful in efforts to improve women's birth experiences and outcomes.

To explore this idea, Tanner works with a range of childbirth professionals, through the vehicle of a Delphi Study, to identify what they consider to be key psychological characteristics of 'self-competent' birthing women, with the aim of developing a measurable concept of self-competency and a means to measure it. This work evokes, but seems far more useful in the context of my inquiry than, Sharon Humenick's review and study, from a psychological perspective, of the construct of women's perceived mastery behaviour in childbirth (Humenick, 1981; Humenick and Bugen, 1981). Tanner's study rather works with a more explicit conceptualisation of birthing women as skilled and knowledgeable agents, and her findings provide evidence that this conceptualisation is shared by many US childbirth practitioners.

Tanner's study does not extend to an interest in how women's competency might develop over their childbearing careers, however; this is because Tanner's research studies the self-competency of women giving birth for the first time. It is also important to note that Tanner's research is situated in a tradition of work emanating from healthcare schools, which seeks to understand - with the ambition of dismantling - the barriers to increased rates of physiologically-achieved births. As such, competency on the part of birthing women in this study was rather narrowly conceptualised, being related solely to competencies relevant to the achievement of physiological birth. Nevertheless, Tanner's work provides a useful - if again isolated - example of how such a conceptualisation has been put to work in the academy.

Finally, a seemingly overlooked element of Robbie Davis-Floyd's otherwise influential doctoral work is the attention she pays to women's learning over their childbearing careers, which she presented as a very short chapter in *Birth as an American Rite of Passage* (1992, p241-251). Much of Davis-Floyd's book is taken up with an analysis of ritual in then contemporary US birth practice, and women's learning is conceptualised in that context through the way in which such rituals send messages to birthing women, and how these may be received (in different ways dependent on women's initial conceptualisations). Davis-Floyd also discusses how some of the women in her study come to subsequent birth experiences drawing on their previous experience(s), however, and makes a clear call for further in-depth research focused specifically on the way in which women's birth stories are constructed and put to work over their childbearing careers (ibid., p245). Whilst her chapter makes for an interesting summary description of a range of childbearing career trajectories, suggestive of the childbearing

career as where birthing women's active agency really comes to the fore, it may be that its relative positioning in her overall thesis has led to its lack of visibility over time.

2.2.2 Improving birth for women and babies: the focus of health scholarship

In addition to social science scholarship, medical and health schools regularly issue research findings related to childbirth, for the purpose of investigating the potential for 'improving' various aspects of maternity services. Much of this research has been based on quantitative research designs, where double-blind randomised control trials have been considered as the gold standard medical research model (Downe, 2010). Typically, this research has worked with a highly pathological model of childbirth, constructing the female body – and its ability to give birth - as weak and prone to failure, with medical technologies increasingly ready to treat any failures of the reproductive system, even if pathology has not yet manifested (for example, via prophylactic treatments wherever these are low-cost). Whilst this type of research has usefully led to the development of a wide variety of medical techniques and technologies to respond to pathologies of childbirth, it has been less useful in developing an understanding of how women can best be supported to give birth physiologically, and how strategies might take account of a woman's multiple birth experiences, rather than just focusing on one birth at a time. Given the purpose and design of such medical research, as well as 'the reductionism of the scientific method' (Walsh, 2010), the knowledge of birthing women themselves has not traditionally been a focus, as it is not generally theorised as important to the task (of treating disease).

Changes in midwifery training arrangements have been influential in starting to shift the balance of this medical research agenda. Until fairly recently in the UK, for example, it was usual to specialise in midwifery only after first training as a nurse. The direct-entry route into UK midwifery, established in the early 1990s via a specific midwifery degree course (Lobo, 2002), and the location of this system of midwifery education in the university, has resulted in an important change in the landscape of new scholarship on childbirth. A growing body of midwifery students and teachers in the UK and elsewhere are now fully embedded into the research culture of the university system, producing research outputs relevant to social science scholarship on pregnancy, childbirth and the postnatal period, alongside the more traditional obstetric research outputs.

In many areas this scholarship seems to carry forward a medical science research agenda, centrally seeking to improve the evidence-base for techniques and technologies for dealing with pathology, although this is sometimes done by seeking to

replace obstetric techniques with midwifery techniques. Thus it could be argued that midwifery research is essentially an offshoot of the medical research agenda, albeit one that seeks to replace an element of obstetric dominance with midwifery dominance, underpinned by a discourse of risk which allocates one group of women (defined as high-risk) to obstetric control and another group of women (low-risk) to midwifery control (evoking Sharpe's findings in Australian birth centres, Sharpe, 1999). As it does so, the value attributed to birthing women's knowledge continues to be restricted, and often recognized only as an important source of knowledge as an input to the research process, via its inclusion within the scientific process. (For an example of this type of scientific valorisation of birthing women's knowledge see McAree, McCourt and Beake, 2010.)

However, a subset of researchers based in midwifery schools also seem confident with a range of methodological and theoretical approaches developed within the social sciences, and this group seems to be growing (Downe, 2010; Walsh, 2010). Thus there is an increasing dialogue between the midwifery and social science literature, including human geography, with the boundaries between the two becoming increasingly blurred; a similar shift can be observed in nursing scholarship. A growing interest in social science methodologies has led to a significant increase in the proportion of qualitative studies being published, where the perspectives of childbearing women - alongside the perspectives of healthcare workers and quantitative medical data - are being taken increasingly seriously.

Whether this brings about a fundamental revaluation of birthing women's agency and knowledge is debatable, however, as illustrated by a tendency, for example, to avoid the labelling of women's knowledge as knowledge at all; rather, birthing women's knowledge is often variously referred to as women's perceptions, beliefs or preferences (Oster et al., 2011; Foster et al., 2010; Walsh, 2009). The usage of the term 'belief' in this context is perhaps particularly interesting, suggesting that women's knowledge, by definition, is 'something not recognized as true by the health-care system' (Foster et al., 2010, p507), reminiscent of the devaluation of women's knowledge through the derogatory usage of terms such as 'old wives tales' (Donovan et al., 1989) or gossip (Duffy, 2002). As a result of such qualitative research, however, the relationship between women's stated preferences and experiences are becoming better understood, and the discursive turn is becoming increasingly embedded in childbirth-related scholarship.

Similarly, and sometimes reflecting an important engagement with social science literature, a critical strand of midwifery scholarship has emerged, which seeks to better

understand the political and social context in which midwives work, and in which maternity services are designed and delivered, rather than simply pursuing a functional line of enquiry in an attempt to improve current service delivery, based on a model which seeks out, or in which midwives are assumed to be, exemplary practitioners (Kennedy et al., 2004; Kennedy, 2000). An important example of this work, led by Mavis Kirkham, has sought to problematise the issue of information-giving and 'informed consent' in the maternity services. In depicting the professional/patient 'informed consent' encounter as one of barely informed compliance, this work demonstrates well the ability of midwifery-researchers to work at arms-length from the maternity services (Kirkham, 2004). Others have focussed on reviving and elaborating upon Davis-Floyd's (1992) critique of the discourse of choice as it applies to birthing women (McAra-Couper, Jones and Smythe, 2011; Jomeen, 2010).

In addition, there is increasing recognition that women's attitudes towards physiological birth are highly influenced by many-intersecting elements of a dominant culture that is deeply antithetical to a positive evaluation of the physiological labour and birth process (and that the ability of an individual midwife to affect this influence is therefore necessarily limited, despite the notion of the midwife as the 'guardian of normal birth' (Fahy, Foureur and Hastie, 2008)). This underpins a research focus that investigates the link between the stubborn persistence of a high level of medical intervention to the gap between 'the normal birth agenda' and the dominant patriarchal – or anthroparchal - culture which - since Descartes and the Enlightenment - has tended to devalue bodies and physiological processes, placing greater value on reason and technologies (Nall, 2014; Jordan and Thatcher, 2009; Cudworth, 2005; Davis-Floyd, 1994; Jordan, 1993; Razak, 1990; Martin, 1987; Rothman, 1982). In the area of childbirth, the entrenched nature of such ways of thinking seems to be clearly evident, despite the increasing weight of evidence which underscores the technologically irreproducible long-term benefits of various elements of the physiological birthing process, for example, the benefits of reducing post-birth interference with the physiological process of blood transfer, through the umbilical cord, to the baby (Mercer and Erikson-Olwen, 2010) or of protecting the physiological production of oxytocin production during labour and birth (Uvnäs-Moberg, 2016).

Other related facets of contemporary culture similarly seem to contribute to a low level of tolerance for the physiological process of birth, which McAra-Couper and colleagues strikingly describe as 'incompatible with [many women's] everyday world' (McAra-Couper, Jones and Smythe, 2011, p92). These include the routine use of negative language about birth and the capability of women to give birth (Hunter, 2006);

discourses of femininity that work to challenge the femininity of the physiological birthing process (Malacrida and Boulton, 2012; Martin, 2003); an intolerance of bodily pain, even where this pain does not imply pathology (Lowe, 2002); societal devaluation of manual labour (Hubbard, 1988); comfort with technological body manipulation and the normalization of surgery (McAra-Couper, Jones and Smythe, 2011; Gimlin, 2010; Holliday, 2009; Holliday and Taylor, 2006; Davis, 1995); the desire for predictability and certainty, and convenient and 'quick-fix' speedy outcomes (Downe, 2004) and the discourse of personal autonomy and consumer choice (Jomeen, 2010). Mainstream and institutionalised cultures, of course, play out differently across both individuals and groups of individuals, and there are counter-cultures and pockets of resistance in evidence.

Despite important emerging strands of critical scholarship, however - which can often implicate midwives themselves in the ongoing reproduction of an overly-interventionist and over-medicalised system - it is important to be ever-vigilant of the professional project that tends to underpin much midwifery research. Perhaps this is inevitable where researchers are employed fundamentally as part of the midwifery production system. For many problems identified, for example, more and/or better midwives seem to be proposed as the primary solution, with a particular focus across the literature on the need for the development of increased continuity of care, to allow for a more meaningful and supportive 'with woman' relationship between the midwife and the birthing woman (Goldberg, 2008; Leap and Pairman, 2006). In that context, outsider perspectives from a range of disciplines continue to provide an important contribution (for example, Westfall and Benoit, 2008; Rothman, 2006; Reiger, 1999a; Annandale, 1987).

2.2.3 Exploring the marginalization of the birthing woman in the context of organisational learning literature

Even if it is the case that the majority of childbirth literature (and practice) seems to privilege the role of professional as primary knower and competent agent in the social practice of birth, it is important to address the issue of whether, and if so how, this is problematic. It might be reasonable to assume, for example, that assigning such status to the professional is both realistic and appropriate (reflecting the professional's likely education, training, experience and expertise in the field of birth): most birthing women seem to desire, and sometimes need, support from competent practitioners. In this section, however, I draw on scholarship which suggests that the exclusion of the birthing woman as a (the?) central actor in the social practice of birth is unlikely to be

effective, in terms of ensuring good outcomes, and nor is the marginalisation of her knowledge and embodied competency.

There has been a long-standing suggestion that women's embodied and experiential knowledge about childbirth has been devalued, silenced and even confiscated with the increasing pathologization, medicalization and professionalization of childbirth (Murphy-Lawless, 1998; Markus, 1997; Davis-Floyd, 1992; Oakley, 1980). In this context, however, it is also important to recognize the scant evidence for a 'golden age' in which women's birthing knowledge was powerful (Davis, 2008). Nevertheless, it is possible to find some evidence for these claims. In particular, the social anthropologist Brigitte Jordan has written about the way in which childbearing women's knowledge (and with it, women's power) had been effectively banished from the medicalized US birthroom by the 1970s, based on her extensive cross-cultural ethnographic work in Mexico, the US and elsewhere (Jordan, 1993).

Jordan's focus on this issue at this point in time is interesting, because for many interested in the history of childbirth in the US, there is perhaps a rather more striking 'low point' for women's agency in birth, represented by the 'knock 'em out, drag 'em out' model of birth management in place in parts of the US in the 1940s (Humenick, 2000, vi). Under that model, a 'good birth' was conceptualised as one in which women's active participation in birth was minimized via the use of heavy sedatives and a practice of literally tying women to the bed (to prevent excessive injury). In contrast, the birth practices observed by Jordan seem to allow the birthing woman far greater agency, even where epidural anesthesia is used, or where a c-section is the chosen mode of birth. But as US childbirth education expert Sharron Humenick has suggested, it is important not to underestimate the effect of such interventions, arguing that it is possible that 'birth has increasingly moved back to being something that happens to a woman instead of something she accomplishes' (ibid., vi).

As part of her work, Jordan offers the concept of authoritative knowledge, a power-infused concept designed to draw attention to the way in which, in different circumstances, particular types of knowledge (and, linked to this, holders of these forms of knowledge) are legitimised, whilst others are dismissed. Jordan's work sought to evidence just how much the dominant culture of the time had worked to undermine the relevance of women's knowledge, with its focus instead on the primacy of expert knowledge and high technology, establishing biomedical knowledge as authoritative knowledge in the then contemporary US. Thus Jordan uses this concept to explore how biomedical knowledge came to dominate the US practice of childbirth by the 1970s, but also to suggest that which knowledge counts (or is authoritative) in a given

situation is open to change. In this context, Jordan envisages a US birth room of the future into which birthing women's knowledge might be reintroduced and recognised as an important source of knowledge and power.

Associated with Jordan's work, which remains influential, and consistent with the more general critique of medicalization within the discipline of sociology, was a normative struggle to reverse this process of medicalization and to reclaim women's power over birth. (This theme of midwives and others reclaiming birth for women recurs regularly, although the perspective of the childbearing women on this matter is less well documented.) I would argue that little of this work directly sought to follow through with Jordan's interest and insights into birthing women's knowledge, however. Despite Jordan's early focus on the issue, therefore, there has been little attention in the literature, certainly in a UK context, on the positioning of women's knowledge in the broader childbirth knowledge landscape or indeed whether or not it matters.

Looking again at Jordan's work, we see that she explicitly seeks to reassert the primary role of the birthing woman in the birth process. Implicitly, Jordan also seems to have been working with the underlying assumption that it is important for any given task to take into account and to draw effectively on all relevant sources of knowledge; this fits well with Jordan's subsequent career move to a business research setting, where she specialised in information and knowledge. Jordan also works with a concept of an ecology of birth, discussing the complexity of the inter-relationship between the birth process, the birthing woman and the birth environment. Although Jordan does not link her work to it explicitly, this assumption has obvious links with the then developing theories of organisational learning, and work around how to create effective learning organisations (Senge, 1994 and 1990; Argyris and Schon, 1974; Shein, 1965). Indeed Senge's theorisation of the five disciplines of an ideal learning organisation (personal mastery, mental models, shared vision, systems thinking and team learning) seems to fit well as a coherent agenda to address the deficits in the practice of birth and the marginalisation of the birthing woman as identified by Jordan.

Senge's approach, for example, suggests the importance of the birthing woman, and her birth supporters, being better integrated into the decision-making team that is in place to bring about a successful childbirth outcome, where a shared vision, mutual understanding and effective communication is vital. Focusing on the different and complementary competencies of each team member, Senge's theory highlights the notion that the birthing woman has a unique and irreplaceable role in the practice of childbirth, and unique access to a particular body of knowledge (personal mastery). Its emphasis on the importance of 'systems thinking' to ensure satisfactory task

completion evokes Soo Downe's subsequent ideas in the childbirth context of the need to adopt approaches that are comfortable dealing with the complexity and chaos of birth (Downe, 2004 and 2010).

Given that theories of organisational learning have been influential in health service management in the UK (Sheaff and Pilgrim, 2006; Davies and Nutley, 2000), it is interesting that only a small scholarly literature has developed to discuss how these ideas might help to address quality issues in the field of birth, especially in the context of a drive towards patient-centred care. On the small amount of evidence available, it seems that the implementation of the organisational learning agenda has been organised in a way that seems to exclude the possibility of the birthing woman, as a particular type of patient, as a subject or member of the team (Cornthwaite, Edwards and Siassakos, 2013; Goh, Chan and Kuziemsky, 2012). An exception to the work, which persists in siting the patient outside of the work team, are initiatives that focus on the participation of patients in teams for 'off-line' tasks, such as service evaluations, improvement initiatives and staff training (Lokugamage et al., 2017; Martin and Finn, 2011; Davies and Nutley, 2000).

Even if the need for good communications with the patient/birthing woman is taken seriously, such an approach is far less ambitious than an agenda which conceptualises the patient/birthing woman (and their families/supporters) as members of the core team. Partly, this may be due to the difficulties in establishing even inter-disciplinary learning teams (Sheaf and Pilgrim, 2006) and the rather innovative approach to the definition of a team that this would necessitate (in maternity care, as temporary, unpredictable in terms of scheduling and duration, specific to each patient's series of care episodes, in-part virtual and possibly increasingly off-(acute hospital)site). Denis Walsh also draws attention to the shifts in professional 'personas and ... institutionalised behaviours' that would be necessary '[f]or obstetricians and midwives to understand 'team' as including the woman' (Walsh, 2010, p492).

Jordan focuses her argument on a particular point in time in US history, and it certainly would seem to be of contemporary interest to investigate how her core concern - that of 'disappearing lay knowledge' - might be relevant in other times and places. Certainly, it would seem that Jordan underplays (if not ignores) the possibility of diffuse and ever-shifting sources of power/knowledge; in particular, her interpretation now seems to lack sensitivity to the idea that women's knowledge had presumably not vanished at all, but continued to exist and develop, albeit not in a way that was - or even could - be grasped by the holders of authoritative knowledge (or, indeed, the interested onlooker). There seems a great deal of scope, therefore, for seeking to re-engage with Jordan's

agenda, albeit in a way that takes as a more central assumption the notion that all social practice is infused to varying degrees with learning, and to investigate exactly how women's diverse experiences, including childbirth experiences, represent learning relevant to the process of childbirth, how this learning creates knowledge, and how that knowledge is positioned and deployed with respect to the broader landscape of childbirth knowledge. This suggests a series of investigations that would need to be conceptualized as highly-situated, reflecting a given place and time; for such investigations, it seems unlikely that theories of organisational learning would provide a sufficiently robust theoretical framework, not least because of their normative nature and lack of attention to issues of power (Stewart, 2001).

2.2.4 Conceptualisations of women as skilful and knowledgeable agents: the role of antenatal education and learning beyond the classroom

Whilst Jordan has talked of 'disappearing lay knowledge', it is of course the case that modern maternity services do conceptualise women as learners in the area of childbirth. One key way in which they do so is in the context of antenatal education, which is an ongoing focus of scholarly interest, not least in terms of questions about its effectiveness, as increasing attention is paid to how scarce healthcare resources are allocated.

Researchers have thus studied group learning settings attended by pregnant women (whether maternity-service led antenatal classes or other types of group-based activity aimed at pregnant women). Such groups are a well-recognised element of the contemporary learning landscape in the UK: despite constraints in public sector funding, the NHS antenatal class continues for most women (and their birth partners) to be a taken-for-granted element of the free-at-the-point-of-use maternity provision in the UK, with the uptake of this provision amongst pregnant women estimated to be 31% in 2014 (Henderson and Redshaw, 2017).

As Molly Stout and her colleagues note, 'antenatal childbirth education as a formal construct was initially conceived in the 1930s' (Stout, Garrett and Stamilio, 2015, p2). Inspired by the prepared childbirth movement of the early twentieth century, with its key proponents including Grantly Dick-Read (in the UK), Robert Bradley (in the US) and Fernand Lamaze (in France), group antenatal classes were developed on the assumption that there is a certain amount of childbirth knowledge and skill that women need to be taught to enable them to give birth successfully. Key elements of this approach, focussing on the benefits of women's psychological and emotional preparation, continue to occupy a central place in thinking about women's knowledge

about birth. Since the 1970s in the UK, Janet Balaskas' active birth model has also been influential. This focuses on women as active birth-givers rather than passive patients, in particular promoting the benefits of women's mobility in labour and upright labouring and birthing positions (ibid., p10; Balaskas, 1983; see also Robertson, 1994). Mary Nolan provides a good overview of different types of formal antenatal education (or birth preparation) classes in UK, many of which aim to communicate to pregnant women and their birthing partners the inseparability of mind/body in the practice of childbirth (Nolan, 2010; see also Wickham and Davies, 2005); for a US-based perspective, see Zwelling (1996).

In the academic literature, there is a focus both on the effectiveness of current antenatal education strategies as well as investigations into how these strategies might be updated to deliver improvements in women's preparations for birth. One such approach pays particular attention to the benefits of women accessing each other's experiential knowledge as a key resource, based on pedagogical understandings of the effectiveness of learning within social networks (McNeil et al., 2012; Novick et al., 2011; Leap, 2010; Rising, Kennedy and Klima, 2004; Ketler, 2000). This builds, inter alia, on the notion that when, where and how women learn about birth and how to give birth has never been constrained to the learning which takes place in antenatal classrooms: the importance of women's learning that takes place within social networks, for example, has long been recognised (Grassley and Eschiti, 2008; Gottvall and Waldenstrom, 2002). The sharing of birth stories, whether first- or second-hand, is discussed as an important mechanism in this context, reflecting an understanding of how women might learn from stories about the experiences of others (Carolan, 2006; Callister, 2004; Pollock, 1999).

Whilst the existence of the childbirth education sector is based on a presumption of [at least the possibility of] a skilled and knowledgeable childbearing woman, this has been observed as playing out in different ways in different contexts, according to the underpinning local educational philosophy. Perhaps implicit in the standard antenatal model, for example, is how an assumed knowledge and skill deficit on the part of pregnant women is best met by formal childbirth education strategies, whether in public or private antenatal classes. Many educators might work on the basis, for example, that it is their role, as expert, to teach a woman skills and give her knowledge to help her navigate the practice of childbirth successfully; this is quite different from an educational philosophy which conceptualises the woman as an independent learner. Indeed it is possible that women's own skill and knowledge rather becomes marginalized by such activity, as childbirth education expert Sharron Humenick has

perceptively suggested, in calling on ‘childbirth educators [to] visualize the extent to which their classes may inadvertently contain lectures that resemble a medical model of care’ (Humenick, 2000, vii). As Humenick has argued, therefore, it is important to note that the routine of attending antenatal education classes may or may not support a conceptualisation of birthing women as skilled and knowledgeable agents: that will depend on how effective such provision is in supporting women - including as their labours and births unfold - to access, valorise and develop their own skill and knowledge.

Alongside these debates about antenatal education and the role of social networks, there is also a keen interest in how pregnant women are influenced through mass communications. This line of enquiry has traditionally focussed on books and magazines targeted at pregnant women, but also seeks to understand the effects of the general mass media, such as newspaper, television and film portrayals of birth (Maclean, 2014; Biasiolli, 2008; Miner, 1996; Bastien, 1993). Media scholar Sofia Bull’s thoughtful analysis of Scandinavian television birthing shows is particularly interesting in this context, and it is interesting to note that Bull’s analysis of how such shows depict female agency does not extend beyond the agency of female professionals, suggesting that the skill and knowledge of birthing women is obscured in this medium (Bull, 2016). Internet resources and social media activity are also foci for the study of how women come to know about birth. This academic conceptualisation of an increasingly diverse learning landscape fits well with practitioner opinion about how women learn about birth. For example, in a US-based study, Handfield and colleagues identify obstetricians’ beliefs about key influences on women’s knowledge and attitudes: they find that obstetricians believed that family and friends were most influential, followed by formal antenatal education, and then mass media, with online sources of information becoming more important than television (Handfield, Turnbull and Bell, 2006).

Finally, there has been some interest in how women’s learning about birth takes place in the context of one-to-one encounters with their midwives. One study in this context is Pasveer and Akrich’s (2001) investigation into how women come to learn about birth as part of their regular antenatal appointments in two contrasting types of antenatal care in the Netherlands. Pasveer and Akrich suggest that different types of lay knowledges are produced as women pass through either an obstetrical or a midwifery trajectory during the antenatal period, with women and their bodies being ‘loaded’ with different kinds of knowledge depending on their trajectory. The midwifery trajectory, for example, ‘loads the body with the abilities, knowledge and confidences’ which prepare a woman well for a low-intervention home birth (ibid., p238). In contrast, they argue that the obstetrical

trajectory has been designed with little attention to such knowledge-distribution effects, resulting in a relationship between the pregnant woman and expert knowledge that effectively undermines a woman's ability to birth without a high degree of technological support (ibid.). From a UK perspective, where the routine organisation of antenatal care - even if generally midwife-led - seems closest to the obstetrical trajectory, this study suggests a huge task for an individual midwife who might seek to promote physiological birth, as well as depicting the birthing woman's agency as low.

At the same time that each of these different elements of the learning landscape for childbearing women have been understood to be influential, each has also been the subject of concern in the academic literature (often reflecting practitioner concern). The mass media is often singled out and blamed, for example, for teaching women to fear birth, with calls for midwives to engage with mass media content creators, for example, to improve portrayals of birth and midwives (Luce et al., 2016). Formal group-based education, in the way that it seeks to deliver a hybrid package of knowledge and skills to pregnant women encompassing both physiological and social elements of birth, has also been the focus for concern, either because it is assessed as socializing women in preparation for a medicalized birth (and thus lowering women's commitment to a physiological birth) - in a similar way to Pasveer and Akrich's 'obstetrical trajectory' - or as preparing women only for a physiological birth (priming them to challenge any attempt to medicalize birth and leaving them open to disappointment if this approach fails) (Ferguson, Davis and Browne, 2013). Concerns have also been highlighted about the content of online learning, with researchers exploring how midwives, traditionally responsible for the educational content and delivery of face-to-face antenatal classes, are seeking to influence this, by extending their role to create their own internet content (Nikolova, 2015).

The existing academic scholarship is thus engaged in a debate that increasingly recognises the diversity of spaces in which women come to know about birth, and how such learning is multi-faceted, consisting of expert-led instruction alongside self-directed learning, formal and informal, planned and unplanned. The importance of understanding women's various conceptualisations of childbirth is also highlighted (Luce et al., 2016). What is less apparent in this literature, however, is the idea that a further key space and time in which women develop their conceptualisations about birth is the labour and birth room, which offers an informal, unplanned and unanticipated type of learning. Rather, a review of existing scholarship about women's learning about birth suggests a learning landscape in which this space is under-theorised: for an approach which take seriously how women might develop skills and

knowledge drawing on their own resources and experiences in the birthroom, I turn to scholarship about relational models of care.

2.2.5 The role of women's knowledge and agency in relational models of care: from knowledge learnt from others to knowledge based on embodied experience

Scholarship about relational (relationship-based) models of maternity care highlights the benefits for women of being supported by a known midwife throughout her pregnancy, birth and post-natal period; ideally ongoing care under this model would be delivered to a woman by a single midwife, but the practical difficulties of assuring this mean that such models also extend to arrangements whereby women are supported by a small team of known midwives. Underpinning this model is the idea that the quality of the relationship between the woman and her midwife is fundamental to delivering good birth outcomes, including but not limited to a high level of protection for the physiological birth process (Homer et al., 2017). Women's access to this model of care has declined significantly in the UK over recent decades, signified by the survey finding that the chances of women being cared for in labour by a midwife she had previously met declined significantly between 1995 to 2014, from just under 50% to 15% (Henderson and Redshaw, 2017). (Such models do not ignore the possibility that women may also need access to the support of other maternity care professionals, rather it is the midwife's role to liaise with an interdisciplinary team as necessary on behalf of her client.)

Analyses of this model of care have opened up a new academic line of enquiry which suggest that this model of care might offer a space - in contrast to typically highly fragmented models of care - in which the birthing woman's knowledge can be recognised, attended to and taken seriously. Thus Holly Powell Kennedy and colleagues, in a US-based study, explain how such one-to-one midwifery practices (currently accessed by only a small proportion of US women) are able to create relationships in which:

> 'midwives regard themselves on an equal level with women, recognizing that women bring a knowledge base to the clinical situation as important as the midwife's' (Kennedy et al., 2004, p16).

Kennedy's understanding of the potential offered by this model of care is also shared by UK-based childbirth activist and independent scholar Nadine Pilley Edwards. In her study of women who choose to birth at home in Scotland, Edwards provides a careful analysis of how relational midwifery might work to create the circumstances necessary

for the development of women's (and midwives') knowledge. This is knowledge, Edwards argues, that is too often 'an unacknowledged source of safety' in an impersonal high-volume care system (Edwards 2005, p149). Edwards thus contrasts relational midwifery to a more fragmented model of care, such as that typically experienced by the women in her study, in which women reported how they had had little scope to develop a trusting relationship with a midwife and felt that 'their knowledge was often unwelcome, belittled or silenced' (ibid., p141). As Edwards explains, this finding reflects well the idea that '[a]n ideology that has no concept of knowledge being located in the woman herself systematically mutes this knowledge' (ibid., p150).

Whilst such a relational model of care is currently merely an aspiration for midwifery scholars and practitioners in many countries - certainly as a nationwide service - this model is at the heart of proposals for the improvement of UK maternity services (NHS England, 2016). It has also been key to reforms in New Zealand maternity policy since 1990. The difficulties of establishing and maintaining such a relational model of care 'based on reciprocity and equality' are not underestimated in the New Zealand context, however. In particular, it has been noted that the relational model of care challenges 'the view that the health professional is always the expert; that the patient (or woman) is the passive recipient of this expertise and therefore the relationship between them is always unequal' (Pairman and Guilliland, 2003, p228). Reviewing the progress of this New Zealand initiative 18 years after its introduction, however, Chris Hendry reports that '[w]omen seem to be taking a much more active role in their pregnancies', which suggests that shifts in attitudes and power are being achieved (Hendry, 2009, p85).

This scholarship which focuses on relational models of care thus offers a renewed conceptualisation of the birthing woman as a knowledgeable agent, whose knowledge and agency - based on her personal and embodied knowledge - is key to ensuring a safe and successful birth outcome. Is it really the case, however, that such a conceptualisation is not possible for women who do not have access to such relational models of care? This strand of research again raises questions, therefore, about the extent to which the academy is able to conceptualise birthing women more generally as skilful and knowledgeable agents, whatever type of birth they desire, model of care they access or setting in which they plan to give birth.

2.3 Conclusion

In this chapter, I have argued that a focus on women's agency with respect to birth has been muted in academic scholarship. This is in the context of an intense and important focus on inter-professional struggles for control over the management of childbirth and non-holistic research approaches that have prioritised investigations related to fragments of women's birth experiences. It is also muted in the growing proportion of childbirth research led by researchers based in midwifery schools, for whom the agency of the midwife is clearly of particular interest and for whom the goal of physiological birth, wherever pathology is absent, is often key.

In the general absence of such a conceptualisation of women as skilful and knowledgeable agents, however, I have also drawn attention to how a perspective which valorises a relational model of maternity care refocuses attention on the role of the birthing woman, reasserting the importance of the birthing woman's agency, skill and knowledge to the achievement of a successful and safe physiological birth. It does this by drawing attention to the birthing woman's unique access to her own embodied and experiential knowledge (albeit in a way which tends to work to reinforce the notion that many birthing women are not - and perhaps cannot be - conceptualised as skilled and knowledgeable agents).

In the next chapter, I propose that a theoretical framework based on the work of Bourdieu might enable an investigation in which a conceptualisation of the birthing woman as a skilful and knowledgeable agent, whose skill and knowledge develops over the childbearing career, may be applied to all birthing women. In doing so, I seek to pay particular attention to the way in which the social practice of birth is structured by, and works to structure, conceptualisations of the relationship between self, society, and the natural world, developing in particular the work of geographer Becky Mansfield (2008a and b).

As part of that discussion, and in proposing that such an investigation is only possible by working from the perspective of a woman's childbearing career, in which childbearing is conceptualised as an ongoing process rather than a series of unrelated events, I will also seek to assess whether the conceptualisation of the increasingly skilful and knowledgeable birthing woman that is central to Bagnold's fictional narrative (Chapter 1) can indeed form the basis for an effective research agenda that valorises women's experiential knowledge, or whether it is an irrelevant fantasy.

Chapter 3 Putting Bourdieu to work in the birthroom: developing a conceptual understanding of the social practice of birth

The focus of this chapter is to provide an orientation towards the key theoretical framework employed in this study. In the previous chapter, I discussed how existing social science scholarship has made little space for a conceptualisation of the birthing woman as a skilful and knowledgeable agent, nor seems to take seriously the idea that such a conceptualisation might be relevant to the safe and successful achievement of the social practice of birth. Where such conceptualisations have been tentatively proffered, I have highlighted the academy's seeming reluctance to commit to them as an ongoing object of study. I have argued that this is partly as a consequence of the predominant theoretical approaches popular in childbirth scholarship, approaches that act to marginalise the birthing woman, within a more general lack of attention on the part of social science scholars to the embodied practice of birth (Oakley 2016; Walsh 2010).

Following on from this analysis, the question arises of whether the application of different theoretical frameworks might better enable a renewed focus on the skill, knowledge and agency of the birthing woman. As the first step in this discussion, I turn to a body of geographical scholarship about education and learning (3.1), but find that this scholarship has little overlap with the current study, except to the extent that this work has latterly started to explore embodied and experiential learning. I then argue that the work of French social theorist and structurationist Pierre Bourdieu offers a rich theoretical framework with which to study women’s learning over their childbearing careers. Bourdieu’s theoretical perspective, both spatially and temporally sensitive, has the potential to underpin an innovative approach to this area of study, fully encompassing spatial and temporal dimensions.

Following a brief review of the application of Bourdieusian theory in human geography (3.2), I introduce some key elements of Bourdieu’s theory of practice as it is drawn upon in this study (3.3). To further contextualise the current study, I then offer a brief critical review of childbirth scholarship that has adopted a Bourdieusian analytical frame (3.4), and discuss a number of issues which arise in this context (3.5). This sets the scene for a methodological description of the empirical study that follows in the next chapter (Chapter 4).

3.1 Conceptualising experiential learning: drawing on geographies of education and learning

Central to the current inquiry is how and what women learn about birth over their childbearing careers. There is a developing tradition of human geography scholarship into matters of education and learning (which goes well beyond a consideration of the teaching of geography itself), and in this section I introduce this body of work and examine how it might be of relevance to the current study.

Rather than constituting a specific sub-discipline, geographers interested in education and learning are located across the discipline, within various disciplinary sub-fields including social geography, children's and young people's geography, cultural geography, economic geography, political geography and critical geography. Much of the scholarship has typically been focussed on spaces of formal institution-based educational provision for children and young people of compulsory school age, often with a keen interest in equality and social justice. The scope of this scholarship is increasingly broad, however, as recent review articles indicate (Mills and Kraftl, 2016; Waters, 2016; Holloway and Jöns, 2012; Cook and Hemming, 2011; Holloway et al., 2010).

First, there have been shifts in terms of the types of educational provision under scrutiny, with increasing scholarship into tertiary sector provision and beyond, for example into the workplace; into the increasing amount of formal provision aimed at children under school age; into learning that takes place in the margins of formal provision; and into private and alternative educational provision. Second, there is an important strand of research which considers mobility in educational consumption, especially in connection with the tertiary sector at various scales (from the local to the international). Third, geographical scholarship is developing in terms of what it takes as its object of study, increasingly casting a critical gaze on the effects of (especially neoliberal) educational reform. Fourth, there is increasing recognition in academic work of informal/less formal spaces of learning, such as homes, neighbourhoods, community organisations and workplaces. Finally, geographies of education are emerging which pay close attention to how educational provision is consumed, and by whom, with geographers concerned to recognise the presence of individual learners, thereby 'moving the subjects of education ... into the foreground' (Holloway et al., 2010, p594), and to understand how different learners experience formal and informal educational provision. This has included a keen interest in the embodied and emotional component of such experiences (Cook and Hemming, 2011). Particularly interesting recent studies

have included a focus on how adults engage in the embodied and experiential task of learning new skills outside of the traditional classroom setting. Two examples of this latter approach are Eric Laurier's work on becoming a barista (Laurier, 2013) and Jennifer Lea's work on learning to be a thai yoga massage practitioner (Lea, 2009). In each of these studies, the formal and informal aspects of 'the practical process of learning an embodied skill' (Lea, 2009, p473) are highlighted, and the highly contextual nature of such skills is underlined.

Despite these new avenues of research, however, most geographical research on education and learning remains firmly tied to an agenda which prioritises the study of institutionalized forms of state-regulated (if not state-financed) education and learning, whose educational purpose is broadly conceptualised as the reproduction of particular (desirable) types of citizen, including, importantly, a stock of employable workers. As a result, the way in which adult learners learn to live their lives, beyond the sphere of preparation for paid employment, has not been central to this research effort. In some ways, recent research seems to herald a shift towards an interest in spaces of adult skill acquisition where the skills in question are not workforce related. Sarah Holloway and Helena Pimlott-Wilson (2014), for example, have considered how 'new and extended forms of teaching and learning ... under contemporary liberal educational reform' impact on adults, with their examination of state-sponsored parenting classes (ibid., p106). Here again, however, the focus is very much on the formal state-sponsored intervention. Thus Holloway and Pimlott-Wilson examine what it means to formalise an area of life skills that have previously sat outside formal educational approaches. Perhaps more interesting in relation to the current study is the work that Jennifer Lea and colleagues have done to look at adult skill acquisition in the sphere of leisure, with their investigation into the embodied and experiential task learning the practice of ashtanga yoga as an adult (Lea, Philo and Cadman, 2016). In this study, Lea and colleagues draw on a Foucauldian analysis to think through authority and power in educational spaces, examining how a distributed sense of authority may manifest, between the expert (or scientific knowledge) of the teacher and the developing experiential authority of the learner.

In this way, it may be seen that there is an increasing interest in embodied and experiential learning, beyond the workplace. The focus of much geographical scholarship on education and learning is rather distant, however, from a specific interest in the everyday informal and unintentional forms of learning that individuals undertake as a consequence of, and in order to live, their lives. For that, I return to Pierre Bourdieu's social theory, drawn on by Jennifer O'Brien in her study of women's

practices of health seeking behaviour in the context of childbirth (O'Brien, 2011). This has, at its core, a preoccupation with the highly situated and learnt nature of social practice. In the first instance, I will locate this discussion within the discipline of human geography.

3.2 Conceptualising social practice: Bourdieu in human geography

Whilst it would be misleading to imply that Bourdieu represents one of the most well-known social theorists in human geography (and for geographers following structurationist approaches, it should be noted that Giddens has been particularly influential), Bourdieusian theoretical approaches continue to sustain an interest in parts of the human geography academy, and for some geographers Bourdieu has been highly influential. Tim Cresswell, for example, noted that Bourdieu 'has provided the most important enduring influence on the way I think about the geography of everyday life' (Cresswell 2002, p379).

There seems to be some debate as to how Bourdieusian theory is most commonly utilized within the discipline. The *Oxford Dictionary of Human Geography* suggests, for example, that Bourdieu's concept of capital is more popular amongst geographers (for example, amongst those whose interests focus on matters of migration, gentrification and consumption) than his concept of habitus (see entries on Pierre Bourdieu and habitus, Castree et al., 2013). Whilst the potential benefits of applying Bourdieusian theory to 'locality studies' (now more usually differentiated in terms of urban and rural studies), including specifically to gentrification studies, was certainly flagged up clearly by leading human geographers in the early 1990s (see Jackson,1991), Cresswell challenges the idea that geographers have been most interested in Bourdieu's notion of capital, arguing instead that '[i]t is Bourdieu's theorisations of the body and its relation to 'society' that are most influential in contemporary human geography' (Cresswell, 2002, p380). Whilst it is beyond the scope of this section to offer a complete review of the use to which Bourdieusian theory has been, and continues to be, put by human geographers, I would suggest that this may be a matter of perspective, if not a rather unproductive dualism. As Louise Holt (2008) reminds us, Bourdieu's notion of capital is inherently embodied. It is also evident that geographical scholarship is increasingly taking a more holistic approach with respect to its use of Bourdieusian theory, with research increasingly drawing on multiple elements of the Bourdieusian conceptual framework.

Thus geographers draw on Bourdieusian theory in a diverse set of research endeavours, across a variety of sub-disciplines, including, inter alia, economic geography, political geography, health geography, rural and urban geographies, children's geography and cultural geography. Recently, such research has featured within urban/rural studies, including research investigating urban housing market developments in Chinese cities (Wu, Zhang and Waley, 2016); educational infrastructure in rural Britain (Walker and Clark, 2010) and the social practices to be found in the Portuguese urban nightlife economy (Nofre, Malet and Wodzinska, 2016). From a lifecourse perspective, Bourdieusian scholarship is also evident in a diverse range of topics of geographical inquiry including mother-infant practices (Holt, 2016), the play practices of young children (Ergler, Kearns and Witten, 2013) and geographies of aging (Antoninetti and Garrett, 2012). Cultural geographers have also used a Bourdieusian frame of analysis, for example to consider the making of moral landscapes (Setten, 2004).

In an overlap with the literature previously discussed, a key strand of recent Bourdieusian scholarship within human geography relates to geographies of education, learning and knowledge. Given the influence of Bourdieusian theory in education scholarship, this is perhaps unsurprising. Thus a number of geographers have adopted a Bourdieusian frame of analysis to examine international student mobility in the tertiary sector, and the mobilization of Bourdieu's concepts of capital and habitus seem to have been particularly productive in this endeavour (see Findlay et al., 2012; Waters, 2009, 2007 and 2006). Bourdieusian theory has been applied to inquiries into disabled children's experiences of life at school (Holt, 2010); student life on the university campus (Holton, 2016); young people's experiences of diverse forms of musical learning (Lonie and Dickens, 2015); the practice of entrepreneurial mentoring in Canada (Spigel, 2016); and the nature of knowledge in transnational bureaucracies (Kuus, 2014). As mentioned in the previous chapter, geographers have also put Bourdieusian theory to work in the context of how women learn to practice birth (O'Brien, 2011).

3.3 Bourdieu: conceptualising illusio and habitus as key to social practice

Even a cursory examination of the broad reach of Bourdieu's 'exceedingly voluminous' work (Lipuner and Werlen, 2009, p39), and his rich theoretical legacy, starts to suggest a multitude of ways in which a Bourdieusian approach might be put to work in the area of childbirth scholarship. In this section, I introduce key elements of Bourdieu's

theoretical legacy to be drawn on in the course of the current study, starting with an overview of Bourdieu's theory of practice, which sets out his central understanding that 'society is constituted in and through human agency, which must be regarded as both structured and structuring' (ibid., p39). I consider how Bourdieu's notion of skilful and knowledgeable agents demonstrating practical mastery of their lives provides a good fit with the central research aims of this study. In this way, I examine how a Bourdieusian approach theorises experiential learning in a way which both encourages and sustains a shift away from any pre-existing schema of what might constitute skill and knowledge (or indeed a lack of these) on the part of the birthing woman.

3.3.1 Understanding social practice, recognising skilful and knowledgeable agents

Bourdieu's theoretical project is conceptualised differently by different scholars. Ghassan Hage suggests that it works primarily to understand the 'economy of social being' (Hage, 2009, online), and this indicates the ambitious scope of Bourdieu's work. Central to all interpretations, perhaps, is an acknowledgement that Bourdieu's main interest was to understand, and expose to scrutiny, the (generally hidden) processes through which inter-generational inequalities are sustained, including, most centrally, those that structure the education sector. Bourdieu was keen for his work not to be viewed as highly abstract grand theory of the kind that pays little attention to the complexities of social practice, however (Mills, 1959). Rather, Bourdieu argued for the empirically grounded nature of his theoretical framework; his impressive production of empirical inquiries on a wide range of topics, alongside the accompanying frequent reworkings of his central theoretical concepts, supports this claim.

Recognizing the highly political nature of Bourdieu's project, Derek Robbins suggests that Bourdieu's project is at heart an emancipatory project: 'Bourdieu's work forces ... you ... to consider recognizing society properly with a view to reconstituting it differently' (Robbins, 1991, p8). It is this inherent desire for intense political engagement that perhaps underpins the continued attractiveness to many scholars of Bourdieu's social theory, including those geographers working from a feminist perspective: 'it does not exist merely to analyse and interpret, it seeks to root out and uncover poorly recognised symbolic domination and violence, laying the groundwork for resistance to the suffering that these produce' (Schubert, 2008, 196). As Renée Gravois Lee and colleagues have also argued, '[i]t is Bourdieu's focus on the processes through which power is legitimated that holds particular promise for feminism' (Lee, Ozanne and Hill, 1999, p235).

Taking into account the guiding objective of taking seriously the social practices of ordinary people, one of the fundamental starting points for Bourdieu's theory of social practice is how individuals are positioned in social and geographical space (Bourdieu 2000, p130). As such, Bourdieu constructs a frame of analysis that works to demystify the interaction between one's embodied self and social and geographical space, an interaction which takes the form of what he refers to as social practice.

3.3.2 (Habitus x Capital) + Field = Practice

In his theory of practice, Bourdieu seeks not only to signal his break with a dualistic understanding of structure and agency but also to foreground the generative capacity of agents: including a sense of creativity, in terms of invention and improvisation (Bourdieu,1994, p13). According to Robbins, 'Bourdieu was most eager to adopt an interpretative framework which would preserve the possibility of free human action' (Robbins, 1991, p86). At the core of the embodied self which produces this social action is something that Bourdieu calls habitus.

Bourdieu's revival of this word - which can be traced back to Aristotle (where it appears in its Ancient Greek form, hexis) and used by many other philosophers since - allows him to construct, as he explains it, a definition which both encompasses and extends the more common day term of habit, and allows him 'to insist on the idea that the habitus is something powerfully generative' (ibid., p87). As 'a structured and structuring structure', the habitus is thus a:

> '[system] of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them' (Bourdieu, 1990, p53)

For Bourdieu, then, the term habitus is intended to denote 'that which one has acquired, but has become durably incorporated in the body in the form of permanent dispositions' (Bourdieu, 1993, p86). Bourdieu conceptualises the habitus as being built up initially in two distinct ways. First, is the primary habitus: 'the set of dispositions one acquires in early childhood, slowly and imperceptibly, through familial osmosis and familiar immersion' (Wacquant, 2014, p7). The secondary (scholastic) habitus 'becomes grafted subsequently, through specialized pedagogical labour that is typically shortened in duration, accelerated in pace, and explicit in organisation' (ibid.).

Wacquant extends this conceptualisation to suggest that further habitus development represents an individual's 'subsequent acquisition of a multiplicity of (specific) habitus' (ibid., p8). Wacquant illustrates this by suggesting that the acquisition of specific skills and knowledge that constitute a martial arts habitus might, for example, represent a tertiary formation, a fighting habitus (ibid., p7). In this study, I draw on this notion to conceptualise a tertiary formation of the habitus with respect to birth, where this birthing habitus represents dispositions developed both from purposeful learning via childbirth preparation classes and other resources (the scholastic birthing habitus) as well as dispositions developed in a manner akin to primary habitus formation, including through immersion in the field (women's experiential learning about the social practice of birth).

Bourdieu is keen to insist that adjustments to the habitus are frequent and 'may bring about durable transformations of the habitus' (Bourdieu, 1993, p87). This 'only exceptionally takes the form of a radical conversion' (ibid., p88), however, given that the habitus 'exhibits a certain friction to change' (Holt, 2008, p233). Bourdieu's notion of habitus thus allows for 'structure' to be conceptualised as being continuously embedded within social agents, and, in the case of the individual, within the human body. As a dynamic and evolving interplay between personal experience and social structure, the 'structured' habitus also acts as a structuring force, creating the social practice which in turn has an impact on [re]producing the social field.

The concept of field - which Bourdieu often discusses in the alternative language of a game - is also integral to Bourdieu's theory of practice: this is where social practice takes place. A series of 'discrete but overlapping social spaces' (Crossley, 2001), each field, or autonomous social microcosm, represents 'a distinct social space, consisting of a network or configuration of objective relations between positions' (Bourdieu and Wacquant, 1992, p97). A field, with its specific internal logic, is occupied by agents or institutions; what positions them in the field (game) is their concentration or possession of specific 'species' of power (or capital).

An agent's position in the field is thus established on the basis of a combination of habitus and access to resources, in the form of various types of capital, the third main pillar of Bourdieu's theory of practice. In challenging an understanding of capital as simply economic, Bourdieu developed a wider conceptualisation of multiple forms of capital: cultural, social and economic, as well as symbolic capital (Bourdieu, 1986). In Bourdieu's schema, capital does not hold a constant value; some capital will count highly across many fields, for example, whilst the value of other forms of capital might be restricted to a single field.

These three concepts inter-lock to provide a basic framework, sometimes set out by Bourdieu in the form of an equation (as in the title to this section), whereby:

> ‘social practice results from relations between one’s dispositions (habitus) and one’s position in a field (capital), within the current state of play of that social arena (field)’ (Maton, 2008, p51).

3.3.3 Social practice: playing the game with intuitive mastery

Habitus thus provides the primary vehicle by which Bourdieu seeks to construct an alternative approach to the structure/agency problem that highlights how the relationship between a person and the world is one of:

> ‘complicity between two states of the social … between the history objectified in the form of structures and mechanisms (those of the social space or fields) and the history incarnated in bodies in the form of habitus’ (Bourdieu, 2000, p151)

According to Bourdieu, if there is a good fit between habitus and field, a person ‘feels at home in the world because the world is also in him [sic]’ (Bourdieu, 2000, p143). Bourdieu also highlights how the fit between habitus and field is not always good, however; nor is habitus always internally consistent (ibid., 160).

In the context of a good fit between habitus and field, Bourdieu has been concerned to underline the generally non-deliberate nature of social practice. For example, he explains how:

> ‘[s]omeone who has incorporated the structures of the field (or of a particular game) 'finds his [sic] place' there immediately, without having to deliberate, and brings out, without even thinking about it, 'things to be done' … and to be done 'the right way’ …’ (ibid., p143)

Thus for Bourdieu, ‘[h]abitus generates practices immediately adjusted’ to the context in which one finds oneself (ibid., p143). In this way, absent sufficient time and information to do otherwise, a 'feel for the game' guides people to follow a logic of practice that is perhaps closer in form to intuition than action based on rational calculation (Bourdieu, 1994, p11). In this way, people's actions are conceptualised in terms of representing 'practical sense'. According to Bourdieu:

> ‘practical sense is what enables one to act as one 'should' in a given field’, drawing on one's dispositions, importantly in the absence of conscious deliberation or formal rules’ (Bourdieu, 2000, p139).

A key element of social practice, represented by such practical sense, is thus how it develops from an exposure to the social world: by being exposed to the world, positioned within a particular social field and inevitably oriented towards that field, a person on the basis of their experiential learning 'is capable of mastering [the world] by providing an adequate response' (Bourdieu, 2000, p142), even in unfamiliar social fields. Here, then, is Bourdieu's concept of practical mastery, which also extends to a concept of virtuosity where the mastery of a game is highly developed.

3.3.4 Illusio and investment: experiencing the world through the games in which we get caught up

In some ways, Bourdieu's theory thus far might be argued as strongly resembling the work of various social theorists that have come before him, albeit with some new descriptors for the various conceptual elements. Bourdieu's social theory certainly builds on the work of others and is similar in certain respects to the theoretical work of some of his peers (see Frank, 2013, for a concise explanation of how Bourdieu's conceptual framework builds on the theoretical work of Parsons, Garfinkel and Foucault; see also Lippuner and Werlen (2009) for brief overview of the two variants of structuration theory developed by Bourdieu and Giddens).

For some scholars, however, a sense of Bourdieu's unique and generative contribution can best be captured through the way in which Bourdieu brings (again drawing on the work of Aristotle) the concept of illusio into his analysis of social practice, arguing that this is key to how individuals both experience and come to produce the social world. According to Bourdieu, '[i]llusio is that way of *being in* the world, of being occupied by the world ...' (Bourdieu, 2000, p135). Following this, Ghassan Hage suggests that our illusios are at the root of our preoccupations in life.

According to Hage, for example, Bourdieu conceptualises how one must first invest in life to enjoy life: 'the more you put in, the more you get out' (Hage, 2009, online). To do this, Hage describes how we build an illusion for ourselves (hold an *illusio,* in Bourdieu's terms) that certain things (and not others) are important. These illusios might be conceptualised as representing an affective component of the habitus (Wacquant, 2014, p9). Thus one person might hold an illusio that the progress of a certain team in the national football league is important, and this preoccupation will feature significantly in the meaning of their life. For another person, league football might be an irrelevance, but the persistent problem of homelessness might capture their attention. It is in giving such meaning to certain aspects of life, Hage suggests, that they indeed become important to us; in this way we give our lives meaning (ibid.).

Frank (2002) takes this one step further, in suggesting that stories about encounters between people are highly interesting for what they reveal about our illusios. Working in the area of health sociology, Frank is interested in encounters between clinicians and patients, and he suggests that awkward encounters very often stem from the ways in which each person is caught up in a different game, unrecognised by the other. Being caught up in a particular game, each person finds it difficult to imagine what is motivating the other, much less to understand the other's point of view:

> 'Each field … involves its agents in its own stakes, which, from another point of view, the point of view of another game, become invisible or at least insignificant or even illusory...' (Bourdieu, 2000, p97)

In this way, Frank constructs a conceptual framework, building on the work of Bourdieu, within which stories of difficult encounters might be interpreted. As Frank explains, the (at times, incredulous) initial response to a story of 'how can they act like that?' (Frank, 2002, p15) is sometimes best answered by an analysis of the way in which people act according to what they understand to be the right way to act. If another person's actions are at first surprising or puzzling, therefore, it is likely that their illusio - or the game in which they are caught up - is not fully understood by the other. Whilst the pair's respective games will likely overlap, the game to which they are each committed is not identical.

3.3.5 Conclusion

In this section, I have outlined several key elements of Bourdieu's theory of practice. Whilst not representing a comprehensive overview, it represents an introduction to the key concepts which underpin the conceptual framework of the present study, and highlights the extent to which Bourdieu's theory of practice works with the notion of experiential learning, in the way that he theorises how repeated exposures to the game allow for an increasing feel for the game.

3.4 Existing Bourdieusian scholarship on birth

In this section, I introduce and discuss existing Bourdieusian birth scholarship. To organise a critical review of this literature, I make a distinction between research that is primarily focussed on the practices of maternity care (that is, the organisation and implementation of practices supporting childbirth) and that which is focussed on the practice of childbirth itself. I find this distinction useful, although it is of course the case that each type of study contributes to an understanding of the broader field of birth, in which these two elements are highly and inextricably inter-related.

3.4.1 Bourdieusian perspectives on the organisation of maternity care

Studies that look at the practice of the organisation of the provision of care to birthing women have been undertaken in Canada, Brazil and the UK. Some of these studies seek to examine the various barriers and facilitators to the implementation (or not) of 'humanised' maternity care (or low-tech midwifery practice). In undertaking their analysis of the implementation of continuous midwifery support in two hospitals in Canada, for example, Jan Angus and colleagues (2003) put forward an interesting discussion of the relative capital held by various members of staff to explain how the implementation project progressed; in doing so, they develop an analysis of how access to capital, and the staff member's position in the field, acts to promote or detract from projects aimed at introducing new ways of working (Angus, Hodnett and O'Brien-Pallas, 2003). Similarly, two Brazilian studies assess the project of introducing 'humanized care' to public maternity settings, employing the Bourdieusian concept of struggle (Progianti and Porfirio, 2012; Mouta and Progianti, 2009). In each of these studies, the explicit identification of issues of power and knowledge work to expose implementation difficulties that often remain unexamined. The findings of these studies provide an interesting contrast to a study of a similar 'humanized care' implementation project in Japan (Behruzi et al., 2010), where Behruzi finds little evidence of any intra-professional struggle, and where success is in large part attributed to the 'women's own cultural values and beliefs in a natural birth' (which in a Bourdieusian analysis could be understood in terms of a supportive patient habitus).

Working further with the idea of struggle within staff teams, Julie Hobbs (2012) has developed an analysis of certain intra-professional tensions in UK maternity settings, focussed on the entry of recently qualified midwives. In this study, the idea of multiple formations of a professional midwifery habitus is developed and Hobbs' careful analysis raises the important question of whether new midwives are inevitably assimilated into the field, taking on the dominant midwifery habitus represented by existing and senior staff, or whether they are able to take up a position in the field that protects their differentiated (for example, a less medicalized) habitus.

Finally, Judith Lynam and her colleagues, in a theoretically focussed piece of work, (Lynam et al., 2007) reflect on the usefulness of applying a Bourdieusian frame of analysis to empirical work, including a piece of research into women's use of cultural resources in the perinatal period. Whilst this paper is designed to demonstrate the benefits of applying a Bourdieusian framework to understand the dual identity of culture as both stable and dynamic, the paper also usefully discusses how a Bourdieusian

analytical approach has, for them, the key benefit of putting the birthing woman centre stage.

Whilst the scholarship discussed so far focuses specifically on the organisation of maternity services, it also usefully starts to build up a picture of the complexities of the field of birth. Most relevant to my own inquiry, however, is the work of scholars Lynam and colleagues, who have sought to develop understandings more focussed on the practice of birth itself, in a way which brings the birthing women more deliberately into the analytical frame.

3.4.2 The practice of birth and the birthing women: Bourdieusian perspectives

Other scholars have commenced their research with the birthing woman as central. In addition to Jennifer O'Brien's work discussed previously (2.1.2), four empirical studies stand out, providing examples of the application of Bourdieusian theory to the field of birth in West Africa, the UK, the US and Iran. In these studies, Bourdieusian notions of capital, habitus and symbolic power/violence are particularly productive in generating novel understandings of the social practices under investigation.

Dominique Behague and her colleagues, focussing on the experiences of women who are affected by near-fatal complications during childbirth in Benin, West Africa, seek to evaluate a new intervention of post-natal patient feedback interviews (Behague et al., 2008). Behague and her colleagues understand this new intervention - which they conceptualise as a change in the field - to be highly useful, providing an opportunity for women to speak up about the care they had received, and how it might have been improved, thus providing an institutionally-authorised space which acts to legitimise women's feedback. As such, the study highlights the increased ability of the birthing woman and her birth supporters to effect change, enabled by this new element of the hospital audit system. Behague and colleagues find that this new feedback opportunity is only taken up by a minority of the women studied, however, and so they also investigate the content of the interviews relating to events during labour and birth; this enables a Bourdieusian analysis of the way in which various forms of capital held by the birthing women and her non-institutionally aligned birth companions (the garde-malades) are converted into capital that is useable in the birthroom, and - importantly - how improvised practices on the part of the birth companions, in the context of disputes with medical staff, offer an opportunity for learning as they help to negotiate this social conflict. It is the resulting transformation of the birth companion habitus that seems to position them well to support the birthing woman in the feedback interview, calling the

provider to account for poor quality of care. Poor quality of care, of course, is not restricted to the global South, and nor is the widespread problem of 'women's evaluative passivity'; thus Behague and colleagues' current study has policy and practice relevance far beyond the study site. The difficulties of sustaining such systems-challenging interventions should not be under-estimated, however (Hutchinson et al., 2010).

The study by Mary Dixon-Woods and colleagues (Dixon-Woods et al., 2006) is not restricted to the social practice of birth, but rather investigates the operation of consent processes for obstetrics and gynaecology surgery. Since twelve of the twenty-five participants in the study undergo birth-related surgery, however, the study provides useful insights into childbirth practice. This UK-based study seeks to understand the circumstances in which women consent to surgery, and does this via an analysis of the 'socially imposed rules of conduct' that operate in hospitals' (ibid., p2742). A Bourdieusian approach to analysis is suggested as offering an elaborated account, and the application of the concepts of habitus, capital and symbolic power/violence is situated within a broader discussion of the relevance of Bourdieu's theory of practice. A key focus of the study is women's generally low access to significant amounts of capital that is valued in the hospital, which it is argued reinforces the symbolic power of the doctor, ultimately enabling a consent process that 'may actively contribute to the disempowerment and disenfranchisement of patients' (ibid., p2752). In this way, the study invites critiques of the operation of the principle of informed consent, and the central message of this Bourdieusian analysis, in its rather pessimistic outlook for the principle of informed consent, is twofold. First, there is the suggestion of the near-impossibility of an effective implementation of informed consent as intended (to enhance patient autonomy and challenge medical paternalism). Second, the possibility of autonomy for birthing women is questioned. In coming to these conclusions, the study highlights the scope for radically different ways of structuring the field, as opposed to an inevitably weak strategy of improvement.

Amy Chasteen Miller and Thomas Shriver apply Bourdieusian theory to their study of women's childbirth preferences in the US (Miller and Shriver, 2012), finding three types of habitus within their study group, which they suggest represent distinct dispositions towards childbirth. Perhaps most fundamentally, this study demonstrates a novel willingness to engage with the notion that individual women are able to hold different understandings of birth, and of safety with respect to birth, and thus different ideas about how they would like to engage in the practice of birth (in a way that is not dissimilar to that proposed in Edward's study of women who choose homebirth in the

UK context, 2.4.5). For Miller and Shriver, this leads to an examination of how such differences in habitus might be accommodated through different choices and of what women might do to achieve their preferences. In this way, the work implicitly engages with Bourdieusian concepts of investment and illusio, and highlights women's agency, already in action at the planning stage of birth, whether a relatively passive role in birthing or a more active engagement is chosen.

This discussion makes for an interesting comparison with the UK context, where the near monopoly of the NHS means, in Bourdieusian terms, that there is less provocation for a woman to consciously deliberate about the type of birth (and thus maternity care) she wants. In this way, the UK seems to offer a more limited discursive space, in which women consider only subsidiary options (such as place of birth, birthing aids and pain relief, decisions which may or may not be accommodated by the NHS), all of these being framed within a standardised model of care. This is significantly different from the plural models of care discussed in Miller and Shriver's paper, where the physician-led pathway, for example, offers a very different model of care to that offered by a homebirth midwife.

The paper is realistic, however, about how women's dispositions – or the acting out of their habitus - might be constrained in the US context, whether for example through the unavailability or lack of affordability of a preferred option. In such circumstances, the study predicts certain clashes between habitus and field, and discusses how different women might seek to manage such clashes. This is suggestive of a productive research agenda in which women's illusio and investment in birth is examined in the context of eventual birthing experiences. The paper also illustrates how women's preferences, and expectations of habitus/field clashes, play out in practice, in individual birth experiences, but the study does not extend to offering insights into how the birthing habitus, in the light of such experiences, might develop over a woman's childbearing career.

The notion of habitus is also key to a study which examines women's place of birth preferences in Iran. This study draws on Bourdieu's conceptualisation of the durable dispositions within the habitus to explain women's resistance to a regime of hospital-based birthing, the local political objective at the time of the study (Saheedi et al., 2013). The Bourdieusian concept of habitus seems to be highly productive in this context, explaining how women's decisions 'make practical sense' and how this contributes to their ability to resist a shift towards hospitalized birth, and the study raises several important questions. For example, given the mortality data presented (which demonstrate good outcomes for home-based births), and beyond the resistance

strategies outlined in this paper, what would be necessary for an effective challenge to the established policy of universal hospitalized birth? Second, the finding that the women in the study manage to preserve their home-birth friendly habitus in face of institutional opposition seems likely to be of broader relevance, whether in the global South, where this institutionalisation of birth continues, or in the global North, where efforts to reverse the institutionalisation of birth are in progress.

In addition to these four studies, I have identified one further paper that has as its central consideration the practice of birth, but into which Bourdieusian theory is fairly loosely integrated (on the basis of a single conceptual term drawn from Bourdieu's theory of practice). In this paper, Kristin Tully and Helen Ball (Tully and Ball, 2013) discuss women's experiences of and explanations for caesarean sections, and offer an interpretation that medically non-indicated caesarean sections, in Bourdieusian terms, might constitute an example of a misrecognition of need, not just on the part of the birthing women but across the care team more widely (see also Klingaman, 2009). Whilst this seems to represent an interesting and possibly highly productive line of enquiry, which complements well the work of Dixon-Woods and colleagues (see above), the implications of this conceptualisation are under-developed, in a way which cast doubts on the likely success of the practice recommendations offered (Tully and Ball, 2013). It is also problematic that the normative objective underpinning the paper, to reduce the number of 'medically unnecessary c-sections', is taken-for-granted rather than itself being subject to sustained analysis; this allows little space in which to explore the possibility that there might exist very different perspectives on this question amongst the various interest groups that the authors hope to target with their recommendations. Secondly, there is also the possibility that the decision to perform a c-section might represent just the latest in a lengthy series of instances of misrecognition that have occurred throughout the course of a particular pregnancy and birth and, from the perspective of the woman, throughout the course of her life more generally. Thus attention to these earlier instances of misrecognition, and their likely embeddedness in the doxa (Bourdieu's notion of the taken-for-granted, that is 'a set of fundamental beliefs which does not need to be asserted' (Deer, 2008, p120)) might be crucial to understanding the object of concern (medically unnecessary c-sections). Such an elaboration necessarily complicates a line of enquiry that is bounded by a keen desire to quickly act to reduce the number of 'medically unnecessary c-sections', but would provide for a richer theorisation of the issues at stake and thus a strengthened basis for action.

3.4.3 How are birthing women conceptualised in Bourdieusian scholarship?

The existing body of Bourdieusian-inspired childbirth scholarship, as I have identified it here, is small and disparate. It can be seen, however, how it evokes and seeks to extend the analysis of long-standing issues of concern in the broader scholarship of childbirth, via a productive application of Bourdieusian theory. In some of these studies, a keen interest in women's agency, and how this plays out in the field, can be identified, especially in how O'Brien (2011), in the Ugandan context, explores women's health-seeking behaviour and in how Miller and Shriver (2012), from a US perspective, identify how women make choices about their birth providers. Saheedi and colleagues' work (Saheedi et al., 2013) is interesting in how it explores the importance of women's knowledge (to keep them in a safe space for birthing); Tully and Ball's work (Tully and Ball, 2013), on the other hand, seems to shift quickly to a focus on the need to improve women's skill and knowledge (to avoid misrecognising a need for a c-section). In these ways, Bourdieusian scholarship certainly starts to move towards an analysis that is highly interested in developing a conceptualisation of the birthing woman as an agent, with the notion of relevant skill and knowledge going beyond what women are able to access, for example, from traditional concepts of antenatal education. None of these studies, however, have worked with the concept of the childbearing career; instead, they focus on analysing individual birth experiences. It is within this gap in the literature that the current study seeks to work.

3.5 Taking a Bourdieusian approach: thinking through its application to the social practice of birth

Bringing Bourdieusian theory into the birthroom is, of course, not without complications. In this section, I focus on three issues: understandings of the concept of mastery, the use of narrative within a Bourdieusian approach, and the use of Bourdieu's metaphor of the game.

3.5.1 Mastery: contested meanings

Mastery (or maîtrise, in the French), according to Derek Robbins, was 'one of Bourdieu's favourite words' used repeatedly in his attempt to 'catch the practical mastery which people possess of their situations' (Robbins, 1991, p1). However it is important to note that the language of mastery is a contested one. Firstly, and most obviously, the word mastery is awkwardly positioned in terms of its highly gendered nature, that is, as a word that is often interpreted as gendered and suggestive of a

particularly male form of action, action which outranks any female equivalent. Given an equivalent word that would be less open to gendered interpretations, therefore, it would seem better to avoid the word mastery.

In the context of presenting Bourdieu's theory of practice, however, there seems to be a good case for retaining this vocabulary, not simply to preserve the authenticity of a Bourdieusian analysis but because its contested meanings, perhaps rather curiously, seem to work rather well in the context of this particular thesis, for reasons which will be explored as the findings of the study are discussed.

Perhaps the most accurate interpretation of Bourdieu's use of the word mastery follows 'the medieval French: *maître*, meaning someone who [is] exceptionally proficient and skilled' (Kleiner, 1994, p194). Closely evoking Bourdieu's usage, Kleiner describes how, in this understanding of mastery, 'there is a sense of effortlessness ... It stems from your ability and willingness to work with the forces around you' (ibid.).

A further important use of the concept of mastery, however, based on its etymological Sanskrit roots, is to signify the idea of 'domination over' something else (ibid.). This usage has been theorised extensively from an ecofeminist perspective by the Australian environmental philosopher Val Plumwood, and drawn on in the context of childbirth by Jeffrey Nall (2014). Plumwood's theory of the master consciousness, is that a dualistic master identity has colonised mainstream culture in Western Europe, an identity which seeks that reason should dominate and control nature (the other) (Plumwood, 1993). In this way, Plumwood problematises a gender-neutral and apolitical reading of the term mastery. For the purposes of this chapter, however, I suggest that Plumwood's concept of mastery is for the moment bracketed, conceptualised as possibly informing different formations of social practice. It will then be a matter of empirical analysis as to whether the social practices of birth as interpreted in this study might fit the conceptualisation of mastery as proposed by Plumwood, or whether social practice within the field of birth might demonstrate a different identity. In engaging in this analysis, the question extends beyond the notion of mastery to questions regarding what form of mastery is best able to support birthing women in the achievement of their goals.

3.5.2 Bourdieu and the role of narrative: focussing on stories and the work that they do

In this section, I discuss the role of narrative accounts within a Bourdieusian analytical framework, drawing attention in particular to a conceptual approach which seeks to identify and analyse 'the work that stories do' (Frank, 2012).

As discussed in 3.1.2 above, central to Bourdieu's theory of practice is that an individual's habitus is continuously informed, or structured, by ongoing interactions between individuals and their social and physical world. Thus the dispositions of the habitus change to reflect the accumulating history of experience over a person's lifetime, based on the experience of being in the world.

It is a central conceptual proposition in this study that the stories that women tell themselves about their birth experiences, representing a process of making sense of those experiences, are highly relevant to the way that they might come to practice birth again in the future. Following Frank (2012), therefore, the study seeks to access these stories and assess the work that they do, in this case in terms of how women come to practice childbirth over their childbearing careers. In this study, I thus explore how personal narratives, and in particular the stories that women tell themselves about their personal birth experiences, might be conceptualised as a key part of the history that, according to Bourdieu, comes to form the dispositions of the habitus, as they are 'inscribed in their bodies by past experiences' (Bourdieu, 2000, p138) .

As Russell Hitchings (2012) and others have discussed, a heavy reliance on narrative accounts is not usually associated with Bourdieu's work. Indeed it is possible to read Bourdieu as being deeply sceptical of the use of such accounts in social research. This position can be understood in the context of Bourdieu's view of practice as intuitive and corporeal, rather than the outcome of consciously rational processes: in this way, the role of the social researcher is to access what is inaccessible to the study participant. In sections of *The Logic of Practice*, Bourdieu goes so far as to declare a reliance on 'native accounts' as 'dangerous' to the social research endeavour (Bourdieu 1990 p102). In his comprehensive exploration of 'Bourdieu's ambivalence toward the self-account', however, Tim Barrett (Barrett, 2015, p2) highlights how Bourdieu himself both seems to utilize elements of self-accounts in his own research and in some places even make claims about the unique and invaluable perspective that they might offer the social researcher (ibid., p3).

In this study, I follow Hitchings in asserting that 'people can talk about their practices' (Hitchings, 2012, p61), and also Frank (2002), who suggests that in listening to people's stories, the researcher may access an understanding about the type of game in which the study participants (and the various characters in their story) are caught up, how these stories are produced in the context of social practice and how these various stories, in turn, come to structure social practice (see also 3.3.4).

3.5.3 The game as a metaphor for social practice and its application to the social practice of birth

Using Bourdieu's terminology of the game, in the context of childbirth, presents a certain awkwardness. In this section, I therefore examine further this conceptual approach, which seeks to improve understanding of social practice by way of applying the heuristic metaphor of the game.

The game is a Bourdieusian metaphor that I apply cautiously to the field of birth, where I am deeply conscious that highly physically and mentally traumatic, and sometimes even tragic, outcomes continue to be experienced by families. Thus in utilising this particular metaphor, it is important to make clear at the outset that its use, as a heuristic tool, in no way seeks to make light of the topic at hand, nor to diminish the important recognition of the immense hurt and suffering that can be - and regularly is (as is evidenced in this study) - sustained in the social practice of birth. It is my firm belief, however, that the analytical purchase provided by this tool warrants its use in this context, although I recognise that it may be a step too far for some readers.

This study thus cautiously proceeds with the metaphor of birth as a game, functioning as an organising framework for an analysis of the social practice of birth as it is conceptualised and practiced by the women participating in this study.

The notion of the social practice of birth as a game is key in providing a dynamic and multi-dimensional conceptualisation of birth in which the social practice of individuals, in this case, birthing women, can be examined, as they are seen to be influenced by personal dispositions (held in the habitus), goals (illusio) and accumulated resources (various forms of capital) as they are able to be deployed in a particular social environment (the field), thus reflecting not just the conditions of the field, but also one's individual position in the field (representing positions of power). As such, a birthing woman's social practice will reflect all of these factors, and represent their skilful and knowledgeable response to what they intuitively know or feel they need to do, within the environment in which they find themselves and with the resources to which they have access.

As I present an analysis of the diverse ways in which women come to master the social practice of birth in subsequent chapters, I suggest that an important point of reference might be provided by an early conceptualisation of the social practice of birth as it might relate to a straightforward physiological birth (not least to note, especially in chapter 7, how so little of this basic 'physiological game design' so often remains). The physiological game of childbirth might thus be conceptualised as follows:

This a game in which birthing women – the main players - are generally able to succeed. On the one hand, the game design is beautifully intricate with many inter-connected and component elements (in the birthing body), but on the other, for the birthing woman, it is at its core a very simple game. The game requires very little in the way of explicit preparation or equipment; the necessary game environment is a simple one; the game unfolds in its own time and at its own pace. The birthing woman is at the centre of the game, perhaps as the only player (or one could conceptualise her unborn baby playing along with her), in what is a non-competitive game of skill (much of which is already held within the body).

To continue, women generally start with a good ability to play the game, but are anyway given the opportunity to hone their game-specific skills as the process unfolds; there are different stages in the game, with different skill sets needed at different phases. The game design, to use gaming terminology, includes access to physiological power boosts (oxytocin) and time outs (for example, the 'rest and be thankful' stage), and pain relief is also available (endogenous opioids) to help women make progress through the game. Like many other games, physiological birth is designed to elicit emotional responses from its players, such as hope and fear which together create suspense, which serve to motivate players towards the game objective. In this context, the achievement of high oxytocin levels might be considered to be a secondary or intermediate goal of the game, and, in contrast, the build-up of a high level of adrenaline might threaten the progress of the game.

How a woman is making progress through the game cannot be measured easily in a linear fashion, as advances may be followed by set-backs (for example, as with cervical dilation), but the achievement of each stage of the game is clear. Sometimes the game involves obstacles (for example, the need to resolve an inefficient positioning of the baby, or to deal with emotional issues on the part of the birthing woman that might be blocking the productive release of oxytocin and endogenous opioids). But these obstacles can be overcome with a good technique - if not by the woman alone, with recourse to external resources.

Some women play the game more than once; in these circumstances we would expect women to play more skilfully each time. Even where new games involves different and greater obstacles, her experience and familiarity with the basic design of the game should serve her well.

This conceptualisation is not intended to represent an ideal. As Becky Mansfield (2008b) reminds us based on her own autobiographical scholarly account (see also Halfon, 2010), the practice of childbirth is always a highly social practice whether the mode of birth is an undisturbed physiological birth or a birth which accesses a whole range of hi-tech interventions. From that perspective, the conceptualisation above underestimates the social nature of a physiological birth practice. In the later chapters of this thesis, and in conversation with the game presented here, questions may be posed, however, about the extent to which childbearing women can and do create a certain type of game of birth for themselves, for each of their successive births, drawing on their experience and knowledge. Or is the game effectively standardised and set out for birthing women before they join, in a way which renders useless women's experience and knowledge? This discussion engages, inter alia, with a long-standing debate about choice and control in childbirth. I will return in the final chapter to suggest that it sometimes seems as if many women would in some sense prefer not to participate in the game of birth, or more precisely in the particular form of the game of birth available to them. This raises the question of how it is that women seem to come to take part in a game that does not always seem to be of their choosing. What might need to change to make for a more desirable game?

3.6 Conclusion

In this chapter I have examined the potential usefulness of a Bourdieusian analytical lens for the purposes of this study, to allow for a conceptualisation of birthing women as skilful and knowledgeable agents. In making this choice, I build on the theoretical work of scholars within the discipline of human geography, who have also considered that the theoretical tools offered by Bourdieu allow for a usefully politically-engaged approach to understanding the social world across a range of issues. I also build on existing childbirth scholarship which has similarly taken a Bourdieusian perspective. I have introduced key elements of Bourdieu's theory of practice, and argued that a Bourdieusian theoretical approach is well-placed to underpin an investigation into a conceptualisation of birthing women as skilful and knowledgeable agents in the field of birth, through a close examination of women's practical mastery of the social practice of birth. In doing so, I have explored how such an approach usefully insists upon the task of reflecting upon, rather than making assumptions about, women's starting points and goals with regard to childbirth, requiring individual illusio and investment to be empirically investigated rather than taken for granted.

One of Bourdieu's key arguments was that theoretical tools are nothing if they are not applied to the empirical context. In Chapter 4, we thus prepare for a shift from the study into the field, to examine the construction of an empirical piece of fieldwork through which the Bourdieusian analytical framework can be examined, and its usefulness assessed, in the context of the current study. In the next chapter, therefore, I introduce the detailed study design of the empirical study that constitutes a key part of this thesis.

Chapter 4 Research design: methodology and methods

In the context of the previous chapter (Chapter 3), in which the Bourdieusian conceptual framework for this thesis is established, this chapter presents a discussion of the study methodology, and presents, and illustrates the application of, the research methods adopted. Key to this study is an integrated ethics approach. Whilst this is also the focus of a separate section (4.5), the implications of this approach are highlighted throughout the chapter, as I draw attention to the integral nature of this approach in discussing research design issues (4.2), data collection strategies (4.3) and post-fieldwork issues (4.4). One particular set of issues concerns how researchers manage research situated in their local community. This underpins a detailed account of participant recruitment strategies (4.3.3). I also explain in detail the analytical approach adopted in this study with regard to managing and making sense of the rich and detailed primary dataset created (4.4.2). In the final section (4.5), two illustrated methodological examples (discussing participant consent processes and the need to safeguard participant well-being) demonstrate the opportunity established in this study for original ethical reflection.

4.1 Establishing the methodological approach

4.1.1 Epistemological and ontological implications of the research focus

As set out in the introduction to this study (Chapter 1), the initial study aims were:

- to investigate how women conceptualize and experience personal childbirth knowledge, especially as it develops experientially over a childbearing career, including its creation, development, communication and utilisation;
- to investigate the status of such lay knowledge in the UK's contemporary hegemonic birthing culture, and in particular in the context of the 'normal birth' agenda;
- and, based on the above, to assess the potential contribution of lay knowledge to the broader UK childbirth knowledge management and improvement strategy, and to explore any implications.

Two important ideas behind the establishment of these aims - both of which reflect gaps in the existing literature - have been key to the study throughout. Firstly, I wished to foreground the birthing woman in my inquiry, and in particular to take seriously the idea that the birthing woman is able to play an active and influential role in the social practice of childbirth, beyond that of a 'birthing machine' or mere 'vessel'; this sits well

with a tradition in human geography that seeks to recognise 'people as knowledgeable social agents' (Cope, 2010, p31). In doing so, this research contributes to feminist scholarship on the agency, knowledge and skill of birthing women. Second, and related to the first idea, I wished to develop the concept of the childbearing career, to understand its potential purchase in theorisations about the contemporary practice of childbirth in the UK.

These two related ideas suggest a number of questions, which I have approached through a Bourdieusian conceptual lens. For example, and from the perspective of birthing women, what can women know about birth? What is birth? Does the process of birth matter? Is the way in which an individual childbirth experience unfolds a matter of chance/luck/fate, or is it in some sense controllable, whether by the birthing woman or others? How do women associate themselves with the process of birth? Can a woman become more skilled at birthing over her childbearing career? What constitutes such skill?

In order to examine these questions, this study works with an assumption that different, and sometimes overlapping, perspectives will be held by those involved in the social practice of birth, including the childbearing woman. It also works with the assumption, established in the feminist geography tradition, that 'listening to real people to explain what [is] going on in their lives' is important (Cope, 2010, p40). On this basis, this study works particularly to foreground the narrative accounts of childbearing women as representing a valid perspective, or form of knowledge, concerning the practice of childbirth. An underpinning assumption of this study is thus that 'our understanding of [the] world is inevitably a construction from our own perspectives and standpoint' (Maxwell, 2012, p5), and this suggests an epistemological stance based on a social constructivist (or an interpretative) perspective. Ontologically, this study seeks to highlight the inherently material and embodied nature of the physiological process of birth and of the birthing body. Alongside social constructions of the practice of birth, there is thus a physiology of birth and of the birthing body 'that exists independently of our perceptions, theory and constructions' (ibid., p5). I take this to be indicative of a realist ontology. Taking this realist ontology together with a constructivist epistemology, this study follows Maxwell's notion of a critical realist perspective (Maxwell, 2013 and 2012).

4.1.2 Identifying a methodological approach: the case study

Charles Wright Mills famously warned of the dangers of becoming dogmatic in relation to methodology (Mills, 1959). It is with that warning firmly in mind that I introduce the

research approach taken in this study, which is perhaps best described as based on a case-study approach. This is a methodology employed frequently in human geography, often without being identified as such (Baxter, 2010; Castree, 2005). This approach allows a researcher to choose 'a specific example within time and space' to 'allow a particular issue to be studied in depth' (Kitchin and Tate, 2000, p225), and thus to 'delve into under-explored and thus under-theorized phenomena' (Baxter, 2010). The validity of the case-study approach is underpinned by a belief in the benefits of an ideographic, or depth-oriented, approach, as opposed to a nomothetic, or breadth-oriented approach, to research (ibid., p85). As such, it is highly congruent with a research question that is to be approached qualitatively, with an interpretative epistemology and a realist ontology.

Working within a social studies case-study methodology tradition, researchers use a variety of data generation and analytical strategies, a common method of data generation being the qualitative interview (Kitchin and Tate, 2000). Analytical strategies are employed to ensure that the analysis is not overly empirical (Stark and Torrance, 2005). One such analytical strategy is to foreground, as the study progresses, the question 'what is this a case of?' (Ragin and Becker, 1992). As Ragin explains, this is not a question that should be asked prospectively, but its answer is rather an outcome of developing understandings of the phenomenon being studied. Indeed Becker has argued strongly that '[researchers] probably will not know what their cases are until the research, including the task of writing up the results, is virtually completed' (Ragin, 1992, p6). An attitude of openness to this possibility (or perhaps certainty as Becker suggests, if the research is carried out effectively), rather than an early concern with defining the case, would seem to meet one of Castree's key concerns with the widespread use of this methodological approach, when he questions the ability of empirical case research to provide 'wider' lessons (Castree, 2005).

4.2 Research design

4.2.1 Selection of methods

Given the study's interpretative framework, and my specific interest in exploring meanings associated with women's conceptualisations of birth and their role in it, and more specifically their understandings of their own knowledge, power and agency associated with birth over their childbearing career, a qualitative data collection strategy which allowed for such an exploration was selected.

I ruled out early on any form of longitudinal design, despite its enticing methodological fit with my focus (Neale, Henwood and Holland, 2012). Whilst I appreciate the particular benefit of such a design in terms of the collection of contemporaneous data at various stages of a woman's childbearing career, I considered the resource implications of such a design infeasible, in terms of the length of time available for the completion of the study. I judged that the time it would take to design such a study, gain ethical approval, recruit participants, follow these women through their childbearing career, and then complete the analysis and preparation of a thesis would likely exceed the time limitations of a PhD programme, not least in light of the unpredictability of birth timing within women's childbearing careers. Thus I decided to access data that were retrospective in nature, in which women recounted and reflected upon their childbearing career.

Many researchers turn to a focus group methodology in order to understand the meanings and values that individuals ascribe to various aspects of their lives. This approach has been noted for its ability to elicit accounts from individuals about their own perspectives, which can be hard to secure in a one-to-one interview (Clark, Burgess and Harrison, 2000). I decided that this method would not be appropriate for this study, however, both because it would be a difficult process to manage as a solo researcher and because a high research priority was to provide an extended and confidential space for each woman to explore her own childbearing career autobiography. These considerations led me towards favouring the traditional one-on-one interview.

The chosen method of data collection was thus a face-to-face interview with each participant. Whilst rapid changes in technology have meant that researchers are increasingly inclined to consider alternative formats, such as telephone or internet-based interviews (with or without video), I believed that personal face-to-face interviews would be more appropriate for the proposed study. And indeed when women were narrating their childbearing biographies in this study, I noted how these narratives became a performance; this was signified by women switching into the present tense, rehearsing words as they recall they had been spoken at the time, and bringing a wide range of emotions into their narratives. I felt that this highly emotional staging of the events being narrated was both enabled by, and warranted, a physical audience. The face-to-face nature of the interview not only ensured an audience (in the form of me, the researcher), which I believe was crucial to the performance, but it also allowed me to witness the non-verbal data included in the story being narrated and engage in active listening.

4.2.2 Research integrity checkpoint: are primary data necessary?

It is important that research interventions involving people are made only when justifiable (although this seems to be a somewhat muted concern with regard to research leading to qualifications, on the basis that students need to practice their craft). Thus a key question in designing qualitative research is the appropriateness of collecting primary data. Given the availability of secondary data sources (existing collections of childbirth narratives), I therefore considered whether these could have been used as the basis for this inquiry. It was also important to recognise the resource implications of research design decisions: in this case, creating even a small set of primary data would be more resource-intensive than accessing secondary sources.

Over the course of the study, I became increasingly confident that there were persuasive methodological arguments in favour of primary data collection. For example, in developing the study design it became important to specify a set of women's narratives about their childbirth experiences that were well-contextualised in terms of information about the local maternity services. It was also important that the data would be relevant to my particular focus. The setting up of the interviews, prefaced with a particular description of my purpose, called on women to prepare and perform a specific autobiography with respect to their childbearing career, allowing me to create an elicited biography (Milligan, Kearns and Kyle, 2011) unique to this particular research situation.

Related to this, I considered whether or not it would make a difference for me to be physically present during the data collection phase, in order to support the subsequent analysis and theory development. As the study progressed, as indicated in the previous section, I realised that my presence in the interview proceedings had paved the way for a deep connection with the data. The experience of sitting with a woman as she told her story had the effect of increasing my appreciation of the embodied emotionality of the experiences she was relating, as well as enabling initial understandings of the worldview that drove her social practices; both were key to my ongoing interpretation and analysis. Thus for this study, primary data collection element was a highly productive element of the study design.

Given these considerations, I was confident that the creation of a new set of primary data was ethically sound. On that basis, I engaged in a process of primary data collection to achieve what I understand to be a highly constructed dataset, consisting of data essentially co-created in this research study as a result of the interactions between interviewer and interviewee.

4.2.3 Qualitative interviews: aims, design and feasibility study

The semi-structured interview was designed to give each woman a high degree of freedom over the way in which she would relate her childbirth experiences, balanced with my desire to ensure that data were produced that addressed the key focus of my inquiry. The activity of women telling their birth stories is not an extraordinary activity, but rather one that is produced on a regular basis, whether in the context of post-natal groups set up for this purpose or as an activity amongst friends and family. I considered the routine nature of this activity as providing benefits as well as risks to my data collection strategy. On the one hand, these are stories that are 'there for the taking'; many women will be familiar with the activity of relating their birth stories, and will have constructed and performed these stories previously (albeit in different contexts, with the stories taking different forms). I thus I expected most participants to be prepared to engage well with the interview task. On the other hand, I was concerned that this familiarity might lead to a more restrictive telling than desirable for the purposes of the study. For example, I was unsure of the extent to which women would 'package their individual birth experiences together', or whether the accounts would be disjointed and provide little clues about links between individual childbirth experiences. As a way of signalling this broader interest, however, I decided to make clear as I commenced the interview that a convenient place to start the narrative would be with hopes and expectations prior to the first birth.

Whilst my thesis focus was clearly predicated on the concept of the childbearing career, the sparse literature to support this concept suggested that a key objective of this study would be to scrutinise this. I was therefore unable to predict the form in which women would tell me their stories: do women believe that there are important and meaningful connections between their individual birth experiences? Where they do, to what extent are such connections valued as important in the context of telling their stories? Whilst I was keen to collect data which would evidence both connections and suggestions of disconnections, I was also prepared for some of that evidence to be a product of my analytical task. On that basis, I was not confident to establish an interview structure that depended solely on an elicited narrative, but instead opted for a design with a two-part structure. In the first part, I invited the participant to share with me an account of her childbearing career, without making reference to any specific issues that should be included, essentially providing a space for an autobiographical account. I was hopeful that sufficient data relating to my inquiry might be offered in this first part of the interview encounter. To manage the risk that this would not be the case,

however, I planned a second part of the interview, taking the form of a traditional semi-structured interview.

For the first part of the interview, I made an assumption that most if not all women would provide substantive narratives, organised chronologically. My interventions during this part of the interview were designed to be minimal, and focussed on encouraging the inclusion of the 'in-between bits' - that is those elements of the account covering the run-up to the birth and period afterwards - which might not traditionally feature in the stories women tell about their births. Thus whilst my interventions were to be generally limited to non-verbal active listening, some verbal interventions were planned. I also envisaged that I might ask for clarification to aid my ability to follow the story being told, where I felt that this was unlikely to disrupt the narrative.

In the second part of the interview, I expected to achieve two objectives: first, I intended to focus the conversation on issues already raised, where I felt that a second telling, or more detail, could provide me with a better understanding of the woman's perspective; secondly, I would ask questions about what I had identified as significant gaps in the initial part of the interview (importantly, not on the basis that these gaps were somehow 'there for the filling', but to support my later analysis, which would take seriously the significance of silence and muted accounts). On this basis, a short interview guide was prepared (Appendix A), to be used as a prompt during the interview.

Working with this basic design, I felt that a single interview encounter with each participant would be sufficient, although I recognised that it would also be important to leave open the possibility for a follow-up encounter. Whilst I was committed to managing the encounter so that the key interview objectives were met within the agreed timescale, I also wanted to provide the scope for participants to participate over two shorter sessions if that was their preference.

In the current study, I felt that it would be useful to undertake a pilot study to 'refine data collection strategies' (Morse et al., 2002, p20; see also Kim, 2012), and in particular to verify the appropriateness of the primary data collection method (in-depth semi-structured interviews with a large narrative component): how well was this method likely to result in sufficient data related to my study aims? More specifically, would this method lead to women talking about their birth experiences in such a way that would allow me to analyse rigorously their talk (and silences) in terms of (their own) agency, knowledge and power? Given this clear and limited objective, and my access to a

relevant set of data created during a recently completed study, I decided to undertake a small desk-based feasibility study. The previous academic study had used a similar data collection method, albeit focused on a different aspect of the childbirth experience (in that case, women's experiences of choosing where to give birth). I thus revisited three randomly selected interview transcripts, seeking to assess how successful this method had proved in encouraging a set of elicited autobiographies that were likely to provide a solid dataset for the current study. From women's elicited narratives alone, I was rapidly able to identify plenty of rich data of relevance to the current study's focus; in some cases, however, I identified that some follow-up questions would have been highly useful to aid my interpretation of the data. In this way, this small feasibility study gave me confidence that the planned design would be productive for the current study. It also provided confirmation that the planned second part of the interview would likely provide an important function.

As the study progressed, I had the opportunity of reflecting on the interview design in the context of the interviews themselves. As expected, narratives provided in the first part of the interview were generally substantive and included rich data on my area of interest. Indeed in three cases, the first part of the interview seemed to be so successful in providing a complete dataset in response to the study objectives that a second part seemed unnecessary. For the majority of interviews, however, the data benefits of the second part of the interview were clearly apparent.

4.2.4 Contextualising the study: the accompanying reflexive research strategies

Whilst a discussion of my approach to primary data collection and handling is foregrounded in this chapter, an important part of the research strategy was reflexivity and contextualising the primary data, and to present an empirical study without making reference to such work would have the effect of erasing from the record this key part of the research endeavour.

First, in the traditional mode of reflexive researcher, encouraged by Bourdieu's methodological approach, I have sought to recognise and subject to scrutiny the existence of prior assumptions and ways of thinking that I brought to this study. Secondly, and reflecting on the inevitable presence of such ways of thinking, I sought throughout the project to extend my familiarity and understanding of other perspectives.

To operationalise these strategies, I included a range of activities in the research schedule. These included exercises to determine and reflect upon my own positionality with respect to the topics under consideration (including an in-depth analysis of the

initial set of research questions and reflection on my own childbearing career, a career which was itself ongoing, before being completed, during the period of this inquiry). As part of this approach, I established early on a deliberate strategy to engage with a range of differently positioned literatures beyond the discipline of geography. Whilst there might seem to be little risk involved in such an engagement, it was interesting to experience first-hand the risk of 'going native', to borrow a term from the ethnographic tradition, through such reading, and becoming completely captured by the standpoint represented by those literatures. In a similar way, I noticed the risk of only superficially engaging with literature that presented ideas that seemed at first to make little sense to me.

As the study progressed, I participated in seventeen birth-related conferences, organised by thirteen different organisations. This served many purposes, which included providing highly productive opportunities for me to share my emerging findings with fellow researchers; opportunities to build up and develop a small network of peers working on birth-related research; opportunities to develop a deeper understanding of the context in which some of the key inter-disciplinary literature is produced; and an opportunity to develop a greater insight into ways of conceptualising and practicing birth that were beyond my own personal experience. Each conference participation contributed in a different way to the strengthening of the current inquiry.

Participation in a UK conference organised by Midwifery Today (a US organisation whose conference mission is to promote midwifery skills worldwide) was highly productive, for example, in exposing me to understandings of birth that were far removed from the understandings that seemed to be held by many of my study participants. For example, it was presented as entirely obvious in the context of that conference that the early phase of labour represents an important foundation for a successful labour, that it should be protected as such, and that disruptions at this stage are to be avoided, since they are likely to be associated with later complications. I was able to contrast this perspective, whilst analysing my primary data, with the taken-for-granted high level of disruption that study participants regularly reported during that early labour phase (6.1). As this example illustrates, this accompanying research activity had the effect of providing a basis on which the discourses embedded in my participants' accounts could be denaturalized, identified as social constructions and subjected to critical scrutiny.

Over the course of this study, I have retained an ongoing membership of various birth-related online discussion groups, which has given me access to a range of different perspectives on birth-related issues. In terms of organisation memberships, I became a

member of the NCT at the beginning of this inquiry but allowed this to lapse after a short period. I have also been, and continue to be, a member of AIMS (the UK-based Association for Improvements in the Maternity Services), and have contributed writing for their membership journal. I decided that withdrawal from my membership of a local Maternity Services Liaison Committee was appropriate, however, from the point at which I began to collect confidential data from participants related to local maternity services.

As expected, the insights gained from these activities were crucial to the analysis of the primary dataset, which involved subjecting to scrutiny taken-for-granted discourses. The question of whether it is ever possible to achieve sufficient knowledge and distance to do so, or to completely stand outside and examine such discourses, is an ongoing debate in the social sciences (Waitt, 2010; p224). This study represents a tradition in which it is accepted as a key task of the researcher to at least attempt such an examination, in order to produce compelling and insightful interpretations of everyday practices.

4.3 Data collection strategies: decisions and practice

4.3.1 Choosing the study location

Another key decision related to the location of the study. The face-to-face interview design suggested the benefit of participant groups that were geographically co-located. In that context, I also needed to decide whether it would be beneficial to design a multi-site study, or whether a single site would suffice.

As already highlighted, it was important to the study's aims to access participants who were likely to offer a high level of diversity in terms of birth experiences, and birth experience combinations, and that such birth experience diversity amongst the participants did not simply reflect differences in the maternity services accessed. It was also important, however, that the study was not restricted to findings that were highly situated in the practice of, for example, just one particular community midwifery team, one community midwife, or one particular institutional maternity setting. I thus decided upon a study design that partially controlled for differences in local maternity service cultures, by opting for a single-site design (in which the residential and/or employment status of participants was geographically close). Given women's access to choice with regard to NHS maternity services, I was confident in making this design selection that the study data would offer some important variation in service provision.

In the selection of this study location, I also considered it important that the maternity services accessed by the study participants had not recently been affected by any extreme events (such as a significant quality warnings). Subject to this proviso, I considered the selection of the study location as relatively unimportant to this study's objectives. On that basis I selected the area in which I lived to locate the study, a semi-rural area in the North-West of England, for which I had existing basic knowledge about local maternity service arrangements (from my experiences as a service-user and as a member of a local Maternity Service Liaison Committee).

A key factor in this decision related to its potential benefits for the generation of good quality data. For a study of this nature, it is necessary to access women who are able and willing to offer up rich data regarding their different childbirth experiences across their childbearing careers. The study design thus depended on my ability to access a group of such participants and then to create the conditions in which a rich dataset could be generated. In both of these areas, the establishment of my credibility and trustworthiness as a researcher would be key. I judged that this would be enabled by my insider status, as a known fellow parent in the local area. I was also confident that my existing position within the study location would contribute positively to my ability to establish a good level of rapport with potential participants. This turned out to be correct: even where I had not - or hardly - spoken to a potential participant before the initial recruitment approach, for example, this effect seemed to be enabled by over-lapping networks of social contacts.

Whilst it would certainly have been possible to site the study in a different location and meet these objectives, there seemed to be no strong reasons to reject the benefits described above. A number of potential drawbacks were considered. For example, it could be the case that some potential participants could be deterred from discussing highly personal issues where the researcher is known to them as a member of their local community. In that case, such a researcher status might act to constrain, rather than enable, the flow of information in the interview context. I considered this risk to be low. Also, given the relatively homogeneous population in the area, this decision had implications for the level of social diversity present amongst study participants; in that context, I judged that a focus on social diversity amongst the participants was not key to this study, not least because the small size of the study would not allow for any robust conclusions on the basis of different social positioning of individual participants. Whilst I consider the case for seeking to explore the study's conclusions further in relation to differently positioned groups of women a strong one, resource constraints

and the depth-focussed research methodology on which this study is based precluded such an extension in the current study.

4.3.2 Participant selection criteria

26 women, with 68 birth experiences between them, participated in the study. During the study design phase, I estimated a need for between 20 and 30 participants. On the basis of my previous research, I expected this number of participants to be likely to offer a sufficient level of diversity in terms of different types of birth experiences and combinations of birth experiences, in turn providing enough rich data to enable a detailed exploration of the research questions. Balanced with this from an ethical perspective, this number of participants would represent the minimum number necessary to achieve the study aims.

The initial participant inclusion criteria was for women living, working or accessing services in the study area who had an experience of giving birth within the previous three years and who had given birth at least twice. Given the interview design, I was confident that women with just two birth experiences would be able to offer rich material with which to work. Nevertheless, and given the study's central focus on how women's thinking about childbirth might develop over their childbearing career in the light of successive childbirth experiences, a further selection criteria was that women with a longer childbearing career, with three or more experiences, should be well represented in the study group. Finally, I was keen that the majority of study participants had given birth recently, no more than a year before our interview, to underpin the study's positioning as relevant to contemporary birth practice.

A critical, but difficult to manage, inclusion criterion related to ensuring a diversity of childbearing experiences amongst the participants. Whilst I was keen to ensure the inclusion of women who had experienced a wide range of childbearing experiences, I felt that it would be very difficult to pre-screen women on this basis. On a practical and ethical basis, such a screening would be difficult to achieve without adding a significant new stage to the project, since it would require the - potentially upsetting - exchange of personally sensitive data during recruitment, before any necessary consent or support structures had been put in place. Politically too, such an approach also suggested difficulties, as I was keen to uphold the standpoint that 'all stories count'; I felt that it was one thing not to approach a woman who I had good reason to believe lay outside my considered inclusion criteria but quite another to approach a woman only to decide that I should reject her experiences. My research experience suggested that this criteria would be easily achieved through a strategy of interviewing a fairly large group

of women as envisaged, and this did indeed turn out to be the case. Nevertheless, this wait-and-see strategy - as I considered whether the data coming in from the interviews was cumulatively adding up to a sufficiently rich resource for analysis - represented a risk to the project which would have needed to be addressed, if it had materialised, by increasing further the number of women recruited to the study.

As recruitment proceeded, I found that a conflict seemed to exist in the local area between these criteria. In particular, the objective to interview women only if they had given birth within the last three years seemed to exclude many women with more than two birth experiences. Thus I relaxed the 'recentness of birth experience' criteria in order to allow the inclusion of women who had three or more birth experiences and to improve the diversity of experience. The youngest children of eight of the women included in the study were thus older than the initially-targeted three years old; in each of these cases, the women had given birth three times or more. Included in this group was a woman who had given birth at home, an experience that was relatively unusual in the local area. Given the likely significant enhancement of the diversity of my data, I invited this woman to participate in the study, despite her youngest child being seven years old at the time of interview.

4.3.3 Participant recruitment: strategies and outcomes

Recruitment took place in three phases between September 2011 and November 2012. Key to this stage of the project was to recruit a suitable number and range of participants who met the established inclusion criteria. But this objective also needed to be seen in a broader context of delivering an ethically and well-managed study. For example, I wanted to be as sure as possible that each of the women would be participating voluntarily in the study, rather than feeling obliged to participate in any way. I also needed to pace recruitment carefully, in particular being aware of the small numbers of participants needed for the study as well as the inevitable ruptures in the process reflecting the local academic year. For these reasons, each phase of recruitment was designed to take place as a rolling process, and consisted of a number of distinct stages. At any one time, there would be a number of women at each stage of the recruitment process, and it was necessary not only to keep good records of this, but also to have them firmly in mind, to ensure that I was ready for any chance encounters with potential participants. This process was aided by a paper-based recruitment tracker.

Working with the study inclusion criteria, the majority of the potential participants were identified through my existing extended social networks. From this I drew up an initial

list of potential participants; this list developed over the period of recruitment. This list was not a convenience sample of 'friends', but rather drew on my knowledge of the local population of mothers with young children meeting the recruitment criteria, in particular reflecting my ongoing engagement with the local school and pre-school. Roughly half of the potential participants on this list represented women with whom I had previously had some contact (for example, some of these women had a child of a similar age to mine, and we had met at local events), and this proportion carried through to the selected participant group. I was on a more intimate footing with just two of the participants at the time of the interviews (for example, having visited each other's houses); one of these I would refer to as a personal friend. Four more women have shifted into that latter category since the interviews took place.

Potential participants meeting the study criteria were approached and told in broad terms about the research. Given the small number of participants required for the study, not all of the identified potential participants were approached at once. The purpose of this first approach was to tell the woman that I was undertaking a programme of study and that I was looking to interview local women about their childbirth experiences. These initial approaches were usually made in the context of naturally-arising opportunities, for example at parent and toddler groups, at pre-school and school drop-off/ pick-up gatherings and at other local family-focussed events. In addition, some identified participants were contacted by email and telephone (where I did not expect to meet them in the course of daily routines). During these initial approaches, the possibility of participation was discussed. Depending on the woman's reaction, I would ask her if she would be willing to read an information sheet about the project. All but three of the women approached in this way expressed a willingness to get involved in the study.

If the potential participant suggested an interest in participating in the research, this interest was followed up by the provision of a written information sheet about the research (see Appendix B), generally a few days later when I next encountered the woman. I made clear that there was no rush to respond, since I was keen that women took away the information sheet and read it carefully, rather than glancing at it and saying yes on the spot, as some seemed inclined to do. I also made clear that taking the information sheet did not signify any obligation to participate.

If the woman had not approached me to signal her decision within a week or so, I would make a third contact with the woman at the next available opportunity to ask her if she had had a chance yet to read the information sheet. In most cases, the women at that stage agreed to participate. We then agreed to talk again to get a date in our

diaries for an interview. At this stage I considered that the woman had been formally recruited to the study. I then instituted what was intended to be an informal cooling-off period, with the making of precise arrangements for the interview during a fourth contact being delayed for roughly a week (or longer if school holidays intervened or were coming up). The intention was that women would thus have a further opportunity to make their excuses if they were not keen to participate in the study.

At times, it felt particularly challenging to make space for these various recruitment contacts. As an example, for the purposes of recruiting in the school playground - relevant to eighteen out of the twenty-six successfully recruited participants - I decided to focus the majority of my recruitment efforts in the afternoons in the few minutes between the parents gathering and the children being dismissed. This very short timeslot meant that I had to be very well organised, since the opportunities for even quick conversations were highly limited, and often precluded; barriers to an effective recruitment opportunity included my chosen 'targets' being absent, already engaged in conversation and inclement weather, which I found produced a marked disruption to usual pick-up routines (as well as soggy recruitment trackers consulted en route).

Over time, I noted how this recruitment work was a lot more laborious and made a more significant impact on my daily life than I had expected. For an extended period, I was no longer free to walk up to school each afternoon relatively carefree. Rather, as I set off for school I would check the recruitment tracker in my pocket, to refresh my memory of how things stood with the women I might encounter that day. I generally had a priority list of women I wanted to approach. Coming into the playground, I was on alert, in case an opportunity opened up to make an approach. I was fortunate to have a friend who understood the situation and was ready both to stand and chat to me but also to break-off our conversation as soon as I signalled the need to go and talk to a potential participant. I was interested to note the relief I experienced when the final interview arrangements had been completed. In retrospect, I realised the significant emotional labour of the recruitment task. I was on show in the field, and had in a short period of time formed new relationships with many women who had previously been relative strangers to me. That these relationships were formed on the basis of a need that only I (and not they) had (that is, to recruit participants for my study) seemed to explain in part the stress involved in the task. More generally, I surmised that being 'on show' in the field is more onerous than generally considered, not just when this is an unfamiliar and exotic field, but also when one is an existing member of the field.

4.3.4 Creating a space for productive interview encounters

Key to the research design was my desire to create a space in which the study participants would feel comfortable and welcome to share a substantive narrative about their childbearing careers. If I failed to create such a space, I was concerned that participants would not share with me narratives of a sufficiently high quality to allow for productive analysis, reflection and thesis development. In this section, I describe how I went about this task, and consider some possible success indicators.

The task of creating a space for a productive interview commenced well before the interview session itself, both in the written material shared with potential participants and during all pre-interview contacts. In this period, I sought to ensure that participants would be able to recognise the trustworthiness of the research process: I was not a researcher, albeit a student researcher, who would play fast and loose with their personal stories. In the rest of this section, I will discuss how the practical arrangements for, and conduct of, each interview were also designed to create a productive encounter.

Once a woman's agreement to participate in the study had been assured, and in order to ensure the least possible disruption to her daily routines (and also the maximum likelihood that the interviews would go ahead), she was asked to choose a timing and venue for the interview. At this stage participants were assured that they were free to change these arrangements, even at short notice, if they turned out to be inconvenient. A number of women took advantage of the possibility of rescheduling the interview, as did I on one occasion; all of the requests for rescheduling were accommodated and these interviews were successfully completed albeit with some delays.

In setting up the arrangements for each interview, I sought to ensure an interview space, or a microgeography of the interview location (Elwood and Martin, 2000), that would be quiet, private, uninterrupted and relaxed, as well as being highly convenient for each participant. The majority of the interviews took place during the day and often commenced as soon as any older children had been taken to school or pre-school. Babies and very young children were generally present at these daytime interviews. A small number of interviews took place in the evening. None took place at weekends. According to their various responsibilities and schedules, participants were evenly split on the choice of location for the interview, with me travelling to the participant's home for about half of the interviews, them coming to mine for a similar number. One participant suggested that we should conduct the interview in her workplace, and this turned out to be quite suitable, offering us complete privacy and no interruptions.

Participants with younger children present at the interview all chose their own homes as the interview location, and this helped to ensure minimum disruption to the interview process, as children were free to get on with many of their usual activities in a known space. The evening interviews were conducted in the homes of the participants.

In setting up the interviews, I was careful to ensure that participants expected a fairly lengthy session. Participants were asked to make themselves available for a single interview, which was expected to last on average between one and two hours. Participants were also told that single follow-up interviews might also be requested, for example if there was too much material offered by the participant to be sensibly covered in a single session. This was intended to be the exception, and in the event just one interview was held over two sessions at the request of the participant. I believe that the elements of repetition provided for in the interview structure, and the sheer length of time provided by this interview format, served an important function in achieving the data collection objectives. I observed how women's stories would evolve through the period of the interview. In some cases, highly significant information would be offered very late in the interview.

Regarding the daytime interviews, for most of the participants with pre-school aged children, the key time constraint was their need to pick up children from the local pre-school or school. The then two and a half hour length of the local pre-school session proved ideal for the purposes of the interview process, with all but one of the women with children at pre-school seemingly happy to devote the whole of this session to the interview. These experiences tended to set the pace for the subsequent interviews, with interviews at other times of day and without those particular time constraints following a similar pattern in terms of the length of the interview session.

At the scheduled time of the interview, both the participant and I were ready to move into work mode straightaway. Following a short discussion of the recording equipment to be used (a small digital recorder) and the review and signing of the participant consent form (Appendix C), the digital recorder was turned on. I then went through some 'domestics', including the proposed format of the session, establishing mutual understanding about the time we had available for the interview and what we would do if there was a phone call/any other need for a break. It was at this stage that I also reiterated my awareness that the topic under discussion was a very personal topic, that it could be the source of various emotions (at this stage I tended to reveal that I had some tissues on me, and suggested that the participant might want to locate some too) and, related to the potentially difficult nature of the topic, that either of us might choose to stop the interview at any time. This preliminary discussion was followed by lighter

interlude, during which I collected some brief demographic information and suggested that the participant might like to choose a pseudonym (or leave the choice to me, as happened in a few cases); this served well the purpose of an 'icebreaker'. Thereafter, I sought quickly to open up a space in which the participant's birthing career narrative might be shared, in the following manner:

> "Well, we would usually start with you telling me about your childbirth experiences. You can start wherever you want, but I usually find that starting with your hopes or expectations when you were first pregnant is quite a good place. If that sounds ok, then it's over to you."

I then sat in an attentive manner, pen poised. In the majority of cases, this introduction led swiftly to a string of highly gripping, at times highly emotional, and often entertaining stories. Rather than reflecting a skilled and effectively planned and delivered research encounter on my part alone, I believe that the willingness of my research participants to launch into their autobiographies in this way reflects the 'tellability' of certain kinds of birth stories, as well a more general willingness when 'approached by someone who possesses genuine interest in them ... [to] open themselves up' (Herbert, 2010, p118). Whilst some participants clearly found it a challenge to maintain a lengthy narrative, and responded well to prompting, this was unusual, and most of the participants seemed to appreciate the opportunity to share their story, from a position of power and control within the interview situation (Karniele-Miller, Strier and Pessach, 2009).

Each of the stories told was important to this study. But I felt that a key indicator of the extent to which the study design was operating successfully was how women shared with me the usually hidden or 'less-tellable' stories. Some women noted that their accounts did not necessarily show themselves in a good light, and they commented on how they knew I would not judge them for that. In other cases, women revealed confidences that they had shared with very few people, not even those - known mutually to us - who were the subject of those confidences; again, a sense of trust in the confidentiality of the process was clearly evident. In one particular encounter, a women discussed specifically how she felt able and willing in the context of the interview - rather unusually for her - to talk in detail about issues that were highly personal in nature. In these and other ways, it seemed that a productive interview space had been created and maintained, evidenced too by the wealth of rich data created by this process.

4.4 Post-fieldwork issues

4.4.1 Data handling: confidentiality and security

Procedures for data handling were outlined and approved as part of the University ethics review process (as detailed in 4.5.1). All personal data relating to participants, including voice recordings, were stored securely after collection. After each interview, each of the interview audio files was transcribed in full; after the first batch of interviews, a third-party was engaged to transcribe the remaining interviews. In making a decision to outsource the transcription work, I satisfied myself that this could be done without compromising confidentiality and data security.

Transcripts of voice recordings were anonymised following their creation, including the use of pseudonyms for the participant, her children, other members of her family and her birthing partner(s). The key which links individual voice recordings and transcripts has been treated as confidential data. Identifiable data (personal data and interview recordings) will be destroyed six years after collection (commencing in September 2017), whilst anonymised data (in the form of interview transcripts) will be retained for twenty years following thesis submission.

4.4.2 Analytical strategies

Typical of many qualitative studies, the primary data collection phase of this inquiry generated a fair quantity of data, with over 50 hours of interview recordings transcribed. One of the key challenges of the resource-intensive data analysis phase of this inquiry was thus navigating the sheer mass of data, whilst ensuring an adequate explanation of that data, in the context of the inquiry's focus. To do this, my evolving approach shifted: from initial readings of whole transcripts to later readings of transcript segments; from readings which took little account of my inquiry focus to readings which were intensely interested in identifying and interpreting data that seemed relevant to that focus; from readings that made little attempt to seek to fit the data into a particular conceptual framework to later readings which were made with an emerging Bourdieusian conceptual framework very much in mind. Throughout this process a large number of memos and lists were created, whether related to whole transcripts, multiple transcripts, specific issues, or imposed and/or identified themes. A brief attempt was made to organise this work with Nvivo software, but I did not find this to be particularly useful.

Repeated whole readings of each transcript have been key to my interpretation of women's accounts. These interpretative readings commenced during the interviews themselves, and continued as I reflected on each one, in the space purposefully

created between the interview and my next engagement. The transcription process provided a space for another reading, whether during the construction of the transcript or during a check of draft transcripts (provided by a third-party transcriber) against the recording.

Further readings of the transcripts were undertaken with text and pen in hand. On the next reading of each transcript (the slowest reading), I engaged with the transcript without reference to my particular focus of enquiry and completed two separate tasks. First, I took detailed marginal notes of words, phrases and issues, as well as 'silences, absences and exclusions' (Jackson, 2001, p207), that struck me as particularly interesting as I read through the transcript and reflected on it as a whole. Some of these notes reflected on the emotional registers in which certain stories were told and heard, features that had been clear in the spoken word but became less obvious in written form (although in some cases these were highly obvious, in the form of the transcriber's note of 'everyone crying here'). Others were cues for me to research specific childbirth-related technical issues (which I followed up with reference books, online searches or sometimes, where these routes failed, discussions with a midwife friend). Second, I extracted data from the transcript to enable the construction of a body of information about each participant and her childbearing career (uploaded into an excel spreadsheet), to support a descriptive understanding and analysis of selected elements of the complete dataset. This was useful in validating the diversity of participant experience, and enabled reflection on how this group sat within a broader picture of national childbirth outcomes.

My next readings of the transcripts were slightly faster readings, this time completed in batches, to facilitate a shift towards a more holistic view of the whole dataset. In these readings, my task was to notice data relevant to two key concepts: the agency of birthing women and the childbearing career. I also started to focus on similarities and differences between women's accounts, and sought an appreciation of the participants' key concerns as communicated through their choice of story, by asking the question: 'what is this story about?' Following this reading, I became interested in developing a typology of childbearing careers, which I subsequently tested out against rapid batch by batch readings. It was also during these readings that I identified a number of puzzles in the data, which I contemplated for some time, including during a subsequent formally approved break from my studies, a process which responded well, perhaps, to Crang and Cook's call to engage in an analytical process that includes more and less systematic phases (Crang and Cook, 2001). Over time, I found that puzzles related to

specific pieces of data, such as ‘how could they do that to such a lovely woman?’, transformed into the standard analytical question of ‘what is going on here?’

With the following (and final full transcript) reading, transcripts were grouped into different batches, to help ensure that emerging analytical ideas were considered in the context of the whole dataset. At times, I found it helpful to draw on elements of the feminist Listening Guide methodology (Doucet and Mauthner, 2008) to focus my attention on issues that seemed to be particularly important (for example, through the use of I-poems). It was only at that stage that a Bourdieusian theoretical framework was adopted, encouraging a ‘conversation between theoretical concepts and the data’ (Herbert, 2010, p74). This had the desired effect of imposing some productive order on the interpretative task, through the testing out of alternative Bourdieusian approaches to the task of making sense of the data in relation to my study focus.

4.4.3 Ongoing trails in the field

Throughout the study, I have been frequently interested to note how the everyday responsibilities of the researcher role have continued well beyond the fieldwork phase of the study, both in time and space, and indeed will likely continue at least as long as I continue to reside within the local study area. For example, in everyday conversations, whether face-to-face or via social media, I find myself recalling that I possess certain information relevant to a given topic of conversation as a result of this study, and thus exclude myself from certain areas of discussion. In encountering participants, I am often reminded of the highly personal birth stories of each of them. On the one hand, this helpfully keeps in mind my responsibility to each participant in terms of confidentiality. On the other hand, it restricts conversations that might otherwise take place.

Throughout the process of analysing data and working with my analyses to develop this thesis, my continued location in the field has also heightened my awareness of my desire to create an adequate account of my data which is respectful of each participant’s perspective. This was an aspect of the study that I predicted to be potentially problematic at the beginning of the study. As will be discussed later in the thesis however (Chapter 8), the adoption of a Bourdieusian conceptual framework has worked well to shift my perspective on some key issues, and thus significantly reduce the scope for any tension between seeking to give a good account of the data as I interpret it and a concern to take care to understand the implications of how I might wish to portray study participants.

4.4.4 The politics of writing up: taking care in the presentation

During a conference, a young and passionate midwife, understanding my research task, asked me please not to produce yet another report that worked to place midwives in a poor light. That request has stayed with me, and has called for the careful consideration of how I present my findings. In this thesis, I have balanced her request with my commitment to make public the experiences of the participants, as they pertain to the focus of my study. Whilst midwives and other health sector workers are not the focus of this study, they are certainly represented (whether as presences or absences), as women's narratives give insights into how their understandings of, and ways of practicing, birth draw on, inter alia, their experiential knowledge of the role played by others, including midwives.

All of the experiences described in this report took place in the context of maternity services provided by the NHS, that 'cathedral of care' which is widely cherished and staunchly defended (McGann, 2017). This raises one of the key sensitivities of this study: what does it mean to produce a study which casts the quality of NHS maternity services in a poor light, especially in the context of debates about privatization? This study does indeed raise difficult questions about the ability of the NHS to provide compassionate and safe maternity care. In that context, I would underline the fact that the findings of this study do not suggest that the NHS does not or cannot provide, in other places, at other times and for other women, a high-quality maternity service. On the contrary, there is research evidence to suggest that the NHS is able to do just this, as studies examining exemplary spaces and models of care demonstrate (Homer et al., 2017; Rayment-Jones, Murrells and Sandall, 2015; Walsh, 2006a and 2006b). Whether it is possible, at any one time, for all women to receive such high quality maternity care is a separate question. Indeed there has long been some suspicion, in a service that is driven by funding crises, in which certain models of efficiency, and not others, are prioritised, and in which there is seemingly little understanding of the benefits of the physiological process of birth, that such spaces and models of care occupy a fragile position, ever vulnerable to disruption, with the closure of the Albany Practice being an emblematic example (Homer et al., 2017). In that context, this report works to underline what this might mean for women giving birth in what might be understood as non-exemplary areas, and offers an understanding of what the skilful and knowledgeable agency of women is able to achieve in that context.

4.5 Research integrity and ethics

4.5.1 Ethical frameworks and an integrated ethical approach

This study is subject to University of Leeds ethical study procedures and was approved by the AREA Faculty Research Ethics Committee (reference AREA 10-101). In addition to the scrutiny of this University process, the study was guided by the Economic and Social Research Council's (2010) Framework for Research Ethics. Related to this, it was intended that the study adopted an 'integrated ethics approach', in which the researcher takes responsibility throughout the life of the project (and beyond) to ensure that an ethical approach is at the core of all study behaviour and decisions (Dyer and Demeritt, 2009).

In this context, the formal preliminary ethics study approval processes might be considered a minimum standard (Macfarlane, 2009). Formal frameworks stipulate, for example, that the researcher has a duty to ensure that close attention is paid to new ethical issues that arise during the course of the project, either dealing with them as part of the project or escalating them for discussion with the project supervisors (in the case of PhD research) or the local research ethics committee as appropriate. A prior question, however, is how a researcher might (or might not) come to recognise such issues. Following Macfarlane (2009), I suggest that effective recognition depends on the ongoing performance of a set of ethical research virtues. The detailed descriptive analysis offered above with respect to data collection strategies illustrates this approach (4.2). On the basis of two extended examples that follow, I highlight further how such an integrated ethical approach operated throughout the study.

4.5.2 Achieving consent through study design

Consent has been referred to as 'the central act' in research ethics (Institute of Education, undated). The consent process for this study was documented and approved as part of the preparatory ethical review process. In the course of undertaking the study, however, I developed an appreciation of some potential ambiguities (Hay, 2016) of the traditional consent-seeking process.

Where qualitative one-to-one interviewing is a key plank of data collection, as in this project, the focus of the traditional procedure to ensure consent is the interviewee. Great care is taken to ensure that consent is obtained from each interviewee, to ensure that all participation in the research project is voluntary and that the potential participant understands the context and objectives of the research, what would be expected of them as a participant and how any resultant personal data will be handled and shared. The rehearsal of this proposed routine and the preparation of the relevant draft

documents (the participant information sheet and consent form) enables the ethical review process to be signed off by the local ethical review committee. As the project proceeds, a growing stack of completed consent forms serves as the symbolic representation that consent has been achieved.

In line with standard ethical guidelines, therefore, this study was designed to achieve valid consent from each participant for their participation in the study, as detailed in sections 3.3.4 and 3.3.5 above. This process prepared the way for the confirmation and documentation of the participant's consent, which took place at the start of the interview session; in advance of starting to record the interview conversation, each participant was provided with the participant consent form and was asked to read and sign the form if she agreed to its contents. Participants were informed that they could withdraw from the study at any time, including before, during and - for a certain time-period - after the main contact (the interview) had taken place. Participants were also informed that it would not be possible to exclude the data they had provided after a given period (3 months from the date of interview), as their data at that stage would have been anonymised and embedded into the resulting analysis, and it would be impractical - if not impossible - to genuinely disentangle it at that stage. In this way, formal consent was achieved. But was it really?

Over the course of the project, and as highlighted in ESRC guidance, I came to appreciate that consent is not achieved as soon as the consent form is signed, but is rather a continuing process. Throughout the life of the project, up until the final draft of the written report and in the context of any associated presentations or papers, the researcher must actively ensure adherence to the implicit contracts set out between researcher and research community as well as researcher and participant (as documented both in the review committee documentation and completed consent forms), for example by ensuring that agreed procedures with respect to confidentiality and anonymity are followed throughout that period.

I was interested to note, however, that the personal information that I was collecting went far beyond that related to the interviewee. During the course of the interviews, detailed personal information was disclosed about other people who had participated in the childbearing experiences being related, including, but not restricted to, birthing partners (in this study, generally the husband of the interviewee), the children of the interviewee, and health sector workers. In that context, can it be said that full consent for this study was obtained? To what extent might these third parties also be defined as being involved in the study, and what would be the implications of this, for example in terms of obtaining further consents?

The traditional response to this would be: no, these third parties are not participants and thus consent from them is not required. However, this might suggest that the current consent routines followed by qualitative interviewers are rather ones of convenience; indeed it is possible that this is simply the only practical approach. As I reflected on this issue, I appreciated how the issue of consent should not be looked at in isolation, but as an individual element of an integrated ethical research approach. Thus, for example where consent is not obtained from such third-parties, this may serve to underline the importance of other elements of standard ethical research procedures. In this case, this would involve ensuring high standards of confidentiality whilst working on the project and, as far as possible, seeking to ensure that all written and other outputs of the study provide anonymity not only for participants, but also for non-consenting individuals referred to in the data.

If such rationalisations are not convincing to an individual researcher, an alternative would be a significant modification of the study design. Thus it would have been possible to use an alternative study design involving data collection from others involved in the particular childbearing experiences that were discussed; for example, both the leading lay person and health sector worker present at the birth might have been interviewed. This would have constituted quite a different project, but would have had the benefit that more (if still not all) of the people involved in the event would have had the opportunity to consent to the event being researched in the manner planned. A study design involving the participation of health service workers would have also triggered an NHS ethics review process, involving employer organisation approval, delivering yet a further layer of scrutiny and consent.

From a different perspective, it is perhaps the focus of each individual study that is most critical when thinking through such issues. Is this study, for example, focused on the birth experiences related by the women, or is it rather about women's conceptualisations of birth, which in this study had been (necessarily) illustrated with reference to their own positioned narratives of their personal experiences? Since I believe that my key focus was the latter, this casts a different light on the nature of the data gathered. Whilst it remains the case that the data includes the woman's positioned recollections and interpretations of third-party activity, it is important to recognise that the participating women have the power to own and share this data if they so choose. On that basis I felt confident that my consent procedures had been ethically sufficient, subject to putting in place extra safeguards with regard to ensuring the anonymity of third-parties. Nevertheless, and despite achieving a renewed sense of confidence in my process in this way, this issue perhaps raises wider questions about the

achievability of full consent in qualitative research. Whilst this issue has been pursued with respect to ethnography (Murphy and Dingwall, 2007) and in the discipline of anthropology (Bell, 2014), it is a discussion that could usefully be extended to other disciplines and research methodologies.

4.5.3 Having regard for the well-being of the participant

A further key ethical consideration in designing qualitative studies relates to the need to pay attention to the potentially negative effects of the proposed research process on participants, to minimise harm. Given the intensely personal nature of the empirical area of study, which has the potential to trigger emotional and (sometimes ongoing) traumatic memories, there is clearly potential for harm in the course of inviting women to relate their childbearing experiences. Despite the potentially difficult nature of this topic, which might be sensitive, embarrassing or upsetting for the participants, a great deal of research is carried out in this area in what seems to represent an ethically sensitive way and I had been sensitized to this issue during my MA research. I was thus confident that this issue could be addressed in a way that complied with the highest ethical standards.

On that basis, I drew up a strategy in this area based around four main elements. In terms of inclusion criteria, I sought to avoid interviewing pregnant women (although one slipped through the net, see below) and I was also keen to ensure that a minimum period had elapsed between the most recent childbirth experience and the interview; in practice, this meant that I did not interview any women with babies less than 12 weeks old. At recruitment stage, whilst I was keen to obtain the participation of women with a diverse set of childbirth experiences, I sought to be clear about the focus of the research with potential participants, so that they had the necessary information with which to consider their participation.

During interview sessions, I highlighted my awareness of the potentially difficult nature of the topic, and informed participants that either they or I could stop the interview, or change the subject, at any time. I was equipped with the details of appropriate support services (e.g. birth trauma help lines) to offer to participants, and in addition, if I had a concern for the wellbeing of the participant at the end of the session, I planned to contact her within 24 hours to check on her well-being and to encourage her to seek support as appropriate.

This approach was documented and approved as part of the ethical review process, and seemed to serve the project well. A number of women with self-defined ‘difficult’ birth experiences decided against participating in the project during the recruitment

phase, for example; I was pleased that they felt at liberty to refuse to participate in this way if, as seems possible, they had decided that it would be too negative an experience for them to participate. Also, despite taking care to ensure that this was unlikely to be the case, partway through the project it transpired that one of the participants had been pregnant during our interview. I had the opportunity to learn about this when I conducted a follow-up interview after the subsequent birth event, and the discussion suggested that no harm had been done by the interview process.

Whilst there were a significant number of participants who had experienced highly difficult events, including two experiences of stillbirth, one case of post-traumatic stress syndrome and a number of cases of postnatal depression, my feeling was that each of the participants had made significant progress in working through their own emotional responses to these experiences to make their participation in the study appropriate. Some of the participants explicitly discussed this, with one noting how she felt able to participate in the study thanks to the cognitive behavioural therapy she had received.

This is not to suggest, however, that many of the interviews were not highly charged emotionally, and in a number of cases there were clear signs of distress on the part of the participant. In one case, I was told in no uncertain terms at the start of the interview that the participant was likely to find it hard to discuss her first childbirth experience, and she suggested that I should commence with another line of questioning. After a very rapid pause for thought, I was happy to agree to this; thereafter, that particular interview proceeded well, with the participant sharing her childbirth experiences after some initial discussion. In a few instances with other women, I did suggest that we might want to discontinue the interview on the basis that the women were clearly upset, but in each of these cases this suggestion was rejected; it seemed that women with difficult experiences were particularly keen to share them, in the hope that this might help other women in the future.

Does all of this suggest that the research process was designed and executed in a way which minimised harm to participants, or at least kept it at acceptable levels? This raises the important question of who might be in a position to judge whether this is the case. During one particular interview, the physical presence of a participant's partner refocused my mind on this issue. The participant had experienced a stillbirth - indeed we had been discussing this when her husband walked in. Our conversation stopped, and - for me at least - there was an awkward silence: what would this man make of our conversation, if he knew what we had just been talking about? What would he think about me triggering a discussion of this experience of his wife giving birth to their stillborn baby, his stillborn baby? Up until that point, I had felt that I was dealing in a

highly ethical way with the issue. It had been the woman herself who had offered the information about this element of her childbearing career, suggesting that it was relevant to her story. Aware of the intense sensitivity of the issue, I quickly took the decision to encourage her narrative about the birth of her stillborn baby, as I felt that any other reaction would suggest my participation in an orthodoxy which offered little place for such 'taboo issues' in mainstream discourse - an issue that indeed emerged in her narrative. But her husband's entry into the room triggered doubt on my part: was I really well-placed to know whether or not the direction of our conversation took proper account of the need to ensure her well-being? Did he (and perhaps others) have a legitimate interest in protecting her from inappropriate research interventions? How would I have felt if the situation had been otherly gendered? It was highly informative to imagine this third-party's perspective on the research process being played out in that moment.

On reflection, this incident brought out for me a contextualised understanding of matters of consent in the context of the power relations invested in the researcher-participant relationship (Bloom, 1998). What I was moving towards was a deeper appreciation of the need to conceptualise the relationship between interviewer and participant as a power-imbued relationship. Within such a conceptualisation, it is possible to see both the participant's and researcher's various responsibilities for different aspects of the research process - with the implication that the research should proceed only if both feel that that the risk represented by the study is at an acceptable level - rather than a conceptualisation that seems to invest all of the power for such decisions in the researcher. In this way, I can better conceptualise the concept of consent, in a way which recognises, and is more respectful of, the agency of the participant and avoids the paternalistic overtones invested in more traditional conceptualisations. This both starts to make sense of the stricter 'duty of care' that is applied to so-called 'vulnerable participants', at the same time invoking important debates about paternalism and autonomy in the research process (Corrigan, 2003).

Thus, in other areas of research ethics too, it is important to understand that the requirements of ethical review committees might be better discussed in terms of minimum standards, rather than representing a complete picture of good ethical research practice, which can be achieved only through an engaged stance which embeds ethical behaviour into the everyday routines of research. This observation is in line with existing literature that suggests a risk, if this approach is not taken, that formalised ethical review processes might serve to weaken, rather than strengthen,

ethical research behaviours (Blake, 2015; Dyer and Demeritt, 2009; Macfarlane, 2009; Askins, 2007).

4.6 Conclusion

In this chapter, I have presented the rationale for the research design chosen for this study, in the context of the resources available and of my broader methodological approach, to enable the construction of a rich dataset with which the focus of the inquiry could be effectively pursued. Whilst the chosen method of qualitative data collection, via face-to-face interviews, is well-used across the social science disciplines, I have highlighted a number of issues that suggest that a reflexive approach when using this method (despite its apparent familiarity) remains important. I have discussed the approach taken to analyse the transcripts created from the interview interactions. I have also drawn attention to a range of ethical issues that have arisen in implementing this qualitative research design, and have suggested the benefits of an integrated ethical approach to deal with these issues. In the next chapter, I locate the study by way of introductions to its geographical, social and temporal location (5.1), to the birth experiences, and childbearing careers, underpinning the study (5.2), and to the perspectives of the participants at the start of their childbearing careers (5.3).

Chapter 5 Locating the study

This chapter provides contextual material for the main study findings. It includes a brief introduction to the chosen study location, a demographic summary of the twenty-six women participating in the study and a discussion of the study's temporal location (5.1). Next, I present a brief descriptive analysis of the sixty-eight childbirth experiences of the participating women; as I do so, a critical analysis of the usual statistical presentation becomes inevitable (5.2). The final section continues this interpretative mode of analysis, but also represents a shift, pursued for the remainder of the thesis, as I focus more intently on the storied content of women's narratives and, in particular, what they suggest about women's dispositions towards birth at the start of their childbearing career. This provides a descriptive and interpretative analysis of how the participating women understand the social practice in which they are about to engage for the first time, including their assumptions about their own role in this practice and their expectations (5.3). With this context established, the way is clear for an examination of how women experience the learning space that is represented by the birthroom over their childbearing careers (Chapters 6, 7 and 8).

5.1 Locating the childbearing careers studied

5.1.1 The geographic location of the study

Study participants were recruited from a small village and its environs in the North-West of England, located on the outskirts of a metropolitan region. The assumption that women might have moved area over their childbearing careers was included in the study design. As it turned out, all but one of the participants had lived in the local - or a neighbouring - area during the whole of their childbearing careers, with just one woman commencing her childbearing career in a different region of the UK before moving into the study area for subsequent births. Thus information about the study location is relevant both in terms of the site from which participants were recruited as well as in terms of locating all but one of the birth experiences discussed.

In terms of health service geography, the study village is sited just within the boundary of a metropolitan district, with the local Clinical Commissioning Group (CCG) area extending some way into a neighbouring administrative area (taking account of the physical geography of the area). This CCG area has its 'own' local NHS trust and general hospital, providing a consultant-led maternity unit and a small co-located midwifery-led care unit, at which the majority of the births included in this study took

place (n=40). This hospital provides the closest accident and emergency services to the study location (within 5 miles).

The midwifery service based at this hospital provides the community midwifery services which serve the study location. This means that all pregnant women living in the local area - unless they opt out of the standard NHS antenatal care service - will be provided with this community midwifery service for their antenatal and postnatal care, irrespective of where they choose to give birth to their baby. Which individual midwives they see as part of the community midwifery service will tend to depend on the GP surgery used by the woman. Since there is no GP practice within the study village, a mix of surgeries, based in neighbouring villages, are accessed; thus there is no identifiable community midwife serving all pregnant women in the study area at any one time.

Because of the rural location of the study area, and the fact that travel to any hospital involves a journey to a neighbouring town, a second hospital (7 miles away), located in an adjacent CCG area, is viewed as equally local by some women, and is where a significant number of births included in this study took place (n=19). As well as these two 'local' maternity units, there is fast (motorway) access to further maternity units in the wider metropolitan area. A small number of the births included in this study took place at the main teaching hospital in the metropolitan area (n=5). The remaining births included in the study (n=4) were planned births at the woman's own home (n=3) and a hospital birth in another region of England (n=1).

Previously, there was a further type of institutional birth setting available locally: a midwife-led birth centre (previously a GP-led unit) within a cottage hospital. Although this facility was 20 miles away from the study location, it was considered local and accessible by some study participants until its closure in 2012. Two of the study participants had planned to give birth at this birth centre, but for different reasons both births instead took place in a consultant-led hospital (one of these as a result of an in-labour transfer from the birth centre).

None of the participants in this study had sought alternatives to replace mainstream maternity services (for example, non-NHS midwifery or doula services), although one participant had considered engaging an independent midwife in the event that the NHS had been unwilling to support her choice of home birth. None of the participants in this study had contemplated giving birth without accessing maternity services. Some of the study participants had accessed non-NHS group antenatal provision (such as NCT classes, private antenatal exercise or private yoga classes).

As outlined above, the study group exhibited some diversity in terms of the service choices they made, within the limited local NHS offer. As a consequence of their use of different GP surgeries within the local area, for example, there were differences in how individual study participants linked in to the various community midwifery teams (albeit that everyone was served, antenatally and postnatally, by community midwifery teams managed from the nearest hospital). The choices made with respect to where study participants planned to give birth to their baby leads to further variation in terms of the maternity services accessed: in this study, this is reflected in choice of hospital. (I found women's accounts to be highly limited in terms of distinctions made between midwifery-led and obstetric-led units.)

I consider that such variation, limited as described, might be considered to contribute to the strength of the study findings. On one hand, the limited extent of service variation allows an opportunity for the diversity of participant experiences to be considered separately from diversity that might be underpinned by different service offers. On the other hand, what diversity of service provision there is in the study (for example, the way in which different birth locations are accessed by study participants) ensures that the study data are not limited to the peculiarities of one particular service provider, whether that be a small team of community midwives (or even one particular midwife) or a single maternity unit.

5.1.2 The social location of the study

The social location of the study, in terms of the 26 study participants, might most readily be characterised as a study of the birth experiences of a small and fairly homogenous group of relatively privileged women, comprising financially secure well-educated articulate middle class white women, living in securely employed households as part of stable heterosexual couples, all benefiting from security of tenure. Whilst this would not be an accurate description, it serves fairly well to initially position the demographic identity of the majority of study participants.

In terms of migration status and ethnicity, the group displays extremely low diversity. All study participants were born in England, and have a good command of the English language, with just four of the study participants claiming a non-English heritage, one of these representing the only non-white woman in the group. Whilst this demographic is representative of the local study area, it is less representative of the wider CCG area.

Second, this is a well-educated group of participants. Only one of the study participants had ended her formal education on leaving school at 16; seven study participants achieved A levels or the equivalent or higher in vocational qualifications; eighteen of

the study participants had graduated from university, four of these having achieved masters level qualifications. All of the women seemed to benefit from good access to the paid labour market, either working outside the home at the time of interview (either full- or part-time) (n=16), on maternity leave (n=5), or having made a choice to be based at home whilst their children were young (n=5). All but two of the women lived in households where one or more adults engaged in paid employment. Regarding type of employment, six of the study participants had experience of working in the healthcare sector, with two of these having had a period of work experience in the maternity services and four were still working in the wider healthcare sector.

All of the participants were living with what would appear to be security of tenure, either in their own home or in the social rented sector. Despite any subjective sense that things might be otherwise, all of these women seemed to be financially secure, at least on the basis of their current relationship status. All but two of the study participants were living in stable heterosexual relationships at the time of the interviews; the stability of these relationships was indicated by the fact that a large majority of birth experiences included in the study were the biological result of the couplings at the time of interview; three of the study participants had experienced giving birth to babies with different biological fathers, with eight of the birth experiences in the study a result of previous partnerships.

In line with the study design, every woman in the study group had given birth to more than one child, with most having given birth either twice (n=14) or three times (n=10); two women had given birth more than three times. The age of the women when they were interviewed for this study ranged from 29 to 48. The average age of study participants when giving birth to their first child was 29, with two women giving birth before their twentieth birthday (aged 18 and 19) and four women giving birth for the first time when 35 or over. There was an average age of 35 for when the women in the study group had most recently given birth (for most, assuming that this would be their final childbearing experience), although three women considered that they had completed their childbearing career when they had been in their late twenties. Four women had continued their childbearing career into their early 40s.

There was some diversity in the long-term health status of the study participants, with five women identified as having long-term health conditions; one of these is registered as disabled. Two such women planned operative births (by caesarean section) for each of their children; another took what she conceptualised as the precaution of giving birth in a large nearby teaching hospital to ensure a good standard of care given her particular condition; another of these women chose to give birth to two of her children

at home. All of the births discussed in this study were a result of natural conception, often following a period of deliberate contraception; thus none of the births were a result of artificial reproductive technologies, although at least one woman in the group had previously attempted to conceive using such technology.

As suggested at the beginning of this section, the study participants might be well characterised as a relatively privileged group. In that context, it is important to be clear that the findings of this small study are not intended to be representative of women's experiences across England, or indeed the local CCG area. It is theorised that the social positioning of participants may be productive in the context of the current study, however, as it allows for an examination of the ways in which such a privileged status 'counts' in the field of birth, and the extent to which these women's accumulation of various forms of capital, prior to the commencement of their childbearing careers, might be protective of birth experiences.

5.1.3 The temporal location of the study

The interviews for this study were carried out between late 2011 and late 2012. Given that the study was designed to include an analysis of women's birth experiences over her childbearing career, however, it is important to note that the birth experiences included for analysis in the study took place over a fairly lengthy period. First, whilst the average length of a woman's childbearing career for the women included in this study was just five years, the childbearing careers of two of the women exceeded a span of fifteen years. Second, women were interviewed at different stages in their post-birth lives. The initial study design suggested that women should be considered for the study where their final childbearing experience had taken place within the last four years. In the event, eighteen of the twenty-six study participants met this criteria and, of these, seven women were interviewed whilst their babies were less than a year old. As a result of the recruitment strategy described earlier (4.3.2), eight women were interviewed whose most recent childbearing experience sat outside the initial research design. These two factors combine to give a span of childbirth experiences of a twenty-seven year period from 1985 to 2012. Within this span, all but seven of the births included in the study took place after 2000, with the main clusters of births taking place between 2006-8 and 2010-12.

This diversity of the temporal location of the birth experiences included in this study, built-in to the study design, is at first glance potentially problematic. It would be difficult to reconcile such a temporal location of data with, say, an ambition to present a review of current practice within the maternity services. It also turns out to offer some clear

benefits. For example, it is interesting to note how some women expected that certain problematic issues related to their experiences would have been resolved for women giving birth more recently. The data collected in the context of this small study raise important questions about how such an alignment with an orthodox belief in the inevitability of progress over time plays out in the maternity service context. This is especially interesting to consider in the context of a related birth literature that is imbued with an objective of 'service improvement', generally to be achieved via the constant examination of, and the implementation of specific improvements to, discrete parts of the process of childbirth.

5.2 Representing birth experiences

There are many ways in which birth experiences might be summarised, depending on the data to which one has access, the purpose of the enquiry and the perspective of the analyst. In this section, I present the beginnings of a descriptive analysis of the childbirth experiences of the women participating in this study, based on a perspective that takes seriously the notion of the childbearing career. The information underlying this analysis is drawn from the accounts provided by the birthing women themselves, sometimes many years after the birth. The analysis draws on a tradition in human geography which seeks to foreground discrepancies and ambiguities in datasets, and choices about what is and is not presented, as crucial to understanding the topic under investigation (Brown and Colton, 2001; Underhill-Sem, 2001)

Official statistics based on hospital activity data (or hospital episode statistics) provide one template for summarising birth experiences. The narratives offered by the women participating in this study provide data that enables a presentation of their experiences drawing on this template, albeit with some gaps (5.2.1). The task of seeking to describe the study births using such an approach raises a number of issues, however, and given the various limitations of this initial descriptive summary, I go on to extend this analysis (5.2.2). In doing so, I raise the issue of how seemingly objective NHS birth statistics might play an important role in reproducing certain conceptualisations of birth whilst restricting the discursive space for others (5.2.3). As part of this discussion, I thus start to consider the question of what can be known, and what is it possible to know, about others' birth experiences, and also the idea that there are material effects related to the dominance of certain types of knowledge which have an important impact on the way birth is, and can be, conceptualised and experienced.

5.2.1 Summarising births

What do we need to know about a woman's birth experience, or about the circumstances surrounding a baby's birth? As one of the many possible ways into this discussion, I begin by considering this in terms how the births in this study might contribute to the official maternity statistics, for example as derived from the English NHS hospital episode statistics (HES) series. This choice of initial presentation is interesting: am I assuming, for example, that this form of data representation is at the top of the hierarchy of knowledge about childbirth outcomes and experiences? As a form of data presentation, it is not without its own in-built assumptions and biases. For example, it seems that much of the data presentation is primarily useful for identifying resources required for the provision of maternity care (including by type of professional) rather than relating more directly to information about the specific treatment provided. These assumptions and biases parallel ongoing debates, reflected in policy, academic and professional spheres, about how childbirth is conceptualised. Nor is the coverage of official statistics without controversy; rather, it is subject to modification over time, including as a result of political negotiations between different interest groups. One continuing controversy about the coverage of the official NHS England birth statistics, for example, relates to their (limited) usefulness in recognising and auditing so-called 'normal birth' (see 5.2.2). And a recent review of national maternity services suggested that 'much [maternity care data] is difficult to interpret and of questionable significance' (NHS England, 2016, p21).

Aside from their usefulness for resource allocation arrangements, national maternity statistics are also purportedly in place to provide a check on, and support the development of, a safe maternity healthcare system. A key element of national data collection efforts, therefore, is to track certain mortality and morbidity outcomes, which is in part done separately from the HES statistical framework. As well as mortality data collected by the Office for National Statistics, for example, birth-related morbidity and mortality outcomes are tracked and audited as part of a UK-wide multi-disciplinary collaborative programme MBBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK). In terms of mortality and severe morbidity risks for the birthing woman and her baby, childbirth in England at the beginning of the twenty-first century is relatively safe, and generally considered to be very safe for babies born to healthy mothers (NPEU, undated). In the UK between 2012 and 2014, there were 8.5 maternal deaths per 100,000 maternities (Knight et al., 2016), and in 2014 there were 1.77 neonatal deaths per 1000 live births and 4.16 stillbirths per 1000 births (Manktelow, 2016). It will already be apparent, given the study

design, that all of the women whose birth experiences are included in this study survived the process of childbirth. For babies, the picture is a little more mixed however. Sadly two of the babies whose births are considered in this study were not born alive. One of these babies suffered an unexplained death in utero at 34 weeks and the second died in utero at 18 weeks as a result of a medically indicated termination; in both cases their mothers laboured to give birth to their babies. At the time of interview, none of the women participating in this study seemed to be suffering from long-term health effects as a result of the birth experiences being discussed. One baby continues to suffer with severe long-term health problems thought to be a result of problems encountered during its birth.

Perhaps the next most examined element of national birth statistics is the 'mode of delivery' data: this focuses on whether the baby is born vaginally or via a caesarean section (c-section) operation. For some time, there has been a particular focus on the c-section rate, internationally and nationally, as well as at the regional and local level, with an official discourse suggesting that efforts should be made to ensure that growth in the rate of c-sections is restricted and that local disparities in rates investigated. In the local study area, the c-section rate stood at just over 25% in 2015/16, compared to a whole England rate of 27% (NHS Digital, 2016a). Where a baby is born by c-section, the statistics also indicate whether this was an operation planned in advance of labour (a planned pre-labour c-section) or whether it was a result of a decision made whilst a woman was in labour, often referred to as an emergency caesarean (see Tully and Ball, 2013, however, for a critical discussion of the language used to categorise c-sections). In this study, 18 babies were born by c-section, of which 12 were planned to take place in advance of labour and 6 were the result of decisions taken during labour.

Examining further the extent of personal c-section experience amongst the 26 women participating in this study, two women have never experienced labour and have experienced childbearing only by elective caesarean (linked to pre-existing medical conditions). Three women have experienced each of their births as culminating in a c-section operation, where at least one of their birth experiences had included an experience of labour. Ten out of the twenty-six women participating in his study have had personal experience of giving birth by caesarean.

If a baby is born vaginally, NHS statistics are intended to show whether the baby was expelled from the woman's body through the physical efforts of mother and baby alone (a spontaneous delivery), or with certain interventions in addition to these efforts, such as the use by a third party of forceps or a ventouse (instrumental delivery). The use of forceps and ventouse is significant not least because it usually entails an episiotomy (a

surgical cut in the perineum). This measure might be assumed to give some indication about whether the birth was experienced as difficult; it has also traditionally identified those births requiring the presence of a doctor, although midwives in England are now increasingly trained in ventouse practice. In the study area in 2015/16, just over 13% of vaginal births were instrumental deliveries, compared to an England-wide figure of over 21% (NHS Digital, 2016a). Of the 68 births included in this study, there were 50 vaginal deliveries, of which 43 might be considered as spontaneous vaginal deliveries and 7 as instrumental deliveries.

How a pregnant woman's labour starts also receives attention in the official statistics. A distinction is made in the statistics between a spontaneous onset of labour and a labour which starts (or is 'induced') via artificial medical (pharmacological) or surgical means. This conceptual distinction is rather less clear than the statistical presentation suggests, however, as I discuss below. Rising national rates of induction have been a matter of interest for some time in England, and the rate of induction in the study area in 2015-16 was 33% (ibid.). (Due to missing data about type of labour onset in 15% of cases, the national statistics on this measure provide an unreliable comparison.) Rising rates of induction are a matter of concern to some people (suggesting the unnecessary use of medical intervention) whilst less so to others (for example, where a strategy of induction is supported as a way of seeking to lower rates of stillbirth). On this measure, 38 of the 56 labours in this study may be considered as having commenced spontaneously and 17 as having been induced; in one case, the type of commencement of labour is unclear.

As explained earlier, the study design did not require any particular mix of types of births or labours; nor did it require any form of representativeness in these terms. Diversity of experience was an important objective, however, and in that context it is reassuring to note the mix of experiences represented in the study data. Given the prevalence of certain forms of medical interventions in childbirth (for example, c-sections, inductions, augmentations, epidural anaesthesia and instrumental deliveries etc.), that the study data contain a reasonable number of each of these interventions is helpful.

5.2.2 Reviewing and extending the summary

So far I have presented basic data about the 68 birth experiences that form the basis of the primary data used in this study, which at one level provides a brief description of the birth experiences considered in this study. However, as I have alluded to, providing a summary based on the official data template has certain limitations. At first glance,

the data presented in 5.2.1 might seem to represent a factual, un-biased account of the type of births that women experience. Looking more carefully at the data, however, it is possible to understand its various ambiguities. As such, this section addresses the ways in which such a presentation can give rise to potentially misleading interpretations of how birth is practiced, as well as reinforcing dominant understandings of the birthing process as pathological. To examine this issue, I draw on two examples: data about the commencement of labour and data about mode of delivery.

Taking commencement of labour first, to ensure an accurate understanding of what this data represents, it is important to consider what it means to categorise each birth in terms of an apparently binary variable of whether a labour commenced spontaneously or whether it was induced. This is important because the definition of induction in this context is conceptually awkward. This stems in part from the ambiguity surrounding the categorisation of the (predominantly midwife's) use of a technique known informally as a 'stretch and sweep' (also known as a membrane sweep). Whilst the clinical guidelines in England and Wales (NICE, 2008) are clear that this procedure is a method of induction (albeit one that has relatively low levels of success), it is excluded from the definition of induction used to collect NHS statistics (as detailed in the HES data dictionary, NHS Digital, 2016b, p81). Thus this particular induction intervention, although formally recognised in other parts of the healthcare system, is simply not represented in national statistics: whilst the use of this procedure should be documented in an individual woman's medical records, it is not routinely collected for statistical purposes.

It is not possible for me to determine precisely whether such a procedure was carried out in, or worked to induce any of, the labours discussed in this study; I found that awareness about the induction role of the procedure was unclear in many women's accounts. But it is certainly the case that less that 38 of the labours in this study commenced spontaneously if this is defined as without any contributory physical intervention by a health worker. In a minimum of 8 cases where standard statistics would suggest a spontaneous onset of labour, the onset of labour - according to women's accounts - was definitely preceded by a membrane sweep procedure. Thus a maximum of 30 out of the 56 labours in this study might better represent a spontaneous onset of labour. Just 6 of the 26 women participating in this study experienced a spontaneous onset of labour at the end of each of their pregnancies, with a further 9 having experienced the spontaneous onset of labour at the end of at least one of her pregnancies. This suggests that only 15 out of the 26 of the women participating in this study have experienced the spontaneous onset of labour at the end

of at least one of their pregnancies. I return to examine how such experiences contribute to women's understandings about the physiology of birth in Chapter 7 (7.1).

Second, the distinction between a spontaneous vaginal delivery and other modes of delivery can be usefully scrutinised, relying as it does on a particular social construction of spontaneous delivery. This categorisation, whilst producing statistics which suggest that relatively high proportions of women achieve a spontaneous vaginal delivery, ignores the fact that many non-instrumental vaginal births are certainly also assisted in various ways, whether physically (for example in terms of the birthing woman's legs being held, or the baby being manually assisted as it emerges from the birthing women's body) or otherwise (for example in terms of a birthing woman receiving instruction on when and how to push their baby out). On this basis, far fewer than 43 births included in this study might be assessed to have occurred spontaneously. In this way it can be seen that the prevalence of assisted birth might be obscured by the way this phenomenon is conceptualised. Indeed what is perhaps most noticeable from the accounts of the births included in this study is how the unassisted birth of a baby seems to be an anomaly, and can come as both a surprise and even a nuisance to health workers, suggesting that the normal expectation is for certain routines to be followed, including that the birthing woman should await and then follow the instructions of her caregivers about when and how to push the baby out.

The discussion in this section reflects a debate that has been going on for some years in England, based on the argument that the current national statistical outputs unhelpfully presume a paradigm of childbirth which sees childbirth as dangerous, and the baby and birthing woman's bodies as weak and at risk of failure. Individuals, including researchers and academics, and organisations seeking to develop a more encompassing set of statistics have raised questions about how national statistics might be compiled and presented if birth was instead conceptualised as normal bodily process, and as if the physiological process of birth was in itself an important object of study. If national statistics are in part to enable an examination of how birth is practiced, then for many it is self-evident that there is a case for the statistics to be developed further in this way, since in their current form they do not allow for an answer to the question of how many women give birth physiologically (Beech, 1997; Downe, McCormick and Beech, 2001).

This debate gained prominence with a report calling for a greater transparency in routinely collected statistics around the interventions associated with birth and rates of physiological birth (Maternity Care Working Party, 2007). (The working party had been established in 1999 to look at rising caesarean section rates, bringing together a

number of organisations including the Royal College of Midwives, the Royal College of Gynaecologists and Obstetricians and the NCT; in doing so, it turned its attention to the issue of physiological birth in 2003.)

One example of a specific birth intervention noted by that working party as being excluded from published national statistics, for example, is the technique known as the augmentation (or acceleration) of labour. Augmentation is a birth management strategy frequently applied once it has been decided by health workers that a woman's labour should make faster progress than it is seemingly doing physiologically, and its use seems to be highly prevalent in the contemporary UK birth experience. The omission of the use of this technique from national statistics seems to suggest its acceptance as a taken-for-granted and benign technology, rather than as an intervention that ought to be carefully tracked at national level, especially given its well-established detrimental effects on the ongoing physiology of the mother and baby (Uvnäs-Moberg, 2016). In the current study, externally managed augmentation of labour was experienced as an infusion of artificial oxytocin into the birthing woman's bloodstream as well as via the artificial rupture of a woman's membranes (ARM). 23 of the 56 labours in this study were augmented: 18 by artificial oxytocin infusion, 17 by ARM, and 12 subject to both techniques. In addition, 3 further births were subject to an artificial rupture of membranes in order for a monitor to be positioned on the baby's scalp.

The use of augmentation techniques makes a significant difference to the birthing woman's experience of labour, with the oxytocin drip tending to produce stronger and more frequent uterine contractions - sometimes experienced as continuous rather than intermittent - than would be the case in a non-augmented labour. These effects are generally accompanied by increased monitoring, which in the current study involved limitations on the labouring woman's mobility (given the apparent lack of access to telemetric monitoring technology). For some women, excessive pain accompanying this intervention is treated by epidural anaesthesia (again serving to reduce the possibility of women's mobility). In the present study, six of the ten labours that were accompanied by epidural anaesthesia had been augmented.

The Maternity Care Working Party therefore discussed modifications to the collection and publication of statistics that would allow for a depiction of the incidence of physiological birth as well as a more inclusive approach to collecting data related to each treatment given to birthing women (Werkmeister et al., 2008; Maternity Care Working Party, 2007). Their final recommendations drew on the ground-breaking work of BirthChoiceUK [sic], who had started publishing normal birth statistics in 2001, having developed a working definition of normal birth with the Department of Health,

leading to its publication in the official Maternity Statistics Bulletin between 2003 and 2007. The summary agreed definition of 'normal delivery' in that context, as a proxy for measuring physiological birth, is a birth:

> 'without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery' (ibid., 2007, p1)

The working group adopted this definition, on the basis that practical difficulties would preclude the early implementation of more ambitious proposals (since these would require significant changes to the existing data collection and reporting regime). This definition thus derives as much from the vagaries of NHS maternity statistics than any clear conceptual underpinning; as such, it is recognized as its proponents as a 'step in the right direction' rather than an ultimately satisfying definition (Beech, 2007).

Across England, BirthChoiceUK have estimated that the proportion of normal deliveries was just under 40% in 2013/14; for comparison, on the basis of a slightly different methodology, the rate for England and Scotland stood at just under 60% in 1990/1991 (BirthChoiceUK, undated). In the current study, based on this definition, a maximum of 10 births might be considered normal deliveries, and there were no births that would meet a stricter definition of a physiological birth (in particular due to the widespread medical management of the delivery of the placenta).

5.2.3 The politics of representing birth: an ongoing and contested area

In this section, I have illustrated how the practice of physiological birth lurks in the shadows of official representations of birth, at best identified by what it is not, rather than what it is. The definition of 'normal birth' in this way perhaps encapsulates the way in which the officially authorised way of representing birth displays a tentative and unsteady grasp of a reality in which physiological birth might be considered of value. The notion of physiological birth is never fully realized in this official description, with the implication that it is not something worth realising, or even possible to realise. (And perhaps paradoxically, any reform of the statistics might work to lend further support to such an implication, given its likely demonstration that physiological birth is rarely achieved.) In this way, the game of physiological birth, and any illusios related to it, are subject to a discursive silencing.

There is perhaps some optimism to be had, however. A new national maternity dataset has been under development since 2005. This Maternity Statistics Data Set (MSDS) demands the collection and submission of far more detailed birth data from hospitals. If fully achieved (although this is by no means certain), the MSDS initiative offers the

possibility of a presentation of national birth statistics that for the first time might recognise the concept of physiological birth. It is not yet certain that the full rollout of this initiative will include the derivation and reporting of an improved measure of physiological birth, but if it does this will be thanks in good part to a group of committed birth researchers and activists, working within and beyond academia, who have tirelessly persisted with this issue over many years, working closely with government statisticians to do so. Absent a clear political commitment from government, continued such efforts will be necessary to bring this initiative to a successful conclusion.

Finally, whilst the concept of 'normal birth' has proved productive in how it has allowed a focus on the decreasing incidence of a discourse of physiological birth, it should be noted that it too has been the subject of criticism, for example in the way in which it seems to be overly focussed on physiological events during the labour and birth, ignoring women's qualitative experiences. As such, it is argued that the normal birth measure is not adequate to properly represent women's birth experiences. This is an important debate, albeit one that is beyond the scope of this thesis. But it further underlines the idea that debates about the description of birth represent a key space of political contest, and are likely to remain so.

5.3 Birthing habitus at the start of the childbearing career

In Chapter 3, I discussed the Bourdieusian notion, highlighted by Ghassan Hage, that people are invested in different aspects of life in very different ways, reflecting the affective component of habitus (Chapter 3.3.4). This section draws on women's narrative accounts to discuss illusios and investments in birth, and in the physiological process of birth, at the start of the childbearing career. The analysis in this section draws specifically on women's accounts of the period leading up to their first birth experience. In commencing at this point, it is important to recognise that personal narratives of one's engagement with any particular social practice, including birth, are not free-standing but are reflective of one's previous habitus acquisition. Following Wacquant, we might say that they represent an initial formation of the birthing habitus (see Chapter 3.3.3).

From this section onwards, short excerpts from interview transcripts are used to illustrate the analysis. In this way, the twenty-six individual women who participated in this study, together with their 68 birth experiences, are gradually introduced. Following each transcript excerpt, the pseudonym of the woman is noted. Some readers might

find it useful to refer at times to summary pen portraits of each woman: these are offered in the appendices (Appendix D).

In subsequent chapters, I examine women's narratives of their experiences of the social practice of birth (Chapters 6 and 7). Whilst the starting points in this chapter provide a useful backdrop to that, they will be recalled more specifically as I examine how women's engagements in the practice of birth - and their exposure to the rich learning environment offered by these engagements - lead to a process of narrative and habitus development over the childbearing career. As women seek to make sense of their birth experiences, in the context of these starting points, I discuss how they reposition themselves, via further work on their birthing habitus, for future birth experiences (Chapter 8).

5.3.1 Illusios of birth, investments in birth

Women's narratives suggest a range of illusios about birth, and about the physiological birth process. Thus different women are invested in birth, and in the physiological process of birth, differently. Few women talked specifically in their narratives about why they might or might not hold certain illusios, or seek to invest themselves in certain ways, regarding birth. In Bourdieusian terms, this seems understandable: it is in the nature of social practice that there are limits to the extent to which people subject their illusios and investments to scrutiny, in the absence of any clear cause to do so. It is not straightforward, therefore, to illustrate these various positions with extracts from transcript data. Rather, glimpses of illusio and investment are more often offered in the context of women's narratives about their own sense of agency regarding birth (5.3.2) and their expectations of their first childbirth experience (5.3.3).

Many women in this study, however, seem to hold an initial illusio that the process of birth itself (in addition to the expected result of a healthy baby and mother) is important to them. For these women, birth becomes a temporary project in their lives: they invest themselves in various ways in the forthcoming birth. Conceptualising themselves as agents, they set themselves goals for the birth and seek to be well prepared, in order to achieve a successful outcome (on their own terms). For many of these women, the illusio is specific in that it is the physiological birth process that is important:

> "we wanted to have as natural a birth experience as possible" (Lucy)
>
> "It was like let's do it with as little intervention. Even though I wanted to go to hospital, I still wanted to do it with as little intervention as possible. I just got into the idea that I wanted as little messing about with as possible really,

because that was best for baby at the end of the day, and best for me" (Pamela)

It seems reasonable to interpret women's dispositions (habitus) in this context, as based on varying dispositions towards their own embodied selves and perceived competency with respect to birth. Each woman has access to different types and amounts of cultural capital (knowledge) related to birth. For some women, this habitus formation and capital at the start of their childbearing career seems to allow for an illusio that the practice of physiological birth is important - it is a game worth playing (and worth playing well), and better than the alternative games on offer.

For other women, the practice of birth seems to be far less important. Indeed the game of birth is not a game that they particularly wish to play; their main interest is rather to emerge with a healthy baby.

> "I didn't particularly want medical intervention, but frankly I just wanted the baby out. So I am not fussed about what kind of birth I have. I am really not that bothered" (Lola)

> "I just wanted to get it over with as soon as possible" (Jane)

For some of the women who do not hold an illusio that physiological birth is a game worth playing, their narratives reveal a strong imaginary of the other: women who do hold this illusio. This is the imaginary woman who, according to those that imagine her, puts herself and her baby at risk by naively believing that the game of physiological birth is important and worth playing. She represents a position from which other women seek to distance themselves:

> "I was certainly not going to martyr myself for a natural childbirth. I suppose I felt that people who have never given birth, who were totally determined to have a natural childbirth, were somewhat foolish" (Barbara)

> "I wasn't one of those who wanted to do it fully naturally" (Naomi)

5.3.2 Conceptualisations of agency

As well as differing in their illusios towards birth, women also seem to hold very different illusios about their role in the social practice of birth. This is not an independent illusio but seems to be strongly associated with women's conceptualisations of the social practice of birth. For example, is birth conceptualised as a game of skill, a game of chance or some combination of the two? If it is conceptualised as a game of skill, involving some form of human agency, the question

arises as to who is able to affect such agency: who possesses knowledge, skill and power in the game of birth?

For some women, the idea that they - the birthing woman - might have a significant agentic capacity, or might consider themselves to be skilful and knowledgeable, and on that basis able to affect the way that a particular birth unfolds, is hard to detect. A strong theme in the data relates to how women represent their own level of knowledge about birth as low, with some representing themselves as not only unknowledgeable but as unable to know:

> "I was very young and did not know what to expect at all" (Jane)

> "Obviously with your first child you don't have a clue what to expect" (Serena)

With such a positioning, it is interesting to speculate about the link between knowledge and responsibility. In declaring their lack of knowledge and ability to know, it is possible that women are conceptualising themselves as not responsible for what happens in the birth room, based on a belief that they have little influence over what happens there. This suggests the birth room as a space in which women are protected from blame if things go wrong or if they do not perform in a certain way.

For other women, such a position was challenged by the notion that women's bodies 'know' how to birth, thus indicating an illusio that they - or at least their bodies - are skilful and knowledgeable with respect to the practice of birth:

> "Your body knows.Years ago, they didn't have all this stuff. Your baby come (sic) where you stood. You didn't have to rush to hospital and have all these tests and medication. I don't dispute that you might need a bit of help, but I think you could give birth to a baby on your own" (Sparkle)

> "I think that as a woman you should be able to do it, shouldn't you? Women have been giving birth forever, haven't they, so surely you must be able to do it? And never having done it before, you just sort of think 'anyone can do it'. I have the right equipment for it. I thought I was born to do this" (Skye)

Other women discuss how they can influence the outcome of their birth by taking an active role, by preparing themselves for the birth in body and mind. For some women, such activity was focussed on keeping fit and healthy, whilst at the same time rested and relaxed:

> "[I was] wanting to keep myself active and ready, so [my] body would be able to cope when [I] did go into labour" (Mary)

> “I was trying to do as many things as I could to make sure I felt relaxed, make sure had a lot of rest” (Cat)

> “Just try and be healthy, do lots of walking. Fitness and things like that can help. Just look after yourself really. Put my feet up. Not get stressed out” (Sparkle)

In this way, women talk about a wide range of activities they undertake to prepare themselves for birth. Two women in this study were keen to improve their chances of a physiological birth by giving birth in a free-standing birth unit, an option that was not routinely offered by the community midwives, but something they had to request:

> “It wasn’t even mentioned, and it was only at my NCT classes that I was told about it. So I just went to my midwife and said ‘right, this is where I’m going’ ” (Jenny)

For some women, agency is signalled by the way in which they reveal their intentions and determination:

> “I was always determined that I was going to have a good labour. I wanted it to be something I enjoyed. I did have intentions, yes. It was important to me” (Cat)

5.3.3 Expectations, hopes and fears in advance of the first birth

Amongst the women in this study, there is a great deal of diversity in terms of what women expect from their first birth experience. These expectations take two forms: first, how women imagine the quality of their first birth experience (ranging from expectations that it will be a highly positive experience to fears of a negative experience); and second, the type of birth imagined (for example, whether an essentially physiological birth or a birth subject to some intervention).

Women’s expectations of the quality of their first birth experience differ significantly. For women expecting a positive first birth experience, this expectation is most frequently associated with women who are hoping for a natural birth. Alice and Mary have particularly strong imaginaries of a highly positive first birth experience. These imaginaries include a firm focus on achieving access to specific birthing spaces, for example a hospital room containing a birthing pool:

> “I always wanted to have a water birth. I thought I was going to have a lovely water birth, with relaxing music and it was all going to be lovely” (Alice)

> “I wanted to have a water birth, natural, you know? Use my TENS machine. I did not want to have a highly intervened labour with lot of pain relief. I wanted it as natural and peaceful, for me and my unborn baby as well” (Mary)

In Chapter 8, I discuss how women's birth narratives suggest that expectations based on access to specific resources outside of women's control are particularly vulnerable to disruption. It is noticeable how women's expectations (predictions of the future) are mingled in with their hopes (desires for the future). There is also a theme of uncertainty about how birth will unfold, alongside intentions about the birth:

> "[I was] open minded, without any particular preconceptions. I just wanted to see how it went" (Barbara)
>
> "I didn't really know how it was going to go, but all I knew was like I wanted it to be a calming experience" (Cat)
>
> "I was hoping for a natural birth. I didn't have any real strong expectations and desires of exactly how I wanted it" (Becky)

In the following chapters, I will address further the notion of women being open to see how it goes/take things as they come, based on an understanding of the uncertainty of birth, and discuss how this positioning on the part of women can play out in very different ways.

In contrast to women hoping for and expecting a straightforward positive birth experience, other women anticipate an unpleasant first birth experience:

> "I know some people are very particular about what they want and I was really not bothered. I think even now I would just be like 'oh let's get it over and done with. It's just not pleasant' " (Lola)

Such a prediction that birth will be unpleasant is often underpinned by an over-riding sense of fear. Whilst the focus of that fear is not always clear (and oftentimes associated with the unknown), in many cases it seems to relate to a fear of the physiological process of birth. In some cases, the source of fear might be further interpreted as a fear of being unable to cope with the pain of labour and birth, or a lack of self-confidence in terms of one's ability to labour and give birth.

> "I was just absolutely petrified of giving birth, absolutely petrified. I was nearly in denial and was just thinking 'this baby has to get out, but I'm not quite sure how I'm going to do that' " (Heidi)
>
> "[My expectations] were probably full of fear. I had written in my birth plan that I wanted the epidural" (Sally)
>
> "I was really, really scared about it and kept trying to put off thinking about it" (Jane)

For some women, the idea that birth might be unpleasant seems to shut down an openness to pursuing effective preparation:

> "I am the sort of person that can scare myself so I thought 'I am sure I will know what to do' but I just read up on the basics" (Lucy)

Lucy's approach seems to protect her, however, from the fear that some women seem to develop based on their learning at antenatal classes:

> "it was all very much the negative that drugs could do and the impact they could have on your baby. I was very scared" (Skye)

Finally, on the issue of fear, Julie suggests that her fear of giving birth caused a significant delay to the start of her childbearing career:

> "we were married ten years before we had any children, because the whole thought of giving birth just filled me with absolute dread. I was very apprehensive about the whole thing, and was not really looking forward to it" (Julie)

In cases where fear is evident, women's narratives suggest little sense of agency, or any strategies available to them to ensure that their birth would be positive. Rather than becoming a personal project, for some of these women the birth seems to represent an undesirable and yet - once they are pregnant - unavoidable game, one in which they are compelled to participate. If there is any escaping the game of birth, it seems that these women would gladly take it. For Julie, for example, a c-section is recommended when her baby is found to be in a breech position, and she talks about how she reacts to this situation with relief:

> "We didn't particularly have any choice really. I was kind of relieved when they said it would be a c-section. I was happy to go along with it. I was so apprehensive really, about the labour bit, so I was just wanting to get it sorted, whatever it took" (Julie)

Expectations also vary in terms of the type of birth that women expect to have, or problems that women expect to encounter with the physiological process of birth. Whilst some women express a clear expectation that they will experience a physiological birth, other women's narratives reveal uncertainty. Except where a planned caesarean section is indicated (for example related to existing health conditions), however, all women's narratives seem to suggest an expectation that their births will follow a physiological pathway. One of the striking things about these women's narratives, therefore, is how a successful physiological birth experience

seems to be taken-for-granted. Within this group, there were many women who simply expected a straightforward vaginal birth (often referred to as a natural birth). None of the women expected major deviations from a physiological pathway for their first birth, excepting some pain relief, and an outcome of an emergency c-section was certainly unexpected (despite the frequency of such outcomes both nationally and in the local area). This is somewhat curious, given the widespread birth interventions actually experienced by the study participants, and indeed the absence of any woman in this study achieving a fully physiological birth (5.2):

> "I thought that everything would be fine, I would be giving birth, you know, she would be delivered naturally, and I would be giving birth naturally" (Sally)

In part, these expectations seem to relate to a woman's confidence in her own birthing competency, and in particular how she imagines her skill in coping with the pain of labour. There is little evidence in this study that many women are doubtful at this stage about whether or not their body is capable of labouring and birthing. Some women's narratives are clear about the likely diversion from a physiological pathway, however, linked with their predicted need for pharmacological pain relief:

> "I would never have thought that I'd have gone in for natural birth without drugs. I definitely would have had pain control" (Alice)

> "Why have pain when there is pain relief available?" (Barbara)

Whilst some women expect to be aided by pharmacological pain relief, therefore, others are confident about their intention and competency to cope with the pain of labour:

> "I was very much 'I am going to use as little pain relief as I can' " (Sarah)

5.3.4 Discursive space at the start of the childbearing career

As well as commencing their narratives with reflections on how they were positioned at the start of their childbearing careers, some women return to this aspect of their narrative at a later stage of the interview. In doing so, they reveal not only how their habitus changes over their childbearing career, but also how the act of constructing a narrative of their childbearing career includes the task of making sense of the fluidity in their personal positioning towards the social practice of birth.

In some cases, this sense-making reveals the complexities of women's positioning at the start of their childbearing careers, and suggests that there is an absence of discursive space for some women to fully explore their own preferences with respect to how they wish to give birth. Barbara, for example, had initially talked about how she

"wasn't overly keen on the idea of natural childbirth necessarily at all", but later suggests that this is not entirely correct:

> "That said, I did feel right from the beginning that I would have preferred it to be a natural birth rather than an epidural birth, even though that is what I had. But I wasn't that sure of my convictions that it was what I wanted, to say I wanted natural childbirth" (Barbara)

Being 'unsure of her convictions' not only seems to silence Barbara's desire to achieve a physiological birth; it also works to shut down the possibility of her attempting it, as she is unable to have a conversation with, and recruit, her midwife to this possibility.

From a different perspective, Heidi also refrained from exploring her preferences for her first birth. Heidi talked about how she was very fearful of birth, so much so that she might have opted for a c-section if given the chance (although she does not seek out this option). Heidi rather keeps her extreme level of fear to herself, a positioning which might otherwise have been diagnosed as tokophobia (fear of childbirth):

> "I could just not get my head around it. I knew it had to come out but I just did not want to go there. It was like denial. I would have liked a c-section, because I just did not want to do it. But like I say, probably nobody knew all that" (Heidi)

In Heidi's case, fear is present throughout her childbearing career. That she did not feel able to communicate this suggests a discursive space in which women feel that such talk is inappropriate. Instead, women such as Barbara and Heidi maintain a silence about their deep-seated fears and desires, as such discussions are marginalised in the context of short antenatal appointments during which the completion of routine forms and physical checks seem to take precedence.

5.3.5 Birthing habitus: starting points

This section has highlighted, through an examination of women's hopes, expectations and fears in advance of their first birth, how women hold different illusios of, and are differently invested in, birth and different practices of birth at the start of their childbearing careers. It also introduces the idea that women's birthing habitus - including their illusios and investment in different practices of birth - might shift over their childbearing careers. Whilst I have highlighted how many women hope, and even seem to take it for granted, that they will achieve a positive and successful physiological birth, I have also discussed how other women approach their first birth with trepidation, especially concerned that they will be unable to cope with the pain of labour and birth. Over the next two chapters, as women's birth experience narratives

are examined, we will see the extent to which the games of birth that women play match up with their expectations, hopes and fears, and how these together work to restructure the birthing habitus.

5.4 Conclusion

This chapter has provided contextual material for the main study findings. First, I have offered an introduction to the location of the study, geographically, socially and temporally. Second, I have provided a brief descriptive analysis of the twenty six childbearing careers (comprising sixty eight birth experiences) that make up the birth experiences of the women who participated in the study. In doing so, I have underlined the importance of critically analysing taken-for-granted statistics and categorisations of birth experiences. Third, I have started to explore the storied elements of women's narratives, to establish an understanding of the diverse starting positions as women enter the field of birth. Over the next two chapters (Chapters 6 and 7), women's experiences in the field of birth are the focus of analysis.

Chapter 6 Exploring the hospital birth space: experiences of trouble in the field of birth

In this chapter I examine women's stories about their experiences of birth drawn from across their childbearing careers. In doing so, I provide an introduction to the field (or social space) of birth that these women encounter and, along with others, work to reproduce. The previous chapter presented an analysis of women's initial illusios and expectations regarding the social practice of birth (5.3). Both this chapter and the next shift attention to focus on women's experiences in the field of birth.

As these chapters unfold, it becomes evident that the practice of birth (or game of birth) encountered by women is often quite different from their expectations at the beginning of their childbearing careers. It is also quite different from the prototype physiological game of birth outlined in Chapter 3 (3.5.3). This chapter offers insights into the social contingencies associated with the practice of birth which seem to underpin this divergence; contingencies associated with the physiological process of birth are the focus of attention of the next chapter.

Running through this chapter are three key questions: how might women come to know the social practice of birth, through their own experiences, as they temporarily inhabit the field of play; in what ways might women demonstrate skilful and knowledgeable agency - or practical mastery - in the field of birth; and, how, through being engaged in the field, do women come to reconceptualise birth, laying the foundation for different kinds of practice in subsequent plays?

Much of the data presented and analysed in this chapter focuses on interactions between birthing women and health service workers. Women tell stories of how they are repeatedly emotionally troubled by events and encounters they have with staff (or that they do not have). In some stories, women find themselves being treated as trouble and feeling like they are in trouble. These are also troubling stories, which in their telling may trouble the listener. As such, I claim that these stories represent an important element of the contemporary birth environment for the women participating in this study. Indeed even where women choose to accompany such stories with more positive stories, and in the context of an overall judgement of their birth experiences as satisfactory (Henderson and Redshaw, 2017), the possibility of negative emotional outcomes for the birthing woman, whether apparently transitory or more persistent, seems to be ever-lurking.

The concept of trouble that is central to this chapter derives from a tradition of narrative analysis: trouble is a complicating event, one of the defining characteristics of a story,

without which a story might be considered to lack form. My use of the concept is drawn from the methodological writings of health sociologist and Bourdieusian scholar Arthur Frank (2012). As I have sought to understand the linkages between women's birth narratives and my focus of enquiry, Frank's attention to trouble resonates well with a key theme in my data in which the development of a woman's orientation towards birth over her childbearing career, discussed in Chapter 8, seems to be affected both by remembered and retold scenes of trouble (as well as by other stories which reveal what is not considered as trouble by the birthing woman). This chapter thus introduces some of the 'Trouble that swirls though stories' (ibid., p29) from the perspective of the birthing woman. It also starts to work with the notion, key to Frank's approach, that such stories do not simply represent trouble but have the capacity too to 'make Trouble' (ibid., p28).

As they are examined in this chapter, it is possible to begin to consider how the development of stories of trouble by childbearing women - representing access to a particular store of privileged and situated knowledge (Rose,1997) - might be an important part of their shifting understandings of, and orientations towards, the social practice of birth over their childbearing career, as they embody a shift in the women's narrative habitus (Frank, 2012, p52). Trouble in this chapter manifests frequently as negative embodied emotions, emotional responses that are key to women's experiential learning about the social practice of birth; such learning is not simply a matter of rational thinking and disembodied knowledge, as Elana Michelson reminds us in her call for the return of the body to conceptualisations of experiential learning (Michelson, 1998).

In this way, the role of these stories can be considered influential in how women are positioned, and position themselves, with respect to further encounters with birth (and with physiological birth in particular). They work to restructure the habitus which, in turn (as Bourdieu would have it), structures subsequent social practice. As such, what I offer in this chapter is the notion of women's birth experiences as a key space of childbirth education or learning. I offer up for examination a conceptualisation of this social space as the antenatal classroom for subsequent births.

Importantly, the evidence presented in this chapter is intended to stand separately from women's stories about their developing understandings of, and their shifting illusio in relation to, the physiological process of birth, which is the focus of Chapter 7. In this chapter, it is the contingency that is represented by the social practice of birth as experienced psychologically (and emotionally) by the women in this study, rather than the experienced or imagined contingency of the birthing body, that is the focus of analysis. It is my contention, however, that the social practice of birth is a key factor in

how physiological birth unfolds, if not for a given birth experience then for the woman's future birth experiences, as it works to either protect or disturb the physiological process: mind and body are inseparable in the practice of birth. This contrasts with understandings of different ways of birthing as resulting solely from the contingency of the birthing body.

I present the discussion in three overlapping sections, each representing a particular stage of a woman's birth experience: early labour, labour and birth itself, and the early postnatal period. Common issues arise across these stages; analysed together, they enable a perspective of a power-infused and inter-connected space of practice and learning for birthing women.

6.1 Trouble in early labour

In this first section, I focus on women's stories relating to the social practice of birth in the early stages of their birth experience. A key theme identified is the unexpected trouble that is encountered by women as they enter the 'unknown territory' (Eri et al, 2015) of pre- or early labour care. Of the 26 women participating in this study, 17 women chose to share detailed stories about troubling aspects of this early stage of their birth experience; for some of these women, such trouble was experienced as traumatic and had long-term consequences. Whilst trauma is an important element of this account, and scholars have investigated the consequences of traumatic experiences on a woman's reproductive history (see for example Gotvall and Waldenstrom, 2002), equally important is the seemingly ordinary nature of the trouble described in women's stories, evocative of the feminist journalist and writer Naomi Wolf's concept of ordinary bad birth (Wolf, 2002), a concept that to date has been little examined in the academic literature.

6.1.1 Crossing boundaries: trouble on seeking care

> "I think the worst thing for lots of people and the build-up [to giving birth] is when do you go to hospital? At what point are you allowed to go, when they won't send you home or you are made to feel unwelcome?" (Liz)

> "the worst experience for me was sitting in the car [en route to the hospital]. I just so wanted to be there and relaxed, and if they hadn't sent me home I would not have had to go through that. It was definitely my worst experience" (Cat)

Pregnant women learn to expect that they should recognise, in early labour, when it is appropriate to call the labour ward to seek advice and then to present themselves in person at the hospital. There is little suggestion in women's preliminary accounts that

this process involves trouble. Trouble at this stage, however, seems to be what many women experience, whether this manifests itself in terms of being turned away from the hospital, being treated unkindly or being ignored. In this section, I examine two stories of women arriving at a maternity unit to seek support in early labour. In both cases, trouble arises when the women are highly unsettled with the reception and type of attention they receive.

Skye, for example, knew what to do when, at the end of her first pregnancy, her membranes ruptured and she saw that the amniotic fluid was green. She was confident in her recollection:

> "It was the one thing I had taken with me from the classes. 'If your waters are green, phone the hospital' so I did" (Skye)

As Skye understood it, the presence of green fluid was not to be ignored. Rather, it was a sign that the baby might be in distress. Thus some action needed to be taken to address this situation: that was the purpose, Skye thought, of contacting the hospital. Unsurprisingly, therefore, she was unsatisfied with what she felt was a 'very very blasé' response on the telephone, essentially telling her not to worry about it, so she decided to go to the hospital. Trouble arose as soon as she arrived, as Skye's understanding of appropriate action was seemingly contradicted by staff, much to her increasing distress:

> "they were just absolutely shocking. It was a battle to get anybody to see me. You know I had to pop in this room, because I didn't appear to be in labour, and I said to the woman on the desk that my waters had broken, the fluid is green and I would really like someone to see me. Because obviously it signifies that the baby might be in distress. So it seemed like a long time before anybody actually saw me. We had to wait about an hour. We were the only people there. Just to be seen, and to be listened to. So there was a lot of me pacing around and getting very upset and I was thinking there is a reason this has happened and I want to know. And then it was just like Carry On Hospital, they couldn't find a torch. They eventually hooked me up to a monitor in the side room and conceded that I was correct and I was having contractions, and every time I had a contraction I am worried that my baby's heartbeat is dipping" (Skye)

The stress that Skye experiences in this situation is clearly still vivid in her memory as she relates this incident. She was extremely worried about her baby's safety, and the care she receives seems to her to be wholly inadequate. Skye's reaction to the advice given to her on the telephone is noteworthy, evoking the work of Helen Spiby and

colleagues (Spiby et al, 2013). Skye's account speaks to a sense of isolation and abandonment, to a lack of attention on the part of staff to Skye's physical and emotional well-being, and to how women seek to mobilize their various forms of knowledge only for it to be dismissed. Skye and her partner are left in the 'care' of a machine, which has obvious limitations in terms of how it is able to meet their needs. It is clear from Skye's overall narrative that this episode has repercussions for how this birth progresses, as well as for how Skye will approach future pregnancies.

Skye's account also reveals an issue repeated in other women's stories: staff being unable to locate basic items necessary for them to perform their duties. This time it is a torch, in other stories it might be agreed pain relief. This might seem to be a minor issue. But if a useful objective for early labour care might be to support feelings of confidence and trust in a labouring woman - both in her own ability to birth as well as in the staff and institution supporting this process - then it is clear that service delivery easily characterised, in this case by Skye, as best fitting the Carry On genre is unlikely to contribute to the meeting of such an objective.

Skye's experience of dissatisfaction with early labour care was not in any way unique amongst the study participants. The issue of women not being attended to kindly or promptly on arrival at hospital in early labour appears in many accounts. For her second birth, for example, Barbara laboured initially at home. Following her arrival at the hospital, Barbara was let in and shown to a private room 'by some sort of orderly' and told that she would be given access to the entenox supply (a mixture of gases intended for inhalation used for pain-relief purposes). Eventually, when this did not happen and no-one had come to talk to her or examine her, her husband pressed the call button:

> "This very officious midwife, who I did not like at all, came in and said 'What is the matter?' I said, 'well, I am having a baby and have been here for quite some time and nobody has looked at us' and she said 'and?' I immediately didn't like this woman" (Barbara)

Shortly thereafter, Barbara recalls how the midwife, who had remained in the room, was setting up the entonox:

> "She looked me and asked 'are you pushing?', and I said 'I don't know what I'm doing' and she looked again and basically the baby was coming out. So then she did hook up the gas and air, by which point I wanted to throw it at her, because it was doing me no good whatsoever" (Barbara)

Barbara relates how the baby was born about ten minutes later. Whilst this immediately provides a positive resolution to the trouble that Barbara has experienced, this does not erase the incident. The stress caused to Barbara by this and other 'poor care' episodes has specific consequences for the way in which she, like Skye, approaches future births, as will be explored further in Chapter 8.

In both of these accounts, the apparent lack of care as these women enter the hospital space is striking, and raises the question of how welcome they really are. A gatekeeping function held by staff (with the responsibility to maintain control over access to the limited resources within the hospital space) seems to work to obscure their role as 'meeters and greeters' and, subsequently, caregivers. It is clear from women's narratives that the playing out of these rather separate functions on the part of staff makes for difficult interactions, in contrast to the far smoother entry to the hospital space when women are accompanied by known caregivers (Jepsen et al., 2017). In addition, the effect of staff seeking to protect the physiological birth process can also be subject to misinterpretation and distrust on the part of women and their families. Whilst staff might be working with a sense that they are 'doing the right thing' and 'being a good midwife' in Skye's case, for example, in seeking to downplay Skye's concerns about pathology, from Skye's perspective such a stance is not experienced as reassuring but negligent, and triggers stress which is likely to be unconducive to an oxytocin-powered labour (3.5.3).

6.1.2 Women's experiences of confrontation

Confrontation is another key theme as women seek to access support. In this study, a highly-charged emotional encounter was represented multiple times in the context of discussions between women and staff about whether or not the membranes of the sac of amniotic fluid surrounding the baby had ruptured: in lay terms, this is a discussion about whether and when a woman's waters have broken. For the maternity care system, the establishment of this information is important because there are clinical protocols defining what action is advisable if a premature rupture of membranes is diagnosed (NICE, 2008).

Thus it was a common experience in the narratives offered in this study that women would seek to communicate to the hospital that their waters had broken, as some had learnt to do from their attendance at an antenatal education session, and as they believed to be the responsible course of action. But rather than representing a neutral exchange, which women expected would lead to the provision of information on what they should do next, some women instead find themselves embroiled in a hostile

situation, in which the veracity of their report is challenged and their status as a knowledgeable agent is undermined.

Jenny's experience of confrontation came as she sought to access labour care for the birth of her second child. Following a traumatic first birth experience, in which she identified poor care as a major cause, Jenny was particularly keen that she was listened to:

> "I was leaking small amounts for several days. Phoned the hospital. They said come into the antenatal clinic and was seen by a nurse who turned round and said 'you're not leaking, you're as dry as the Arizona desert' sort of thing 'but I will get the doctor to check you'. Doctor checked me, both very dismissive of me, almost slightly rude really. So I came away thinking 'well, they've examined me, they know best', but obviously, you know, not very happy, you know, that they had dismissed me.
>
> "Anyway, on the Monday morning, woke up, turned over and went gush. So again, phoned the hospital, went in, and it was the same midwife who'd seen me on the Friday. And she said I'm sure you hadn't, sort of thing, she was sure I hadn't had a leak and I asked her to examine me please. So she examined me again and said I was as dry as the Arizona Desert again. She said 'I think you've wet yourself and hadn't realized it' and I told her that I would know if I had wet myself. I might be pregnant, and my [first baby] might have done a load of damage, but I'm quite capable of controlling my bladder. I'd know if I had peed myself. And she said, 'oh no you have not leaked, it must be wee'. So I pulled the pyjamas out of the bag and said 'well, smell those, because it is not urine'. And so she very grumpily, she said she could get a doctor to examine me but that I would have to wait until lunchtime and this was like half past nine in the morning. So I said 'I don't care if I have to wait here all day. You get a doctor to examine me, because I am not leaving here until you have' " (Jenny)

In Jenny's account, we can see how Jenny's mistrust of midwifery staff, and the ongoing dispute over whether or not her membranes have ruptured, leads Jenny to take action, first to assert her position (by taking into the hospital proof of amniotic fluid on her pyjamas) and, when this fails, to demand an assessment and examination by a doctor.

Heidi also experienced a confrontation with staff on this issue. When Heidi's membranes ruptured at home at the end of her third pregnancy, she visited the hospital

the following morning. Already anxious about the forthcoming birth, Heidi relates how she experienced an unsatisfactory discussion with the staff:

> "they were saying I had lost control of my bladder and I said 'no I haven't'. They said 'you cannot hold your waters. If the water comes out, they come out'. I was saying 'it is not urine, I am not doing a wee, I am sure it is the waters'. They said 'no, it can't be'. So they sent me home and said 'no it is definitely not, that cannot happen' " (Heidi)

Heidi recounts how 'I just remember feeling that my opinion doesn't really matter'. Heidi was even more anxious when she returned to the hospital after her contractions had become unmanageable the following night. 'In a bit of a panic, that same feeling of terror', Heidi at first resisted her husband's suggestion that it was time to go in. Once there, Heidi was drawn into a further conversation about whether or not her membranes had ruptured:

> "they kept saying to me 'have your waters gone?' and I was trying to explain the situation. And they said 'no, they cannot have gone then'" (Heidi)

Later in her story, Heidi returns to the question of whether her waters had gone or not, when she experiences the 'waters dispute double whammy'. Whilst women's reports of ruptured membranes might be repeatedly rejected before the birth, after the birth, when it comes to staff decisions about how long the woman and her baby will be requested to remain on the postnatal ward for observation, the possibility that the membranes had ruptured according to the woman's reports shifts from being impossible - a wholly unreliable piece of information - to a possibility. This happened in Heidi's case, much to her annoyance:

> "But after, I had them saying 'no we will have to keep you in because it might have been' and then me saying 'well I thought that couldn't happen' and they said 'well it might have been, we are not sure'. But I am not an argumentative person so I just said 'right, whatever'. There was no point in arguing, because it would not achieve anything. I was really annoyed" (Heidi)

In interpreting Heidi's account, it seems that Heidi's interactions with staff do not necessarily undermine her trust in her own knowledge. What they do achieve, however, is a reduction in Heidi's willingness to communicate with, and to trust, staff; certainly Heidi seems unable to hear an offer of an extended postnatal stay as a safety-based recommendation. For Heidi, the experience of giving birth was clearly highly anxiety-provoking. But Heidi's anxiety seems to have been heightened by her

experiences of the social practice of birth beyond anything related to the physiology of birth.

As a final example of such confrontation, which plays out in different ways in different circumstances, Liz relates how she was asked to go into the hospital when she phoned in to report that her waters had broken:

> "I remember being taken into one of their rooms and the midwife being so rude, really unpleasant. She was like 'I don't know what you are talking about. Your waters haven't broken, just go home'. Really, like 'why are you bothering us?' You feel like you are being sent home with your tail between your legs, doing something wrong" (Liz)

The next evening when she returned to the hospital, however, staff were unable to rupture her membranes:

> "they are like 'oh, your waters are broken'. I said 'yes, if you look on the records, I told you this twenty-four hours ago' and that is when they went into panic mode" (Liz)

This panic mode on the part of staff is something mentioned by many women; indeed Liz relates how a similar scene was played out in her second labour when she explains how staff again changed their mind about whether her membranes had ruptured. Again, they had at first been sure that they had not (and this time Liz had made no effort to claim that they had), but as Liz describes 'I think they also worked out that my waters had broken the day before' which from Liz's perspective leads to 'two hours of frenzy', disrupting any attempt on her part to have a calm birth.

The effect of such uncertainty and confrontation seems significant: as well as introducing a level of anxiety and stress into the situation, they act to give women a new understanding of their positioning within the social practice of birth. The disputes' positioning at the very start of the hospital birth experience is significant, functioning to both unsettle and put the woman 'in her place' as a non-expert and untrustworthy, as if nothing the woman has to say is important. Even where the woman is sure of herself and her knowledge, whether embodied or biomedical, the effects can include some level of self-doubt on the part of the birthing woman, and a recognition of the limitations of her ability to participate fully in the management of her birth. At the same time, such disputes can lead to distrust both in the expertise of the maternity care system, given the gap between 'expert' opinion and the woman's lived experience, and in its ability to offer appropriate care. How all this affects the woman as her birth unfolds, and how it affects the unfolding of the birth itself, is addressed in women's accounts. Heidi's

account suggests the damaging effects of such episodes on her trust in the maternity care system and on her self-belief, despite her ongoing confidence in her privileged positioning with regards to bodily knowledge:

> "you feel really really silly and that you know nothing. And I do remember saying 'oh well, you know much more than me' and stuff like that. It is wrong when they do not listen to what you say, the person who knows most about what is going on in their body. I just remember coming away feeling really silly and a bit embarrassed and feeling a bit daft" (Heidi)

As with the experiences discussed in the previous section, it is possible to offer an interpretation based on the different illusios of the various players. For some midwives, for example, a concern to protect the physiological birth process (as a key objective of the game that they play) might underpin an approach in which women's experiences of ruptured membranes should be downplayed; whilst this may represent a midwife's mastery of the game, it plays out rather differently for the birthing woman, who might experience such an approach as incomprehensible, negligent, upsetting and deeply disempowering. It also raises important questions about how such encounters might work to disrupt the physiological birth process.

6.1.3 Experiences of poor care on the antenatal ward

The accounts so far discuss trouble which arises in the context of women seeking to access support before labour commences or in early labour. Trouble also arises when women go into labour as an inpatient, having been admitted to hospital antenatally. Rather than this location giving them good access to support, these women come to learn that their ability to command support from this location is highly limited. They find that it is for the staff team to decide on the timing and extent of support provided, in a way which may or may not seem responsive to their needs. In some cases, staff decisions lead to much stress, frustration and embarrassment.

An inpatient induction process occurred in around a third of the labours experienced by study participants, thus it was to be expected that many women would start their labour in hospital. This did not seem to be reflected well, however, in hospital arrangements to ensure good early labour support for such women, as Melissa's account illustrates. After starting the induction process for her second birth, Melissa explains how she was on a ward with other women (and their visitors) when she started to experience contractions. As her contractions became stronger, she approached the staff desk to inform them and to ask for some pain relief. She explains how she was told four times that someone would attend to her in due course, but that there would be some delay as

it was currently changeover time. Eventually, Melissa was provided with some co-codamol (a compound of codeine and paracetamol), at which point she suggested that it was too late for this, as she felt she was going to be sick. Not long afterwards, Melissa managed to get the attention of a staff member; her membranes by this time had ruptured and amniotic fluid was spilling onto the ward floor, and she was shortly to start vomiting. Melissa experienced this further request for help as being met with 'a real cross look' from the midwife. For Melissa, her inability to command the staff's attention was frustrating, and she experienced the commencement of her labour in a communal space as particularly humiliating, representing a highly stressful start to her labour:

> "They were just looking at me and I had been asking for I don't know how long for some help. It was so embarrassing because all these people with their families are still there, with me puking and what sounds like weeing going on" (Melissa)

This episode, as recounted by Melissa, suggests a gap between the organisation of maternity services and the needs of birthing woman in early labour which manifests as a distressing experience for the birthing woman. As Melissa discovered, the changeover period seems to represent a closed period in terms of non-emergency service from staff. Melissa's experience also highlights as problematic a lack of access to privacy for women who commence their labours as inpatients.

Whilst unsettling, this episode also depicts a rich learning environment in which Melissa has unexpectedly found herself. As she experiences her requests for help being refused, her bodily knowledge being distrusted and her desire for privacy ignored, Melissa - frankly baffled by the staff's behaviour - comes to understand that she is unwelcome in this place, feeling treated as a timewaster or as a naughty child:

> "They were just so condescending and you think 'why can't you be at least nice and reassuring? Why are you all so condescendingly rude?' You are here to have a baby and it should be a nice experience. You shouldn't be in trouble for something or feel you are wasting their time" (Melissa)

6.1.4 Being caring, uncaring, careless or careful: subjective understandings and emotional responses

If trouble often relates to encounters with staff, Claire's story further focuses attention on how some women experience trouble as an absence of care. But Claire's narrative of her first birth experience may also be usefully analysed in terms of how it illustrates the subjective nature of care, the links between care and women's emotional

experiences during birth and the dynamic nature of understandings and experiences of care over the course of a birth experience. Claire has already discussed how she was scared in the run-up to her first birth experience. She then takes up the story of being admitted in early labour in the early hours of the morning, on the basis of staff concerns about her baby. Obviously anxious about her baby's well-being at this point, Claire describes how she was isolated in a room on her own:

> "They said 'oh, we are going to keep you in, we'll send your partner home and we'll keep you in because there's a, we feel the baby's like in a bit of distress'. So I'm like all panicky. And I get put in this room completely by myself. Dan has gone home. Bearing in mind that they'd told me that the baby had err, that they were concerned about his heartbeat. I wasn't checked on until about 8 o' clock the next morning, and by this time the only reason I was checked on was because I was over the bed in absolute agony and when this nurse checked me I was actually 5cm dilated. So that's why I was kind of in agony and they rushed me down then to the labour room and they called Dan. And at the time, you don't think that's strange. At the time you just think right, that's fine. I'm not one to go 'excuse me' " (Claire)

This extract from Claire's narrative speaks to themes which are present in many women's accounts. In terms of the care experience, this passage at first glance might suggest an absence of care: this certainly seems to be Claire's perspective, but it is not clear that this is a perspective that is likely to be shared by the staff on duty, raising the question of whether there can be an objective measure of what constitutes an appropriate level of care. In this case, Claire's expectation of care seems to differ significantly from that provided by the healthcare team (for whom the provision of a single room, in close proximity to hospital staff and resources if required, might represent a satisfactory provision of care in the circumstances, especially if they also assumed that Claire was likely to be sleeping). From Claire's perspective, however, it seems that she experienced the care for her and her baby as poor, provoking anxiety on her part. The perceived absence or poor-quality of care is compounded by the enforced absence of support in the form of her chosen birth-partner.

Claire's expectation seems to be that she is in the antenatal ward to be cared for, given the stated concerns about her baby's heartbeat. But she is able to identify no care in that context. And her description of the care she does identify - in the form of a transfer to the labour suite the next morning and her husband being called back in - seems to suggest that the care was indeed unsatisfactory, in particular given the rushed nature of the transfer. This extract also raises again the issue of shared room (ward) versus

single room accommodation. Single rooms, experienced as a space of abandonment for some like Claire, are a key demand for others. At least Claire - unlike Melissa - had the opportunity to labour in private, but given the diagnosis of trouble, she did not want to be there and do this on her own. Claire's account also illustrates well how institutional care routines can create or significantly contribute to the phenomenon of rush, and panic, in labour (rather than this being inextricably bound up in pathologies associated with the physiological process of birth).

6.2 Trouble in the birthroom

In this section, attention shifts to narratives about women's labouring and birthing experiences; in institutional terms, this is when a woman has been deemed to be in active labour, and this stage is usually signified by the woman's admittance to the labour ward or delivery suite. In many ways, and in contrast to the narratives of the early labour and postnatal periods, an overview of women's narratives relating to this stage might suggest that 'the birthroom' represents a social space in which women are provided with a good quality of care; certainly women seem to expect that it is a space in which they are entitled to continuous surveillance and to support as necessary/ when desired. In some narratives, therefore, there is a sense of relief when a woman is allowed access to the labour ward; in other narratives women express their fear about being sent back to an antenatal space. In this way the birthroom is depicted as a hospitable space for women, as Ruth, Gillian and Claire suggest:

> "so I went down to delivery and it was a different midwife and a different consultant at this point. Amazing, fantastic. So we went down into this quiet dark private room. Tea and coffee facilities, tv. It was so much more relaxing. I felt better down there" (Ruth)

> "So I went down to the labour ward, and I just remember the midwife saying '3cm - that a doctor's 3cm, was it?' she said. 'Yeah, well you're not.' And I just thought 'please don't send me back up to the ward, not up there'. She said 'no no, you're staying here' " (Gillian)

> "But then that was fine. It was really nice actually in the labour room. I had a really lovely midwife who was so nice. I managed to do it all without drugs or anything. I was really excited" (Claire)

It is not always the case, however, that women go on to experience the birthroom as a positive space of care. In the birthroom, as in other spaces in which the social practice of birth takes place, women seem intensely vulnerable to unexpected trouble of a non-

physiological kind, for which they are quite unprepared, and for which their relatively high level of various forms of capital offers them little protection.

6.2.1 Women's representations of uncaring encounters with staff

> "I was just looking at her and thinking 'you are so rude, you shouldn't be speaking to me like that' " (Heidi)

Amongst the twenty-six women interviewed for the purposes of this study, twenty women offered detailed stories of trouble encountered during labour and birth. For many women, this trouble is described in terms of perceptions of how they were treated by staff, experienced as upsetting and/or anxiety provoking. These examples include descriptions of staff being experienced as threatening, bullying, bossy, rude and unfriendly.

During her second labour, Sparkle relates how she experienced the midwives as unsupportive and how she and her partner felt that they were trying to scare her, using the threat of a c-section to get her to follow their instructions. Whilst the staff's actions might not have been intended to have had this effect on Sparkle, and might rather have been envisaged as likely to motivate Sparkle towards a mutually desired outcome of a vaginal birth (resonating with Ellen Annandale's (1988) work on how midwives seek to accomplish natural birth), the strategy and its implementation, from Sparkle's perspective, was weak. Sparkle's partner complained about the support being offered, and Sparkle came to her own conclusion about next steps:

> "Mike said 'I want to see your manager nurse or whoever's in charge really'. And she said I was the person. And so Mike said 'well, you really shouldn't scare the woman on the ward about what could happen and what they're going to have to go through if they don't do something you want them to do'. And she said she would get him escorted off the premises. I was on drugs and I'm like 'no you won't'. But it got sorted out, 'cos the woman said she was sorry and the nurse said 'maybe I said it wrongly and I'm sorry about this'. But it shouldn't come across like that anyway, it shouldn't be if you're not going to do this, then you'd going to have a c-section. It shouldn't be put across like that. So that's why I said to them just do a c-section. If that's what you keep implying then you do it. 'Cos everything they came out with was 'if you don't do this, you're going to have a c-section'. 'Do it then. Don't just keep saying it, do it then' " (Sparkle)

Rather than being motivated by the staff to achieve a physiological birth, Sparkle became discouraged and suspicious, and a caesarean section operation was

organised. This feeling of being bullied and reprimanded by staff is not unique to Sparkle. Liz recounts how she was shouted at by the midwives:

> "I had started to want to push but I don't know whether I was pushing in the right way. They were almost really shouting at me, that I was doing it all wrong, that I wasn't pushing properly" (Liz)

As in the context of women's various experiences in early labour, in each of these cases it is possible to interpret the midwives' intentions, words and actions as supportive of keeping these women on track to achieve a vaginal birth: it is possible, for example, to understand that they are caught up in playing a rather different game from the birthing women, and that they seek to play that game to the best of their abilities as the field of play allows. As previously discussed, that people within the same social space will be playing overlapping but not identical games is not unexpected. The extent to which the actions of staff are experienced by women as unkind and unpleasant, however, seems to suggest an undesirable lack of mutual understanding. And indeed complicating these accounts, some women suggest that some firm direction on the part of staff in some situations is probably necessary and helpful, although not necessarily experienced as such at the time. Claire, for example, reflects on the treatment she received from midwives during her fourth labour:

> "So it went from being quite nice, you know the trainee one, to the head one, and there was no nice then. It was 'you need to get out of this bed and you need to stand up'. After, I said to her 'I should have listened to you' and she said 'you should have listened to me two hours ago' " (Claire)

In interpreting this story, it is important to note that the midwives in this case were not simply seeking to achieve a vaginal birth. This birth represents one of just three births in this study that took place in a domestic environment, and, as such, it is clear that the midwives were also seeking to meet one of Claire's key goals, which was to avoid a transfer to hospital.

It is also productive to consider that some of the rudeness that is perceived by women is not necessarily intentional on the part of staff. An example of this might be when Naomi talks about her arrival at the operating theatre for an in-labour c-section, where the doctors made no attempt to introduce themselves:

> "I found them quite rude. It was only at the end, there was a trainee. There was a gentleman, the consultant, and a trainee. And at the end she actually looked at Hettie and then came over and said 'congratulations' but that was it. There was no like 'hello, I am …" (Naomi)

In Lucy's case too, introductions are overlooked as a paramedic, arriving at her house when she is in labour with her second baby, seeks to attend to what he understands to be the imminent birth of her baby. Lucy describes how she perceives the paramedic to be acting inappropriately and rudely, and in reaction to this Lucy describes how he is told to wait outside whilst she and her supporters talk by telephone to staff in the hospital for their advice:

> "I'll never get over this. He said 'well I don't know what she's doing with her shorts on, 'cos she's going to have it'. I told him to piss off. I just didn't like his body language" (Lucy)

Again, it is possible to understand these awkward encounters in terms of both parties holding very different understandings of the game being played. In the case of emergency service workers, represented here by operating theatre staff and ambulance personnel, it can be understood that taking speedy action to save lives is paramount; that this results in a lack of attention to expected levels of courtesy is perhaps a second-order concern (if indeed it is identifiable for such staff). This is not an issue which is restricted to the maternity services, as the 'hellomynameis' campaign demonstrates (Hello My Name Is, 2017). That campaign was launched by a doctor who, when terminally ill with cancer, was horrified by a similar lack of compassionate care she encountered.

Not all encounters with staff are described by women in these terms, of course. It is important to stress that for most women even the most vivid accounts of troubling encounters with staff are usually put into some relief with the introduction into the narrative of far more positive staff members and a positive resolution to trouble (the baby being born). Many women, for example, include at least one description in their overall childbearing career narrative of a 'brilliant' or 'lovely' member of staff, often, but not always, identified as a midwife.

Frequently this character appears in the birthroom, as women are labouring and birthing; this might be linked to how this space is one in which the gatekeeping role of the midwife is generally absent, which eliminates one potential source of trouble. A recent study concluded that a high proportion of women (89%) claim that midwives always treat them well, with respect and kindness, during labour (Redshaw and Henderson, 2015). This would seem to support the notion of the labour room as a space of relatively positive encounters with staff.

However this also seems to work to underscore women's vulnerability in face of the key birthroom contingency represented by unpredictable changes in the staff allocated to

their care. I will return to this issue, which links importantly with ongoing scholarly and policy debates about continuity of carer in the maternity services (see also the discussion on relational models of care, 2.4.5). Women seem to accept that they cannot rely on a known member of staff, or a member of staff with whom they have formed a good relationship, to accompany and support them throughout their birth experience. There is little sense in these accounts that women have a midwife 'rooting for them' (Finlay and Sandall, 2009). Regular changes of staff seem to go unquestioned, even where the impact is clearly experienced by the labouring woman as problematic, as Heidi suggests:

> "the midwife changed probably about 2 or 3 in the morning and when that happened I was really distressed, really distraught" (Heidi)

Thus changes of staff are accepted by women as inevitable, and women come to recognise that things can go quite differently depending on the member of staff around at the time, as Barbara and Sparkle reflect:

> "the midwife [who was there at the birth] was really nice, but had it been the second midwife, it would have been a different matter" (Barbara)

> "if you get a good one you're alright, but if you get a snotty one you're buggered really" (Sparkle)

6.2.2 Women's representations of trouble as an absence of care

Women's experiences of trouble in the birthroom are not limited to experiences of staff doing something that is interpreted as unsupportive or unkind. An equally strong cause of trouble, again repeating a theme established in the context of early labour troubles, relates to an apparent absence of care, for example in terms of carers (or decision makers) literally being absent at key points during labour, causing delays in diagnosis which, when made, seem to escalate frequently into panic. Sally and Alice, for example, talk of experiencing periods during their labour where staff absences become a matter of concern:

> "I had quite a negative experience in that Hazel's heartbeat really slowed down and we'd been left, I remember, my husband, myself and my mum had been left in the delivery room for a good hour or so on our own and at that time I was on a monitor where the baby's heart beat was being checked and that monitor started beeping and I was half dazed. Andy was quite quick to react to it and he quickly ran out and told the midwife who was looking after me at the time. But she took a while to come to us and when she did come to us it had gone to a

> stage where she started panicking. And then that fear came inside me, thinking what's happening and then all of a sudden Andy kicked up a fuss and said that there's something wrong and you've not really been around when we needed you. You know, we want to change the midwife, we don't want you as our midwife" (Sally)

> "the doctor that was on call that evening would not make a decision about getting in contact with his consultant as to whether they should do a c-section or not. It took a while to get in touch with him. Then he said 'yes, we will do a c-section' but it was really unlucky because it was changeover time for staff, so then I had to wait another couple of hours. So then they suddenly rushed me in. They had delayed it so long really, then they thought 'oh god, we do actually have to get this baby out now'. The general perception to me was that it was all a bit of an emergency and panicky" (Alice)

As suggested above (6.1.1), if a key function of labour ward staff is to provide reassurance and encouragement to the labouring and birthing woman, it is notable how many narratives provide evidence to the contrary. Many women's narratives describe an impression of staff panic and 'rushing around', after a period in which care has been perceived as absent. Sally and Alice's stories describe how this might trigger much anxiety on the part of the labouring woman and her support person, as well as providing the basis for distrust in future encounters.

A further point in the maternity experience where an absence of care frequently seems to be encountered is when the baby is born. At this point, it is not uncommon for women to describe the baby being taken away, with little sense that staff place any priority on attending to the emotional needs of the birthing woman. Women's narratives illustrate how this situation can provoke intense anxiety about the well-being of the baby, as in the case of Skye following the birth of her first baby:

> "I know I am alive but there is no baby crying, there is no sign of any baby and there is nobody telling me what is going on" (Skye)

Similarly, Serena describes how her baby was taken away:

> "They didn't even give me Lawrence. They just took him away, you know. Obviously they wanted to make sure he was alright. So they didn't actually give him me, which was horrendous" (Serena)

Listening to the emotion in such accounts, it is compelling to consider whether the extent of such distress could be avoided. Whilst women come to understand the

disappearance of their baby as temporary, and that there may be good reasons why the baby was taken away (and indeed at some level seem to tacitly accept that it is the institution that 'owns' the baby at that point, in the knowledge that it is the institution that will provide any treatment it might need), the intense level of anxiety experienced under such circumstances seems to be an important part of the birth experience for a significant number of women, and one that is not significantly altered by such later realisations. Such stories also talk to the notion that many woman seem to hold an expectation - which to them is highly plausible - that their baby might not have survived the birth. This theme is explored further in 7.2.4.

Serena's narrative also raises the issue of subjective perceptions of time. It may be clear to staff, for example, that the baby will be returned to the parents very quickly with no unnecessary delay, taking into account their intimate knowledge of the procedures that might be followed in such circumstances. It is perhaps inevitable that this sense of a prompt delivery of the baby back to its mother does not always represent the lived experience of parents, however, who, unaware of these regular routines, sometimes experience the length of time that the baby is absent to be inexplicably lengthy. Whilst it is possible to see the behaviour of staff in such circumstances to be highly careful, focussed on doing what they feel is necessary to ensure the well-being of the baby, it is possible also to hold an understanding that the staff team at the same time demonstrates a certain carelessness, in failing to recognise that a key part of their job might be to give information and reassurance to the mother. Indeed such an objective might be better met by altering routines to provide bedside care for the baby, so that it is not removed from the mother at all (Klingaman, 2009).

In a significant number of cases, then, the birth of the baby leads to an emotional response of anxiety provoked by the disappearance - or removal - of the baby from the woman. Whilst at one level women seem to accept this process as routine ('just the way things are done around here'), it is clearly deeply troubling to some women that the baby is taken out of their sight, and this becomes part of their emotional experience of childbirth. In Gillian's case, it was interesting to hear how the resolution of this type of highly distressing story, in the form of the reassurance she received about her baby's wellbeing, came not from a midwife or doctor but from a member of staff who she believed to be a porter:

> "she had to be resuscitated as soon as she came out. Something had obviously gone on. So they took her off, and resuscitated her. At this point I wasn't even told if it was a boy or a girl. I didn't know if it was a boy or a girl. Simon was going 'I think it's a girl, I've no idea', and it was the porter that said. He was there, and I

just remember, I'll always remember this guy, I could point him out in a line-up. And he was the one, he stood there, 'she'll be fine, she'll be fine' " (Gillian)

Whilst it is of course the case that any member of the staff team should be able to detect and respond compassionately to such a need for information and reassurance, this episode raises questions about why it is that the midwife is often absent from this role in women's accounts. In Chapter 9, I return to the issue of the midwife's positioning in such narratives.

6.2.3 Women's role in the birthroom, and how women learn that their knowledge does not count

In the birthroom, as in early labour, women's stories reveal how many come to understand that, rather than being central to the process, they find themselves sidelined, their bodies objectified and having to wait for others to make decisions about what is to be done to their bodies. Women's stories repeatedly demonstrate how they come to feel that their opinions and expressed feelings count for little, with the information they offer treated as untrustworthy. This sidelining of women from the decision-making process, and the denial of women's knowledge, can lead to deeply upsetting experiences.

Perhaps most troubling, a small minority of women related stories of invasive procedures being performed by staff without their consent, including internal vaginal examinations, injected pain relief medication (for example, pethidine, an opioid pain relieving drug) and even an episiotomy (a surgical cut in the perineum). In Suzanne's case, the lack of discussion with her about the procedures to be carried out on her body during her first labour underscored for her how staff considered her to be irrelevant to the decision-making process:

> "I felt that professionals very much made assumptions about my intellectual ability, my capability to make decisions about what I wanted for my birth, and kind of took over a little bit. I absolutely remember in Fran's delivery, them giving me pethidine without me being asked and I think there was a sharp scratch on one side of my bottom. Wow. They have given me something and I haven't asked for it and I did feel that before that I was coping perfectly well. As labour kicked in and I delivered Fran it was highly medicalized, doctors appeared and lots of midwives were in the room. She was a forceps delivery. I was given an episiotomy and not told, but felt it happen, which I was again cross about" (Suzanne)

Mary told of how a doctor attempted to perform a vaginal examination without either consent or prior notice during her labour with her second baby:

> "the consultant came in and said 'we think you are getting closer', and then without asking me just did an internal examination midway through a contraction. I was so angry. There was no 'can we do an internal examination?' I just felt completely demoralised that somebody could just think that actually I am just going to do an internal without asking your permission. And it was a female consultant as well. Well, I burst into tears, and the midwife said to the consultant 'you can't do that to her without asking her, she is midway through a contraction. I will tell you when you can' and the consultant stormed out of the room. The midwife was so apologetic. She was like 'I am so, so, sorry. I have not seen that happen in years'. She said 'I had made it very clear on your notes that we talk about everything with you' " (Mary)

Aside from the feelings triggered in Mary as a result of this incident, there are two features that make this story particularly interesting. First, this episode happened whilst Mary was in the care of a midwife whom she had earlier been describing as extremely competent and friendly, and very protective of her desire to labour with minimal interventions (evoking the work of Kathleen Fahy and colleagues on the role of the midwife as guardian of the birth territory, Fahy, Foureur and Hastie, 2008); nevertheless, it was this midwife, in the room at the time of the incident described, who failed to protect Mary. Second, there is the implication that Mary should have been protected from such an experience because it had been written clearly in her notes that her consent should be obtained before any intervention; rather than protecting Mary in this case, however, this reference seems rather to draw attention to the suggestion that other women might not expect such a consent process as standard.

A further striking element of the data, repeated across several accounts, concerned situations where women described how they felt ignored or disbelieved when they try to give information to staff based on their bodily experiences. One such situation is where women report to staff that pain relief does not seem to be working. Suzanne, for example, tells of how she attempts to communicate a faulty epidural to staff, only for staff to deny the possibility that she might be correct:

> "So they sat me up and started to put in an epidural. As they sat me up, the pain was absolutely like I have not felt labour pain before, and as I sat back I said to her this is not working. And she said 'it is working, it is just pressure you can feel'. She was quite abrupt. She didn't take notice of what I was saying at

> all. As she started to take the epidural down she did say to me ‘I am very sorry, you were right about the epidural, it is all stuck in the tube’. The medicine was all stuck in the tube. It hadn’t gone through and I hadn’t got any of it. The tube had kinked and all the medicine was in there. So that was a waste of time and all I ended up with was a whacking headache for a few days from where they had been trying with the epidural. I got quite cross because I tried to tell her" (Suzanne)

Suzanne’s case is not isolated; in this study a number of women report experiences of faulty pain relief, experiences which seem to be dismissed by staff (as based on a lack of knowledge about how the pain relief is supposed to work) and sometimes also by the women themselves (as unimportant), as in Jane’s case:

> “I also found out afterwards, I was on gas and air but the pipe was split so [I thought] I was taking the gas and air [but] it was coming out, so I wasn’t feeling the effects of the gas and air at all” (Jane)

Whilst Jane relates this incident as ‘just one of those things’, Suzanne feels that something is wrong and seeks to speak up about it. Subsequently, Suzanne forms the view that there is a problem with the way the system works to produce such incidents, in terms of the balance of power between women’s and staff knowledge. Suzanne is not willing to dismiss such incidents as a one-off, but rather uses it to inform her understandings of the social contingencies of birth.

A further, and repeated, example of women’s bodily knowledge being ignored or denied in the birthroom occurs when women indicate that they are about to give birth. In one case, for example, Jenny relates how a midwife, with her back turned, sought to deny that Jenny could be ready to give birth to her second baby:

> “I got the urge to push. Obviously she heard me and turned round and said to me: ‘oh breathe away, you’re not ready yet, miles not ready yet, breathe it away’. She grumpily put her gloves on and lifted up the sheet and literally said ‘oh fuck’ because Daniel’s head was half-way out. And literally five minutes later, three pushes later, he was out” (Jenny)

Similarly, Suzanne’s claims that she was on the verge of giving birth to her baby was rejected by staff, who were pre-occupied with preparing for an operative birth:

> “At this point, as they were prepping me for the c section, I said to the midwife ‘I want to push’ and she said ‘you don’t want to push, love, you have ages yet’. I said ‘I want to push’ and the doctor said ‘no, you have a long time yet’. And I

> birthed her there and then. So they didn't listen to me again. It just infuriates me. I told them I needed to push, they told me I had got ages yet, and I birthed her. She was out in two pushes" (Suzanne)

Women also experience the opposite situation when staff tell them that they are ready to push their baby out, and should therefore start pushing, when the woman herself does not have any urge to push. This practice of directed pushing seems to be so common across women's experiences that it has become almost invisible, and it certainly seems difficult for a birthing woman to imagine a more spontaneous birth. During her first labour, Jenny tells of how she sought to challenge an instruction to push:

> "I can remember actually being slightly confused by what she was saying, so in between the contractions, I at one point actually sat up and looked her in the face and said 'so you're telling me that I need to push even though I haven't had any more urges? I just had that couple of two minor urges but no more have come. Are you telling me I need to push?' and she said 'yes, you do'. So I then started having to push through my contractions" (Jenny)

That some women do seek to insist on the possibility of the value of their bodily knowledge is a testament to their resilience and determination, in the face of an approach to birth in which the woman seems to be rarely conceptualised as either a decision-maker or as a skilful and knowledgeable agent. In speaking up, women are able to contribute to the safety and success of their birth, but too often, as found in this study, they go unheard (see also Rainey et al., 2015 and Rance et al., 2013).

6.2.4 Trouble triggered by a word out of place

Trouble in the birthroom, as discussed in relation to the examples presented so far, can manifest itself in many ways. In this next section, I focus on the particular way in which the language used by staff, or the discussion of certain topics, can provoke distress on the part of the birthing woman. Heidi, for example, explains how a discussion between two midwives and two student midwives caused her much alarm:

> "there had been meconium in the water and I sensed that they were panicked and the midwife who had gone was back, and they had strapped me down to get the baby's heartbeat. She was feeling for my pulse and they were trying to do baby's and I remember just hearing them saying 'that's no good that's mum's, that's no good that's mum's' about four or five times and I remember just thinking 'no way, no way' thinking it was dead. It was horrendous, and Colin said that happened in the space of less than a minute or even less but for me it

> seemed forever and it was just real panic, thinking ‘I can't believe this, I can't believe this, please, please’. All the prayers you can imagine and thinking please let it be alright. And then, ‘it's ok I think we have got him’ and then within minutes he was out and I was done. Sheer relief thinking I am not going to have to do that again. Just sheer sheer relief, joy and elation and all the rest of it” (Heidi)

In this case, Heidi’s distress is provoked by an overheard conversation between staff. It is possible, therefore, to consider how staff in such circumstances might have better considered the implications of being overheard in this way. Trouble seems to be resolved in Heidi’s narrative (with the birth of the baby), but the anxiety suffered during her labour was so vividly re-enacted by Heidi as she related this story that it is hard to overestimate its importance to her and to her understandings of birth. There is no suggestion that these words are spoken with the intention of triggering anxiety in Heidi but this was their effect.

In hospital to give birth to her first baby, Claire is also propelled into a state of anxiety late in her labour on overhearing a conversation in which a doctor says to another member of staff: ‘this girl needs help’. Claire relates how this made her feel scared. It is noticeable how Claire is not reassured by the suggestion that she is being offered help to ‘try to get the baby out’; rather, she experiences this as a sign of trouble. Claire goes on to describe how she seeks to resolve this trouble, and succeeds in doing so:

> “I just pushed him out then at that point” (Claire)

Unlike Heidi, Claire’s story explores how she felt that she had some ability to resolve the trouble identified in the overheard conversation, and so as well as provoking distress it also provoked in Claire her positive action to resolve the situation. Thus in this case, in contrast to Heidi’s experience, the distress unintentionally provoked by the incident seems to have been somewhat productive.

Finally, Serena relates how she is highly distressed by ‘a word out of place’ spoken on the part of the midwife after the birth of her third baby. This time, the midwife was speaking directly to her:

> “Anyway Lucy was born with the umbilical cord around her neck, and, you know the midwife said to me, and I quote: ‘So goodness me, if that had been just a minute more your baby would have been dead’. That is what she said to me. I was absolutely hysterical. I was absolutely hysterical, and ‘is she alive, is she alive?’ ” (Serena)

For Serena, this conversation makes for ‘a good birth spoiled’, as she realises the implications of the midwife’s words, and relates this back to words spoken earlier in her labour about the short-staffing of the unit that evening. Serena’s intense shock seems to be related to her imagination about how things could have turned out otherwise (that is, how her baby might have died), and as such this incident is formative in her developing understanding of the risks associated with childbirth.

6.2.5 Trouble in the birthroom, disguised by the joy of birth

In this section I have presented an analysis of some of the various ways in which women encounter ‘trouble in the birthroom’. I have drawn attention to the key idea that women’s narratives seem to reveal plenty of unexpected trouble, trouble - like that encountered when women seek to access labour care - that is separate from any emergent pathology, and that seems to be associated with care routines that reflect the illusio of staff members rather than that of the birthing woman. Such trouble is often embedded in a more positive overall story of birth and, as such, women’s accounts often seek to downplay birthroom trouble. In its telling, there is also a sense that birth-related trouble might be considered to be resolved by the accomplishment of the birth of the baby: this has been referred to as the ‘halo effect’ (Forssén, 2012; p1536). In-depth qualitative research seems uniquely able to grasp, however, how women continue to retain such stories of trouble in their childbirth narratives, and to offer an analysis which suggests that this trouble (as with the trouble encountered when seeking early labour care) has a significant ongoing impact on the social practice of birth. Such trouble also emerges on the postnatal ward, which is the focus of the next section.

6.3 Trouble on the postnatal ward

> “That’s where I had the most horrific experience then up on the ward for about two or three days and it was just awful. They were, they were just so horrible, so rude, didn’t help with feeding him. Made me feel like I was like this young girl, that I shouldn’t have had a baby. They were rude to my family, really rude to Dan’s mum. It was just horrendous. It was just, if I’d have known any better, I’d have walked out. I did ring up the ward when I’d heard that they’d upset my mum. I just said ‘you know, that’s really out of order’. I can’t really explain it, it was just not nice. It just, I’m quite a nice person, what you see is what you get, so it just didn’t feel right to me the way I was being treated. But I was cross with myself that I allowed it” (Claire)

As part of their childbearing career narratives, women in this study frequently include a focus on experiences in the hospital during the postnatal period. Although not the final stage in their encounter with the maternity services (given the continued ongoing contact with community midwifery services, and also the possibility of re-admission), this period represents the final contact with hospital based maternity staff for the majority of women. An analysis of women's narratives reveals this as a complex social space in which various forms of trouble, unrelated to pathology, are either unexpectedly encountered or lurk as an ever-present possibility.

In only three of the twenty-six narratives shared with me by study participants was there an absence of talk about inpatient postnatal experiences, and only three women talked about them positively. The remaining twenty women talked in mixed terms, and for more than half of these women their accounts revealed significant dissatisfaction. This echoes previous UK-based research findings on women's postnatal care experiences (for example, see Bhavani and Newburn, 2010). What is particularly striking about this data is the extent to which childbearing women, again, find themselves embroiled in unexpected trouble. Positioned in the unfamiliar environment of the postnatal ward, cut off from usual sources of support, in the early stages of recovering from their diverse experiences of childbirth and becoming familiar with how they might best meet the needs of their newborn baby, women's narratives provide compelling insights into how women in this situation encounter and seek to manage trouble as best they can.

Reprising a common thread which runs through this chapter, many episodes of trouble on the postnatal ward seem to be underpinned by a lack of a shared understanding between birthing woman and staff, whether of the purpose of the stay, of what constitutes necessary or good care during this stay, of different orientations towards physiological reproductive processes or of the respective roles and responsibilities of staff and patients, for example in relation to the care of and responsibility for the baby. Note that trouble rarely seems to be triggered by a mismatch of expectations about resources; women participating in this study seem highly conscious of resource constraints, and display a keen desire to avoid unnecessary calls on limited resources.

6.3.1 Diverse understandings of the purpose of the postnatal inpatient stay: the postnatal ward as place of confinement or care?

This study suggests an important lack of clarity about the purpose and necessity of postnatal inpatient care. This was expressed most frequently by women through the notion that they were 'desperate' to 'escape' the postnatal ward, in a way that does not

always, or even usually, seem to represent a desire simply to go home but rather a keen desire to free themselves from the confinement of the institution (Sharpe, 1999, p91; Oakley, 1980). In this context, the inpatient stay is repeatedly referred to in terms that bear a strong relation to notions of involuntary incarceration, the hospital as a 'prison' and discharge as 'release'. This is the case even in relation to inpatient stays which otherwise do not suggest a trouble narrative. (In some women's accounts, however, trouble seems to have been left unspoken: Amy's comment that a subsequent postnatal stay 'wasn't as awful as last time', for example, follows no mention of trouble related to her previous postnatal stay.) This representation by women of the postnatal ward as a prison evokes previous UK-based research findings about women's experiences of maternity care (Baker et al., 2005), and suggests a potential new avenue for carcereal geography scholarship, where attention to healthcare settings has to date been focussed on analyses of psychiatric settings.

In its simplest form, an inpatient postnatal stay, from the perspective of the maternity service, might represent a desire to keep the woman and/or her baby on-site, to allow convenient access to the medical resources of the hospital whilst women and babies are recovering from the labour and birth, to treat known pathologies or to be ready to treat possible pathologies that might emerge in the period immediately following the birth. In this model, the woman and baby can therefore be discharged once all known pathologies have been dealt with, and at the end of the high-risk period for infection development/detection.

What women's accounts seem to show, however, is a disconnect between women's embodied feelings of wellness or care requirements and what they feel is being provided on the postnatal ward. Whilst some women clearly recognise the therapeutic value of staying in hospital for a short period (for example, to recover before going home from major abdominal surgery or whilst the effects of various drugs taken in labour wear off), suggestions that the stay is also useful (and indeed perhaps critical) to allow for the early detection and treatment of the onset of any birth-related pathology are far less tangible. Where the establishment of breastfeeding becomes a rationale for the stay, women become frustrated by what they experience as the patchy (at best) nature of the support offered. Indeed some women come quickly to the realisation that the privacy and calm of their own home, together with the support that family and friends can offer there, is likely to provide a more therapeutic environment in which they would better be able to focus on their recovery and baby's wellbeing:

> "I was like, why do I have to go to a ward now, it doesn't make sense. I remember sitting there listening to some poor woman desperately trying to

breastfeed and other people refusing to breastfeed and asking for bottles and all this commotion going on and thinking 'I actually don't want to be here and there is no real advantage for me being here' " (Barbara)

6.3.2 What constitutes care: encountering troubling experiences of care

"So where's the care?" (Gillian)

If a key theme running through women's postnatal stay narratives in particular is a desire to exit the institution, it is interesting to see how this might emerge from care experiences of women on the postnatal ward. At first glance, it seems unproblematic to define each encounter between a woman and staff on the postnatal ward as a care encounter, and the postnatal ward as a place in which women should come to feel well-supported and cared for. Unfortunately this does not always seem to be the case. Rather, it is noticeable the extent to which women's narratives suggest that these encounters are sometimes experienced as uncaring, working to complicate a simple understanding of the function of 'maternity care'.

The women participating in this study seem to understand the pressures on ward staff; they understand that resources are limited and seek to keep their calls on staff time to a minimum, demonstrating a high degree of patience in doing so. In that context, a request for help is not made lightly. Lucy's story works with a strong theme in the data which is the difficulty in getting the attention of staff, or the experience that a staff member agrees to come back (or send somebody else), only for the staff member in question never to return (or never to send a colleague as agreed). Indeed the characters of 'nobody' and 'no-one' seemed to play a substantive role in women's experiences of postnatal maternity care, and women again talk of feeling 'abandoned'. Lucy illustrates the difficulty she experiences in accessing care in an episode which ends with a fall, her calls for help having been ignored:

"Then I was like, hang on a minute, they went off and were going to come back with a drink of water but they didn't come back. It was one thing after another so I buzzed and a lady came. 'To be honest with you I really need to go to the toilet.' So she said 'hang on, I will get someone'. Off she went, didn't come back again, so I had to buzz again but nobody came and so I thought I am just going to find the toilet. They had put a bassinette next to the bed, so I popped Abby into it and then she started moaning and then I was really scared about leaving her. I just felt absolutely out of control, I felt horrendous and then I ended up going to the toilet because I was desperate, and on the way fell on the floor because I could barely move my legs, you know when you are just so tired. I

> felt like Bambi. Someone had heard me fall, one of the other ladies, and a midwife came and helped me. So I said 'can you watch my baby?' I just felt all over the place and I realize now, with hindsight, I was absolutely out of my tree, in a state of confusion, and there had not been any care or anyone looking for that or anyone spotting that or anyone thinking 'maybe this woman is in a bit of a state and could do with a bit of care'. There is the medical intervention that obviously happens, but it is care. It is that feeling of somebody checking you are just ok" (Lucy)

Lucy's observation that a focus on caring for each individual woman (and baby) seems to be missing from the postnatal ward is not an isolated one. Naomi was also surprised that she received so little care for herself after a caesarean section. Eventually, Naomi's concern about her baby led her to seek help, but she too found it difficult to command the staff's attention:

> "people didn't come and check on you. I mean there was one day in the hospital with Hettie, nothing was happening and there was no problem but I didn't see anybody until the rounds. In fact at one point I did go and find someone, because she was a little underweight because she was quite small and obviously you have to keep them warm, don't you? And then she kind of got overheated, so they said they would come back and check her temperature but nobody came back, so I went to look for someone. But nobody came to check on me" (Naomi)

In some cases, women's concerns about the level of care they are offered seem to arise from a mismatch between their perceptions of their physical capabilities and the expectations placed on them by staff. Both Alice and Skye talk about the apparent unwillingness of staff to provide care and assistance as they recover from birth:

> "I had just had a section and nobody seemed to acknowledge that fact and I couldn't get out of bed. There was nobody around and nobody checked on me. Nobody gave you any assistance" (Alice)

> "I had never had a c section, and never known anyone that had, and I was terrified that if I moved my whole insides would cascade. And yet there were people saying to me 'right here's a tray, if you just carry that somewhere' or 'go and have a shower, you need a shower'. I just felt bullied, that nobody was helping me, completely isolated" (Skye)

For Alice and Skye, the postnatal ward does not represent a therapeutic environment, either for well or for unwell women; indeed, it is a place in which staff seem quite

unable to make that distinction. These notions of the therapeutic nature of particular spaces speaks to the well-developed scholarship around therapeutic space and place (Williams, 2010), in which William Gesler's innovative work (Gesler,1992) has been developed within and beyond the discipline of geography into sophisticated understandings of the relational and socially constructed, rather than intrinsic, nature of therapeutic space (Conradson, 2005).

A further strand of some narratives is how requests for help are experienced as being met with a reprimand from staff. Alice explains how she felt reprimanded by a member of staff when she resorted to calling for assistance:

> "The one time I did call a nurse in the middle of the night, the midwife came in and actually gave out to me for changing the nappy on the bed. But I did not know any different. Obviously it was hospital policy but no-one had said anything to me" (Alice)

Serena also tells of how she experienced being reprimanded for failing to follow ward rules:

> "It was just a bit of a mad hospital and I remember umm going to the toilet and thinking I'm not leaving my baby, I'm going to the toilet and I'm taking my baby with me. But the problem I did, I took the baby out of the plastic thing that you're meant to and I'm like holding my baby for dear life, 'cos I've seen films and stuff, thinking I'm not having the baby out of my sight and I got a bit of a telling off for that, you know" (Serena)

Whether from feeling ignored, reprimanded or otherwise unsupported, many women seem able to build a remarkably similar depiction of the postnatal ward - and the midwives who staff it - as uncaring and hostile and as something from which one must try to escape.

6.3.3 The postnatal ward as a space of transition: taking responsibility for the baby

> "It was a bit strange when it was time to go. 'Right, thanks very much for coming in. Bye now.' And that was it. And it's like 'I'm going home with a baby?!' " (Ruth)

Some of the troubling care encounters illustrated in the previous section relate to women's perceived need for support as they try to care for their newborn baby. This links to an important facet of the inpatient postnatal stay: its positioning as a transitional phase in which the well-being of the baby shifts from being the responsibility of the

clinical team to the responsibility of the woman. After the birth, unless some pathology has been identified which leads to a period of clinical supervision (perhaps in a neo-natal ward), the baby is physically given over to the woman, who is expected to take on the caring responsibility. Thus the postnatal stay for some women may be experienced as a period of adjustment to this new situation. Trouble in this context arises where women have expectations which are not aligned with those of the staff, for example where women such as Jane, feeling physically unable to pick up their baby, assume that the staff might be willing to help them:

> "I couldn't walk on my own. I couldn't really pick Connor up out of the cot and I thought they would take him away and put him in a nursery but they don't do that. They just leave you with them" (Jane)

As Gillian explains, this sudden change in expectations can be experienced by women as both surprising and unreasonable, especially when they are at the same time deprived of the support of their birth partner:

> "Suddenly to expect, 'well, you've done that, now off on your own'. It's ridiculous, to not have anybody to stay there, particularly if the midwives aren't going to provide the nursery care" (Gillian)

In some situations, the staff might decide that a woman requires or 'deserves' some time without her baby; in such cases, they might offer to take the baby for a few hours. This is not a resource that women can command, however. Gillian and Skye tell of how they were eventually offered such respite:

> "I was expected to get out of bed, lift him up, try and feed him, which he just would not do. There was no way that was happening. He just screamed constantly and there was only one midwife maybe on about the third day, who said 'I will take him off you, I will take him down to the dayroom and you get some sleep' but I couldn't sleep. I don't know, I suppose I had been awake for so long" (Skye)

> "I couldn't settle her. She'd been fed. I went through everything and I was just, I didn't know what to do. I was so tired, I was falling asleep. I carried the baby down to the nurses' station and they just said 'well we don't [take babies off mothers] anymore. But put it in its crib and then bring it down and we'll give you two hours to sleep' " (Gillian)

Skye and Gillian were pleased to be allocated this respite from caring for their baby. For some women, however, such 'care' can turn out to be highly problematic. Two

women in this study, Mandie and Sally, relate how their babies were fed formula milk during such periods of respite, without their consent, significantly undermining their sense of responsibility for their babies. Mandie was rather incredulous, as well as despondent, as she related the following experience:

> "I think it was four nights with Maisie I was up in the night and I was getting to the point, you know, when you just. And the nurse took her away and they brought her back and they had actually given her formula without my consent and relished the fact that she had drunk 3oz of this formula and it was about 3am in the morning and I felt that [breastfeeding] would never happen again after that. But I couldn't really say anything about that" (Mandie)

For Sally, the respite care was not even agreed with her, but she awoke to find her baby missing, and was extremely worried about its whereabouts. Sally's continued sadness and despondency about what had happened was obvious as she recounted her story:

> "They said they were sorry but they had seen I was tired and needed to rest and they took her to feed her, and I know I did say at the time that I wanted to breastfeed her, that I didn't want to give her formula milk. So they said 'don't worry, you can still breastfeed her, but we thought you were tired and, you know, you needed a little bit of rest and she was crying so we thought we would take her to just give you some rest'. But I didn't agree with that. I thought they could have woke me up and just told me 'do you want to feed her?' and I would've got up and the instincts would have kicked in and I would've breastfed her. So anyway her first milk was the formula milk" (Sally)

Beyond the scope of this report, but evoking previous scholarship (for example Dykes, 2005), these and further stories of trouble experienced by women in relation to breastfeeding on the postnatal ward illustrated what many women experience as routine institutionalised diversions from the physiological process of breastfeeding.

Women's accounts thus suggest that the midwives' stance on the provision of respite care is quite unpredictable, and it is possible to see in their accounts how women come to learn this and try to keep their requests for support to a minimum, seeking instead to look after themselves and their babies as best they can. This is not straightforward, however, and women are at risk of trouble if they take more on than they can manage, or if they accept the help of an unauthorised person. In Becky's case, her postnatal story focuses on how she felt reprimanded by staff when she is offered help by another patient:

> "It wasn't great really. I was in a lot of pain with having the section and I couldn't get out of bed and he was crying and it was agony and that was really hard so I was crying a lot. I actually met a really good friend who was in the bed opposite. Because she had a [vaginal] delivery she kept coming over to help me and the midwife kept shouting out 'you shouldn't be picking that baby up' and I said that she was just helping me because the midwives were very busy" (Becky)

The unpredictability of staff is a major theme in stories of trouble on the postnatal ward, sitting within a more general theme of women's growing incomprehension of the logic that seems to apply in institutional spaces of birth, as one of Claire's stories illustrates:

> "I mean I was desperate for a shower the next day, absolutely desperate, and I didn't know, I didn't know if I was allowed. In the end I needed one, I needed the bathroom desperately, to change and everything. But I left him and was really, really quick and I was coming out I thought 'oh gosh'. I just knew that was my baby screaming, and I went to him and a nurse turned round and said 'yes, he's making such a terrible noise'. And I just thought that's their job to pick him up. I don't know, a natural instinct for a woman, you know, 'cos he was probably driving the other women mad and I just felt so guilty" (Claire)

In this extract, Claire suggests something other-worldly about the postnatal ward: rather than being a space infused with care, Claire identifies the postnatal ward as a place in which even the most routine behaviours of mutual care - based on what she calls 'natural instinct' - might be suspended.

For many women, the moment of discharge is long-awaited. This does not mean, however, that all women react to this moment without some feelings of ambivalence, as the transition of responsibility for the baby is, for the moment, seemingly completed. For Skye, for example, her reaction to the staff's discharge decision is mixed:

> "I so desperately wanted to go home and I think in the end he must have had one feed and they said 'he's fine, you can go'. I remember saying 'well, how am I going to feed him now?' They just said 'oh well, you have done it now, you will be fine'. Of course it wasn't fine" (Skye)

This ambivalence reflects a key, if muted, theme in many women's narratives about their relationship with the maternity services and the institutions which support them over their childbearing career. Despite the extent to which these services and institutions seem to cause them trouble, every woman in this study views them as necessary components of the birthing experience; none conceptualise the possibility of birthing without them.

6.3.4 Crossing boundaries: the power to discharge

The concept of discharge, as present in most women's accounts, is infused with a stable power formation. It is a passive formulation: 'they discharge you'. Women imagine themselves - and are imagined - as being unable to determine for themselves when they might safely leave the institution. Discharge decisions are taken by others, and these decisions are put into effect according to the routines and schedule of the institution. Women perceive their exit from the institution, like their entry, as being subject to control.

From Lucy's perspective, for example, the power to discharge is clearly located in the staff:

> "When he came in, they weren't ready to let me go because they just wanted to keep an eye on Abby and me and do all the notes and everything, and they finally let us go in the afternoon after they had done all the checks. Abby was absolutely fine and they were happy with her. They said 'well she is feeding ok, great, just get yourself home' " (Lucy)

In some circumstances, women are seemingly offered a rapid discharge option after a straightforward birth. But even these arrangements can become embroiled in the routines of the institution and subject to delay. Some of these delays are associated with hospital staffing schedules (shift changes and staff handover periods), and unless women are adamant in their desire to avoid such delays, they will not be discharged until it is convenient for the institution. Some women's narratives illustrate how the refusal of certain treatments allows women to avoid delays in their discharge arrangements. For example, after giving birth to her second baby at 2.45am, Lola was asked at 6am whether she wanted to go home:

> "They were saying 'do you want to go home?' And I said 'yes I do want to go home'. Jim went home at six to get the car seat, because we were just presuming I would be there a bit longer. So we didn't get in until about mid-morning, because by the time they change the shift at seven, then somebody has to do the baby check, and they said they could get the hearing test done and I was like 'no I can get this done later, I just want to go home' " (Lola)

Similarly, Amy (an adult woman) avoids a delay in her discharge, associated with the apparent need for staff to show her how to bathe her baby. She describes how she gets her mother to sign a form saying she will be supported in this task, thus clearing the way for her to be discharged:

> "On Saturday I was climbing the walls and the midwife said I couldn't go home until they had showed me how to bath the baby. And I said 'I know how to bath a baby. I have a sister fifteen years younger than me - I know what to do with a baby'. So in the end my mum had to sign a form to say that she would show me how to bath a baby and then they let me go home. It was so silly. I was just desperate to go home but they don't like you to, especially with your first baby, because they think you don't know what to do with them" (Amy)

Some women, like Alice and Claire, imagine more radical possibilities. During a poor experience on the postnatal ward after her first baby's birth, Alice imagines discharging herself:

> "I just felt that the care was horrendous and ended up almost discharging myself after two and a half days because I felt that I would be better off at home, certainly I would get more assistance at home" (Alice)

Claire goes one step further, as she actively seeks to discharge herself and her second baby:

> "I had to fight to be um what d'you call it when you leave hospital? I had to fight to be discharged at 9 o' clock in the morning and it's only because Dan rolled up with Louis at 9 o'clock demanding to come in with the seat and everything. And them saying 'no, no, no, you have to be discharged by the midwife that delivered her'. And I said 'no, no, no, no, I'm going'. And she went 'well, she might not come. She's worked all through the night. We do work all through the night, you know'. I said 'I absolutely appreciate that but I'm going'. Anyway, I'd said that, she came in for her shift and she said 'what's all this fuss?' And they were very rude to us. They were awful. They didn't say goodbye. They normally help carry the baby out. I was quite proud of myself that I did that and it was brilliant, yeah" (Claire)

In this way, Claire successfully challenges the notion that women are not at liberty to discharge themselves, a notion that works to reinforce the principle, apparent in so many areas of women's maternity experience, that women are not sufficiently knowledgeable, capable or competent to make such decisions for themselves. But it is not simply a matter of knowledge, capability or competence: it is also a matter of authorisation. Women's stories illustrate how women understand and seemingly accept that they cannot be discharged from the institution with their baby until the system has authorised this.

6.3.5 Postnatal care experiences as a key component of the birthing habitus

For the majority of women, the inpatient postnatal period represents the final stage of the birth-related hospital encounter; it is a further stage during which some women are introduced to birth-related trouble quite distinct from pathology. In line with previous research (Bhavnani and Newburn, 2010), my analysis suggests that the scope for dissatisfaction with this element of the maternity service offer is high. But women's dissatisfaction with postnatal experiences is not simply a 'postnatal issue', however important this may be in itself with women seemingly routinely subject to avoidable and unnecessary hurt and suffering during this period.

In addition, I suggest that the postnatal stay represents a crucial final opportunity for the maternity service to [re]build women's confidence in inpatient maternity services. That this opportunity is missed in so many cases is a cause for concern, positioning women quite specifically with regard to further possible encounters with the maternity services and birth itself. On the basis of the evidence presented here, the postnatal ward is both a rich learning environment for women and a space in which women can be seen to act on the basis of learning from previous experiences. Women seem to learn that this space is not necessarily a therapeutic space for them or their babies, and they learn that they need to protect themselves as best they can against poor care, or the risk of poor care.

In postnatal experiences, part of the foundation for future birth experiences is established. The stories of trouble presented here suggest a foundation in which there is a reduction in trust between the birthing woman and the maternity services, a dent in a woman's confidence in the capabilities and power of her birthing body, and growing concerns about the extent to which the limited resources of the maternity services are well-aligned with a desire to support and protect the physiological reproductive process. The negative consequences of such postnatal experiences are potentially far-reaching.

6.4 Conclusion

In this chapter, I have presented an analysis of women's stories about their encounters with the maternity care system, and with health sector workers, across three stages of their (generally) inpatient experience. I have suggested that these stories together describe a particular space of learning, offering experiences which are likely to significantly restructure women's birthing habitus. Compared to the game that women

expect to play (5.3) and to the prototype physiological game of birth (3.5.3), trouble of an unexpected nature features strongly in this space. The notion of trouble has been illustrated by many examples of birthing women's perceptions of being an unwelcome visitor to inpatient maternity services, feeling abandoned, feeling that their knowledge is dismissed and ignored, being treated unkindly and feeling uncared for. Such findings of trouble are not unique to this study, but are in line with previous qualitative research into women's experiences of childbirth, including Chadwick and Foster's proposition that a key element of birth-related risk for birthing women are risks related to the social practice of birth, such as being objectified, suffering a loss of dignity and being shamed (Chadwick and Foster, 2014; see also Forssén, 2012). These findings of trouble might be conceptualised as representing violations of the birthing women.

These findings also highlight the unequal power relations inherent in the field of birth as these women experience it, where health service workers have a number of key advantages associated with their familiarity with the field, access to resources unavailable to the birthing women, and the nature of the game they seek to impose on the birthing women. In this context, women's ability to exert significant agency is relatively low, but this varies amongst women.

I have discussed how a key contributory factor to these stories of trouble seems to relate to inter-personal relations in the field of birth. Each person involved in women's stories can be understood as operating within the bounds of their own practical sense of what is right, given their location in the field and the resources to which they have access. Nevertheless, the presence of overlapping, but not identical, illusios of the various people involved in women's birth experiences represent unexpected social contingencies. In Chapter 8, I reflect on these findings from the perspective of the childbearing career, as I develop an analysis of how such experiences seem to play out in terms of women's shifting birthing habitus. Rather than constituting experiences that contribute to the development of physiological birthing virtuosi, skilled at protecting the physiological birth process, I explore how such stories of trouble, infused with extraordinary emotion, often seem to lead to defensive practices on the part of the birthing women which act to shut down, rather than open up, possibilities for women to birth physiologically.

Whilst stories of trouble, as presented in this chapter, might underpin quite substantially women's reformulated illusios of and investments in birth over a childbearing career, these experiences work alongside many other stimuli. The next chapter focuses on women's experiences of the contingency of the performance of the birthing body: how it finds form, how women's understandings (or illusios) develop and how these

understandings also contribute to a reshaping of the habitus. In contrast to the stories discussed in the current chapter, the lack of trouble assigned by many women to stories of routine diversions from the physiological birth process will be of particular interest.

Chapter 7 Nature/society relations in the making: women's experiences of physiological birth

What do childbearing women know, and what is it possible for them to know, about the physiological process of childbirth? How does this knowledge affect their practice of birth over their childbearing careers? In this chapter I examine women's birth narratives to understand how and what women come to learn about the physiological process of birth through their personal encounters in the field of birth.

In Chapter 6, I started to explore women's stories about their experiences of the social practice of birth, drawing attention to a significant theme of trouble in women's stories about inter-personal interactions in the field of birth, during early labour through to the inpatient postnatal period. I considered how these stories of troubling encounters might be a key component of a woman's restructured narrative habitus with respect to birth over her childbearing career, reflecting the work that stories of such trouble might do. I return to this theme in Chapter 8, but in order to prepare for that, I wish to present in this chapter an interpretative analysis of a second key element of women's stories: stories about their encounters with the physiological process of birth in the field. In doing so, I focus on how women's conceptualisations of the physiological process of birth are (re)structured as a result of encounters as they become engaged in the social practice of birth.

In feminist birth scholarship, there is a well-established critique of a medical model of care (Rothman, 1982, p23), or a technocratic model of birth (Davis-Floyd, 1992, p52), in which birth is conceptualized as 'inherently pathological' (Davis-Floyd et al., 2009, p456) and 'a dangerous and traumatic process for both woman and child' (Davis-Floyd,1992, p54). In the context of that model, the notion of birth as harmful for the baby - a process, for example, in which the baby must traverse the 'dangerous passage' of the birth canal (Pitts-Taylor, 2008, p535; see also Humpstone 1920, quoted in Murphy and Hull, 2012, p23) - is discussed in terms of a flawed understanding of the physiology of the human body (Downe, 2004). Instead, the inherent healthy and normal nature of birth is proposed, as a key underpinning element of what is variously termed the midwifery model of care or holistic model of birth (Davis-Floyd et al., 2009, p442). Under this model, the sophistication of anatomical design is highlighted, which leads, for example, to an argument that a certain level of stress for the baby during childbirth is both safe and productive, in terms of helping the baby transition from intra-to extra uterine life (Downe, 2004). This is not to say that this literature seeks to ignore the possibility of pathology in birth. But in taking a perspective

that denies the inherent weakness of the female reproductive system it seeks to develop knowledge about how to support birth safely, safeguarding the benefits of the physiological process rather than overriding it, whilst - importantly - taking care to notice and avoid iatrogenic harm.

This chapter contributes to that discussion, by drawing attention to the way in which such conceptualisations are not irrelevant to women's birth experiences, but how they are intensely present in the way in which women conceptualise and practice birth. In Bourdieusian terms, this is because such debates are not 'out there' but located within the birthing body, as the birthing habitus of women comes to be structured by, and in turn works to structure, the field of birth as she enters the field and plays the game of birth successive times over the course of her childbearing career.

In contributing to this discussion, I work with two key ideas. First, I work with the idea of the field of birth as a diversionary landscape, wherein women frequently experience routine diversions from the physiological birth process. To exemplify this diversionary landscape, I take as a focus for analysis women's experiences and understandings of [diversions from] a spontaneous physiological onset of labour (7.1). Second, I work with ideas around how institutionalized spaces of labour and birth work to produce certain discursive understandings of the [lack of] safety of the physiological birth process for the baby (7.2). Taken together, I find a remarkable similarity in women's stories in the way that the field of birth is often represented as working to position the physiological birth process as unnecessary, abnormal and dangerous, in a way that works to structure women's experiential learning about birth and what it is possible for women to know about birth.

7.1 The diversionary landscape of the social practice of birth

> "There wasn't the discussion. It was, it's almost like 'it follows this pattern, and this is how it should go from here to there, and if you've not had it by that point, that's abnormal. This is the solution and we'll bring you in for that'. The thing about induction, I would say, it's just so matter of fact" (Gillian)

In this section, I examine how women's experiences of birth, and understandings of the physiological process of birth, are framed by a social practice of birth that is infused with diversions from a physiological birth process, so much so that I suggest that many women's experiences in this study represent institutionalized spaces of birth as a diversionary landscape. Drawing on women's birth stories in which this diversionary landscape is apparent, I examine the near inevitability of many diversions from the

physiological birth process. Examining women's understandings of such diversions, the findings in this section provide an important contribution to understandings of how the birthing woman's conceptualisation of physiological birth comes to be structured over the childbearing career.

In offering a conceptualisation of a diversionary landscape, this analysis works with a key question: why it is that such a diversionary practice of birth is continually reproduced, given that many women seem, at least initially in their birthing careers, to hold an illusio that is pro-physiological birth? The analysis allows for a discussion of how experiences of a diversionary practice of birth lead many women to evaluate the physiological process of birth as one of which they are incapable, as unsafe and as unnecessary, and in this way position them well to play a part in its reproduction. As well as having implications for understandings of the sustained diversionary practice of birth found in the social field in which these women come to practice birth, I suggest in Chapter 8 how exposure to such a diversionary landscape has important implications for how women are able to practice birth over the course of their childbearing careers.

The social practice of birth represented in this study routinely effects a divert away from the physiological birth process. Routine diversions can be identified at many points of women's stories, especially where intensive monitoring and pain relief medication are in widespread use, both impacting on physiology. Intravenous drugs and physical manipulation are frequently used to augment (or speed up) labour, with a specific diversionary intent and impact. Routine diversions can also be identified in women's stories of the birthing of their baby and the delivery of the placenta, where non-physiological management techniques (such as directed pushing or the further use of drugs) are routine. Following birth, women's stories also reveal the extent of institutionally-endorsed diversions from physiological infant feeding (including but not limited to the promotion of artificial breast-milk substitutes). In this section, I examine the routine diversions that many women encounter in the context of transitioning from pregnancy to labour, to illustrate the diversionary landscape at work.

7.1.1 The widespread experience of a non-physiological onset of labour

In discussing women's understandings of the spontaneous onset of labour, perhaps the most important observation is how many births seem to take place in its absence (5.2.1 and 5.2.2). Of the sixty-eight birth stories in this study, less than half included an undisturbed physiological transition, with only six of the twenty-six women participating in this study experiencing this in each of her pregnancies. The majority of the women

participating in this study thus experienced intervention in this transition at least once during their childbearing career.

The high frequency of routinized diverts from the physiological onset of labour mean that many women have a limited opportunity to experience and reflect upon the element of the physiological process of birth that is represented by a spontaneous onset of labour. From this, it might be inferred that for many women, a physiological onset of labour is not experienced as necessary. The impact of the diversionary landscape goes far deeper, however. For even when women relate a story suggestive of a physiological onset of labour, there seem to be two important qualifiers that need to be taken into account. First, such stories are generally told in the context of the woman's understanding, and tacit acceptance of, the induction routine to which she would have been subject if her labour had not commenced before a certain date. Second, these stories are sometimes (and perhaps curiously) told in the context that an induction intervention (for example, a membrane sweep) had actually occurred. Such is the game of birth in which women's understandings of the spontaneous onset of labour are framed: a game in which women are not expected to go into labour spontaneously, and in which interventions intended to induce labour have become so routine that they become invisible. Stories told by the women in this study certainly did not frame induction - as they might otherwise do - as a form of premature labour brought on by medical intervention, or iatrogenic prematurity (Amis, 2014; Tully and Ball, 2013, p108).

7.1.2 Women's investment in a spontaneous onset of labour

Set against an initial illusio of physiological birth as important, normal and safe, most women's stories suggested that they are well informed about the way induction interventions are offered as a routine part of the local maternity care process. Thus women repeatedly demonstrate their knowledge of the process that will be followed if spontaneous labour does not occur before a certain date:

> "So what they do is they get you in on your due date, if you haven't had the baby see, and basically at that appointment they make you another appointment, a new date, for the induction, if the baby hasn't come like. There's no discussion about it, that's just what you do. If the baby hasn't come by then, then you go in with your bag and stuff and they induce you. And that time you know for sure that you're not going to be coming out of there without your baby" (Sparkle)

Reflecting their initial illusio of birth, many women suggest that they are concerned about a hospital induction intervention, and the induction appointment becomes a quasi-character in their story that they would prefer to avoid. However there is a noticeable lack of detail in women's accounts about their reasons for wanting to avoid induction, suggesting that the women in this study do not hold a strong illusio that the achievement of a physiological onset of birth is important. The stakes of this particular move in the game of physiological birth are rarely recognised. Only one woman (Melissa) voiced concerns about the possible harmful effects of the intervention, suggesting that she recognised what was at stake with this particular element of the game:

> "Being induced with unnecessary drugs in the body cannot be good for the baby" (Melissa)

For other women, the recognition of the possible importance of a physiological labour onset reflected separate concerns. One woman (Mary) was concerned that an induction would lead to further interventions, and her focus seemed to be on avoiding those rather than induction per se; some women voiced scepticism and suggested that induction might be more to do with an institutional money-saving agenda, which worked to objectify them, rather than demonstrate a concern for their welfare; another woman referred to how an induction would separate her from her husband:

> "Then it kind of hit me that I wasn't going to have the labour that I wanted at all. It was going to be highly intervened in, because I was going to have to be induced" (Mary)

> "You don't know, but some of these interventions, are they not just speeding up the process, to clear the beds? And that's where it becomes the process rather than the person. You're not a person, and they want you out, they want the bed for the next one" (Gillian)

> "I didn't really want to be induced. Partly because I didn't want to go to hospital. Particularly as you have to go on your own. It is not like you can have your partner there all the time. I just felt that I would be isolated and I didn't want that" (Liz)

In addition to this muted opposition to the principle of induction, women's stories are largely silent about the potential benefits of a physiological onset to labour. The very limited data on that particular point in this study can instead by drawn from women's stories of arrangements for operative deliveries. When planning a caesarean birth, for example, women's stories suggest that there is no discussion of any benefits of waiting

for a spontaneous onset of labour. Instead, the definition of an appropriate birth date seems to be almost entirely focused on an estimation of when the baby's lungs are likely to be sufficiently developed, in order to avoid the administration of steroids in advance of a planned operative delivery. Discussing the rationale for scheduling her elective caesarean at 39 weeks, Mandie tells of how:

> "They just go to thirty nine weeks, they always do. Apparently they used to do it two weeks early, before forty weeks, but they like the extra week now, just so the lungs are properly formed. They just don't want you to go into labour" (Mandie)

Whilst these data are positioned in the context of operative deliveries, and it is important not to misrepresent it as anything else, it is interesting that no women in this study allude in any way to any specific benefits of awaiting spontaneous labour.

7.1.3 What do women understand about induction?

Whilst women tend to be very familiar with the local routines for induction, and women suggest that they are fairly reluctant, for a variety of reasons, to go along with it, women's birth stories reveal how, in the event, most women do accept the induction interventions offered to them. Women's stories suggest how their understandings develop to explain this apparent paradox. The following extracts suggest how women come to learn, for example, that induction - rather than awaiting the spontaneous onset of labour - represents the recommended option:

> "I think it was the safety aspect. Isn't there a certain, after two weeks, that it then becomes harmful for the baby? That is what I was told. I was told, you know, it reaches a turning point where it can actually be harmful for the baby. They would let you go overdue for so long and then really, once you had reached a certain point, it is safer for the baby to help them out" (Pamela)

> "My midwife said I was going to have to go in for an induction. 'We will put you in when you are ten days over. We really don't like to leave babies longer than that because the placenta doesn't work as well after that' " (Suzanne)

> "They basically wanted to induce me on his due date, and they said that was completely due to age. Their research said that the quality of the placenta in older women deteriorates very, very quickly, and so they had basically booked me in for an induction on my due date. It was the consultant who was very clear, that really was his preferred option and for me, I believed him" (Liz)

It is interesting to note that the legitimacy of each of the arguments outlined in these extracts is the subject of some controversy, illustrated by the decision of the birth activist organisation, AIMS UK, to commission work to guide women through their decision on this intervention (Wickham, 2014). As one might expect, few women in this study seem to have either the desire or ability to verify the advice they are given; whilst some women suspect that the arguments in favour of induction might not be as straightforward as they are being led to believe, few imagine that the advice they are being given might not be based on good evidence or might even be harmful.

Some women are quick to admit that they know very little about what being induced is likely to involve, either at the point at which they consent to being induced or later:

> "I just knew that induction was a medical way to get the baby out. I didn't know what it involved" (Melissa)

> "I was very naive as to what the inducement programme was - still am" (Alice)

It is also clear from some women's stories, especially the stories of those whose births became complicated following a hospital induction intervention, that some of the downsides of agreeing to the induction process are apparent only once consent has been given and the intervention well underway. Women's stories repeatedly suggest surprise, for example, that a pharmacological induction is not wholly effective on the first attempt, and that further interventions are seemingly necessary:

> "I think it was at day 10 they took me in to induce me. I had four suppositories in total and absolutely nothing happened and that took me up to exactly two weeks overdue. And so they then decided to give me a drug through, an intravenous drug. I cannot remember what it was called, and broke my waters for me. After five hours of that I was still undilated so they chose to do an emergency section" (Alice)

> "About eight sweeps, nothing. Managed to break my waters, nothing at all was managing to bring me into labour so in the end I had to go on to the drip" (Mary)

> "On the first day I had two pessaries. Nothing happened. The second day, another two pessaries, and nothing happened. They were like 'well, we will break your waters tomorrow'. So on the Saturday, which was my due date, they broke my waters about nine in the morning and put me on the drip, whatever it was, to speed things along. It was 'this is what we will do'. We didn't query it" (Naomi)

Women's stories thus highlight the inevitability of the next steps in the induction process if the pessary intervention is deemed to be ineffective. Women describe finding themselves effectively locked into a succession of interventions, with little possibility of escape. Whilst many women simply accept this as 'yet another thing being done to them', the clear shifts in treatment, with little further opportunity to be consulted and for their preferences to be taken into account, come as a surprise to other women. The consent to be induced seems rather to be consent for the staff to do whatever they wish with the aim of producing a vaginal birth. Even the decision about when to call a halt to this strategy and divert to an operative delivery is for the staff alone to make, as Gillian and Alice note, as they observe how their preferences are seemingly irrelevant in this context:

> "If there is a medical reason to bring the baby out that quickly, is that not where a section should be used, rather than a massive barrage of drugs?" (Gillian)

> "If they said 'right, ok, we don't think anything's going to happen here. You can either choose to have an elective or we can try again' " (Alice)

This seems to suggest a deficiency in the informed consent process for induction. The principle of a woman having a good understanding about the likely implications of an induction intervention - and confidence in the knowledge on which [a belief in the effectiveness of] an induction strategy is based - seems to be a low priority. Instead, women are encouraged to play a game without an understanding of where the first move (the induction intervention) will lead. Before the first induction pessary is inserted, many women in this study are unaware that a highly interventionist augmentation strategy will be effected if the pessaries fail to achieve a commencement of labour, with a shift to a strategy of an instrumental or operative delivery if augmentation too fails to progress the labour. Once play commences there seem to be no further point in the game at which the woman is able to make any decisions about the way in which play will proceed: rather, they must 'lie down in the bed they have made' (Dombroski, McKinnon and Healy, 2016, p232)

7.1.4 Matters of agency and control: women's talk about commencement of labour

Women's stories in this study all repeated a similar theme in terms of the lack of choice about the process that would apply at the end of their pregnancies, evoking Lindsey Skyrme's notion that 'the scope and authenticity of informed choice withers under scrutiny' (Skyrme, 2014, p400). For many women, this lack of choice did not seem to be a matter of great concern:

> “Cathy ended up ten days overdue. I had an appointment to discuss what the plan was and they decided that they would only leave me ten days before they induced me. They gave me a date to go in to be induced” (Julie)

> “You are in the system and it is what the system tells you to do. I mean, I do what the system tells me to do” (Melissa)

The notion that women have no choice, and are swept along by the system, is a key point of many stories. Some stories also suggest how some women are keen for their pregnant state to come to an end and are thus positively inclined towards the recommendation of induction:

> “That is what they said they would do and I was happy to go along with that because I just wanted to get the baby. I didn’t necessarily opt for it, I don’t think. I just think I didn’t know any different. ‘Oh, you know, ten days post due date we induce you’, and I knew no different so I said ‘fine’ ” (Alice)

> “I remember being like really limited mobility wise, and begging the midwives: ‘please induce me, please induce me. Please get me into see Dr G. I need to like beg you, induce this baby because I can’t walk, it’s going to be massive, I’m going to be buggered for life’. And the next day an appointment came through the post, I saw the man himself. Brilliant. He said ‘yep, no problem’ ” (Gillian)

Whilst Alice and Gillian are receptive to a process in which induction is routine, and Gillian talks about how she took the initiative in proposing an induction, other women reveal dissatisfaction with the process:

> “You accept the appointment because that is what they tell you. I wasn’t happy. I didn’t want to be induced at all. I didn’t question that. It was like ‘this is what we do’. I don’t think I would have fought against it, even though I didn’t want it” (Barbara)

> “I felt like I didn’t have a choice. They were saying ‘this is how it is’. I think as well it is just like getting the response of ‘well, I have worked in this profession for so long’. You know, it is almost like they are saying ‘this is my job. I have delivered a million babies and induced a lot of women’. Almost like, ‘don’t argue, because that is just the way it is done’. You know, it’s like if you do think outside the box. Why can’t anyone out there have a discussion with you about it?” (Cat)

Cat is unusual in this study in taking issue with the lack of opportunity for discussion about this proposed intervention. The local service provision, as Cat encounters it, is

not set up to deal with her desire to engage in the decision about whether or not induction is necessary: this discursive space does not seem to exist. Instead, it is left to women themselves - as they are presented with a specific induction routine as the safest and recommended option - to develop an understanding that different options should be available. Some women in this study illustrate their understanding of such options:

> "But they could monitor you. If they monitored you, if you went, possibly every day, to listen to the baby's heartbeat. Yes, it is a bind to go every day, but if you are that far gone. I wouldn't have minded going every day to have the baby monitored, to make sure she is moving, that she is doing ok. I didn't think it was available to us here. I didn't think it was an option for us here. You are not given a choice, even though the NHS is supposed to be all about choices, you are not actually given the choice. You are given what the procedure is for this area and what they are comfortable with. You know, just to get people through faster and quicker" (Melissa)

7.1.5 Mastering the onset of labour: women's skill and knowledge in inducing labour

As women come to understand the inevitability of a hospital induction process, their reluctance or inability to challenge it paves the way, paradoxically, for their acceptance of an alternative induction intervention, the clinic-based midwifery induction intervention of a membrane sweep. As with the hospital induction process, the induction intervention of the membrane sweep seems to be a taken-for-granted, if sometimes uncomfortable, part of the maternity care regime:

> "I think when it is your due date I think it is expected to have a sweep on your due date. I think it is expected because that is what they tell you all along. That is part of the plan. You know about it while you are pregnant and before you are pregnant. Everybody talks about having a sweep and how uncomfortable it is" (Melissa)

Whilst some women might resist a membrane sweep on the basis of discomfort, only Cat suggested that a membrane sweep might be inappropriate:

> "He ended up being overdue by ten days. I think I was booked in for induction, which I was really sort of fighting against, I really did not want to be induced. I was trying to argue my point, but I didn't feel like in a position. I thought 'well, babies can go longer' but you know, in the system we have here they obviously have to do it on a certain day. I didn't have enough of an argument to say

> something. They seemed to know what they were doing, so at that point I was like 'ok, just give me a date'. So that is why, when they offered me the two sweeps at that time I thought 'I am going to have the sweeps' because even though I didn't really want to have a sweep, I just took it, so I didn't have to be induced. The lesser of two evils" (Cat)

Cat is alone in this study, seemingly based on her consistent illusio in the game of physiological birth as inherently worth playing, as identifying the function of a membrane sweep as questionable, absent any signs of pathology. Cat repeatedly questions the principle of interfering with a spontaneous onset of labour. In the end, however, even Cat accepts this and other interventions. But for many other women in this study, it seems that any activity designed to avoid the hospital induction routine is conceptualised as helpful and benign:

> "I think you would rather have a sweep than an induction, everything you can to avoid drugs" (Melissa)

> "It's just something they do, really, to get you started really, which is a good thing in a way" (Sparkle)

If the membrane sweep does not result in the onset of labour, some women are motivated to draw on their own resources to try a range of traditional remedies, whether at home or from an alternative healthcare provider, to achieve that outcome. For many women, then, the key focus of the final stage of their pregnancy seems to be primarily about how they might skilfully and knowledgeably trigger labour, "to try to induce it naturally rather than medically" (Melissa):

> "For the two weeks I was overdue it was 'how can I make this baby come? How much pineapple can I eat?' You know, all of those things to try and bring on labour" (Mary)

> "It was all the pineapple and the curry and how's your father and stuff like that" (Heidi)

> "I tried every single old wives tale/medical thing in the book to bring on labour. Obviously nothing dangerous, but raspberry leaf tea and all that, I used to have. I got acupressure on my toes" (Liz)

> "I didn't want to be induced. You know, I tried anything, like eating pineapple, curry, you know, everything to get this moving naturally but it just wasn't working. So I actually went to acupuncture. I went to acupuncture the week before they induced us because I thought that was the way it was going and

had read about acupuncture and that it can help to stimulate your uterus to get things moving. It was great. But it didn't get Abby going, so I had to have the pessaries" (Melissa)

With an induction appointment in the diary, and the clock ticking away, the question of whether it is appropriate to await a spontaneous onset becomes seemingly irrelevant. In this way, I suggest that women become socialised into a practice of birth in which the value of the physiological process - in this case awaiting the spontaneous onset of labour - is low, and the tolerance for an externally managed birth process is high. In this situation, women develop a cultural competence - or become complicit - in the task of seeking to induce their labours. The broader question of whether it is necessary to induce labour is left unexamined, as women seek to deal with the more immediate threat of the induction appointment. This is made all the more possible because many women seem to have no clear illusio that a spontaneous onset of labour is important; some might indeed have a clear preference for an early commencement of their labour, and other women come to identify the social costs of resisting the routine as high.

Regarding women's preferences, an analysis of women's stories suggests the multiple benefits that some women come to associate with a managed onset of labour; thus they recognise that the stakes involved in the induction game are worth playing for. These stakes are described by women in terms of practicality, a desire to end the pregnant state, a desire to meet the baby in the flesh, and a certain level of impatience (both on the part of the pregnant woman and those around her):

"In some ways, because you have one child, and the whole uncertainty of when you are going into labour and everything like that. So actually it was a practical kind of thing that I could say to my mum that I am going into hospital on this date. It was a very practical thing. I actually thought that it would be right for me to do that" (Liz)

"I was fed up, I was sick of those phone calls: 'have you not had the baby yet?'" (Mary)

"40 weeks and 13 days over, I'd had more than enough. I'd had more than enough at about 36 weeks, to be honest" (Ruth)

"I was just told come in on this date. I wasn't asked. I was more, like, you're like fed up. You do want a means to an end, and if they're the health professionals and that's what the healthiest and best" (Gillian)

> "Your body's low then, you just want to get it out then, and love it and cuddle it, and take it out for its walks in its new pushchair" (Sparkle)

> "I didn't want to wait any longer to see her. You want to see your baby" (Melissa)

There is also a strong sense of women feeling that they are 'in limbo' between their due date and the commencement of their labour, which women and their social networks seem to find uncomfortable:

> "It's like when you go past your due date you are like in limbo, there is nothing. You haven't made plans after your due date and you are just kind of wanting it to happen so you can carry on" (Julie)

Only Lola described the potential benefits of induction, in this case induction following the rupture of her membranes with no signs that labour was about to commence, in terms of specific worries about her baby's well-being:

> "I didn't really want my waters to go and have to sit around, because of infection. I was like 'I will get induced'. I didn't really want to get induced, but I would just be sat around worrying about infection. 'I just want this baby out now, I just want to know that everything is fine' " (Lola)

In this context, the benefits of simply going along with an imposed induction routine, absent any signs of pathology, seem to be much higher for women than any benefits associated with resisting this routine, especially when some women come to consider difficult issues of responsibility involved in such a move.

For some women, it seems, a key issue around induction is related to who is responsible for birth outcomes, and this idea helps to explain why many women might not be keen to resist a recommended diversion away from the physiological process. Women discuss how they are wary of getting involved in decision-making about their baby's birth, and often explain this in terms of a fear that such an involvement would necessarily involve a key shift of responsibility, from the health care professional to themselves, for the entire outcome of any birth in which such a 'non-standard' decision had been made by the woman:

> "I think they gave me the information [about the choice between induction at 10 or 14 days] but in a way that made me feel like if I had pushed it then I would have been responsible" (Suzanne)

> "If the consultant was saying to me 'you have to have this induction now' and I didn't have it and something went wrong, I would never forgive myself." (Barbara)

From one perspective, these concerns underline how far many women in this study feel that they have been successful in shifting responsibility for the outcomes of their birth onto their healthcare providers. But it also highlights a perspective in which there is no half-way house: there is no sense of a partnership model in action. Instead, women feel that they would only have themselves to blame if they go against local routines. Illustrating this, one woman in this study, Gillian, who has explained how she played a major part in pushing for an early induction for her second baby (7.1.4), reveals that she has had to consider just this issue:

> "I'd be mortified if it's the reason for her problems now. But I still think it was the best thing for me then, at that time. But there wasn't much discussion" (Gillian)

Left largely unspoken in women's stories seems to be a feeling that it is unwise to await a spontaneous onset of labour; that bodies cannot be trusted to go into labour spontaneously; that bodies and the physiological process of birth rather pose a threat to the well-being of the baby, and perhaps the mother, and that intervention in this physiological process is the safest course of action. This marginalisation of the belief in the functionality of the physiological birth process is felt keenly by some women. As Melissa explains, for example, a preference for awaiting the spontaneous onset of labour, unless it occurs before the woman's officially recognised due date, becomes an abnormal stance, and one which has the potential to instil fear:

> "I didn't think there was any alternative. I was scared, because it is not normal to wait until they are ready. I would have been the first one to wait until she was ready, you know, and then something goes wrong, you know. You wouldn't be able to live with yourself, you know, if it was your fault. If you could apportion that blame on to somebody else, it is not nice, but at least you could live with yourself" (Melissa)

In this way, Melissa illustrates how a desire and tolerance to await the spontaneous onset of labour, representing the game of birth she wants to play, seems at the same time to become conceptualised, as she engages in the local field of birth, as unnecessary, abnormal and dangerous.

7.1.6 Displacing the physiological process of birth

In this section, I have discussed, with reference to the example of the commencement of labour, how women in this study represent their birth experiences as being subject to routine diversions from the physiological process of birth, within what I have conceptualised as a diversionary landscape. On the one hand, women's stories suggest that these diversions are imposed upon them: they have little choice in the matter. At the same time, however, my analysis suggests that women themselves develop a cultural competency, or complicity, in these diversionary routines, playing a key role in their reproduction, drawing on various forms of skill and knowledge to do so. As such, it seems that many women are able to align themselves with the basic beliefs underlying these diversionary routines, including an understanding that constituent parts of the physiological birth process have little benefit in themselves, are unnecessary, and are potentially dangerous. Women come to this position based on their personal experiences of birth, and it is clear that the social practice of birth in which women in this study engage is limited in its ability to afford women the possibility of other ways of knowing physiological birth. This renders problematic women's understandings of whether or not their bodies are capable of birthing, because for many women this experiential possibility remains unknowable. In such a context, the logic of the widespread displacement of the physiological process of birth is evident.

7.2 Birthing in the contemporary UK: understandings of physiological labour and birth as dangerous for the baby

In this section, I seek to contribute to debates about conceptualisations of the safety of physiological birth, by examining how such conceptualisations come to be structured in the context of women's experiences of birth. Whilst a key focus of current debate is how women's access to negative media portrayals of birth contribute to understandings of birth as dangerous (2.2.4), I would suggest that less attention has been paid to how women's experiences of giving birth might also play a key role in underpinning such understandings. In this context I present an analysis of women's narratives on the impact of physiological labour and birth on their baby, which examines how a knowledge of childbirth as dangerous for the baby are also produced from personal experience. In doing so, I suggest that many of the dangers that women perceive might derive not from the physiological process itself but from the socially constructed practice of birth with which they engage. Nevertheless, my key contention is that their personal experiences leave many women suspicious of claims that the physiological birth process is safe and trustworthy.

Given the focus on experiential understandings of physiological labour and birth, I exclude from analysis in this section data relating to two women whose babies were each born by elective caesarean section. For the other twenty-four women, my analysis revealed a surprising 'headline finding' that all but two of the women told stories about their birth experiences that might be interpreted as including a significant understanding of physiological birth as dangerous for the baby. To illustrate this, I examine four types of experience: the experience of being told that the baby is distressed during labour, the experience of being given to understand that the baby is stuck and unable to be born vaginally, the experience of witnessing a baby being born in a poor condition and the experience of feeling that the baby might have died.

7.2.1 Labour as dangerous: babies can get distressed

A key way in which an understanding of birth as dangerous for the baby seems to emerge is related to women's experiences that babies can become [di]stressed during labour, and to women's understandings that such [di]stress is a sign of danger. In this study, fifteen women's stories suggested that they had the experience of understanding that their baby was in distress during labour, generally based on staff readings of the foetal heart rate monitor (often referred to by women as 'the trace': the visual record of the readings that the monitoring machine displays as a digital output).

Women's talk about labour is often infused with a focus on the monitoring of their baby's heart rate; they talk about how 'the heart rate monitor was beeping'; how midwives were sometimes 'unsure about the baby's heart rate'; how the baby's trace was 'erratic' (a finding which sometimes leads to the testing of oxygen levels of the baby's blood, via a foetal scalp monitor). Women talk about how they came to understand that their baby 'was showing severe signs of distress'; how their baby's 'heart beat had decelerations, severe decelerations', or how the baby's 'heart beat started to drop every time [there was a contraction]'. Women's stories revealed their understanding of danger in such circumstances as additional staff are called in response to the identification that the 'baby is in distress' and as interventions are planned. The centrality of the readings of the foetal heart monitor to the labour experiences of many women is underscored by stories told by three women who explain how staff 'lose the trace' on their baby. In these situations, women do not even have to experience the news that their baby is distressed; the absence of a 'reassuring trace' alone gives rise to the understanding that something might not be right. It is as if labour cannot progress safely unless there is constant access to technologies to see inside the body, in this case real-time information about the baby's heart-rate provided

by the monitor. In this way, we see that these machines, or non-human actants, 'have a significant role to play' in women's experiences of birth (McKinnon, 2016)

Listening to women's stories, I was interested to identify that such episodes of distress on the part of their baby were rarely linked by women to a possible cause; it simply happened that babies could become stressed in labour/as a result of the labour, and that this could develop into severe levels of stress on the part of the baby, which in turn would warrant some sort of intervention, including the surgical removal of the baby via a c-section.

Given the widespread use of foetal heart rate monitors, diagnoses of distress on the part of the baby also seemed to be almost routine in the experiences of many women in this study. For many women, therefore, that their baby might be in distress seemed to be taken-for-granted, and women were largely reassured that the trained staff, hi-tech equipment on hand, would be able to resolve the problem. Some women, however, were clearly anxious in this situation. Sally was told, for example, on the basis of a reading from the monitor that an operative birth might be necessary for her first baby:

> "a more senior nurse came along and said that it seems like you will need an emergency caesarean because the baby's in distress and the heart beat has really slowed down. 'There's something wrong; am I going to lose the baby?' " (Sally)

Whilst this situation was resolved, and Sally's fears allayed, as the baby's heart rate was later declared to be fine by another member of staff (thus ensuring the avoidance of an operative birth), it is clear that Sally had quickly latched onto the idea that her baby's life was in danger.

As in Sally's case, many women's stories clearly indicate an understanding that staff's concerns about their baby's safety are to be taken seriously. In that context, eight women in the study tell stories about how they were given to understand that a good outcome to the birth was at risk unless the baby was born very soon. Liz talks about how a midwife told her that "this baby needs to come out very quickly". Gillian recalls how "they were quite insistent that she needed to, sort of come out". Pamela, labouring in a birthing pool, received a similar message: "they said they needed to get me out [of the pool] and get him out". Ruth talks about how she was told by a doctor that:

> "the baby's in distress. I would like to have this over now. The baby is not coping. We need to get this over. We need to say enough now, the baby's definitely not coping" (Ruth)

Jane recalls how she was told that "you need to get him out quick". In some cases, women's stories described a panic that they perceived seemed to set in amongst staff on the identification of a baby's distress, exemplified by Alice's story of the lead-up to a caesarean section for the birth of her first baby:

> "They were obviously monitoring John's heartbeat and it was ok, but then it did start to increase and there were signs of distress; then they thought 'oh god, we do actually have to get this baby out now' " (Alice)

In each of these cases, preparations for a caesarean section were made, although one woman birthed her baby vaginally before the operation was performed. As women tell these stories, it seems that birthing women receive a very clear message: all is not well, and left to its own devices, your body is not capable of birthing your baby safely. For these women, drawing on such understandings of birth as dangerous and their bodies as incapable, it starts to become inconceivable that they could imagine birthing safely without highly qualified staff and hi-tech life-saving resources on hand. This understanding seems to be confirmed as some of the women tell of how their baby's lives still seemed to be in danger on being born (see sections 7.2.3 and 7.2.4), underlining for them the importance of the rescue function of the maternity services.

According to women in this study, the distress of the baby in labour is rarely the focus of discussion between the mother and the maternity care team after the birth. In the absence of discussion, women's stories reveal how they come to their own understandings, including about the rationale for, and necessity of, 'rescue' intervention. Ruth talks about how, without the emergency c-section that followed a diagnosis of distress on the part of her second baby in labour, 'it could have got to an emergency situation'. Only two stories feature the idea that the diversions from a straightforward physiological birth might have an iatrogenic source. Naomi tells of how she and her husband suspect that the augmentation intervention had been carried out too fast:

> "We did think that the syntocin had been given too quickly. They sped it along too fast and something went wrong" (Naomi)

In Jenny's case, her suspicion was that the midwife who had instructed her to start pushing too early was to blame for the way in which the birth developed into a traumatic succession of complications. More generally, however, reflection on the

reason for a baby's distress in labour either does not feature in women's stories or remains an area of uncertainty. Sparkle illustrates this, as she explains that the reason why the birth of her second baby turned out as it did (with an operative birth) is somewhat of a mystery:

> "You don't know. You never know, do you" (Sparkle)

In this way, for many women participating in this study, if the issue was raised at all, there was a strong sense that the cause of any problems with the way the birth unfolded was simply unknowable, and the possible reasons for a baby's distress during labour left unexamined. It rather seems as if it might reasonably be taken for granted, by the story-teller and her listener, that this is just the way things are: labour and birth cannot be guaranteed to proceed smoothly and safely. This leaves open a number of questions. Why is it that so many seemingly healthy women, with seemingly healthy pregnancies, seem to encounter problems in achieving a straightforward physiological birth? Why do so many babies seemingly experience unbearable stress during labour? An understanding that a successful physiological birth is a matter of luck, and that birth might be inherently dangerous for the baby, is seemingly sufficient for the women in this study to draw a line under their experiences and consider their stories as complete.

7.2.2 Birth as dangerous: babies can get stuck

A further way in which women experience birth as dangerous, both for the baby and potentially for themselves, arises in situations in which the baby is diagnosed as being in the 'wrong position' for birth, and/or with a cord that is apparently too short or poorly positioned to allow for the birth of the baby: in these circumstances, the notion of the baby as being 'stuck' looms large in the imaginary of birthing women. In this study, women told stories of instances in which their baby was unable to be born due to positioning or cord issues, and such stories add weight to the perspective that the baby is not always safe during a physiological labour and birth, and that external intervention and rescue is often necessary.

For the three women in this study whose babies were in a breech or transverse position, all were persuaded that vaginal birth was not a safe option and thus an operative birth was arranged and became taken-for-granted. Women gained understandings of the risks involved in vaginal birth in such circumstances from their maternity care team. Ruth's view that a c-section for a breech presentation is preferable, for example, is clearly made in the context of her recollection of the views of her consultant on the matter:

> "he said 'he can't be turned and I don't think that he'll come out safely either'; it's more than likely that he would have just got stuck" (Ruth)

Just one woman in this study, Pamela, reported experiencing a diagnosis of shoulder dystocia, where the baby's shoulders seemed to be stuck after the baby's head had emerged. Noteworthy in Pamela's story is the sense that the danger associated with this situation is averted more as a matter of chance than planning, that it was lucky that a highly experienced midwife was on duty at the time and was able to resolve the situation. The implication is that things might not have turned out so well:

> "I think I was quite lucky with an experienced midwife. There was a lot of turning around, legs up, and literally manipulating me" (Pamela)

Whilst attention to the specific skills and agency of the midwife, and the possibility of a different outcome if those had not been present, is key to Pamela's story, other stories of babies apparently being unable to be born vaginally - whether due to the baby's positioning or due to cord issues- rarely seem to suggest the possibility of agency on the part of either midwives or the birthing woman to effect a successful outcome, whether during or in advance of labour.

For other women, such events seem to be associated with a notion of bad luck, and lead overwhelmingly to the telling of stories in which the impossibility of the baby to be born vaginally, and the necessity of external intervention, becomes fact: the birth could not have proceeded otherwise (or at least, not successfully). Thus an instrumental or operative delivery was the outcome for eight women in this study, including Lola, who experienced births where their babies were 'stuck' in a 'back-to-back' position. Such positioning was understood by women to be the reason why their labour had been difficult, and as the reason for ultimately diverting from the physiological pathway:

> "we were just told that I needed a c-section because he was back-to-back and I didn't query anybody, it was just something that happened" (Skye)

> "it didn't look like he was going to come out" (Becky)

> "she just wasn't coming out. She was stuck and she just wasn't for coming" (Lola)

> "my over-riding fear was that this baby was completely stuck. I was just terrified that I was going to lose the baby" (Skye)

In these women's stories, there are very few references to the possibility that there exists another form of knowledge that might have resolved, or even prevented, these positioning issues, such as the various fetal positioning techniques promoted by Gail

Tully (Tully, 2017) or by the Make Births Easier campaign (Make Births Easier, 2017). For the women in this study, without the knowledge of such strategies to address the positioning of their baby, a back-to-back positioning and its resolution via instrumental or operative means rather serves as evidence of the dangerous nature of the physiological birth process.

A related experience that can act to render labour and birth unsafe at worst, or a matter of chance at best, derives from women's understandings of cord positioning as dangerous for the baby. Thus a number of women make reference to how their babies are born with the umbilical cord wrapped multiple times around the neck. For Serena, the fact that third baby was born with the cord around her neck seems to be offered as an explanation for her baby's poor condition at birth. Sparkle's awareness of this cord positioning is also sufficient for her to explain, retrospectively, the need for an operative birth for her second baby:

> "She had the cord round her neck. That's why I couldn't give birth to her. Obviously it must have been put round her so tight that she couldn't do anything. The baby wasn't moving nowhere" (Sparkle)

In Sparkle's account, as in others, there is a strong imagery of the umbilical cord literally strangling the baby. Explaining the situation that occurred during labour, Sparkle explains how the cord wrapped around her baby's neck was killing the baby:

> "it's killing itself. It chokes. 'My baby's dying' "

Interestingly, this interpretation of events is not offered without some reflection. Sparkle also offers the information that she knows the baby was not actually being choked. In discussion, she points out that she knows that babies do not actually breathe before they are born. But this does not seem to trigger any further curiosity on Sparkle's part about what exactly caused the need for a diversion from a physiological birth pathway. In the same way, and in the absence of any discussion with caregivers after the birth, other women in this study come to form their own conclusions about the inherent danger of a cord wrapped around the baby's neck, adding to the perspective of birth as dangerous; I was particularly interested to note that there were no balancing references in women's narratives to stories about babies being born vaginally, in a healthy state, with a cord wrapped around their neck.

7.2.3: Labour and birth as dangerous: babies can suffer

A third theme that strongly suggests the provision of cues to birthing women that birth is/ has been unsafe for the baby relates to women's stories about babies being born in

a poor condition. If birth is conceptualised as a normal healthy physiological transition, one might expect that the vast majority of babies will make this transition well, and be born in an alert healthy condition, with an uncomplicated respiratory and nutritional transition. Yet listening to women's stories, this outcome does not always fit with their lived experience.

For six women in this study, a focus of their birth stories is the experience of their babies not breathing when they are born. Women explain how this leads to the resuscitation of the baby. In this study, such resuscitation efforts always seem to be done away from the mother's bedside, the baby's cord being cut immediately on birth to facilitate this:

> "she had to be resuscitated as soon as she came out. Something had obviously gone on. She sort of came round and that was that really" (Gillian)

> "they had to take him off to the resuscitation table 'cos he wasn't breathing on his own. And he was fine after that" (Ruth)

In every case, these resuscitation efforts were successful in terms of helping the baby to establish breathing. In terms of the stories told about these events, the success of the treatment provided provides the basis for a story in which the necessity for expert assistance is not questioned but rather treated as fact. The success of the resuscitation procedure is sufficient to resolve the problem (that the baby was not breathing on birth) and thus there is little call for the women to reflect further, for example about why their babies were not breathing at birth or whether the treatment provided was appropriate; indeed there is no sense in the women's accounts that things could have, or indeed should have, been otherwise.

Melissa's story underlines the pervasive understanding of a non-breathing newborn baby as signalling pathology demanding medical attention, as she relates how she believes that her first baby was actually dead when it was born:

> "Reading my notes afterwards, Cindy wasn't actually alive when she was born. And I didn't know. She had to be resuscitated so she was dead" (Melissa)

This understanding of a newborn baby being dead at birth is clearly very powerful and upsetting. Melissa seems to equate the state of a baby who is about to be resuscitated to a state of death; it is this state, as she understands it, which renders the resuscitation necessary.

There is little sense in women's accounts that there might be other ways to interpret a baby's condition at birth (for example, as a short delay in the transition to extra-uterine

respiration) and other ways to support the baby's transition to extra-uterine life, for example, by ensuring the placental oxygen supply to the baby is maintained until the cord stops pulsating, whilst engaging in some gentle bedside intervention until the baby starts to breathe of its own accord (see Mercer and Skovgaard's 2002 call for new paradigm for understanding neonatal transitional physiology). Instead, the acceptance of the notion that babies are often born in a state that requires the immediate separation of the mother and baby for 'rescue' intervention suggests an understanding of birth as dangerous, an understanding that is complemented by a belief in the necessity for staff who are experts in birth pathology, with their hi-tech equipment, to be present at all births.

Perhaps less dramatic in story-telling terms, but also notable in women's stories, is how women refer to their babies as being particularly distressed when they are born, with many babies reported to have cried constantly during their first few hours of extra-uterine life. Skye talks, for example, about how 'it was just like we had this screaming thing in the room with us. He just screamed and screamed'. A further group of women told of how their babies seemed to display problems in adjusting to the nutritional transition from placenta to breast: in these stories, it was difficult to detect any sense that babies might be understood as being able to make this transition in an uncomplicated manner. On the contrary, for some women the experience that their baby has trouble breastfeeding is presented as unsurprising. Women seemed to have low expectations - or indeed no expectations - that their baby is either physically capable of, or interested in, breastfeeding:

> "She wouldn't latch on. I thought she couldn't do it" (Sparkle)
>
> "Scott just did not want to latch on. He just wouldn't latch on" (Becky)
>
> "She latched on but was too lazy to feed" (Lola)

Reinforcing this point, other women suggested that a straightforward start to breastfeeding was surprising and unusual. Thus women made specific reference to how smoothly their babies had been able to make this transition, as if this was quite extraordinary. Amy, for example, expressed her surprise when her first baby took to breastfeeding in a straightforward manner, evoking Suzanne Colsen's work on the instinctual process of biological nurturing and the ways in which this process is frequently disrupted (Colsen, 2017):

> "They just lay her on me and she just fed herself. She just knew what to do. Quite crazy really" (Amy)

7.2.4 Labour and birth as dangerous: babies can die

The extent to which death is an ever-present theme in thinking about human reproduction generally and childbirth more specifically has been discussed extensively in the academic literature (Murphy-Lawless, 1998). In the current study, the death of a baby in utero was a reality for two women. Women's stories also expressed the pain of experiencing non-viable pregnancies; many women told stories of one-off or repeated miscarriages. In relation to the process of labouring and birthing, the imaginary of the baby's death re-occurs. In some cases, the baby's death is imagined during labour, in other cases death is imagined after the baby is born, especially if the baby is taken away from the mother immediately at birth. Seven women in this study made specific mention of the possibility of their baby's death during either labour or birth.

The understanding of death (for mother and baby) as a frequent outcome of birth in the not-too-distant past - or in the present, in the global South - was also offered by a number of women. For many women, it is taken for granted in this way that childbirth is dangerous:

> "Didn't a lot of women used to die in childbirth?" (Pamela)

> "Should/can a woman give birth? Yes they can, but not always successfully. 'Cos we forget, we've got modern medicine now. We forget how bad it was, how bad it still is in the developing world. They don't have modern medicine and look at the death rates, even in like the 50s. Child death rates, well infant mortality and ermm maternal mortality. The rates were still a lot higher than what they are now" (Ruth)

There was little acknowledgement by the women in this study that factors of poverty, poor nutrition, poor public health and poor hygiene practice on the part of medical practitioners might have contributed significantly to such poor outcomes; rather, the physiology of birth itself is treated as suspect. In this discursive context of birth and death, whether spoken or unspoken, it is unsurprising that for some women, the birth of their baby is greeted with such joy, a marker that the dangerous passage (that is, the birth canal) has been navigated successfully by the baby. 'Until they are in your arms', as Amy puts it, there is a sense that anything can happen. Lola talked of 'just want[ing] the baby out': 'until that baby is out and I am alive and the baby is alive'. Looking back at her childbearing career, Heidi talks similarly about how she was 'so grateful that it [childbirth] was over and they were here'.

7.2.5 Reproducing understandings of labour and birth as dangerous for the baby

In this section, I have discussed how women develop their understandings of the safety of the physiological birth process for their baby, as they encounter the field of birth, and I have suggested that it is unsurprising (and indeed entirely reasonable) in that context that many women come to play a part in an ongoing reproduction of understandings of labour and birth as dangerous for the baby. This finding - that women's constructed stories of their birth experiences might lead them to a knowledge of physiological birth as dangerous for their baby - seems to be an important one, likely to affect how women go on to practice childbirth over the course of their childbearing careers.

7.3 Conclusion

In this chapter, I have examined how the game of birth that women play comes to structure their narrative habitus with respect to their conceptualisations of birth and of physiological birth, based on their personal experiences. I have examined how women's stories reveal their illusios of birth, of physiological birth, and of elements of the physiological birth process, discussing how these illusios seem to shift as a result of women's lived experiences, restructuring the birthing habitus as they do so. In particular, it seems evident that women's conceptualisations of physiological birth as unnecessary, abnormal and dangerous are frequently grounded in their personal experiences of the social practice of birth. One way of conceptualising the data presented in this chapter is in terms of how the social practice of birth frequently represents a discursive and material violation of the physiological process of birth. These findings raise interesting questions about the role played by health workers, and the maternity services, in contributing to such violations.

I have developed this line of argument in two ways. First, focussing on women's experiences of the onset of labour, I have raised questions about the way in which the field of birth - described here as a diversionary landscape - encourages certain understandings of the [in]capacity of women's bodies and their babies to birth/be birthed physiologically. In this context, and within the diversionary landscape in which the game of birth is played, I have also suggested how women's experiences might underpin a revised understanding for many women of the physiological process of birth as unnecessary, abnormal and dangerous. Second, I have examined women's birth experience narratives concerning the well-being of their baby during labour and birth, and considered how the discursive and material space of the birthroom often works to produce understandings of the physiological birth process as dangerous for babies.

Taken together, I suggest that these two elements of women's birth narratives are likely to contribute significantly to a restructuring of the birthing habitus. In the next chapter, I consider further the work that these stories might do over the course of a woman's childbearing career, and how they seem to 'work on [birthing women], affecting what [they] are able to see as real, as possible, and as worth doing or best avoided' (Frank, 2012, p3).

Chapter 8 Developing a feel for birth over the childbearing career: exploring women's skilful and knowledgeable agency

This chapter explores how, over their childbearing career, birthing women demonstrate skilful and knowledgeable agency, illustrated by the various strategies they develop, and action they take, as they re-enter the field of birth, to achieve their birthing goals. Following Bourdieu's theory of practice, I suggest that an important component of this social practice is previous personal experience, as women narratively come to understand it. This previous experience, embodied in the birthing habitus, plays a key role in informing how, for subsequent birth, 'a good birth' is conceptualised (the illusio of birth) as well as offering skill and knowledge (capital) to support its achievement. Repeated engagements in the field of birth allow women to get a feel for the game of birth; as women develop this feel for the game, it is possible to observe how their understanding of birth, and their relationship to it, shifts. Women's practice, whether reflexively planned or more intuitively improvised to take account of contingencies encountered, can be understood from an analysis of the way in which their narratives suggest a developing practical mastery of birth, albeit mastery that takes different forms.

In the previous two chapters, I have offered insights into key features of the social practice of birth as women have narrated it. In this chapter, I identify two (related) narrative shifts which seem to develop from women's immersion in the field of birth. First, there is a defensive positioning, as women approach birth for a subsequent time seeking to protect themselves against trouble arising from encounters in the field of birth (Chapter 6). Second, drawing on experiences of diversions from, and new concerns about, the physiological birth process (Chapter 7), some women seem to become more sceptical about the possibility of physiological birth over their childbearing career, with increased doubts about their body's capability to birth safely with little or no medical intervention.

In the first part of this chapter (8.1), I examine how these two narratives sometimes come together to underpin an approach to subsequent births in which some women exert their agency to avoid the physiological birth process. In the second section (8.2), I examine how other women seek to reassert their illusio of the physiological birth process as meaningful and important. In both cases, I discuss how skill and knowledge underpins women's agency, as they seek to negotiate the social field of birth and play

the game (whether the one offered to them or their chosen variant) to the best of their ability.

In the final section, I introduce the notion of [mutual dependency and] self-sufficiency in birthing women's narratives. Many women's narratives in this study suggest the absence of an important relationship with a midwife. Instead, therefore, I draw on women's narratives to discuss the idea that the successful mastery and achievement of physiological birth may be most easily achieved when women are confident in their relative self-sufficiency in this endeavour (8.3).

8.1 Mastering the social practice of birth: displacing the physiological process

8.1.1 Giving birth: a social practice to be avoided

For some women in this study, their feel for the game, or social practice, of birth, based on their initial birth experiences leads them to be highly wary of a further experience. At one extreme, some women discuss how their first birth experiences led them to decide, initially at least, that they do not want to play the game ever again:

> "People had always said to me that the second it was over you forget all about it. I didn't forget all about it. For a good month she was going to be an only child, maybe even for a year she was going to be an only child. That was it, I was not going there again, but eventually I did" (Heidi)

> "I have to say, after that one, it's amazing that we've actually got two others. 'Cos for about 18 months, you know, I wouldn't have, that was it, you know, I was never ever doing that again" (Jenny)

> "[my first birth experience] had a lot to do with the age gap between the children. I did not want to go through the childbirth experience again" (Skye)

> "I vowed never to have children again after Lawrence, because I couldn't possibly go through that again" (Serena)

For such women, a traumatic experience places a hold on their childbearing career, making them highly reluctant to become involved again in the social practice of birth. Rather than being viewed as a temporary positioning of little research interest, this stance can be understood to have important implications for how these women eventually approach the game again. Gottvall and Waldensrom's (2002) discussion about the limiting effects of negative birth experiences on women's subsequent fertility is highly relevant in this context.

For some women in this study, including those who may have put their childbearing career temporarily on hold, their feel for the game leads them to develop a highly pessimistic outlook regarding the likelihood that their birth experience could be better next time round:

> "You feel if they get it so wrong the first time, is it going to be a disaster the second time? I think psychologically I'd already written it off as a disaster. At every stage I was expecting a fight. That's just me, reflecting the first experience" (Gillian)

Such a reluctance to engage again in the social process of birth, or the holding of a pessimistic outlook regarding a further experience, is also associated with a reluctance to engage in preparations for a further birth. For some women, their previous experience is such that they put off thinking about subsequent births until the last possible moment:

> "I tried not to think about actually having her until the day before, because it was so awful last time" (Amy)

Despite their various forms of reluctance, all of these women do encounter again the social practice of birth. For them, the question thus arises of how best to approach it; for many women, the answer lies in a strategy which has the effect of displacing the physiological birth process.

8.1.2 Giving birth: a physiological process to be controlled

In approaching birth for a subsequent time, my analysis suggests that it is imperative for some women to place a higher priority on protecting themselves against the social trouble that they have previously experienced (and thus come to expect) in the social process of birth, than to safeguard any previous commitment to, and illusio in, the physiological birth process. The stakes of the physiological birth game are not stakes that they can any longer recognise as valuable. In some cases, women's practical mastery of the game of birth might take the form of a need to control - and in some cases avoid completely, by opting for a planned c-section - the physiological process of birth. The embodied and emotional nature of this need, as illustrated by the notions of desperation, trauma, stress, fear and lack of trust in the following narratives, suggests that this is something much more than a rational re-appraisal of how best to re-enter the field of birth :

> "I wanted an epidural. I was desperate for an epidural because of what happened with Lawrence" (Serena)

> "I had an elective c-section with Niamh because I just didn't want to go through it again. I just didn't, could not have allowed it to happen again" (Skye)

> "My major thing was the trauma, the psychological stress I felt with John. There was just no way that I would have put myself and my family through it again. I had made a decision that I was not going through that again. So I was booked in for a caesarean. It's the fear of that happening again - it's like a phobia, isn't it. That experience took my trust away from the medical profession" (Alice)

> **"**You know when you go for your first hospital visit. I'd already told the midwife. I'd already said to her 'I'm having a caesarean, an elective caesarean. I don't care, whatever happens I'm having an elective caesarean' " (Jenny)

Thus for some women in this study, protecting themselves against a repeat of their first traumatic experience becomes their priority, and they take action to achieve this goal, in Skye's case even before they are prepared to allow a further conception:

> "Before I came off the pill, I went back to see my GP, and said 'I do not want to go through that again, can I have an elective c-section?' " (Skye)

On the basis of their previous encounters in the field of birth, these women decide that a more controlled approach to their birth is most likely to deliver satisfactory outcomes, as they have defined them. It is a way of achieving birth in which the birthing woman's investment in the physiological process of birth takes second place to the more immediate need of protecting her own, and her family's, physical and psychological well-being. Such a game is understood, and experienced, as less susceptible to unexpected contingencies, especially those related to delays and uncertainty, which seems to be crucial for many women as they seek to avoid the trauma they experienced in previous births.

Women's narratives suggest a highly positive evaluation of such births. Whereas a planned physiological birth might turn into a (sometimes highly traumatic) narrative about negative encounters with staff and incomprehensible diversions from the physiological process, a planned c-section becomes the basis for a highly positive birth narrative.

8.1.3 Giving birth: the elective c-section as providing for a good birth

Whilst every woman participating in this study chose to describe particular interventions and care episodes during their childbearing career as unwanted, unnecessary and unpleasant, an unexpected finding was the extent to which women also presented significant interventions in the physiological process as desirable, necessary and

pleasant. Women's narratives of planned c-sections illustrate this point, with a significant number of women in this study presenting the case that a planned c-section provides for a good birth experience:

> "I know it is a completely unnatural experience but it was just so straightforward and well organized" (Skye)
>
> "It is so odd, you know. It goes against any Mother Nature feelings that anyone might have. There were times when it did feel completely unnatural, very weird. But I felt much better afterwards than I did after John's birth, so it just suited me better. [It was] far more relaxing and quite enjoyable really" (Alice)
>
> "Yeah, I had a planned section that was really straightforward. And it was a really pleasant experience. I remember the night before going in, I was at home and slept really well. So it was, you know, a nice experience" (Becky)
>
> "It's just pretty straightforward, really" (Sparkle)
>
> "It was a brand new theatre. Everything was sparkly white and sparkly silver, so that was great. It's reassuring to see that it's all clean and safe. You didn't feel like you'd failed by having to have a section. You know it's the bizarrest thing in the world. Realistically, you know that you've been sliced right open for want of a better word but I couldn't give a monkey's, I couldn't care less. I was happy. I had my baby and it was over. The pain had gone away and it's not coming back. It can't hurt you anymore. It's a calm environment. It's peaceful" (Ruth)

Evoking Klimpel and Whitson's (2016) findings of imaginaries of modernity in the context of the c-section, Ruth's description of the clinical birth space represents a progressive vision of birth, a birth that is safe, clean and calm. It is not - at least as far as Ruth wishes to admit it - a vision of birth in which women are cast-off as reproductive failures, their bodies violated. Neither are the stakes involved in violating the physiological process of birth recognised as important.

Some women also talk about the benefits of an elective c-section in the way that it enables a different organisation of staff. In Chapter 6, I explored women's narratives in which staff changes during labour, mostly experienced negatively by the women in this study, feature frequently. In contrast, and in the context of an elective caesarean, Mandie discusses how she comes to meet the midwife caring for her during the birth of her third baby: it is clear that staffing decisions, made possible in the context of an elective c-section, can work extremely well for women:

> "I know it sounds strange in the NHS. As soon as she came to me, she said 'you are my only customer today' " (Mandie)

This introduction, Mandie goes on to explain, immediately gives her to understand that she can be assured of the midwife's undivided attention, of 'a very personal, private service'. Similarly, Amy's positive experience of having a midwife allocated to her for the c-section birth of her second baby contrasts strongly with the stories of trouble related by women who are subject to a succession of shift changes whilst in labour:

> "And I can tell you how different it was this time, because I knew who the midwife was. She stayed with me. She stood by me the whole time. She was there" (Amy)

Importantly, both Mandie and Amy's narratives start to suggest how planned and timetabled treatment seems to allow for an improved experience in a way which is not apparent where the physiological birth process takes precedence (that is, where the inpatient episode is necessarily unplanned in its commencement and unpredictable in length). In this way, a decision to have an elective c-section seems to open up the possibility of dedicated one-to-one midwifery support during the inpatient episode, evoking some of the benefits claimed for relational models of maternity care (2.4.5).

A highly positive experience of a planned c-section ensures that for many women, there is no question about doing anything different next time round:

> "Probably, the first time, I was dreading having a c-section, and it was nowhere near as bad. Now I wouldn't be put off having another c-section. Now, if someone were to ask me what it was like, I could say 'oh it is fine'. It was so easy" (Amy)

> "If I was pregnant again I would go for the elective c-section again. Having done it this time round I know how easy it is" (Skye)

> "If it was up to me I would have another section" (Naomi)

Ruth, having experienced an elective and an emergency c-section, is also clear about her preference for any further birth, to the extent that she has already discussed it with a senior midwife before becoming pregnant again:

> "I would have an elective section. Done. The end. I just wouldn't want to put my body through that. I'm not doing labour again. I'm not. And I feel strong enough in myself to say 'no, I'm not'. And my reason is no, 'cos I don't want to. I'd rather know when I was having it, and going and having it in a safe, calm, relaxed environment." (Ruth)

This much-repeated narrative of planned c-sections as providing for highly positive birth experiences raises important question for birth scholarship. Women's high level of comfort with a planned c-section brings into focus once more, as discussed in Chapter 7 in relation to the induction intervention, the positioning of many women with respect to the unplanned and unpredictable nature of the physiological birth process. In this study, these features of the physiological birth process, reinforced by a low level of confidence in the potential benefits of the physiological process and frequently accompanied by unpredictable care, work to position the avoidance of the physiological birth process, for some women, as the effective mastery of the social practice of birth.

8.1.4 Giving birth: a good birth as a theatrical production

In reflecting on her planned c-section birth (which follows a traumatic first birth experience), Skye relates the social practice of birth to the metaphor of production:

> "it is just like a production really. You know, you get your time, your date, you go, it happens. It is all very pleasant" (Skye)

Skye here suggests a positive imaginary of a planned c-section birth as a theatrical production, evoking Oakley and Houd's (1990) use of the same metaphor. This contrasts with the more usually encountered imagery of birth as taking place in the context of a factory production-line (Chapter 6). Skye's imaginary of a planned caesarean birth as theatrical production, in contrast, is an imaginary of a social process of birth that is satisfactory, that has been mastered and from which many elements of uncertainty have been banished. In this theatrical production, the show is scripted in advance, the scene can be set, the actors are ready in place with the necessary props. Everything is controlled, orderly, with no worrying delays or unpleasant surprises. The planned c-section, as Skye imagines it, may stand little chance of achieving the potential euphoria of a successful physiological birth. But whilst it may in some sense always produce a birth experience which will fall far short of the potential brilliance of an improvised piece, its relative certainty in providing a good-enough performance is valued highly.

On the basis of many of the narratives offered in the current study, this production metaphor seems helpful in explaining why a planned c-section works well for many women (if not, of course, for the physiological birth process). The sense that emerges from women's narratives in this study is that planned c-section - which might be imagined as a planned theatrical production, well-rehearsed and well-resourced - can offer a far better option for a birthing woman than an attempt at giving birth physiologically, where this might be imagined as an improvised piece, bringing with it

fears - well-grounded in women's experiences - of the inadequacy of overall piece, including the possible inadequacy of each of the actors involved (including the woman herself, in the form of her potential inability to birth physiologically), and indeed fears that the right actors might not turn up either on time or with the necessary props. In contrast to Oakley and Houd's use of this metaphor, which focuses on the way in which women 'have their parts written for them' (ibid., p161), Skye's conceptualisation is of a production of birth in which women's agency features strongly.

8.1.5 Mastering birth: violating the physiological birth process

In this study, I claim that women come to demonstrate skill and knowledge in the game (or social practice) of birth in a variety of ways. In this section, I have explored the narratives of women whose initial experiences of the game give rise to a sense that they would rather avoid a repeat play, and the hurt and suffering to which it can give rise (against which they seem unable to protect themselves). Since this positioning is often in conflict with a desire on the part of these women to accumulate more birth children, women develop strategies for giving birth whilst avoiding the hurt and suffering that they have experienced previously. This sometimes involves seeking to exert significant control over the circumstances in which they will give birth, including by making the decision to opt for a planned c-section. Thus the concept of mastering birth for some women in this study is represented by narratives in which the physiological birth process is displaced, or violated. This type of birth narrative seems to be a highly important part of UK contemporary birth culture in the study area, and suggests that the local organisation of the maternity services is perhaps best able to deliver - or indeed only able to guarantee - satisfactory experiences in the context of highly controlled non-physiological birth plans.

In the following section, I turn to how the narratives of many women also show how women seek to retain a central place for the physiological process. I should note here that it is clear from a detailed analysis of the twenty-six childbearing careers in this study, however, that such practices are not mutually exclusive. Rather, there is an important non-linearity to many women's childbearing career trajectories that contrasts strongly with the example of experiential learning presented by Bagnold (1938). Examining next that element of women's narratives, however, it will be seen that there often occurs a displacement of the physiological birth process, as attempts to protect it prove evasive in the context of a diversionary field.

8.2 Mastering the social practice of birth: intersections with learning to birth physiologically

For many women taking part in this study, their explicit strategy in respect of subsequent births - even if they have experienced their first birth as problematic in some way - is not to seek to avoid or displace the physiological process of birth. For these women, the achievement of subsequent births rather involves some level of continuing commitment to protecting and enabling the physiological birth process. Some of these women seem to hold an illusio that a physiological birth is not only desirable but possible, and seek to protect themselves against potential diversions. In this section, I explore how such women demonstrate skill and knowledge in seeking to achieve this goal, examining evidence about how women respond to unexpected contingencies, as well as how women proactively seek to avoid potentially diversionary contingencies.

8.2.1 Mastering physiological birth: the role of agency

As highlighted in Chapter 7, there are a number of reasons why women might experience a diversion, or suggested diversion, from a physiological birth pathway. This could be triggered by subjective understandings of the implications of time (as in the case of induction and augmentation interventions) or of electronic monitoring results. For many women, the emergence of the notion that their baby is lying in a position that may be unconducive to a straightforward physiological birth, whether this is identified before or during labour, is narrated as a problem which represents a key challenge for women wishing to maintain a physiological birth pathway. Often, these issues are represented as an unexpected contingency, beyond women's control and inevitably leading to a disturbance of the physiological birth process (including, in some cases, an emergency c-section, and in other cases an instrumental delivery). In this scenario, skill might be identified in the way in which women defer to the suggestion that their births should take a non-physiological turn, as a way of ensuring that the birth is brought to a swift, safe and satisfactory conclusion. Here, however, I focus on the narratives of women who display an alternative engagement in relation to this issue. These women demonstrate an approach which primarily seeks to protect the physiological birth process and, in doing so, allows them to develop their knowledge and skills with regard to physiological birth.

Whilst some women thus seem to accept a recommendation of intervention due to their baby's positioning without question, for example, other women seem to take it upon themselves to resolve the positioning issue in a way which allows them to progress

towards a physiological birth. Mary, Cat and Jenny, for example, were active in their efforts to resolve positioning issues before the commencement of labour:

> "I had spent from thirty-two weeks kneeling over a birthing ball, going to loads of extra Pilates classes, determined that I was going to turn him. And he turned dead on thirty-nine weeks" (Mary)

> "He had been spine-to-spine, and I heard that it wasn't an ideal position to give birth, because it could cause more pain. So, I did think the midwife was trying to manipulate at one point, and I did say that I wasn't very comfortable with that, so I would rather try it myself with my own methods at home. I used my yoga ball, just lying down and being in the all-fours position and slowly rocking the ball and I thought that might help turn him and it did, about two weeks before" (Cat)

> "I spent hours watching tv on the birthing ball in the hospital, because it was said that rocking backwards and forwards. The other thing was walking up and down stairs" (Jenny)

These narratives illustrate how some women seek to take an active role in resolving a positioning issue, aiming to give themselves and their babies a better chance of achieving a physiological birth. In seeking to avoid automatic diversions associated with the positioning of the baby, they demonstrate a good understanding of the work necessary to achieve a physiological birth. Sometimes, a woman's understanding of her agency in this area is retrospective. Lola, for example, reflects upon the possibility that she herself had perhaps contributed to her baby's problematic position in labour:

> "To be honest, Amy was back-to-back with me because I was very lazy when I was pregnant and used to sit watching television like this, you know. So I know with Amy it was my own fault. I blame it on sofas" (Lola)

Lola continues her narrative by talking about how this understanding of the relationship between her posture in pregnancy and her baby's positioning in labour has material effects. Lola explains how she subsequently advised a friend to adjust her posture in late pregnancy, to try and encourage her baby to move, seeking to help her friend avoid a difficult back-to-back labour. Whilst Lola has not demonstrated this skill and knowledge in her own childbearing career, she is thus keen to encourage it in her friends.

These narratives describe an active engagement by birthing woman, founded on a level of understanding about the physiological birth process which makes such an

engagement seem worthwhile. They demonstrate a clear sense that the actions of birthing women can have a significant influence over how birth unfolds. For them, the contingency of a 'poorly positioned' baby is no reason for an inevitable diversion from the physiological birth pathway, but an issue to be resolved. As such, I suggest that these women display a stance towards birth which is firmly rooted in a desire to protect the physiological process, building on their understanding of the game of birth as one in which they can and should actively participate.

8.2.2 Mastering physiological birth: working with pain

Women's narratives around the technology of pharmacological pain relief provide further evidence of women's differing forms of skill and knowledge in the context of labouring and giving birth. All women in this study are able to talk about issues associated with, and reveal preferences for, various forms of pharmacological pain relief. Whilst some women are keen to insist that the choice to use pharmacological pain relief is very much up to them, other women's narratives seem to undermine the notion that women's decisions in this area are free from external influence. Many women's narratives illustrate how pain relief is routinely offered to women in labour, for example, as a key element of the dominant diversionary game, and often accepted by women whether or not they need it:

> "It was like 'do you feel you need something else?' and I was like 'yes', it was getting quite painful, 'I think I will have something'. I didn't feel at any point that it was pushed on me" (Naomi)

> "Like the midwife said to me 'it's totally your choice. If you don't have it you don't get a medal for it. Nobody's going to come in and high-five you afterwards if you manage to do it without pain relief.' And from that, I thought 'well, why put yourself through [the pain]' " (Gillian)

The notion that 'you don't get a medal' for putting up with the pain of labour is especially interesting, representing an overt signal that the potential benefits of an unmedicated birth go unrecognised by, or are perhaps unimaginable to, some maternity service workers. As such, they work to shut down for some women both the imaginary and the possibility that women might learn to birth physiologically (and that this might be of some value). Whilst framing her talk in terms of choice, the midwife in Gillian's narrative clearly suggests the positive and routine emplacement of pharmacological pain relief in the local field of birth, and specifically reinforces the notion that there is no benefit in women foregoing pharmacological pain relief. In the face of such advice, women whose physiological labours might otherwise proceed

[more] successfully without pharmacological intervention find themselves accepting it, and this acceptance does not necessarily represent demand for this technology. Barbara talks, for example, about how she is approached and offered pharmacological pain relief - an epidural - during her first labour, and how she remembers thinking:

> "how part of me said 'no I am fine' and the other part of me said 'oh for goodness sake just have it'" (Barbara)

It is interesting to consider how Barbara's birth might have unfolded differently if instead of being offered an epidural at this point during her first birth - when Barbara clearly thought that she was coping well - Barbara had been offered support and advice about how she might work with the pain of labour, and Barbara discusses exactly this point later in her narrative. Instead, women's narratives illustrate both the routine nature and the powerful voice of the local maternity care team with respect to pharmacological pain relief, and how staff have it within their power to offer (or withhold) various types of pain relief.

As women experience birth more than once, however, their relative power in this situation tends to increase. Based on their experiential knowledge, for example, some women discuss strategies for ensuring good access to their preferred form of pain relief in subsequent births. Whilst this clearly demonstrates a growing skill and knowledge on the part of these women, it is a further example of how women's skill and agency might work to displace a physiological process.

For some women, however, a developing area of skill is how to increase their ability to birth physiologically, without access to pharmacological pain relief, and this stance draws on their multiple experiences of birth. After experiencing birth with and without an epidural, for example, some women discuss their developing knowledge of the transitional stage of labour, and suggest, in retrospect, that an epidural was unhelpful, as illustrated by Barbara's account:

> "I think on looking back, the epidural really did hold things up and put things back, because what I found [my second time] was you had contractions and they were fine. And you just got to the point where you think 'these are really quite bad, I don't think I can handle this a lot longer' and then it changes. Then it becomes completely different. I think I was just getting to that point with Sally when I had the epidural and that kind of stopped it. I am sure in myself that, looking back, I was getting to that point where I think, had I not had it, she would have been out a lot sooner. I suppose I didn't give it a chance. I wasn't

> supported through it. Had I had a different midwife, someone who said 'you are doing really well and I think we can do this, we are getting close" (Barbara)

In this account, Barbara demonstrates well her increasing skill in identifying and managing the phase of transition between the first and second stage of labour. Barbara is not alone in having to work out such issues over the course of her childbearing career. Melissa similarly suggests after her second birth experience (which she achieves, albeit against her will, without pharmacological pain relief) that she has come to regret having accepted pethidine during her first labour:

> "In hindsight, with Cindy I think I shouldn't have had [any pain-relieving drugs]. You know, you can cope. Yes it hurts, but you can cope. It is not something that is out of this world painful. It is quite nice not to have the painkillers, to feel everything happening" (Melissa)

Lola's narrative also reveals how she comes to understand that her use of pharmacological pain relief during her first labour might have been unhelpful, in the context of advice she receives afterwards:

> " 'Don't let the pain get hold of you, Lola, as soon as it gets hold of you that's it.' And she is absolutely right. I was thinking 'I am not letting the pain get hold, I am just going to keep going' " (Lola)

Reflecting on her two birth experiences, very different in terms of the pain relief strategies she adopts, Lola comes to understand the possibility of her agency with respect to managing labour pain, aside from that of accessing pharmacological pain relief. Like Barbara and Melissa, Lola demonstrates the possibility of women developing experiential knowledge about how to cope with the pain of labour as a key element of learning to birth physiologically.

Whilst the narratives of Barbara, Melissa and Lola suggest women's ability to develop a developing competency with regard to the physiological process of birth, through their developing understanding of the role of pain in labour, an analysis of many women's narratives relating to the role of pharmacological pain relief in labour underscores the idea that women in this study are rarely expected to gain such competency, in contrast to quite different expectations within different models of care (Homer et al., 2017). To summarise thus far, then, the idea that women might learn to manage any labour-associated pain without pharmacological support is repeatedly positioned in this study as highly unorthodox and unnecessary to good labour outcomes. Indeed where narratives reveal that women have given birth vaginally without using any form of pharmacological pain relief, this is almost always linked to the fact that they simply had

no access to it, for example having arrived at hospital very soon before the birth of their baby. For some of these women, practical mastery thus centres around learning how to ensure better access to an increased level of pharmacological pain relief in a subsequent labour. Sarah's narrative provides an interesting point of contrast in this context.

In this study, Sarah's understanding of the positioning of pharmacological pain relief with respect to physiological birth represents a different knowledge from that of every other woman in this study. Sarah talks about how she comes to her birth experiences invested with an understanding that all types of pain relief have the potential to interfere unhelpfully with the progress of physiological birth. As it turns out, Sarah was exposed to a working with pain philosophy as part of a pregnancy yoga course at a local gym. As part of this course, Sarah became aware of and took seriously the notion that there is a rationale for the pain typically associated with the physiological process of birth, related to the role it plays in sending signals to the brain about how birth is progressing and thus triggering further progress. As part of these classes, Sarah and her partner were offered a memorable experiential learning opportunity:

> "One day [the teacher] even brought in ice cubes. 'Hold an ice cube in your hand and see how long you can hold it for', to try to get you to hold it for as long as a contraction would be, to give you an idea of how to breathe through the pain" (Sarah)

This technique seems to have been part of a broader approach taken by Sarah's yoga teacher, drawing on innovative ideas in which women are encouraged to 'practice [pain-coping] techniques frequently to gain mastery' (England and Horowitz, 2007, p282). Sarah talks about how she learnt that to seek to reduce (rather than learn to cope with) pain signals, whether pharmacologically or otherwise, would lessen their effectiveness and should therefore be avoided. This gives Sarah an important reference point which seems to be lacking for other women in this study:

> "I always remember him saying that your brain does not know that it is going through labour unless it can feel pain, so if you have something that blocks that pain your brain doesn't know how to carry on with the process of childbirth and it will slow everything down. So 'if you can manage', and he was lovely, he was not overbearing with it, he said 'if you can cope with the pain, your childbirth will actually be easier because your brain will make it happen quicker'. I have no idea whether any of that is true or not, I really don't know, but that really saw me through both births. It meant that when I went into labour and felt pain I was

> actually thinking ‘this is good, this is making the whole labour move along’. To have things like an epidural just seemed like madness to me.” (Sarah)

In the absence of such knowledge that Sarah has accessed in this way, some women who otherwise demonstrate themselves to be highly invested in the physiological birth process seem unable to conceptualise different forms of pharmacological pain relief as potentially problematic. Indeed the very achievement of an unassisted vaginal birth in the UK seems to be linked to the availability of this technology, which seems to have become a taken-for-granted element in efforts to achieve a vaginal birth for the women in this study, as Pamela’s narrative illustrates:

> “I don’t know whether it would have been the same for me had I not had the gas and air. Well I am not sure I could have done without it because it enabled me to detach myself from the pain” (Pamela)

The widespread availability of entenox in the UK, including as part of the NHS home birth service, thus positions women birthing in the UK quite specifically (in the US, for example, entenox is not approved for maternity use on safety grounds), on the one hand working to reduce the use of epidural and other technologies whilst on the other hand effectively erasing the imaginary of a physiological birth without pharmacological pain relief. The roll-out of enhanced national statistics on the use of this technology (5.2.3) would allow for greater scrutiny of this issue.

8.2.3 Mastering physiological birth: access to healthy blue spaces

As a further technology for promoting the successful achievement of physiological birth, the phenomenon of labouring and giving birth in water has become increasingly popular in the UK, evoking health geography scholarship on the therapeutic nature of watery spaces (Foley and Kistemann, 2015). Many women in this study were aware of the potential benefits of water immersion during labour and birth. The issue of women’s access to a birthing pool, or even a bath, in labour and for the birth thus arose frequently in women’s narratives. For the women who were keen and able to access birth pools during labour and birth, this element of their birthing experience seemed to contribute to their achievement of a straightforward vaginal birth.

Women’s narratives also revealed, however, how the local maternity services were not always prepared to meet demands for access to a pool. Thus a woman’s ability to access to a pool represents a further contingency in some birth narratives. Firstly, this was explained as related to the relatively small number of labour rooms with pool facilities, which meant that it was a matter of chance if one was available:

> "I was lucky that the pool room happened to be free, and that is a major thing because quite often when it has somebody in it that is it" (Pamela)

> "Luckily the midwives offered it to me straight away when I went in, so I thought I am definitely taking that. I did feel a bit shocked. I just kept thinking 'ooh that is really great' " (Cat)

Secondly, the organisation of the service is such that significant periods of early labour in an institutional setting are discouraged. As Sally explains, access to pools, and other useful active birth equipment, is thus highly limited, as many women feel unwelcome in the hospital until late in their labours:

> "A lot of the women now don't even have that chance, because they have been told to come in so late. When can they sit in the birthing pool, when can they use the equipment?" (Sally)

Women's narratives reveal a range of approaches as women sought to negotiate access to a birthing pool. In a small number of cases, women's narratives revealed how some women's mastery of the situation plays out in terms of self-denial. These narratives suggested a pragmatic stance: women knew that access to a birth pool was not assured, and their mastery of the situation - with a primary aim of avoiding disappointment - therefore took the form of being reluctant to even contemplate the use of a birth pool:

> "I think I liked the idea of a water birth because I thought that would be very relaxing. We did go and look around the hospital and they were quite vague. It was more or less pot-luck if you could have one. I didn't want to sort of think I would have that and then get there and not have that" (Heidi)

> "Having loved the pool with Joe, I would have wanted it with Daniel. I was told that you can have a pool 'but'. And there were so many ifs and buts. And you just thought 'yeah, that is as likely as hell freezing over' sort of thing" (Jenny)

In these cases, it might be argued that a certain lack of courage - to act in the face of potential disappointment - underpins a reluctance to argue for access to pool facilities. Other women seemed more willing to remain committed to their desire to labour in water, but when they come across obstacles, as many seem to do, they displayed varying degrees of commitment to engage with this situation as a challenge to be overcome:

> "I had wanted a water birth, but I was hooked up to the monitor so I could not have a water birth" (Skye)

> "I did ask, but they wouldn't let me. I think it probably would have helped. I did ask several times, and I was told no. 'Cos there were no baths, only showers, so I couldn't run myself a bath" (Ruth)

Whilst Ruth's narrative suggests that she made some attempt to overcome the obstacles in the way of her accessing a pool, other narratives are less clear. In some cases it seems that women readily accept, rather than subjecting to challenge, that access to a pool is not possible. Pamela's narrative, however, suggests that a positive challenge can be successful, and that success is more likely to be achieved if women are well-informed and willing to persevere:

> "There was an argument. I was adamant that I wanted to go in the pool, and the midwives wouldn't allow it. It had to have the consultant come down and say that it was allowed. I mean when the midwives say they had to check with the obstetrician it wasn't as though 'oh no, I think they will say no'. It was more of a case that 'we cannot authorise that, our guidelines say that if you are a week overdue or if you are high risk then you cannot, so we have to refer the decision to the consultant'. Which was what they did, and the consultant was quite happy" (Pamela)

Pamela's narrative (and not just because she was ultimately successful in her negotiation) seems to display a different level of practical mastery of the situation. Highly committed to achieving her desire to labour and birth in water, Pamela is able to interpret a midwife's refusal as the first rather than the final stage in her negotiation. It is possible to see how the outcome for Pamela would have been different, absent her commitment, skill, and courage to be disappointed if necessary.

8.2.4 Mastering physiological birth: developing understandings of water immersion

Pamela's narrative gives some insight into how water immersion in labour and for the birth might be highly effective at supporting a physiological birth process. She understands it as a far more conducive environment than the non-pool rooms, where she suggests that the bed seems to determine one's whole way of being in labour and when giving birth:

> "after I had witnessed the broom cupboard delivery rooms other women had and I thought, you know, you are just in that little box, a tiny room with a big sink and a chair for your, whoever is helping, and literally the bed. And that is the room. There is no space to, you know, the only place you can have the baby is on the bed. One of the things I liked about the pool was the fact that it was round and you could be sort of on your knees with your chin on the side of the

> pool with your gas and air quite comfortably, and you could spread your legs around, and you had something to push your legs against. Or you could be sat on your bum leaning against, and feel supported by the pool. I just found it offered you more permutations for the positions you could get yourself into, and also because you were almost enveloped in nice warm water and it was lovely - 37 degrees I think it was - close to body temperature, and it was comforting and relaxing. I think you almost felt enclosed by it whereas when you are on a bed you are wide open to the elements, as it were. Whereas I guess I was closed in in the water, without being completely covered up" (Pamela)

For Pamela and others in this study, labouring in water did indeed seem to be conducive to the achievement of a vaginal birth; this is not equivalent, however, to suggesting that the strategy of labouring and giving birth in water is sufficient or necessary to achieve a physiological birth. A number of narratives in this study suggest how this strategy might even contribute to or cause a diversion from the physiological process, even if a woman's labour and birth had followed a physiological pathway up to getting in the water.

As Sarah reflects on her own experience, for example, it is instructive to consider how she develops a highly contextualised practical understanding about how the choice of water immersion as a form of pain relief in labour can lead to a diversion from a physiological process:

> "I had decided I wanted to have a water birth, and this is where I should have listened to [my yoga teacher] more, because as soon as I got into the water the pain does go away but it did slow everything down for me. It was certainly great for relieving pain, but it was like 'duh'. So yes, in hindsight, if I had another one, which I have no intention of, I would probably not get into the water until a lot later on. I think it slowed the process" (Sarah)

In Sarah's case, she comes to understand that using a pool to relieve the pain in labour can contribute to labour slowing down, and this has consequences - in the form of physical and pharmacological intervention - for how her labour is then managed by others.

It is noteworthy that none of the women in this study who laboured in water went on to achieve a physiological birth of the placenta. No woman in this study seems to have a firm commitment to achieving a physiological third stage of labour, thus to some extent this diversion from the physiological process is not unexpected. Nevertheless, it is

interesting to note that both Cat and Pamela suggest that a key factor in this diversion is that they had given birth in water:

> "I had done a bit of research in advance and read up on that and doing it naturally, but I think at the time when I was in the pool I just said, I mean at the time it is just like 'yeah, whatever', sort of thing. I mean it all happened really quickly. It was almost like I had had him, I had to hand him over, I just wanted to get out of the pool and have him, and I just didn't think. It was almost like 'do what you have to do, I just want to get out of the water'. So that anything that I had read didn't really click into my mind" (Cat)

Similarly, Pamela explains how she re-evaluated a physiological third stage as undesirable after giving birth in water:

> "I got out for the placenta with all of them. I mean I actually had the jab to make it come out quicker. I knew that there were options, that you could wait for it to come out on its own but it could take quite a bit of time. And I think once I had given birth you kind of, well I kind of got cold in the pool, even though it was warm. It was kind of wet and cold, and I kind of wanted to be somewhere warm. Wrapped up warm and dry with my baby, and feed the baby. So getting out of the pool felt like a better place to be and I think in terms of being fiddled with, with the whole placenta business, and having to get rid of that, I just thought the quicker that was out the better really. I just wanted to get all that done with." (Pamela)

For women wishing to give birth physiologically, the linkage in this study between giving birth in water and then diverting from the physiological process may be unusual. But it underscores how any particular birth technology is likely to have a complex relationship with a strategy to enable a physiological birth process, evoking geographical scholarship on the contested nature of therapeutic blue space (Foley and Kistemann, 2015). Thus it is not simply a question of whether water immersion is beneficial during labour and birth; it must also be considered how water might best be used at various points in the labour and birth, and the ways in which it might affect various elements of the physiological pathway. In this study, and based on their own practical experiences, Pamela, Cat and Sarah begin to engage skilfully with these issues during their childbearing careers.

8.3 Learning to birth physiologically: self-sufficiency as a key tool

In this study, a woman's success in achieving a physiological birth often seems to be highly dependent on factors that are beyond her control, whether this is the willingness or ability of staff to support this goal, the ability to command certain resources, or the ability to ward off certain unwanted interventions. Indeed a key part of the feel for the game that many women come to develop over their childbearing careers is a recognition of the limitations of their power in the social practice of birth (as opposed to the physiological process). This is apparent when women find, for example, that they cannot demand to be seen immediately by medical staff even when this is highly important to their sense of well-being, that they cannot insist that their plans for a domino-supported birth be respected, or that they cannot be assured of the continuity of staff attending them during labour. If such elements are crucial to women's plans for achieving a physiological birth, then this inability to be sure of securing them will inevitably cause trouble.

Despite the contingencies of the social practice of birth to which women are exposed, the birth narratives in this study are also replete with instances in which women are successful in determining how they practice birth, in a way which can tip the balance again in favour of a physiological birth outcome. As women get a feel for the social practice of birth, their narratives suggest a growing confidence in fending off unwanted interventions. Such successes can make a big difference to how women go on to evaluate their birth experiences.

Mandie and Mary, for example, come to exert agency and achieve success over suggested catheter interventions. Following a poor experience of premature catheter positioning in advance of her first elective c-section, Mandie rejected this early intervention next time round; similarly, Mary achieved an improvement in her second birth experience by refusing to use a catheter at all:

> "I learnt that, and with Allie I said 'I will have the catheter in when I am in theatre please' " (Mandie)

> "the first thing was they wanted me to use a catheter, and I said 'I am not having one this time, I did that last time. I will take myself to the toilet' " (Mary)

And whilst many narratives suggest that 'offers' of intervention are non-negotiable, others demonstrate how these offers might be challenged:

> “When I had Hazel they did suggest using forceps, and even with Sarah, she suggested using the ventouse. And I said no to both. I said ‘no, I don’t want you to use anything’. I was adamant with Hazel that I didn’t want them to use anything” (Sally)

In this way, women’s narratives reveal how they successfully challenge assumptions made on their behalf about their labours and births. There are women who, rather than accepting the first date offered, negotiate extra time before an induction appointment takes place, significantly increasing the chance that they will go into labour spontaneously; there are women who simply refuse to engage with members of the healthcare team who do not seem to them conducive to supporting a physiological birth; there are women who make the case to choose their positioning in labour, despite having been told that they must be positioned in a particular way; there are women who successfully insist on the use of intermittent monitoring, to avoid significant constraints on their movement and positioning.

Perhaps a more powerful form of agency, however, is one based on a woman’s sense of her inherent self-sufficiency in birth. Whilst there are no examples in this study of women even imagining the possibility of giving birth without the presence of medically trained staff, there are glimpses in this study of women conceptualising the game of birth as a one-player game, and one in which they are effectively self-sufficient. Some women adopt birthing strategies, for example, that involve - absent any pathological developments - no-one else but themselves, in which their social support network (social capital) is deployed to fend off unwanted interference from staff. This evidence suggests that the woman is choosing a game of birth in which a physiological birth seems far more assured.

For some women in this study, for example, a technique of focusing inwards, ‘switching off their neo-cortex’ (Odent, 2014) and allowing their body simply get on with its work of birthing best represents their birthing strategy; in this way they seek to ignore events going on around them that are irrelevant to this task:

> “I think for me, because in the past I have done a bit of yoga and meditation and I really think for me that stepped in. I think that really helped me. It sort of almost removed me from the situation” (Cat)

> “When I am in labour I don’t want to talk to anybody. I am completely honed in on what I am doing. I don’t want to be having discussions. I want to be left alone. But this kind of falls on deaf ears. They don’t like this leaving you alone business. Through a lot of the prodding and pestering that goes on in labour I

> can honestly say that I can ignore it. I can stay focussed on what I am doing and ignore it. I am very shut in to what I am doing" (Suzanne)

During the final labour of her childbearing career, Suzanne explains how she hid from staff when she went into labour, thus better fulfilling her aim of enabling an undisturbed labour and birth, and avoiding the violations of her body to which she been exposed previously:

> "I went and got a birthing ball and rolled it round the corridor. I rolled it through and went and got myself in the tv room where no-one ever goes. I got myself on there and quite happily stayed on there for the next couple of hours. I didn't want them messing with me" (Suzanne)

In this context, the effective use of skilled and knowledgeable birth partners also seems to support an otherwise self-sufficient strategy focused on achieving physiological birth. Suzanne describes how her strategy depended on her birth partner's involvement, and Pamela concurs with this view:

> "I did prep Pete, you know. I was saying to him 'if I say that to you, I need you to take over and make sure you tell them'. And I remember telling him 'look, I can say it once to you while I'm coping with pain. I can't say it three times to them, so I need you to say it for me'. We had this little conversation and little pointers that I could easily get across to him, and then he would intervene on my behalf" (Suzanne)

> "And you also need your partner to be fighting in your corner for you as well. You know Seth was saying 'go and sort this out', you know, 'what are you doing about this?' If he had been any sort of meeker or milder and said 'ooh, they are doing all they can' then maybe it wouldn't have got sorted out. He was hassling them a bit at times about it" (Pamela)

In this way, a shift in mindset from one of being dependent on staff (and various technologies) during labour and birth to one of being more self-sufficient (albeit within one's own social network and resources) would seem to be a way of providing for a more robust framework to protect the physiological birth process (Leap, 2010). Pamela perhaps alludes to this when she discusses what she understands to be the appropriate role for maternity care staff, and in particular how seemingly 'helpful' midwives might actually reduce a woman's likelihood of achieving a physiological birth:

> "There is that sort of looking at it that actually a midwife who wants to help you more is actually interfering with your whole process of giving birth. Whereas the

midwife who left you to it, and was just there in case of any major problem, would be the one that would allow you to have a birth occur naturally, as if they weren't there" (Pamela)

8.4 Conclusion

One of the starting points for this research was a desire to develop an understanding about how women learn how to birth physiologically over their childbearing careers, given the increasing wealth of experiential knowledge to which they have access. In Chapter 5, I described how many women commence their childbearing careers optimistic about their chances for having a straightforward and pleasant birth experience. There is good evidence to suggest that many women at this stage seem to hold the illusio that the physiological birth process is important and they choose to invest in it. In Chapters 6 and 7, I analysed how many women's birth experiences then become overshadowed - or indeed overwhelmed - by 'trouble' in the form of difficult encounters with the staff (or the social process of birth more generally) and by new 'insights' into the apparently defective physiology of birth.

In this chapter, I focussed on some of the work that such narratives do, in terms of the practices on the part of childbearing women to which they give rise. In the first section, I examined the narratives of women who, after an initial birth experience, were highly reluctant to proceed with a subsequent physiological birth experience, either at all or in a way that would allow the physiological birth process to take precedence over their need to protect themselves against hurt and suffering. I presented an analysis of how these women developed strategies and took action which produced, for them, a satisfactory birth outcome. I concluded that, for these women, efforts to master the social process of birth are quite distinct from learning to birth physiologically, where mastery of birth consists of an intention to avoid, or at least highly control, the physiological birth process. I have also highlighted ways in which women seek to reject such a diversion from the physiological birth process. Whilst these attempts are not always wholly successful, the skill and knowledge demonstrated by women, their effective use of the resources to which they have access, and their conceptualisation of different kinds of therapeutic space, support them in their desire to establish a different game, a game in which the mastery of the social practice of birth is focused on protecting the physiological process.

In this analysis, it is clear that every woman exhibits skill and knowledge as she engages in the social practice of birth. But if on the one hand this chapter seeks to

expose and indeed celebrate women's mastery of the social practice of birth over their childbearing careers, it also inevitably exposes the frequently violatory effects of such mastery, on the physiological process of birth, upon women's own bodies and, sometimes, although this is rarely discussed, on the well-being of their babies. In exploring how women themselves in this way are implicated in the reproduction of a contemporary birth culture in which the physiological birth process is frequently erased, and rarely experienced in full, this chapter complicates an understanding of women's role in the social practice of birth as passive and powerless.

This seems to make sense when reviewing the issue of experiential learning about birth over a woman's childbearing career. The extent to which women retain or develop as a goal the notion of improving their skill and knowledge in respect of physiological birth over their childbearing careers varies widely, and the process is by no means linear. This study suggests that contemporary experiences of giving birth in the UK might very often lead, rather than to an increasing level of commitment and skill on the part of women to achieve a physiological birth, to the reduction in women's commitment towards the physiological birth process over their childbearing career. The factors that seem to be associated with such a reduction in commitment are an initial weak commitment to physiological birth (perhaps weaker than the woman herself is able to acknowledge), an experience of birth which is emotionally distressing and an experience which seemingly undermines the value and very possibility of the physiological birth process. Whilst a number of women manage to retain a commitment to physiological birth, despite their exposure to the same social field, the modifications to the dominant game required to put into effect to this commitment are perhaps difficult to achieve, if they are even identified. Thus it is unsurprising (and perhaps rather disappointing, given the starting point of his inquiry), that this commitment does not seem to translate, in the study area, either into (even a small proportion of) births that might be classified as physiological nor indeed into the emergence of an identifiable cadre of virtuosa physiological birthers.

Chapter 9 Conclusion

Over the last few years, I have taken particular pleasure in the apparent incongruity of two very different books sitting side-by-side on my bookshelf. For scholars of contemporary birth culture, each makes for a highly informative read. Both aimed at pregnant women, they offer very different perspectives on how women might best be supported in the social practice of birth. The first, *Choosing Cesarean: A Natural Birth Plan* (Murphy and Hull, 2012) suggests that birth by elective caesarean section at 39 weeks plus represents the safest way for a baby to be born, and discusses evidence for why this might be the case; the second, *The Hypnobirthing Book: An Inspirational Guide for Calm, Confident and Natural Birth* (Graves, 2012) encourages women, inter alia, to practice hypnobirthing as a way of preparing their mind to allow the physiological birth process to work most effectively. Despite their striking differences in approach, both books seek to fulfil the same task and I believe that both are honest in their intentions in doing so: to offer women the chance of a positive birth experience.

Both books, reflecting the negative birth stories that many women tell, thus aim to help women play a different game of birth from that expected by their local maternity service. In doing so, these books offer a damning indictment of the field of birth and its routine production of negative birth experiences, at the same time as offering women strategies for navigating the field successfully. Graves (2012), for example, recommends a firm, courteous and protective approach towards the possibility of negative encounters with health care workers, recommending that women in labour do not engage in any conversations with staff unless absolutely vital, and that they should ask staff (via a pre-prepared written note) to keep all intervention and conversation to a minimum (Graves 2012, p160-163). Murphy and Hull (2012), in contrast, seek to 'defend the legitimacy of a planned cesarean on maternal request' (Murphy and Hull 2012, p19), offering information about the risks of physiological birth as it is often constituted in the field of birth, as well as the risks and benefits of c-sections. In this way, the book constitutes a useful resource for women who might wish to shortcut the learning experience of an attempt to birth vaginally which might be, according to Murphy and Hull, a highly traumatic one and one that leads to long-term poor health.

Together, these two books offer an interesting reflection of key aspects of the current study: in terms of what they say (or imply) about women's experiences in the field of birth; of what they suggest as the necessary diversity of strategies that women might usefully develop, given these experiences, over the course of their childbearing careers; and by the way in which they seek to offer short-cuts to women, relieving them of the need to otherwise develop this knowledge themselves over their childbearing careers. Whilst none of the women in the present study have adopted consistently

strategies quite as extreme as those suggested in either of these two books, there are clear parallels. In line with Murphy and Hull's advice, for example, some women do come to master the process of physiological birth by marginalizing it (8.1) whilst others, reflecting Graves' advice, seek to become more expert at removing the obstacles to physiological birth, including by keeping staff at a distance (8.2).

The point at which I realised that I was able to take seriously both of these books - as both, in their different ways, representing birthing women's diverse experiences and strategies in the field of birth - represents a key juncture in this study, confirming that I had taken seriously the notion that women have diverse conceptualisations, or illusios, regarding birth (see also Davis-Floyd, 1992, p282). In this concluding chapter, I reflect further on the issue of scholarly engagement in this context, as I draw together and reflect upon the various findings and conceptual contributions of this study, to geographical scholarship of birth as well as to the wider academy, and highlight the potential for further scholarship in this area. Finally, I return to a question posed in Chapter 4: 'what exactly is this a case of?'

9.1 Birthing women as skilful and knowledgeable agents: nature/society relations, spaces of birth and birthing bodies

By offering an interpretation of how birth is practised by a small group of women living in the North West of England, in different ways over their birthing careers, this thesis adds to international geographical scholarship about what takes place, and what is able to take place, in ordinary spaces of birth. In examining what goes on in such spaces of birth, I have developed the notion that birthing women are skilful and knowledgeable agents in the social practice of birth, and that experiential learning in these spaces, as part of a tertiary habitus formation, plays a key role in how women develop skill and knowledge, shifting their dispositions towards birth over the childbearing career. This argument represents an important contribution to the geographical literature on birth and spaces of birth, which has tended to marginalise discussion about ordinary institutionalised spaces and about the expertise of birthing women. In developing this argument, this thesis contributes to existing scholarship in three main ways.

First, I have explored how an empirical investigation of social practice offers an opportunity to investigate how individuals come to produce and reproduce conceptualisations of the relationship between self, society and the natural world. Building on the insights offered by geographer Becky Mansfield (2.1.4), I have examined the relationship between birthing women, the field of birth and the physiological birth process. By examining how the field of birth works to structure, and

is structured by, the social practice of birth, it is possible to examine how the social practice of birth in turn structures, and is structured by, the habitus of agentic birthing women, and in particular their illusios of (or dispositions towards) the physiological process of birth. I have suggested that the field of birth experienced by the women in this study operates as a diversionary landscape, positioning the physiological process of birth as unnecessary, abnormal and dangerous, and explored how this works to influence women's practice. I have also noted, however, how many women continue to engage in social practices which work to challenge such a positioning of physiological birth, drawing on their embodied experiential knowledge to do so: thus a contested positioning of physiological birth is observed.

Second, in the limited scholarship which engages in a sustained way with a conceptualisation of birthing women as skilful and knowledgeable, I have noted how skill and knowledge is often located only in a specific group of women, for example those choosing to give birth at home or to give birth without the presence of healthcare sector workers, those with access to specific forms of care, or those who make 'unusual' choices or who have 'unusual' experiences. This study, in contrast, has sought to extend the conceptualisation of women as skilful and knowledgeable agents to all women.

Third, I have noted how skill and knowledge on the part of the birthing woman is only infrequently conceptualised as being a result of experiential learning: more usually, other types of formal and informal learning are considered more relevant, whether those delivered through formal pedagogic vehicles such as antenatal classes or other educational resources aimed at pregnant women, or through the influence of mass (and increasingly social) media. Learning on the part of the woman during the birth itself is also often conceptualised as being led by the healthcare professional. Where experiential learning based on women's personal experiences of giving birth - in ordinary spaces of birth - is identified as having taken place, this is often in the context of a discussion about the challenges that the resultant knowledge presents to healthcare workers for the successful achievement of future births. In contrast, this study offers a conceptual contribution which suggests the importance of women's experiential learning in the field of birth.

9.2 Reconceptualising women's mastery of birth: moving away from a physiological focus

This thesis set out to explore how women, as skilful and knowledgeable agents, might demonstrate an increasing mastery of the social practice of birth over their childbearing careers. Underlying this line of enquiry was an expectation that such mastery, or

competency, would take the form of women becoming increasingly familiar with and able to perform physiological birth, in line with the prototype offered by Enid Bagnold in her fictionalised account (Bagnold, 1938).

Whilst this form of mastery was indeed observed amongst some women in this study (although often in a highly non-linear form and constrained by interesting absence of a physiological birth illusio and imaginary), the more striking finding was how women's developing mastery of the social practice of birth more frequently seems to diverge from the task of becoming competent at giving birth physiologically. This study suggests how this divergence between learning to birth physiologically and mastering the social practice of birth is associated with women's shifting habitus over their childbearing careers. Based on how women come to conceptualise their repeated encounters in the field of birth, I have explored how women's dispositions towards the social practice of birth shift significantly over their childbearing careers. This finding contributes to existing scholarship by problematizing the claim that '[m]ost women, in every country across the world, would prefer to give birth as physiologically as possible' (Downe, 2014).

In terms of shifting personal priorities, women's narratives have illustrated how, for many women, the goal of self-protection from negative encounters with staff (where these have been experienced, for example, as confusing, disrespectful, hurtful or highly traumatic) becomes highly important, often working to displace a previous priority of protecting physiological birth (Chapter 6). In the light of their experiences, some women subject this early goal to scrutiny, find it to be based on naivety and reject its relevance to their own childbearing career. In terms of women's conceptualisations of birth, a key theme of women's engagements in the field of birth, as represented in this study, is how some women come to conceptualise physiological birth as unnecessary, abnormal and dangerous. This is not necessarily an accurate understanding of physiological birth but it is one that is firmly grounded in how these women have come to understand birth as they have experienced it (Chapter 7.) Underpinned by this shifting habitus, women's mastery of the social practice of birth over the course of their childbearing careers, as observed in the current study, is thus often achieved at the expense of the physiological birth process (Chapter 8). In this way, it is suggestive of a form of mastery which is distinct from Bourdieu's use of the term, instead representing a particular nature/society relationship akin to a desire to exert mastery over nature/natural processes (Plumwood, 1993). In this way, these empirical findings complement and extend Nall's (2012) analysis of mainstream US birth practices as representing a form of mastery over woman and birth (3.5.1) and evoke Robbie Davis-Floyd's (1992) work on the technological imperative.

9.3 The concept of the childbearing career: a useful analytical perspective?

Central to this thesis has been the development of the temporal concept of the childbearing career, operationalised in this study as a key analytical perspective. This concept is intended to reflect the notion that women's individual birth experiences are not isolated events, but are a part of a sequence of birth experiences which together form an over-arching object which may be examined in order to resolve certain puzzles and answer certain questions, with the aim of developing an improved understanding of women's birth experiences and the improved functioning of the services that are intended to support them. In particular, this study set out to investigate women's experiential learning about birth over the childbearing career.

In taking this analytical perspective, I consider the childbearing career to be an existing material structure in women's lives, albeit one that is largely ignored in health policy, practice and scholarship. I acknowledge that the concept may feel awkward for some readers, for some perhaps reinforcing concerns about the objectification of women with the way in which such a concept might work to create a false separation between this and other parts of women's lives: these are concerns which demand attention. My main concern here, however, is to consider to what extent it is a productive concept for the purposes of this inquiry. How successfully has it enabled new ways of thinking about birthing women as skilful and knowledgeable agents? By identifying and seeking to operationalise the concept of the childbearing career, I believe that I have been able to introduce an important discussion about how women's birth-related knowledge and skill develop over time in diverse ways. That is not to dismiss how birthing women demonstrate themselves to be skilful and knowledgeable agents in each individual birth experience, but to acknowledge the cumulative effect of that skill and knowledge as it builds up over successive childbirth experiences (or, indeed, as it might manifest in women's decisions to avoid childbirth after a first or subsequent birth). In that context, I would suggest that a woman's childbearing career provides a highly productive analytical perspective. The key analytical work of this thesis has been enabled by this temporal concept in a way which would have been impossible if restricted to separate analyses of single birth experiences.

9.4 Enabling a conceptualisation of women as skilful and knowledgeable agents: the contribution of Bourdieu's theory of practice

Some of the insights developed over the course of this inquiry have been surprising. I had expected my analysis to demonstrate how some women were more competent

than others at developing the requisite skills and knowledge to birth physiologically. By investigating and analysing this phenomenon, I envisaged that it would be possible to contribute to the design of interventions aimed at increasing rates of physiological birth. As the study progressed, however, my findings and analysis went beyond this frame of reference. Thus where I found women to be less competent at developing their knowledge and skills with respect to physiological birth, I came to appreciate that it is not the case that this is because such women are in any way 'less competent' more generally: it is simply that they are, and have come to be, invested differently in the social practice of birth over their childbearing careers. Their competency, or mastery, takes a different form.

Thus an important finding of this study is that whilst each woman is focussed on ensuring for herself a satisfactory birth experience, there is a diversity of ways in which this focus can be, and is, legitimately put to work. That this will sometimes, or perhaps often, as in the current study, work against the achievement of physiological birth might suggest that these findings represent a threat to a project aimed at increasing the rates of physiological birth. This, though, is a rather separate issue, and I would rather prefer to see the current study as a constructive contribution to a developing understanding of the immensity of the challenge faced by such a project.

I believe that this finding would have been far more difficult to identify, and accept as significant, if a Bourdieusian frame of analysis (including the scholarship of Frank, Hage and Wacquant) had not been adopted, that is, one in which a conceptualisation of birthing women as skilful and knowledgeable agents, and in which the notion that individuals might invest differently in different areas of life, is assumed. This analytical framework allowed for the recognition of diverse examples of skill and knowledge on the part of birthing women, rather than forcing a narrow conceptualisation of skill and knowledge onto the rich empirical data set.

In this way, this inquiry has been able to recognise a diversity of skill and knowledge, rather than excluding from the analysis all women who did not exhibit a growing competency in physiological birth. This inclusive approach has contributed productively to and formed the basis of the key findings of this thesis. I therefore suggest that Bourdieu's theory of practice has been key to my creation of a novel perspective on women's birth-related competency, focusing on the skills and knowledge developed as a result of their encounters in the field of birth: one which allows for the creativity and ingenuity of every woman, in seeking to meet her personal birthing goals, to be recognised. In doing so, I have identified other elements of a Bourdieusian approach which offer exciting opportunities for further birth-related scholarship, for example the further mobilization of the metaphor of the game (and how individuals might change the

game) and some more explicit work around the violatory effects of the doxa and social practice. At a more basic level, I have identified a gap in the resources available to scholars interested in building a Bourdieusian theoretical approach into their work.

9.5 Reflections on study methodology

9.5.1 Retrospective nature of the research design

In this study, I used a retrospective research design to investigate women's shifting dispositions towards, illusios of and investments in birth, and the physiological process of birth, over their childbearing careers (the habitus of the birthing woman), and how these both structured, and were structured by, women's birth experiences. As discussed earlier (4.2.1), an alternative to the retrospective design chosen in this study would be the use of a qualitative longitudinal design.

The key practical benefit of the chosen design was that I was able to identify and access a group of women meeting the study criteria over a period of a few months, at, or towards the end of, their childbearing careers, and obtain, usually in a single interview contact, all of the primary data required for the study. An important limitation of this approach is that it relies on participants being able to provide rich accounts of the phenomenon under investigation located many years prior to the interview encounter. Whilst most women participating in the study demonstrated very high levels of recall, this was not universal, with some women giving very brief accounts relating to their earliest childbirth experiences, and thus it seems that some data were lost as a result of this retrospective approach.

Separately, a retrospective approach encourages participants to offer reconstructed accounts of how they might have been positioned at a previous point in time. This represents a challenge to a study which seeks accounts that offer insights into how women felt at that earlier point in time, without the benefit of hindsight, as well as reflective retrospective accounts. In this study, an interview format was designed in which there would be plenty of opportunity for women to discuss and reflect on the accounts they gave. This approach seemed to work well, with some women returning to earlier parts of their accounts at a later stage in the interview, reflecting on these and offering different interpretations. In this way, I consider that participants did much themselves to strengthen the quality of the study, realising the importance of this data to the study.

9.5.2 Single-site research design

The findings of this study are based on data gathered from a single study site, and, as such, questions arise about the representativeness and potential generalisability of the

study findings. In line with much qualitative research design, it is not integral to this study that a representative study site or (a representative group of participants) should be selected. However, it would be of concern if the choice of site limited the opportunity for theoretical conclusions reaching beyond the particular study location or body of participant experience.

Over the course of the interviews, I identified as a cause for concern the extent to which many participants offered data related to the phenomenon of 'trouble in the field of birth' (Chapter 6), since this is not something widely reported in existing scholarship. Was there something particular to the delivery of maternity services locally that could explain this finding? To better understand this issue, I have participated in multiple birth-related events, both to listen and to share my emerging findings with researchers and practitioners, and from this engagement I have concluded, with some disappointment, that the local study site is probably not highly unusual in terms of this phenomenon.

It is possible, however, that this finding has been accentuated in this particular study because the study has been carried out by a researcher who is neither a healthcare worker nor an academic working in a health-related area of the academy. As such, it is possible that participants have been more forthcoming about their perceptions of negative behaviours of healthcare staff, and of midwives in particular, than they would have been in a differently resourced study. For some women, reflecting the halo effect (Forssén, 2012; p1536), it might also be the case that women were more able to present complex narratives, including such negative aspects of their experiences, due to the temporal design of the study, which allowed for a lengthy time-period between experience and interview.

9.5.3 The midwife as an absent participant

After I had concluded the interview phase of this study, I attended one of an ongoing series of international midwifery conferences. For the practising midwives present, it seemed to offer an important, nurturing and challenging retreat-like space, offering confirmation of what it is to support a birthing woman to give birth physiologically, offering the opportunity for participants to [re]learn and practice skills to help them in this work, and encouraging and inspiring participants to stand firm in their vocation as a midwife, in the midst of a sometimes hostile practice environment.

For me, in my primary role of observer, this conference was a little less comfortable, as I reflected on the birth experiences of my study participants. One particular issue contributed to a sense of personal unease: my surprise at the extent of the midwifery skills, knowledge and compassion shared at the conference that seemed to be far beyond that held by, or at least recognised by study participants as being held by,

many of the midwives depicted in the study narratives. Indeed it was clear that such skills, knowledge and compassion might have given effect to quite different birth experiences for many participants in my study. Second, I was struck by the intense appreciation of session leaders of the risks that can present in birth, to the extent that they seemed to offer a vision of midwifery practice that was far more risk-averse than I had previously imagined. In doing so, they modelled ways of practicing that valorised the need for close respectful partnerships with other birth professionals, in order that needs of women that were beyond the skills and knowledge of the midwife would be met in a safe and timely manner. That this was integrated into also modelling the action they took to protect the physiological birth process offered a vision of a skilful balancing act indeed. Especially in the context of the Kirkup Report which drew attention to potentially problematic aspects of 'an ideology of normal birth' within a midwifery team in the North of England (Kirkup, 2016), I retain this highly reassuring model of professional midwifery that does not play fast and loose in matters of safety.

In much of the current study, however, the role of the midwife is muted, and it is perhaps a matter of regret that midwifery cannot be portrayed in a better light. I am also mindful of women's narratives in which other workers - including porters, anaesthetists, GPs and obstetricians - have been represented as an important alternative source of care and compassion, in a way which for me provokes questions about the role of the midwife. But if I have refused to silence a story which raises questions about how midwifery seems to work in the context of these particular study narratives, it is not out of disrespect, but because it is an important part of the story. Indeed working with a study design that does not foreground exemplary midwifery practice has been useful, in the way that it allows for a focus on the skill, knowledge and agency of the birthing woman. In doing so, this study, at the same time as pointing to the challenges involved in combining lay and practitioner skill, knowledge and agency, also starts to suggest the potential rewards of doing so, perhaps conceptualised as a relational model of midwifery care. In this way, I suggest a resolution to the puzzle of the relevance of this study, in the context of few women's childbearing careers in the UK extending beyond two births. Conceptualising midwives, as part of a wider social network and inter alia, as an important transmission mechanism for women's knowledge about birth, is perhaps the next step in this project, in a way that is more inclusive of practitioner voices.

9.6 Future scholarship and action: recommendations

9.6.1 Building a more sustained engagement between geographical scholarship and the social practice of birth

As discussed in Chapter 2, the discipline of geography has been a latecomer to the scholarship of birth, with little ongoing engagement, for example, with the widespread research efforts within and beyond the academy to understand the issues associated, for example, with the twentieth-century shift of birth in much of the global North to the hospital, and with the large-scale industrialised models of maternity care developed in this context. As such, geographers have access to a sparse evidence base within the discipline with which to enter the academic conversation about a range of injustices and inequalities identified in the production and consumption of the practice of birth. This is disappointing, because it is clear that the discipline of geography has the potential to contribute well to this area of scholarship, not least to challenge the mistaken view that to have an interest in, and respect for, the material reality of the physiological process of birth is to somehow self-identify as an unreconstructed essentialist. Geographers are well placed to ask questions about how individuals and society deal with this particular embodied intersection between the human and the natural.

Whilst some ground has since been made up, with a number of interesting contributions to the scholarship of birth by human geographers (and with more in the pipeline), it also seems to be the case that geographers interested in issues of human reproduction and the female body have a tendency to be drawn irresistibly to an exploration of the exotic, rather than paying attention to the mundane, in terms of where they choose to focus research efforts. As such, this study provides an important contribution to the sparse geographical scholarship about routine practices of birth that take place in ordinary institutionalized spaces of birth as they are temporarily inhabited by ordinary birthing women. There is space for much more.

More specifically, geographers are particularly well-placed to develop and problematise categorisations of different spaces of birth, contributing to work on inequitable access to different types of birth facilities and the material effects of this, building on the growing empirical and theoretical work of birth scholars across and beyond the academy. Geographers might also wish to contribute to investigations into the spatial patterning of different types of birth, and of birth-related treatments received by labouring and birthing women, addressing ongoing deficiencies in national birth datasets and data presentations (5.2).

Geographers are also well-positioned to play a key role in problematizing questions about what constitutes progress in childbirth practice, including by asserting the importance of recognising, rather than seeking to deny, the power and functionality of the physiological process of birth. In much childbirth scholarship, there has been an assumption that there is an inexorable shift towards a dominant Western biomedical model of birth, in which expert obstetric knowledge, institution-based birth and the use of high-technology is privileged, working to marginalise alternative models that draw on different types of knowledge concerned to protect the physiological birth process. This international circuit of knowledge is powerful, and is evident in the global South (Klimpel and Whitson, 2016; Melberg et al., 2016; O'Brien 2012) as well as the global North, for example in the Netherlands, which had tended to follow a different trajectory from the rest of Western Europe, but now displays signs of increasing conformity, with recent significant increases in rates of institutionalized birth (Christiaens, Nieuwenhuijze and de Vries, 2013). A partial response to Klimpel and Whitson's (2016) recognition of these global knowledge networks would be to examine how these networks continue to be populated by certain ideas and not others. Geographers might also usefully contribute further to holding open a discursive space for alternative circuits of knowledge: in doing so, geographers can play a small part in repairing the damage done by the use, and export, of defective Western biomedical technologies.

9.6.2 Policy and practice reflections/recommendations: what happens when we recognise the childbearing career?

In this thesis, a focus on the childbearing career has been instrumental in developing an understanding of a conceptualisation of birthing women as skilful and knowledgeable agents. In a similar way, a perspective based on the childbearing career could also inform policy and service development, drawing further attention to the benefits of a non-reductionist, or holistic, approach that places women, babies and families as the conceptual basis of all service provision (Davis-Floyd, 1992, p303). One of the ways this can be achieved is through social activism, and there is some exciting work ongoing in that context as part of the National Maternity Voices initiative (National Maternity Voices, 2017), giving women a platform to share their birth and childbearing career stories with practitioners and policymakers to inform specific areas of practice and policy. There is much scope for connections and mutual learning between this participant-led activity and academic research approaches, including in challenging taken-for-granted ways of doing research, especially in the areas of ethics and representation.

The current UK policy agenda seeks to offer women continuity of carer over single birth experiences (NHS England, 2016). Whilst this commitment is valuable, and would

certainly seem to promise improvement over the current organisation of care as represented in this study (Dagustun, 2013), I would argue that this policy agenda risks being too limited in its approach, with the danger that a narrow focus on the technology of continuity of carer is in itself reductionist (even though this might well be one of the most effective technologies available in terms of supporting women to birth well, however that birth is eventually achieved). Whilst a full elaboration of this discussion is beyond the scope of this thesis, this study contributes to an understanding of the limitations of the current formulation of this policy, in drawing attention to its particular temporal frame.

Just as the birthing woman draws on her understandings of her previous birth experiences in successive birth experiences, anecdotal evidence suggests that a high-quality model of care is one in which the woman's chosen lead professional (who will usually be a midwife in the UK) is also familiar with the woman's previous birth experiences, ideally having provided care to her across her childbearing career (Sandall et al, 2016; Jenkins et al., 2015; Beake, Acosta and Cooke, 2013). It is possible, then, that continuity of care over a woman's childbearing career might increasingly be considered an important objective for the temporal configuration of maternity services. Even taking into account inevitable changes in the local midwifery workforce (e.g. arising from retirement, career breaks, relocations), the relatively short time-span of most women's childbearing careers suggests that there should be no insurmountable barriers to such a model of care being offered to a high proportion of women.

To develop further understanding, evidence might usefully be gathered about such care relationships and their related outcomes. Whilst such evidence might be found within the mainstream NHS system, I would also recommend seeking evidence from the UK's independent midwifery sector which is structured to offer continuity across a woman's childbearing career. The compilation of an evidence base from that sector would usefully be an early priority, given the current threat to this sector's existence (Ford, 2017). Individual doulas, social-enterprise midwifery organisations and others might also be an important source of evidence. An initial desk-based study could be organised relatively quickly, drawing on elicited written contributions based on a semi-structured questionnaire.

9.7 End-note: so what is this a case of?

Following Ragin and Becker (1992), I suggested that the nature of this case-study might not be known until towards the end of the study (4.1.2). On that basis, I position my answer to this question at the very end of this thesis, to offer my closing analysis of

what this case represents and where the over-riding analytical interest might lie. For whilst this has been an empirical study of contemporary birth experiences in the North-West of England, the case-study approach calls on the researcher to consider whether it also represents more than that.

As I sought to understand how women learn to birth over their childbearing careers, this study has highlighted the presence of two key phenomenon in the birth experiences of the women participating in this study: first, women's frequent and highly distressing encounters with various forms of trouble as they engage in the social practice of birth, and second, how the social practice of birth frequently works to constitute the physiological process of birth as unnecessary, abnormal and dangerous. Both of these phenomena might be conceptualised as linked violations, first of the birthing woman and second of the physiological birth process (although this is not the language used by study participants: rather they are more usually discussed in terms of their ordinariness). Drawing on Bourdieu's theory of practice, I have examined how women seek to cope with such violations over their childbearing careers, drawing on their skill and knowledge to do so, primarily by developing strategies to avoid further violations of themselves. Whilst such strategies demonstrate a growing mastery of the social practice of birth, a commitment to avoid a violation of the physiological birth process is frequently, and understandably, marginalised by many women. As such, I would suggest that this study offers, through an examination of the discursive and material spaces in which the social practice of birth takes place, an important example of how certain nature-society relations come to be (re)produced.

What I find particularly interesting in all this is how birthing women take part in the process of violating the physiological process of birth, given that this, at some level, is also to violate the integrity and power of their own birthing body. Only by somehow managing to distance ourselves from the reality of our embodied selves does such a move seem possible. This then is perhaps the best clue to what this is a case of: drawing on Davis-Floyd's (1992) analysis, a constituent part of a technocratic project, in which humans seek to differentiate themselves from nature, underpinned by their apparently superior technological expertise. This goes some way to explain why such violations, against women, babies and the physiological birth process, are not only accepted as normal, and have also lost much of their power to shock, but are rather accepted as the price to pay for a belief in a human superiority over nature that dominates Western culture whilst violating so many/much. Through an examination of women's embodied experiential learning in the field of birth, however, I have also illustrated how some women are able to access and practice a different way of knowing birth. This represents an important counter-narrative, which links to a knowledge of an ecology of birth (ibid., p302) which I have suggested is systematically over-ridden as

the primary conceptual basis for maternity service activity (ibid., p303), and I have been pleased to take the opportunity to give this counter-narrative discursive space in this thesis.

Appendix A

Interview Schedule

Preliminaries

1. Recap purpose of interview/my role (for a research qualification; not midwife but geography student/ mum of 4)
2. Explain two-part nature of the interview/ check time available
3. Ask participant to read and sign consent form
4. Discuss sensitivity of the topic: remind participant that interview/tape can be paused or stopped at any time
5. Turn on voice recorder, and together complete pre-interview warm-up (inc choice of pseudonym and demographic information)

Part One: telling birth stories (a narrative approach)

1. Encourage narrative telling of birth stories for each child, beginning with expectations/preparation for first birth
2. Conclude and move on/ check need for a break

Part Two: specific questions

1. **Birth narrative follow-up as necessary, eg:**
    - explore key points in birth trajectories that might have been open to different outcomes eg if different **choices** had been made by the participant or others (and whether the participant feels that different outcomes were possible/ that there was any scope for such choices)
    - spend some time exploring/ clarifying the inter-relationships**/**transitions between individual birth experiences if these aren't clear from the narratives; introduce the idea of the childbearing career, and **the notion that a woman might become increasingly skilled at giving birth over her lifetime**: does this resonate with the participant's own experience?
    - whatever her personal experience, elicit the participant's own stance on **the notion that a woman's body generally knows how to labour and give birth successfully**
2. **The improving birth agenda – what does this mean from a lay perspective**

- *"Thinking still of your childbirth experience(s), can you tell me if it/they might have been improved, and, if so, how and what might have made a difference?" (If nothing offered: "Are there any examples of what <u>you</u> might have done differently?")*

3. **Different perspectives on how women 'should' give birth**
    - *"One thing I'm struggling with is why there seems to be such a divide between people who think that 'natural birth is best' and 'how it should be done' and other people, on the other hand, who see no problem with opting for lots of technology to help the baby be born. Can we discuss your own perspective on that issue?"*
4. **Working with imaginaries: imagining the next stage in a childbearing career**
    - *"Finally, I'd like us to imagine that you are pregnant again. Can you tell me a little about your hopes or plans for the labour and birth/ how your previous birth experiences might help you during this future labour and birth? And between now and the birth, is there anything you would like to do or to learn more about to ensure you have the best possible birth experience and outcome?"*
5. **Conclude** by noting that I have finished my questions, and asking if there is anything that the participant would like to add/ any other observations she would like to make on any of the issues that we have been discussing.
6. Thank participant.
7. Turn off tape

Appendix B

Participant Consent Form

Research project: 'Her knowledge counts too': the place of women's experiential knowledge in childbirth experiences and outcomes

Researcher: Jo Dagustun, School of Geography, University of Leeds

1 I confirm that I have read and understand the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.

2 I understand that my participation is voluntary and that I am free to withdraw from the study any time up until three months have elapsed from the date of our final interview without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular questions, I am free to decline.

3 I understand that my personal information will be kept confidential, although some of responses, in an anonymised form, are likely to feature in reports, publications or presentations that result from the work. I understand that my name will not be linked with the research materials, and I will not be identified in the reports, publications or presentations that result from the research.

4 I agree to audio recordings being made of interviews in which I take part and I understand that these will be used for transcription and analysis purposes only.

5 I agree to take part in the above research project and will inform the researcher should my contact details change.

Name of participant	Date	Signature
Researcher	Date	Signature

To be signed and dated in presence of the participant

Appendix C

Participant Information Sheet

'Her knowledge counts too': the place of women's experiential knowledge in childbirth experiences and outcomes

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this

What is the project's purpose?

Women's personal knowledge about childbirth - including how we develop this knowledge during childbirth experiences and how we might seek to use it in subsequent birth experiences - has not been paid much attention by researchers to date, and I believe that some additional research on this topic would be helpful to ongoing initiatives aiming to improve childbirth outcomes and experiences. I am carrying out this research as a PhD student to gain a qualification.

Why have I been chosen?

I would like to interview local women who are willing to talk to me about their childbirth experiences, what they feel they have learnt from those experiences and how they might have been able to put this knowledge into practice. I am looking for around 20 to 30 participants in total.

Do I have to take part?

Not at all. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form and you will be given a copy of that document - as well as this one - to keep. You are free to withdraw from the project at any time, up until three months have elapsed from the date of our final interview, without giving a reason.

What do I have to do if I take part?

You will be invited to take part in a one-to-one interview, probably lasting around one to two hours. You will be able to choose when and where the interview takes place. Normally one interview will suffice, but if we agree that it would be better to take a

break and resume on another day then that would be fine with me. If you need to arrange childcare for the duration of the interview then I have a small budget available to reimburse reasonable childcare expenses.

During the interview I will be inviting you to tell me your childbirth stories as well as to respond in depth to a range of open and closed questions related to those childbirth experiences and to the topic of childbirth knowledge more generally.

Will I be recorded, and how will the recorded media be used?

Audio recordings of the interviews will be made and these will be used only for transcription and analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?

Talking about personal childbirth experiences can be difficult and emotional, and sometimes even traumatic, so you will need to be sure that you feel comfortable about participating in interviews where we will discuss such issues. The interview will also take up some of your time, but I would hope to minimize the inconvenience this will cause by arranging it at a time and place to suit you.

What are the possible benefits of taking part?

Whilst there are likely to be no immediate benefits for participants, it is hoped that this work will contribute to the future improvement of childbirth outcomes and experiences. However, my experience suggests that some women benefit from and enjoy taking part in such research, as it gives them a chance to reflect on the issues raised.

What happens if the research study stops earlier than expected?

If the project is stopped before completion for any reason, I will inform you and confirm that all personal data related to your participation has been destroyed.

Will my taking part in this project be kept confidential?

The personal information that I collect about you during the course of the research will be kept strictly confidential. The words you use in an interview, however, will not be confidential: this is because I aim to use a selection of these - in the form of anonymised quotes - as data to illustrate my findings and substantiate my analysis in reports, publications and presentations relating to the research. The fact that you have personally taken part in the research will not be recorded in any reports, publications or

presentations, and I will also seek to ensure that you are not identifiable from the anonymised quotes (for example, by using pseudonyms and removing identifying data). You should be aware, however, that these materials may be read by a wide range of people, including fellow participants, some of whom might be well-placed to identify you from such quotes. Because of this, you might wish to keep confidential - as I will - the fact that you have taken part in this research.

What will happen to the results of the research project?

The results will primarily be used in my PhD thesis. When it is completed I will provide you with a summary, and also let you know how to access a full copy (for free). In addition, I would hope to present my findings at conferences and to publish the results of the research. You will not be identified in any report or publication.

Who is organising and funding the research?

I am organizing the research myself, as part of my studies at the University of Leeds, and I am funded in my studies by the Economic and Social Research Council.

Contacts for further information (REDACTED)

[Main contact (researcher); secondary contact (research supervisor)]

Thank you for thinking about participating in this project.

Appendix D
Participant Pen Portraits

Alice, 34, works part-time in the NHS. She lives with husband and their two children. Alice describes her first birth experience as extremely traumatic, eventually leading to a chaotic emergency c-section. By contrast, she describes her second birth, an elective c-section at her request, as straightforward and stress-free. For a future birth, Alice would definitely envisage a further elective c-section.

Amy, 33, lives with her husband and two children. Currently on maternity leave, Amy usually works in education. Given a long-term health condition, Amy was advised by her medical team to give birth by c-section. Amy's first experience of a planned c-section was highly traumatic, but she experienced a second c-section - in which she felt that far more attention was paid to her individual needs - as much better.

Barbara, 46, is a healthcare professional, living with her husband and three children. Each of Barbara's childbirth experiences included a spontaneous start to labour, leading to a vaginal delivery without instruments. For her first birth, Barbara chose to labour with the support of an epidural. Barbara was keen on an epidural for her second birth too, but there was no time for it. This experience led Barbara to question the need for such interventions, enabling her to give birth to third baby at home.

Becky, 38, works part-time in the social sector and lives with her husband and two children. Becky's childbirth experiences include an experience of stillbirth and two further births, one of which was an elective c-section. Becky explains how her birth experiences have been hugely affected by the unexplained stillbirth of her first baby.

Cat, 37, is a part-time freelance worker, and lives with her husband and two children. Cat had practised yoga and meditation for many years before she became pregnant, and she thinks this helped her during pregnancy and childbirth. After a straightforward first birth, Cat had access to a birthing pool for her second birth; whilst finding this rather unfamiliar and even scary at times, she felt she well supported by the attending midwives, who were very encouraging and supported her to birth her baby in water.

Claire, 36, is a stay-at-home mum, and lives with husband and their four children. Claire worked as a secretary before having children. Claire's first experience of childbirth was straightforward but rather spoiled by what she describes as poor care in the local hospital. During her second experience, Claire worked out that she would have been better off staying at home. She gave birth to her third and fourth babies at home.

Gillian, 31, works in the social housing sector. She lives with her husband and their two children. Gillian describes her first childbirth experience as traumatic, ending with a forceps-assisted birth. By contrast, she describes her second birth experience as much better, and she was pleased to be able to push the baby out herself. If she had another baby, Gillian says that she would look forward to even less medical intervention next time.

Heidi, 39, lives with her husband and three children. She has no plans for any more children. Heidi describes each of her childbirth experiences as traumatic, and her accounts are filled with fear, terror and panic. Heidi did very little in the way of planning for birth, describing herself as being in denial about the process. Whilst Heidi birthed all three babies vaginally and with very little assistance, she displays little confidence in her body's ability to birth, and a brief discussion about hopes and expectations if she became pregnant again evoked a unusually high level of emotion, focussed on her likely worry and fear that something might go wrong.

Jane, 31, works in the beauty sector (as the main wage earner in the household), and lives with her partner and her three children. Jane and her current partner have had one baby together; the two older children are from previous relationships. Jane describes her three childbirth experiences (all spontaneous onset, unassisted vaginal deliveries) as 'all pretty normal', and she suggests that they have also seemed to get easier and easier. Thus she would expect any further childbirth experience (not anticipated) 'to be even easier', and would also expect it to be quick.

Jenny, 47, is a trained healthcare worker currently running her own small-business from home. She lives with her husband and three children. Jenny found the labour and birth of her first baby, during which she transferred from a free-standing birth centre to hospital, extremely traumatic, and began her second pregnancy requesting an elective c-section. She reflected further on this during the pregnancy, however, and gave birth to her second son vaginally, in what was again a difficult experience. Jenny's third baby was born by elective c-section, due to the baby's transverse lie: this birth was experienced by Jenny as pleasant and straightforward.

Julie, 44, is a healthcare professional and lives with her husband and three children. Julie describes how she feared giving birth, and managed to avoid labour and vaginal delivery for her first child, with a caesarean section as her baby was breech. Julie agreed to an induction of labour for her second baby, which progressed to a vaginal delivery (without a requested epidural) which she describes as a good experience. For

her third baby, Julie gave birth with no pain relief after a requested epidural failed. Julie is keen to tell friends that giving birth 'was nowhere as bad as [she] was expecting'.

Liz, 43, currently works part-time as a freelance consultant. She lives with her husband and their two children. For both births, inductions were proposed and scheduled by the hospital team, but in both cases induction was avoided due to the spontaneous onset of labour. Both of Liz's babies were born vaginally; an episiotomy was performed before the birth of her first baby.

Lola, 34, lives with her husband and two children. Lola works part-time as a healthcare professional. Before her first birth, Lola was keen to ensure timely access to pharmacological pain relief in labour, but she changes her mind on this over her childbearing career. Lola also comes to appreciate how her time in labour was, at least in part, made more difficult due to the lack of attention she had paid to her posture in late pregnancy, suggesting that 'back labour' is the price women pay for lounging around on sofas.

Lucy, 32, lives with her husband and two children. Lucy has a teaching qualification and works freelance. Lucy describes a highly traumatic first birth experience and how she suffered from postnatal depression. For her second birth, Lucy unofficially recruited a neighbour, a retired midwife, to support her in early labour, and Lucy this time achieved a far more positive birth experience. Lucy is the only study participant who had been involved in birth activism, spurred on by contacts with a local activist group during her experience of post-natal depression.

Mandie, 39, lives with her husband and their three children. Mandie is currently on maternity leave from her job as an administrator. Mandie was born with a physical disability, and she was aware well in advance that she would have to give birth by c-section. Mandie's disability had involved her spending a great deal of time in hospital when she was a child and young adult, and Mandie used her knowledge of the healthcare system and hospital routines to her advantage during her births, describing successively more positive birth experiences. Mandie is not intending to have any more children.

Mary, 31, lives with her husband and two children. Mary is currently self-employed, running a small business from home. Mary describes her first birth as traumatic, beginning with her labour being first induced, then augmented, ending with problems related to the delivery of the placenta. Mary was highly anxious about her second birth, but describes the experience as better. The birth was overshadowed, however, when

her baby had to be re-admitted to hospital shortly after birth and a bout of post-natal depression.

Melissa, 32, lives with her partner and their 2 children. Currently on maternity leave, Melissa usually works full-time in the retail sector. Melissa's birth experiences were not as undisturbed as she had hoped (both, for example, commenced with a pharmacological induction), but rather than the medical interference in her births, Melissa was particularly surprised by the poor quality of care she feels she received, in terms of how she was treated by staff.

Naomi, 37, lives with her husband and their two children. Naomi is currently on maternity leave from her marketing job. Naomi experienced high blood pressure towards the end of her first pregnancy, and her labour was induced. After initial induction attempts proved unsuccessful, efforts were stepped up to progress Naomi's labour (too fast in Naomi's view) and Naomi ended up giving birth by emergency c-section. For her second birth, Naomi was planning a vaginal birth. When her pregnancy was overshadowed by an unexpected family death, however, and Naomi's blood pressure again became an issue, she agreed to a planned c-section, which she described as a far better experience.

Pamela, 41, is a stay-at-home mum, and lives with her husband Seth and their three children. The family is currently claiming out-of-work benefits, following Seth's redundancy a few years ago. Pamela describes the key feature of all her birth experiences as the use of a hospital birth pool, in which two of her babies were born. Pamela has positive recollections of her childbirth experiences, despite experiencing difficulties in each one.

Ruth, 31, lives with husband and their two children. Ruth has returned to study part-time since the birth of her children and also runs a home-based business. Ruth's first experience of childbirth was an elective caesarean, as her baby was in the breech position. For her second birth, and after much deliberation, Ruth decided to try for a vaginal birth (a VBAC) and went into spontaneous labour at 42 weeks, but that birth was also concluded by c-section. Ruth is firm that she would plan on an elective c-section for any future birth.

Sally, 39, lives with her husband, Andy, and their three children. Sally describes each of her childbirth experiences as very different, but she describes them all as natural births, albeit with the intervention of an epidural for the first birth (following augmentation). Sally describes nearly having to have an emergency caesarean with her first baby, a much better second birth experience (a far shorter labour, with much

less intervention), and a third labour and birth that was a much more positive experience.

Sarah, 40, lives with her husband with their two children. Sarah works part-time in the financial services sector. Sarah discusses how she was especially pleased to become pregnant physiologically following an earlier unsuccessful attempt at fertility treatment. Sarah initially suggests that there is little to talk about regarding her births. As her stories unfold, however, it is clear that Sarah was exposed to some innovative teaching in pregnancy, and this seems to have served her well during her straightforward vaginal births.

Serena, 48 lives with her husband and child. Serena also has two further children from a previous marriage. There is a big age gap between Serena's children, and Serena expresses surprise that the standard of care offered by the maternity service over the years has not seemed to improve, describing her final experience as the worst.

Skye, 37, lives with her husband and two children. Currently on maternity leave, Skye is a health professional and usually works in the education sector. Skye found her first birth experience extremely traumatic, afterwards suffering from post-natal traumatic stress syndrome. Skye's second birth was by planned c-section. Due to the trauma of her first birth, Skye does not contemplating giving birth again.

Sparkle, 29, is a stay-at-home mum who left school without qualifications, and lives with her two children. Sparkle describes her first childbirth experience (a spontaneous onset/ vaginal birth) as brilliant. She describes her second experience, by contrast, as much less positive, ending up with an emergency c-section. Sparkle maintains a relationship with her children's father, who lives nearby, and they are keen to have a third child: she hopes for another birth like the first and is quite optimistic about this. But she fears that she might be made to have another c-section.

Suzanne, 40, lives with her husband and her three youngest children. Suzanne works full-time in the education sector. Suzanne describes her first birth experience as poor, with little respect shown to either her or her body. Suzanne's subsequent childbearing experiences have been varied, testing her commitment to physiological birth, but Suzanne demonstrates a high level of awareness of her own abilities, and developing skill and knowledge, regarding birth.

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